CONVERSATIONAL NOTIONS OF HEALTH, MENTAL HEALTH AND WELL BEING

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ABSTRACT

This paper aimsto clarify whether the concepts of Health, Mental Health and Wellbeing overlap or if there should be a proper definition for each one of them. Taking advantage of previous studies with students from two Polytechnical Institutes, conversational notions were used to form a questionnaire around the three topics above. The cooccurrences in the responses of the 43 subjects indicate that the central concept is Wellbeing, and that Health differs from Mental Health because it is closer to positive and negative ways of coping.

Keywords: health; mental health; wellbeing.

RESUMEN

Nociones conversacionales de salud, salud mental y bienestar. This paper aimsto clarify whether the concepts of Health, Mental Health and Wellbeing overlap or if there should be a proper definition for each one of them. Taking advantage of previous studies with students from two Polytechnical Institutes, conversational notions were used to form a questionnaire around the three topics above. The cooccurrences in the responses of the 43 subjects indicate that the central concept is Wellbeing, and that Health differs from Mental Health because it is closer to positive and negative ways of coping.

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INTRODUCTION

The present paper aims to clarify whether the concepts of Health, Mental Health and Wellbeing overlap or if there should be a proper definition for each one of them in scientific language and in conversational notions.

Health, you don't value it until you lose it! Would you say the same about Mental Health? For Public Health a global definition is available. In 1948 World Health Organization (WHO) defined it not only as the absence of disease but "asa state of complete physical, mental and social well-being". The inclusion of "social" was a concession tothe then called Third World countries, today called developing countries. It became more explicit in the subsequent versions of the definition. In 1977a more pragmatic concept of health emerged: "the ability to conduct a socially and economically productive life" and the 1984 revision defined it as "the extent to which an individual or group is able to realize aspirations and satisfy needs and to change or cope with the environment." In 2022 the WHO defined Mental Health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community." In this progression of the definition the homeostatic biopsychological basis for the concept of health seems to have been undervalued in favor of psychosocial, environmental and economic aspects. The question is now, beyond what is mainstream, if to evaluate Mental Health we may disregard the ego and the moral and spiritual dimensions of the human being.Can there be Health without Mental Health?

Can there be Mental Health without Health? In both questions the "absence of disease" is paramount. The scientific conception of the nature of mental illness came along with the French Revolution (foundation of Psychiatry) and a consensus among scientists was only reached in the 21st century: mental diseases included in the Internationa l Classification of Diseases (ICD-11) are not different from all other diseases. They have an undeniable organismic homeostatic component. Such a component is necessary to both the general and mental health diagnosis when we ask the patient to express his subjective feeling of being or not being well. At a psychological level the development must generate a dynamic balance between instinctiveness and understanding, between learning to live in the world and being able to modify it. In short, to take control of experience and of life itself, placidly.

Mental Health cannot be merely defined in social and political terms because there is a risk of contributing to repression and totalitarianism (Arendt, H. 1973). Anthropologists, Medical Doctorsand Social Psychologists facethe object, that isa subject, atan interpersonal level. When one studies mentality one does not study mind *(mens)*. Mentality belongs to everybody while not belonging to anyone. The subjects of social, medical and educational psychology studies are analyzed under a group context (both intra and inter group). One may have a group as a reference or be a part of it; the group may either be formal or informal; face to face or conversational. The latter is the newest expression of the current digital communications reality.

It is therefore necessary to determine how strong may be the influence of current mentality on the mental health of the person we are dealing with. It is necessary to determine the groups that affect it. It is necessary to find the ways how the interaction with other people, present or not present, real or fictitious, dreamt or imagined, influences the recognition, the perception, the empathy and the attribution of whomever one pretends to influence, educate,treat or care for.

There are contrasting theories on Health, Mental Health and Wellbeing concepts. In Wellbeing Economics its own concept of health is central. A population is considered healthy if its members are active and have regular steady jobs. For instance, the number of refrigerators per capita as an indicator of wellbeing... The American management mystique was led to consider healthy those who are noton sick leave. Perhaps that's why some think Economics may solve the health issue (even for addictions...). From Economics to Management, to Law, to models and algorithms used for health statistics, health services which should have asmatrixthe doctor-patient relationship become subjugated to political and economic bureaucracy.

The classical Roman Republic idea of mental health present since Juvenal's dictum "*mens sana in corpore sano*" (sec. I) became the guideline forthose who developed public hygiene in *the polis.* The term "mental hygiene" first used in 1842 was replaced by "public health" in mid-20 century. The appeal to "social", which always stresses stability, overshadowed the Greekand Christian norm of aiming "for the better". One cannot conceive Mental Health out of this need for permanent improvement. Health is not the mere balance between opposite statistical factors but the overflow of the meaning of life.

Recent global events, particularly the confinement due to the covid-19 pandemics, turned the focus of empírica l studies to students' mental health in the Portuguese academy. The constraints that polytechnical students' lives suffered originated new daily routines and new ways of conversation. Social media intensified conversation reflected changes and brought new *conversational notions* to the small group. *Conversational notions* are proto concepts emerging and persisting in conversations (either face to face or digital) and only understood by the members of the small group when communicating with each other.

Sherry Turkle (2015) in the best-seller *Reclaiming Conversation* enphasises the primacy of "faceto face conversation first" for the digital communications overloaded 21^ century. In each and every social context, in the reinvention of conversation, it is vital to find the key words unconsciously exchanged by the participants. Both words and short phrases are *social representations* carriers of human expressivity. According to Durkheim (1898), concept words are either collective or social or individual representations. Collective concept words are those found in every dictionary. Social concept words are generated from the interpersonal relations inside the different groups of a larger community. Individual representations are idiosyncratic. The conversation is mostly an exchange of notion words which vary either according to the formation and disintegration of groups or as a result of disrupting social events.

WHO considers *determinants of health* to be the social and economic environment, the physical environment and the persons' individual characteristicsand expressive behaviors, that is the circumstances in which people are born, develop, work, live and age. This statement presided to our previous studies in which, Goncalves, R, Brito,S., Pereira, O. & Ravara,(2015), identified several proto concepts to be used in research to determine the influence of health illiteracy in risk taking behaviors and coping with stress. Then, students from two different schools of a polytechnic institute, a school of Health and a school ofTourism, were interviewed and submitted toa questionnaire on risky behavior concerning alcohol, sugar, fast food and cigarettes habits, abuses and addictions. It wasfound that Health School students had curricular education on health problems and no less risky behaviors than the ones from the Tourism School. Accordingly, we should be circumspect about health literacy programs' effectiveness.

In the above referred research habits were considered as risks. Pereira, O.,Gongalves, P. & Mendes, S. (2016), examined the role of everyday stress on the persistence of habits that potentially intensify behavioral disorders and negligence to promote one's health. It was determined that coping strategies model stress effects in keeping harmful habits. This comes across in a circular causality loop, that the subjects are not aware of. They may also respond dissonantly, making "external attributions". Coping strategiesare either of action or of thought, depending either on the adoption of specific action (behavior) or just on the mental projectionof thinking what to do, or not.

The next step was a longitudinal study focused on the three first years as students. Anthropometrical data were included for the first time. Meanwhile the covid-19 confinement required an adaptation of the study plan. Goncalves, R, Mendes, S., Brito, S. & Pereira, O., (2021), report consistent variations of weight, height and body mass index. The variations were not related according tothe school attended but to the adopted coping strategies. The confinement induced a dominant (66%) use of thought coping strategies over action related ones, predominantly the humoristic approach and the denial of the current situation (confinement). From the above came the hypothesis of this being the *causal attribution mechanism* for the negationist forms that emerged.

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METHOD

A digital questionnaire inquire of conversational expressions was set upto students of the two Polytechnical Institutes who participated in the previous studies. Conversational notions are interpersonal communication expression modalities used by diffuse groups, face to face or web connected, constituted by people who share some affinities. In these specific semantical notions emerge in relation tothe way they face reality. They are like a butterfly in its first flight. They may immediately die (the conversation is suspended) or evolve into new shared forms (in the group conversations).

The "OLÁVIDA -BOASAÚDE" (Hello Life-Good Health) questionnaire of conversational expressions is a digital interpellation to every subject accepting the distinction between health and mental health, asking them on their personal view of several aspects of their own life. The selected ones are: health, mental health, well-being, stress and coping strategies.

Health is considered as having two aspects. The first is pro active and takes into account the meaning of life and well-being as well as groups and social media participation. Therefore the question: "I feel well in my body" with three answering alternatives: "always", "not always" and "no, I'm sick". The second aspect concerns overcoming and resisting the hardships of living. Another example: "I try to face the stress of living" with three answering alternatives: "always?', "not always" and "it's best to run from it". One more example: "I can solve family conflicts" with three possible answers: "easily", "not always" and "I run away". There are also propositions touching pathological deviation: "in order to be cautious one must always be aware of other people's machinations and conspiracies (which either wish us evil or too much well)" with three alternatives: "always", "when we are attacked" and "I don't think about it". These affirmations were taken from expressions used by subjects in previous questionnaires. In total there are ten questions complemented by two propositions relatively to Health and Mental Health.

The questionary had no questions directly related to anxiety because in previous studies it was verified that such theme was answered with social desirability.

RESULTS

The analysis of the responses of 43 subjects tothe questionary started with the two last *propositions* (11 and 12) pertainingto Health and Mental Health. The frequency of the superior codification values is 56% for both. -This could mean that the second concept is included in the first one. This is reinforced by the negative expression *(pathos)* of Mental Health (questions 8 and 9), be it a paranoid dimension or an obsessive compulsive one, or even by latent anxiety (a deduction). (See also table 2)

Now we defined six variables aggregating the questions (1 to 12):
- questions 1 and 2, Pro-Health   *[health]*   H ;
- questions 3 and 10, Pro-Mental Health *[mental health +]*   MH+
- questions 8 and 9, Opposite Mental Health *[mentalhealth -]*   MH-,
- questions 5, 6 and 7, Coping   *[coping +]* C+ ;
- question 4,   Lack of Coping   *[Coping -]* C- ;
- questions 11 and 12, Wellbeing   [wellbeing] WB;

In order to calculate frequencies, we set an ordinal scale for the hypothesis of response, with maximumvalue (5 for questions 1 to 10 and3 for questions 11 and 12) and a minimal value (1 for all 12 questions). (The subjects had no knowledge of these scales)

The frequencies of the combined variables with maximum positive value are in table 1 and the ones with minimal values are in table 2. Table 3 shows the co-occurrences between combined variables.

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Table 1 -Frequencies of combined variables, maximum values (n=43)

-Maximum positive value for positive questions

Wellbeing (Q lie 12) - 56%

Mental Health + (Q3 e 10) - 35%

Health (Q 1 e 2) - 30%

Coping + (Q5, 6 e 7) - 30%

-Maximum negative value for negative questions

Mental Health -(Q8e 9) - 23%

* [Q 8 paranoid deviation -35%

[Q9 obssessive compulsive deviation -46%

Coping - (Q4) - 7%

As table 1 shows, the variable Wellbeing has maximum values in more than half of the subjects, meaning it is the main ingredient of the two notions of health. The other variables, Health, Mental Health + and Coping + have close to a third of maximum value responses.

At the negative side Mental Heath-gets 23% and Coping- gets 7%. Given this result we evaluate the frequency of responses to questions 8 and 9, being 35% and 46% respectively. This shows there is a stronger deviation of the obsessive-compulsive inclination (Q 9) than of the paranoid inclination (Q 8).

Table 2 -Frequencies of combined variables (n=43)

Minimal values for positive questions

Wellbeing (Q 11 e 12) - 0

Mental Health+ (Q3e 10) -2%

Health (Q1 e 2) - 0

Coping+ (Q5,6 e 7) - 0

Maximum va lues for negative questions

Mental Health- (Q.8 e 9) - 0

Coping- (Q4) - 58%

When we consider the maximum positive values of negative questions we see that Coping- has the expressive value of 58%. On the contrary, Mental Health-had no responses. This means that many respondents "do not use social media to escape facing people whom they communicate with".

So, it was necessary to fix the cooccurrences between combined variables.

Table 3 Matrix of combined variables cooccurrences (n=43)

Maximum values   Minimal values

	H	MH+	C-	C+	MH-WB	H	SM+	C-	C+	MH-	BE
H	9	9		6	0 11	0	0		0	0	0
MH+	10			4	0 10	0			0	0	0
C-				9	0 14				0	1	0
C+					0 8					0	0
MH-					0						0

In the Matrix for maximum values the larger number of cooccurrences (14) is between Coping- (no need of coping) to Wellbeing. Next, Health and Wellbeing (11) confirms the former expectation. There are two values (10), both involve Mental Healths, one is with Coping- and the other with Wellbeing, as expected. With (9) there arethree cases, Health with Mental Health+, Health with Coping- and Coping- with Coping+. With 8 Coping+ with Wellbeing.If we plot these cooccurrences in a nonmetric space, we get:

WELLBEING
COPING-MENTAL HEALTH-r HEALTH
COPING+

The picture is dominated by Wellbeing closer to Coping- than to Health. The latter is at the same level as Mental Health+. The other variable, Coping-, is closer to Mental Health+than to Health. These relations are relevant, at least, for the definitions of Health a nd Mental Health, in the human conversational context studied.

We are not able to attribute meaning to Mental Health- which only had one cooccurrence on the negative side.

DISCUSSION

The way in which the subjects responded the "OLÁ VIDA - BOA SAÚDE" questionnaire of conversational expressions shows thatthe linguistic notions of Health and Mental Health used by the students are very similar, being almost indistinguishable. This is mostly true because both notions depend equally on the notion of Wellbeing which is dominant in the defined space. Health and Mental Health are at the same level of co-occurrences. They only differ by the proximity of the latter with Coping- and Coping+. There is an apparently intriguing result – or maybe not -, the negative relation between Coping- and Wellbeing. In fact if one does not feel stress (strain) one should not need coping strategies to overcome it. Health by itself is better explained by Wellbeing.

The notions we are dealing with should be clearly distinguished from those used in

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health definitions of medical science, law, economics, political science, cultural anthropology over the centuries and in the present time. The questionnaire itself was constructed with conversational notions that are not the same as the lingüistica I concepts. While the last ones are invariant within each culture, the conversational notions are actual and part of fluid reference and belonging groups andaré dynamic and interactive (even if the groupsare digital). They come and go between interlocutors and as time goes by acquire new local meaning.

It is erroneous to assume that in the context of a living language written and spoken words are the same, are invariant and always correspondent to what dictionaries register. It is possible that Health Literacy campaigns fail due to the use of collective word-concepts (from the larger group) instead of word-notions actually used within the actual psychosocial groups they are directed to. It is likely to be beneficial to agents of public health campaigns to have preliminary contact with members of the targeted groups and to study the conversational notions they use.

Insum: conversational notions of health and mental health used by the students a nd the linguistic concepts are similar. Although there is a negative relation between coping- and wellbeing. Conversational notions are actual, dynamic and interactive while lingüistica I concepts are invariant within each linguistic group. Health literacy campaigns may fail due tothe use of collective words concepts instead of conversational notions in use by the members of psychosocial groups they are directed to. Preliminary contact with members of the targeted groups may be beneficial to agents of public health campaigns to take knowledge of the conversational notions they use.

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APPENDIX:

Questioná rio: OLÁ VI DA - BOA SALIDE (HELLO LIFE -GOOD HEALTH)

Assinalar apenas urna op?ao em cada frase tripla: (Chose only one option in each treble sentence:)
1-Aminhavida tern um rumo: certo (5); inconstante (3); nao tern (1)
(There is a direction in my life: sure; not always; there is not)
2 - Sinto-me bem no meu corpo: sempre (5); nem sempre (3); estou doente (1)
(I feel well in my body: always; not always; I am sick)
3-Consigo resolver os conflitosfamiliares: facilmente(5); nem sempre (3); fujo deles (1)
(I can solve family conflicts: easily; not always; I run away from them)

4 - Uso as redes socials para escapar a encarar as pessoas com quem comunico: sempre (1); quando me for?am (3); nao uso (5)

(I use social media to escape facingthose whom I communicate with: always; when I am forced to; I do not use it)

5-Consigo ultrapassar as dificuldades notrabalho: em geral sim (5); sofro com el as (3); tentó fintá-las (1)

(I manage to overcome job difficulties; in general, yes; I suffer with them; I try to avoid them)

- Ten ho um grupo onde discuto as quest oes socials e políticas que ocupam os meios de comunicado social: o grupo é permanente (5); mudo de grupo quando calha (3); nao me deixo influenciar por grupos (1)

(I am a member of a group where I discuss current mass media social and political questions: the group is always the same; I switch group whenever; I do not let groupsto influence me)

- Procuro enfrentar o stress da vida: sempre (5); nem sempre (3); o melhor é fugir-lhe (1)

(I try to face the stress of life: always; not always; it is better to run from it)

- Para se estar precavido tern de se estar sempre atento as manobras e esquemas e conspiracies dos out ros (que nos qu erem mal mas, também, nos podem querer bem demais): sempre (1); quando nos atacam (3); nao pensó nisso (5)

(In order anticipate, one must always be alert to maneuvers, conspiracies and schemes from others (who either wish us evil ortoo good): always; when they assail us; I do not think about it)

- Antes de mais é necessário meter tudo na ordem perfeita, verificar tudo e pensar duas ou tres vetes antes de agir: sempre (1); só as vetes (3); em geral nao me ocorre(5)

(First of all one must put everything in perfect order, verify everything and thinktwo or three times before acting: always; just from time to time; in general it does not occurto me)

- Lembro-me de tudo o que se passou na minha vida: sim (5); quase só me lembro do que correu mal (ou bem) (3); tenho lapsos efalhas e até apagóes (1)

(I recall everything about my life: yes; almost just remember what went wrong (or well); I have lapses, omissions and blanks)

11-Comose encontraem termos de saúde: bem (3); assim assim (2); menos bem (1)

(In terms of health, how do you find yourself: well; so so; less well)

12 - Como se encontra em termos de saúde mental: bem (3); assim assim (2); menos bem (1)

(In terms of mental health, how do you find yourself: well; so so; less well)

CONFLICTO DE INTERESES

Los autores declaran no tener ningún conflicto de intereses y que han participado activamente por partes iguales en la elaboración del manuscrito.

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