The promotion and the protection of physical and, recently, mental health is a globally recognized priority. This is not true though with regard for their interrelationship which has received little attention from both medical branches. It is well known that physical health problems or disabilities are accompanied by or combined with mental health symptoms or disorders and vice versa. The advantages of a holistic, individualized approach, which covers not only the subjective complaints of the patient but also the interaction between physical and mental health are well established based upon credible scientific data.

Key words: Mental health, physical health, holistic approach, individualized approach.

One of the most ancient and most revered axioms in Medicine, since the Age of Asclepius and Hippocrates, states that “a healthy mind resides in a healthy body”.

This axiom retains its validity nowadays more than ever, especially in the case of mental illness. The impact of mental disorders on the overall burden of disease was likely to be underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions, due to various economic, social and scientific factors. Therefore the trend has been to neglect or at least marginalise the fact that poor physical health linked particularly with chronic or terminal conditions can make patients susceptible to poor mental health. Persons with an enduring mental illness are at much greater risk of developing certain physical health problems, most notably cardiovascular disease and diabetes and consequently of increasing the already substantial economic cost of the health care treatment, with a direct negative impact on national economies.1

This is, for instance, the case of most low and middle-income countries where mental health remains a low priority and of developing countries which tend to prioritise the control and eradication of infectious
diseases. This also applies in developed countries which prioritise non-communicable diseases that cause early death (such as cancer and heart diseases) above those that cause years lived-with-disability (such as mental disorders). Consequently, although the importance of promoting and protecting both physical and mental health is well recognised, the complex interaction between the two has received comparatively little attention until recently. Of course the impact of poor mental health on physical health has been documented for many decades: yet this has only emerged as a major issue in the last ten years, as evidence on this relationship grows rapidly and the results of relevant studies have shown that unless the issue is duly taken into consideration, its social and economic impact shall seriously damage (personal, familial, national, European and global) economy at all levels. For instance, the fact remains that in the WHO European region, mental and neurological problems account for 22% and 17% of the total burden of disease respectively, second only to cardiovascular disease. Also about 14% of the global burden of disease is attributed to neuropsychiatric disorders which increase the risk for communicable or non-communicable diseases, while conversely many health conditions increase the risk for mental disorders.

These facts have led the WHO European Ministerial Conference Mental Health Plan for Europe of 2005, in Copenhagen, to the conclusion that there can be "no health without mental health", which in essence is nothing more than just a variant verbal formulation of the above ancient Greek medical axiom.

The substance of this slogan, also endorsed, among others, by the EU Council of Ministers and the World Federation of Mental Health, is that mental disorders make an important contribution to the burden of disease worldwide as shown by the WHO Global Burden of Disease Report. This has revealed the degree of contribution of mental disorders by use of an integrated measure of disease burden, named the disability-adjusted life year, (i.e. the sum of years lived with disability and years of life lost). It should be added that of all the non-communicable diseases, neuropsychiatric conditions contribute the most to the overall burden, more than cardiovascular diseases or cancer.

In this context, neuropsychiatric conditions account for up to 25% of all disability-adjusted life-years and up to 33% of those attributed to non-communicable diseases, varying on the income level between countries. Mental disorders are the neuropsychiatric conditions that contribute the most disability-adjusted life-years, especially unipolar and bipolar affective disorders, substance and alcohol-use disorders, schizophrenia and dementia. Neurological disorders such as migraine, epilepsy, Parkinson’s disease and multiple sclerosis make a smaller but still significant contribution. More specifically, according to the 2005 WHO’s report, 31.7% of all years lived-with-disability are attributed to mental disorders with the unipolar depression occupying the first place among five major contributors (11.8%) followed by alcohol-use disorders, schizophrenia, bipolar depression and dementia. Conversely, the proportion of cases of disability that would not have occurred in the absence of mental disorders could be as high as 0.69%, which suggests that failing health and consequent disability could be the most important contributory cause for late-life depression.

As far as mortality is concerned, the same WHO estimates refer to neuropsychiatric disorders accounting for 1.2 million deaths every year and 1.4% of all years-of-life lost, most of these caused by dementia, Parkinson’s disease and epilepsy; only 40,000 deaths were attributed to depression, schizophrenia and post-traumatic stress disorder and 182,000 to use of drugs and alcohol. It should be noted that these numbers are almost certainly underestimated since the report attributes the yearly 800,000 deaths by suicide to intentional injury. However a systematic review of relevant studies identified mental disorders as important proximal risk factors for suicide with a rate of 91% in suicide completers and of 47–74% in a population-attributable fraction.

Schizophrenia is generally acknowledged as a life shortening illness with patients dying on average ten years earlier than the general population (one third due to suicide and increased risk of accidents and two thirds due to poor physical health). Individuals with depression have a 24% increased risk of dying in the next six years compared with the general population.
In parallel, evidence consistently indicates that the mortality rate or many physical illnesses, most notably cardiovascular disease and diabetes (with the exception of most cancers), are significantly higher for people living with enduring mental problems than rates found in the general population, regardless of the type of the mental problem (it was found in England, for example, that the risk of coronary heart disease related mortality was 188% greater than the general population for those aged between 18 and 49 and 76% for those between 50 and 75).6

Similar estimates were reached for risk of death from stroke with more than 139% for those aged under 50 and 83% for those over 50.

Beyond the particular issue of mortality and early death, mental health carries an equally strong association with non-communicable diseases such as cardiovascular risk exposures. It was found in that sense that psychoses of people living in London were associated with a 80% increase in the ten year risk of cardiovascular disease and that people with clinically severe depression were at greater risk by 150% of having stroke and heart attack, while those suffering from mild depression were at greater risk by 39%.

Conversely, poor physical health can be a cause of mental health problems. One US based study reported that cardiovascular disease was a significant trigger for depression and anxiety in people over 45 compared to the same age group of the general population (15% versus 7.1%). The same with stroke, chronic obstructive pulmonary disease, cancer, diabetes and arthritis.

Mental disorders also affect other health conditions such as obesity, smoking and medical conditions. One US study reported that 50% of women and 41% of men receiving psychiatric care were obese compared with 27% and 20% of the general population respectively. Further people with mental problems are twice as likely to be smokers. In the case of medical conditions, such as hypertension, arthritis, peptic ulcer and diabetes, the rate is almost three times greater than that of the general population and the evidence for comorbidity between mental disorder and the disease is much stronger. The prevalence of diabetes in people with schizophrenia being consistently shown to be about 15% compared with a typical community prevalence of 2–3%.7

Finally mental disorders also interact with some particular health conditions such as the medically unexplained somatic symptoms and syndromes which are strongly associated with common mental disorders. It should be noted that at least a third of those with somatisation have no comorbid mental disorder.

With regard to communicable diseases—mainly AIDS—which continue to cause substantial death and disability in low and middle-income countries, some indirect evidence shows that people with mental disorder are at heightened risk of contracting HIV/AIDS and that for patients with schizophrenia, mental illness generally precedes HIV infection. Moreover, apart from the psychological trauma the infection itself has direct effects on the central nervous system, and causes neuropsychiatric complications, depression, mania, cognitive disorder and frank dementia, often in combination.

Generally speaking, the interactions between mental disorders and other health conditions are widespread and complex. Mental disorders are risk factors for the development of non-communicable and communicable diseases, and contribute to accidental and non-accidental injuries. For some infectious diseases, mental disorders in infected persons increase the risk for transmission. Many health conditions increase the risk for mental disorder, or lengthen episodes of mental illness. The resulting comorbidity complicates help-seeking, diagnosis, quality of care provided, treatment, and adherence, and affects the outcomes of treatment for physical conditions, including disease-related mortality.8 For many health conditions, mental illness makes an independent contribution to disability and quality of life.

In a nutshell, mental disorders affect the rate of other health conditions, some health conditions affect the risk of mental disorders either by affecting directly the brain though infection, diabetes etc, or by creating a heavy psychological burden and, finally, some comorbid mental disorders affect treatment and outcome for other health conditions though delaying help seeking and reducing the likelihood of detection and diagnosis. Thus, it is evident that there are inextricable links between good physical and mental health. People living with a range of mental
Ψυχική και Σωματική Υγεία – Ολιστική προσέγγιση

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Η διεθνής κοινότητα έχει αναγνωρίσει ως προτεραιότητα την προαγωγή και προάσπιση της σωματικής υγείας και πρόσφατα παρόμοιας αναγνώριση έτυχε και η ψυχική υγεία. Δεν συμβαίνει όμως το ίδιο και για την αλληλεπίδραση μεταξύ τους, η οποία δυστυχώς τυγχάνει μικρής προσοχής και από τους δύο επιστημονικούς κλάδους. Είναι πολύ καλά γνωστό ότι η σωματική αρρώστια ή αναπηρία συνοδεύεται ή συνυπάρχει με ψυχιατρικά συμπτώματα ή διαταραχές και το αντίθετο. Τα πλεονεκτήματα μιας ολιστικής, εξατομικευμένης προσέγγισης, που καλούμε να ισχυριστούν ως υποκειμενικά ενοχλημένα και βασίζονται σε αξιόπιστα επιστημονικά δεδομένα.

Από την άποψη των συνεπειών της ολιστικής προσέγγισης, η αποδοτικά έχει δείξει ότι η προετοιμασία των πολιτών υποτίθεται η χρήση φαρμάκων σε σχέση με την υγεία τους. Συγκεκριμένα, οι γενικές και ειδικές καταστάσεις υγείας που είναι πληροφορημένα στην υγεία των ανθρώπων, δεν θα υποκείντονται σε ειδικές καταστάσεις υγείας, αλλά θα είναι σε ισχυρισμό που να θεωρείται ως ισχυρή η συνεπεία της ολιστικής προσέγγισης. Από πλευράς της υγείας των ανθρώπων, οι εποικοδομίες της ολιστικής προσέγγισης είναι ισχυρές και ανάγκης μεταβλητές σε πολυμερείς καταστάσεις υγείας.

Λέξεις ευρετηρίου: Ψυχική υγεία, σωματική υγεία, ολιστική προσέγγιση, εξατομικευμένη προσέγγιση.
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