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På tide å droppe dikotomien «psykisk og fysisk helse»?

Ragnar Nesvåg

27.10.2021

Agenda

- Litt om dikotomien
- Psykiske plager ved kronisk somatisk sykdom
- Overdødelighet ved psykiske lidelser
- Sammenheng mellom livsstil og psykisk sykdom

Dikotomien går langt tilbake

- Rene Descartes
  - Kroppen er adskilt fra sjelen
- Kropp og sjel angripes fra ulike faglige retninger
  - Helsefag vs teologi/filosofi
- Freud etc
  - Psyken manifesterer seg i kroppen
  - Psyken kan påvirkes med terapi (også kroppslig terapi, f.eks. trening)

Forsøk på å forstå sammenhengene

- Bio-psyko-sosial modell (Engels 1977)
- Immunopsykiatri
- Neuro-psychoanalysis
- ME
- Muskel- og skjelettplager vs angst og depresjon

Somatisk sykdom vs psykisk helse

Ferske norske tall

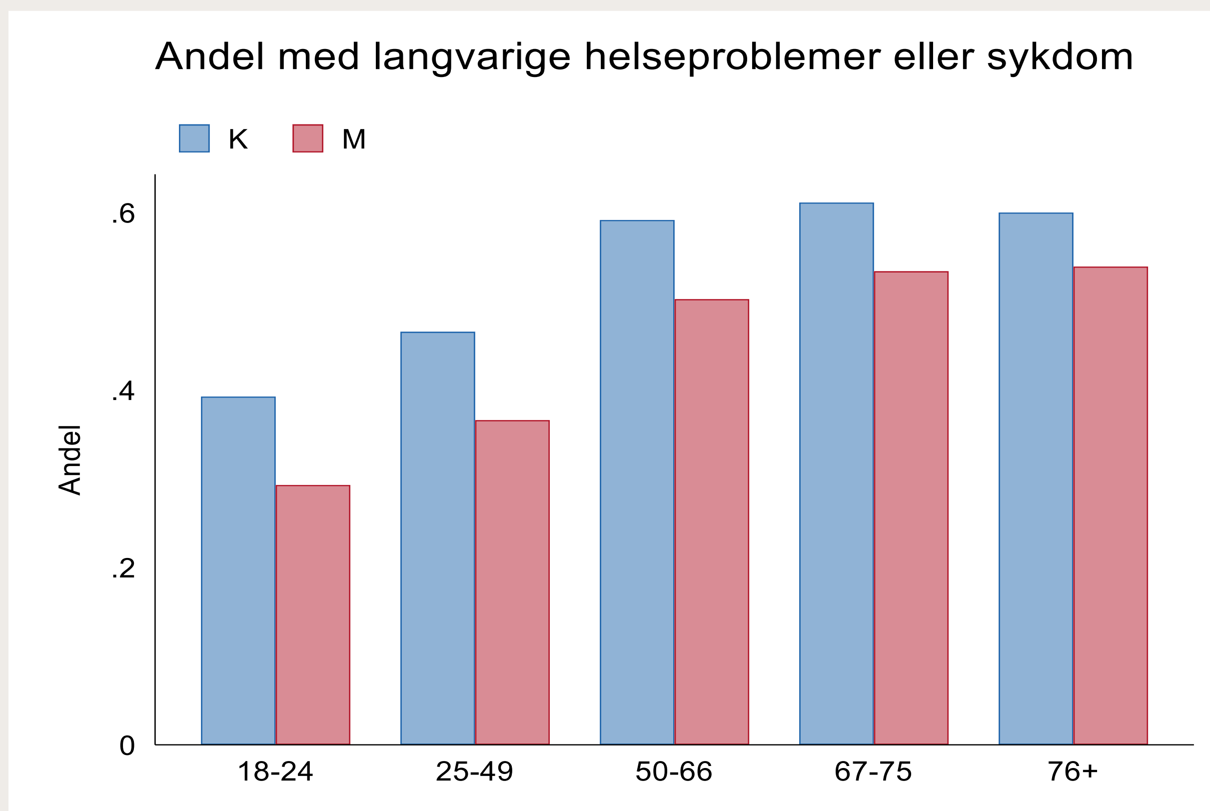
Den nasjonale folkehelseundersøkelsen (NHUS)

- Alder 18+
- Gjennomført 21.10-4.11.2020
- 23219 inviterte, 8852 svar (38,1 %)
- ca 2000 fra hvert fylke

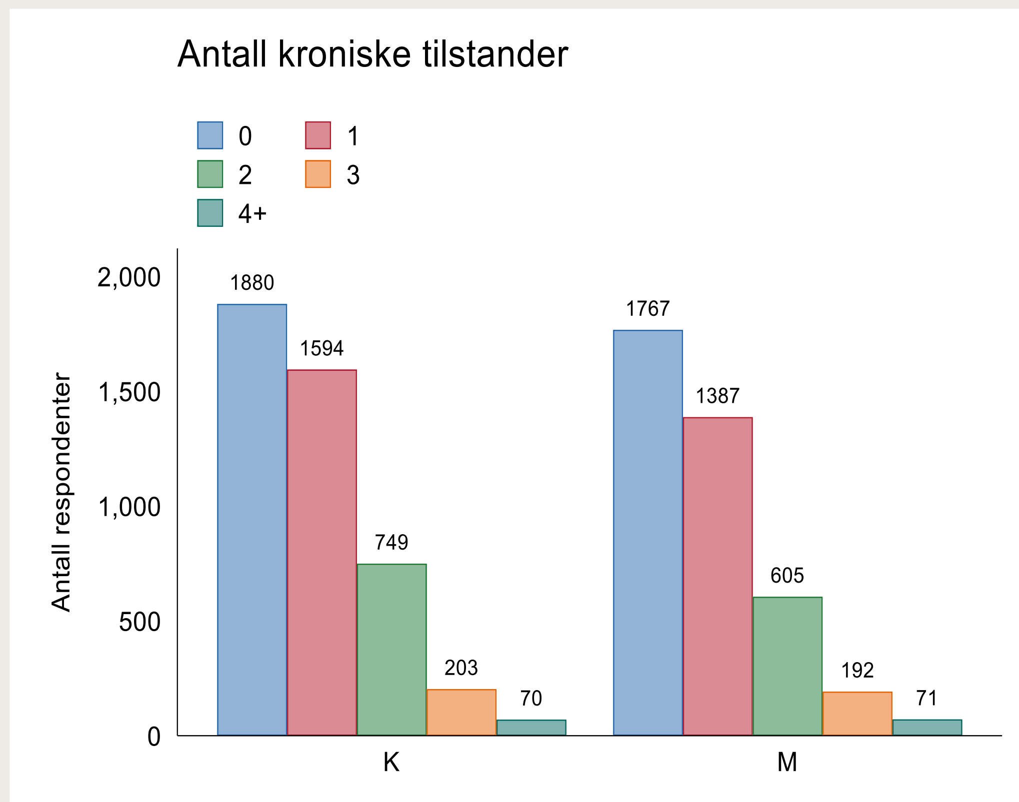
- https://www.fhi.no/studier/nhus/

Rundt halvparten har langvarig sykdom eller helseproblemer

Tall fra NHUS

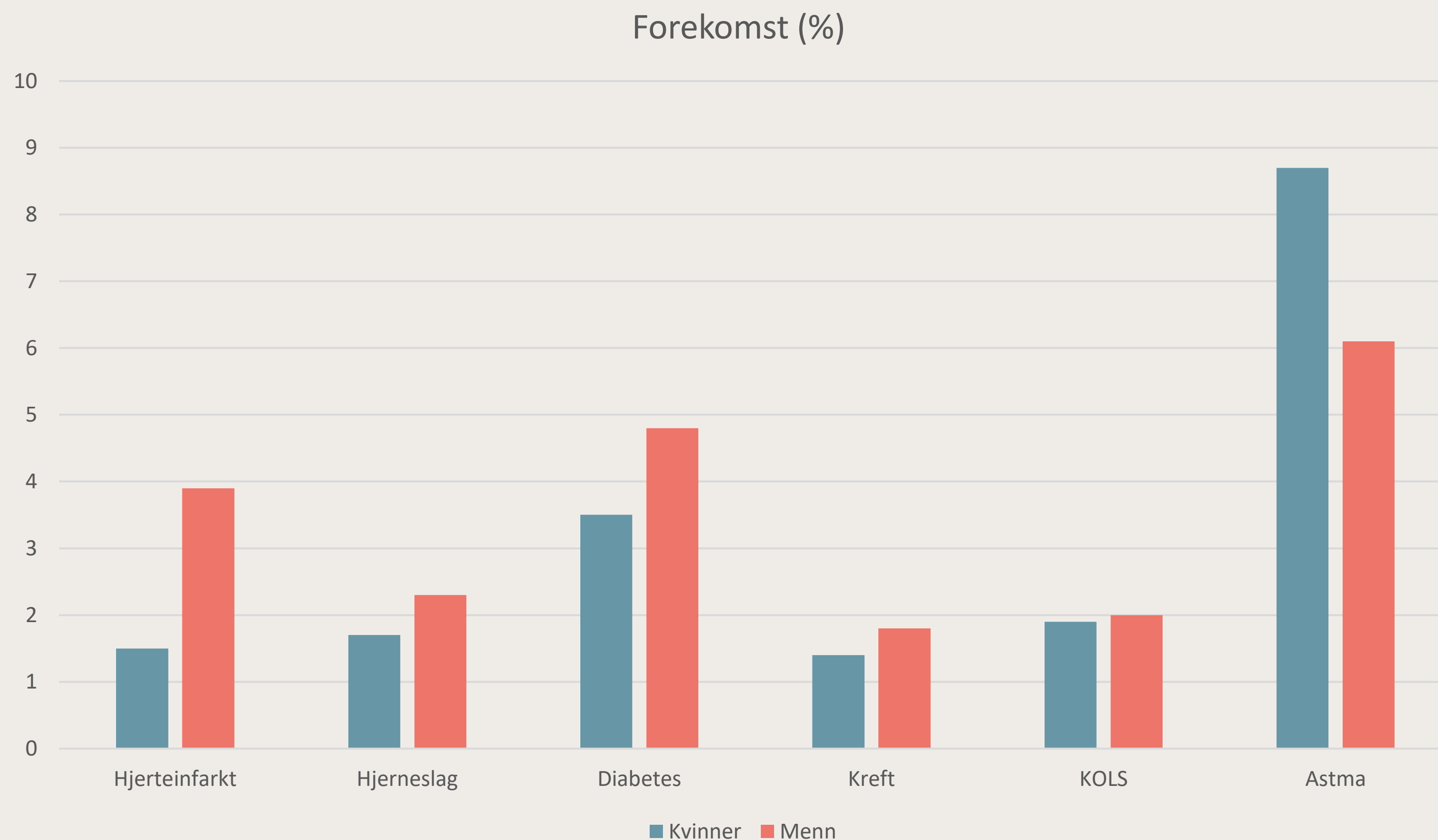


Vanlig å ha flere kroniske sykdommer

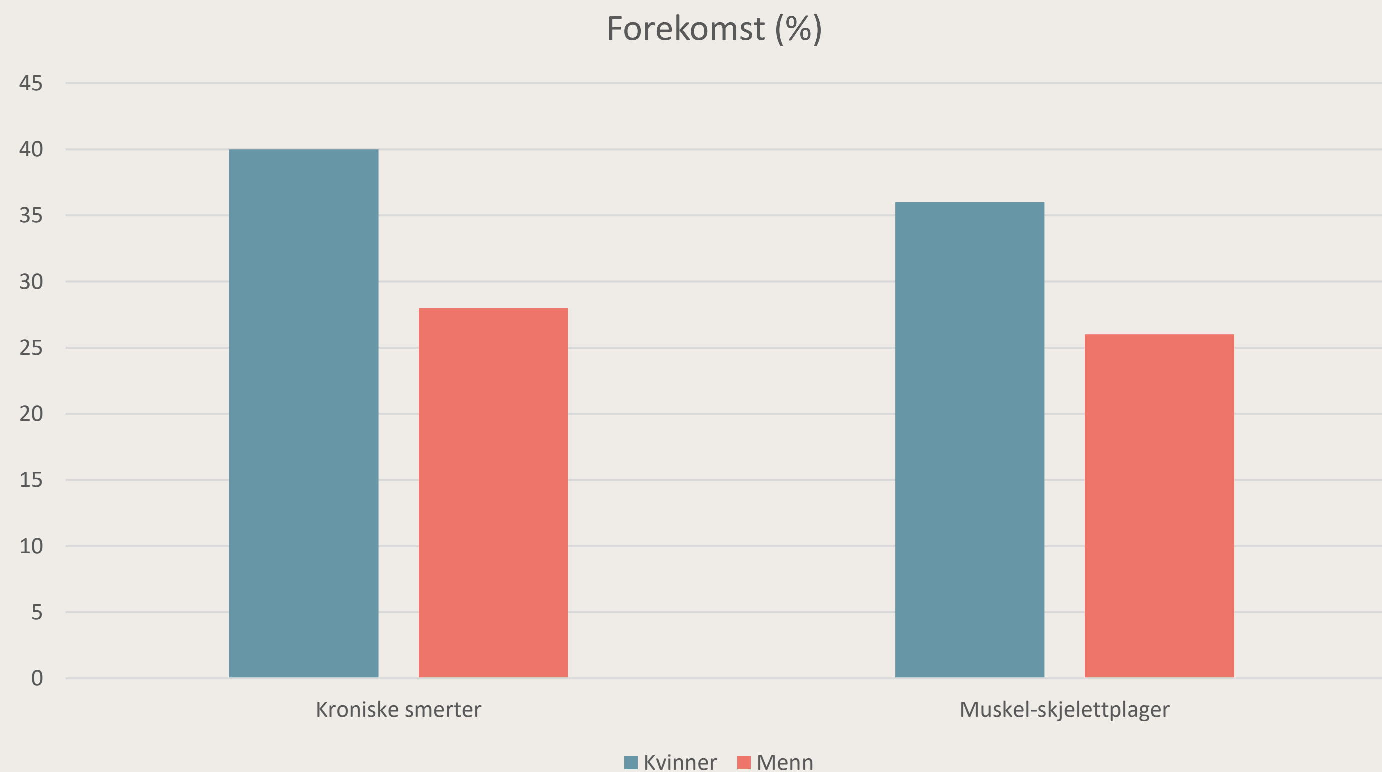


Forekomst av hver enkelt sykdom 1-9 %

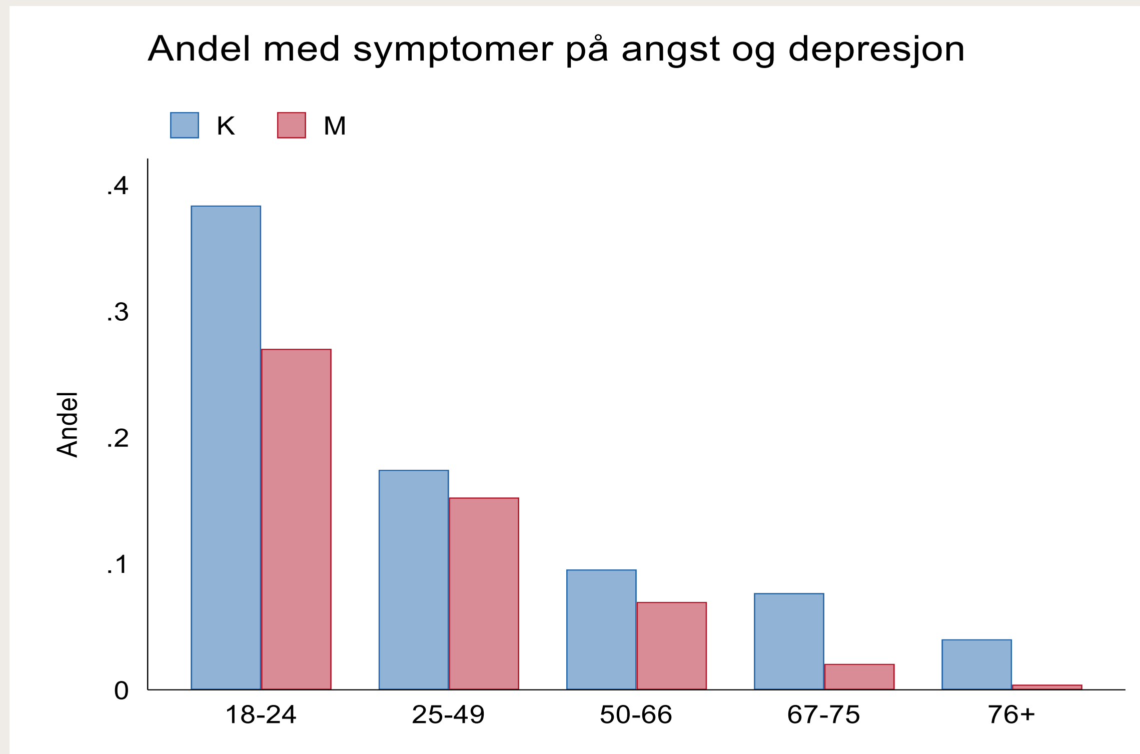
NHUS



25-40 % har generelle fysiske plager

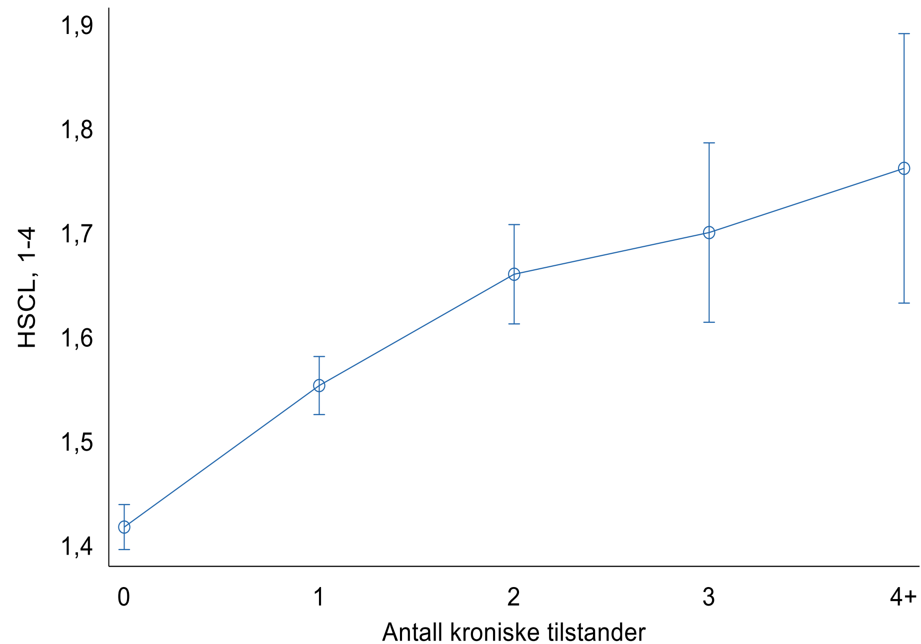


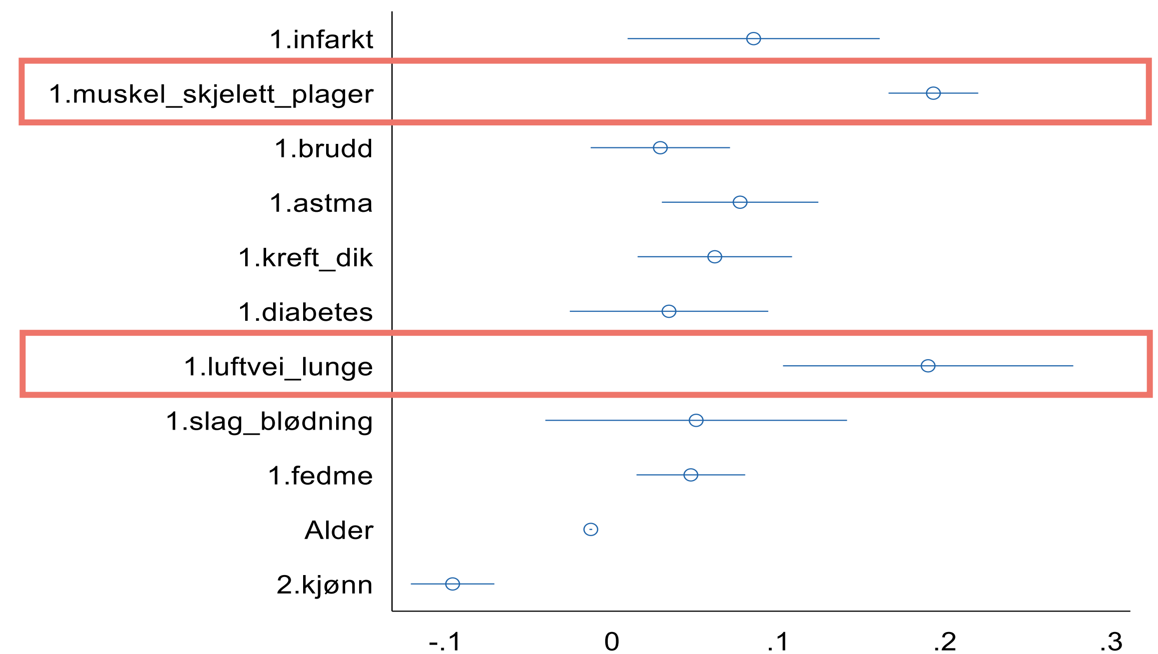
30-40 % av de yngste har angst/depresjon?



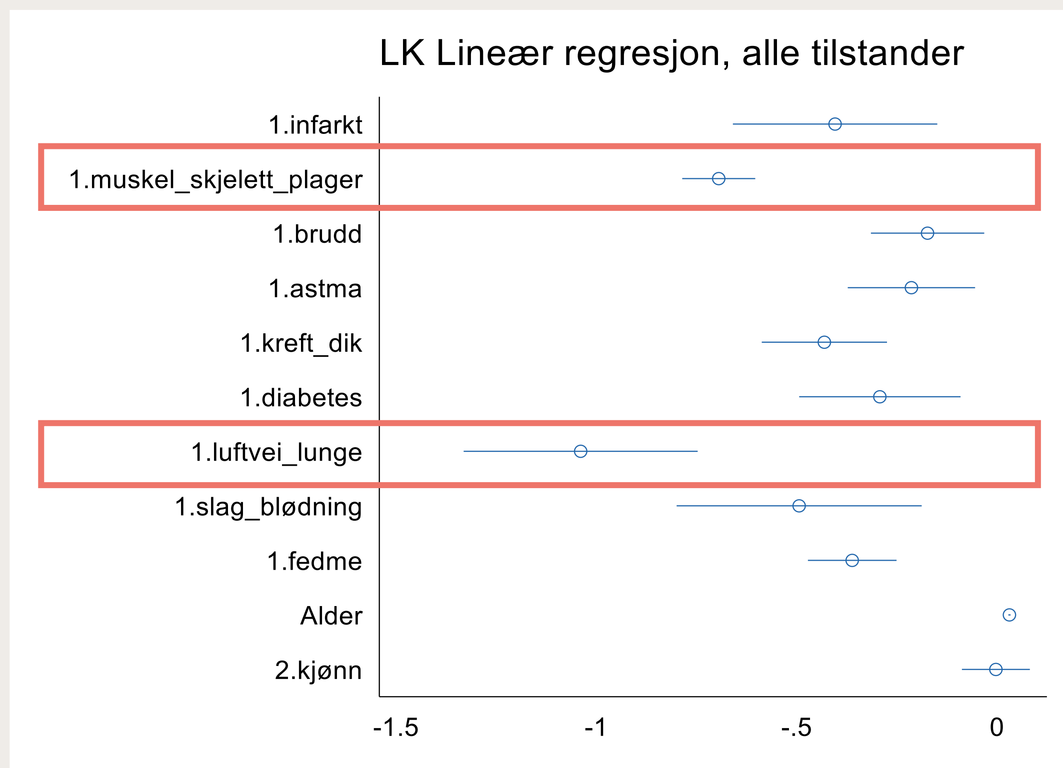
Kroniske sykdommer vs angst/depresjon

Tall fra NHUS





Kroniske sykdommer vs livskvalitet



Overdødelighet ved pyskiske lidelser

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De dør 15-20 år for tidlig

Alvorlige psykiske lidelser

- Schizofreni – 0,5 %
- Bipolar lidelse – 1-2%
- Alvorlig depressiv lidelse 2-3%?

Folkehelserapporten, 2018

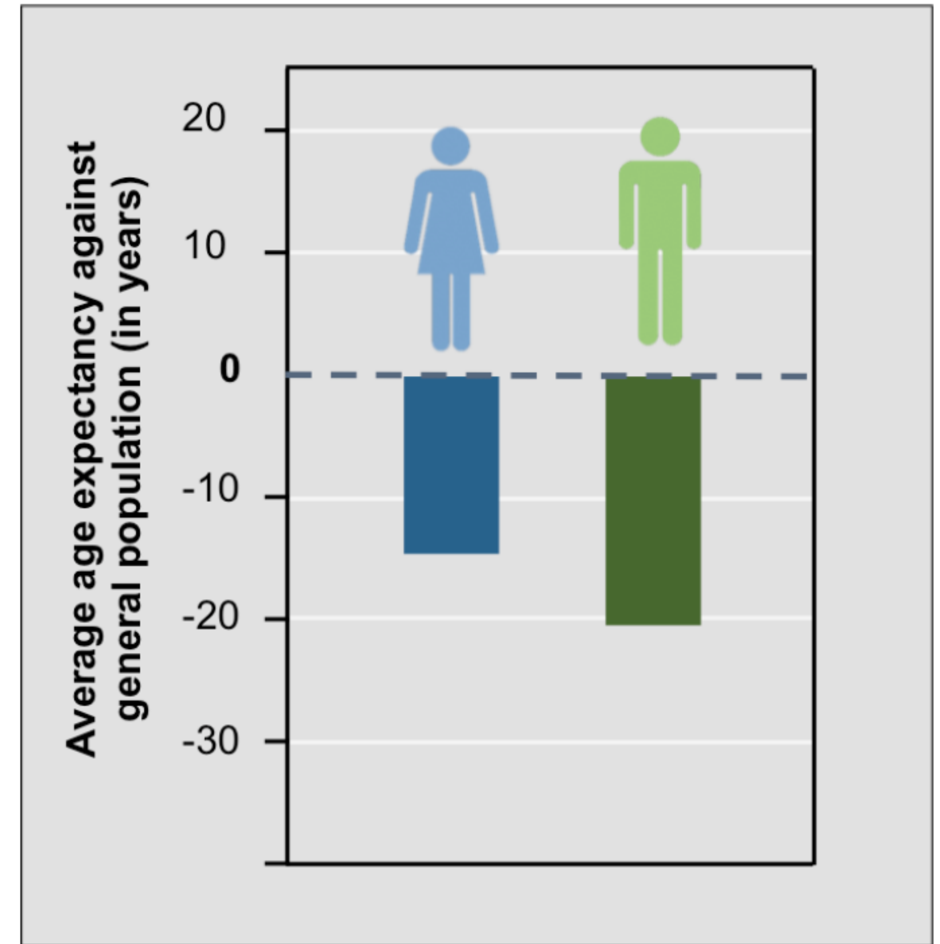

Figure 1. *Difference in remaining life expectancy at age of 15 among female and male patients with schizophrenia compared to general population (adapted from Laursen et al.[1] from data collected in Denmark).*

[1] *Laursen et al., PLoS ONE 2013*

Overdødelighet ved psykiske lidelser

- Mest redusert for menn
- Skyldes både naturlig og unaturlig død
- Selvmord er mest forhøyet sammenlignet med befolkningen
- Somatisk sykdom er viktigste årsak til tapte leveår, særlig
  - Kjerte-/karsykdom
  - Luftveissykdommer
  - Kreft

De dør i hovedsak av naturlige årsaker

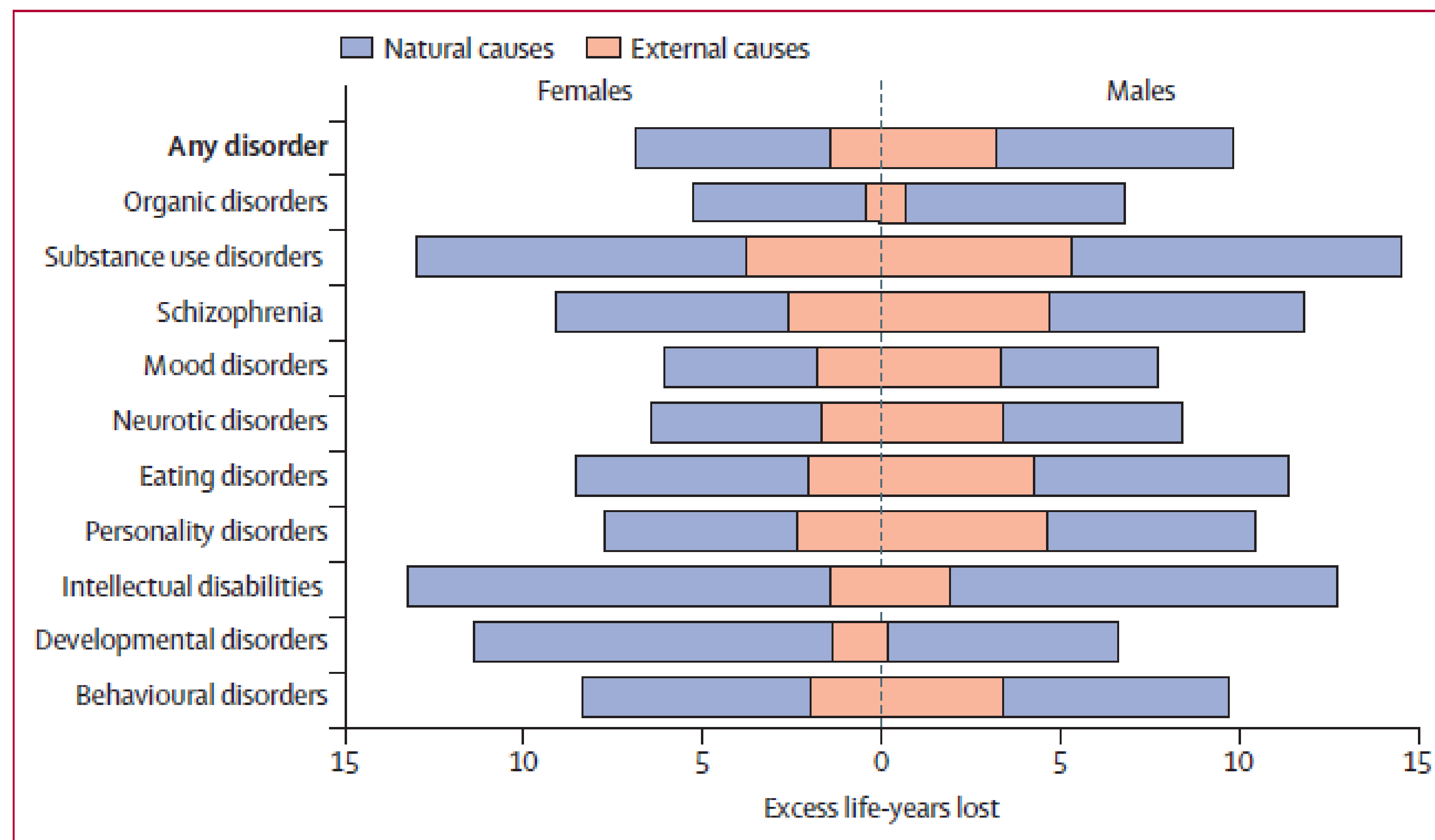

Figure 3: Excess life-years lost for individuals with any mental disorder and each specific type of mental disorder compared with the general Danish population of the same sex and age

Plana-Ripoll et al, Lancet Psychiatry 2019

RESEARCH REPORT

Risks of all-cause and suicide mortality in mental disorders: a meta-review

EDWARD CHESNEY, GUY M. GOODWIN, SEENA FAZEL

Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford OX3 7JX, UK

A meta-review, or review of systematic reviews, was conducted to explore the risks of all-cause and suicide mortality in major mental disorders. A systematic search generated 407 relevant reviews, of which 20 reported mortality risks in 20 different mental disorders and included over 1.7 million patients and over a quarter of a million deaths. All disorders had an increased risk of all-cause mortality compared with the general population, and many had mortality risks larger than or comparable to heavy smoking. Those with the highest all-cause mortality ratios were substance use disorders and anorexia nervosa. These higher mortality risks translate into substantial (10-20 years) reductions in life expectancy. Borderline personality disorder, anorexia nervosa, depression and bipolar disorder had the highest suicide risks. Notable gaps were identified in the review literature, and the quality of the included reviews was typically low. The excess risks of mortality and suicide in all mental disorders justify a higher priority for the research, prevention, and treatment of the determinants of premature death in psychiatric patients.

Key words: Mortality, suicide, mental disorders, substance use disorders, anorexia nervosa, meta-review

(World Psychiatry 2014;13:153–160)

Mulige årsaker til økt dødelighet

- Levevaner (røyking, usunt kosthold, fysisk inaktivitet)
- Tilgang på gode helsetjenester
- Bruk av legemidler
- Sosioøkonomiske forhold (bolig, familie, inntekt)
- Genetikk

Liu et al., World Psychiatry 2017

Færre får hjerte-/kardiagnose før hjertedød, selv om nesten alle har vært hos lege

Results: Individuals with SCZ were 66% more likely (OR: 1.66; 95% CI: 1.39–1.98), women with BD were 38% more likely (adjusted OR: 1.38; 95% CI: 1.04–1.82), and men with BD were equally likely (OR: 0.88, 95% CI: 0.63–1.24) not to be diagnosed with CVD prior to cardiovascular death, compared to individuals without SMI. Almost all (98%) individuals with SMI and undiagnosed CVD had visited primary or specialized somatic health care prior to death, compared to 88% among the other individuals who died of CVD.

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Undiagnosed cardiovascular disease prior to cardiovascular death in individuals with severe mental illness

Heiberg IH, Jacobsen BK, Balteskard L, Bramness JG, Næss Ø, Ystrom E, Reichborn-Kjennerud T, Hultman CM, Nesvåg R, Høye A. Undiagnosed cardiovascular disease prior to cardiovascular death in individuals with severe mental illness.

Objective: To examine whether individuals with schizophrenia (SCZ) or bipolar disorder (BD) had equal likelihood of not being diagnosed with cardiovascular disease (CVD) prior to cardiovascular death, compared to individuals without SCZ or BD.

Methods: Multivariate logistic regression analysis including nationwide data of 72 451 cardiovascular deaths in the years 2011–2016. Of these, 814 had a SCZ diagnosis and 673 a BD diagnosis in primary or specialist health care.

Results: Individuals with SCZ were 66% more likely (OR: 1.66; 95% CI: 1.39–1.98), women with BD were 38% more likely (adjusted OR: 1.38; 95% CI: 1.04–1.82), and men with BD were equally likely (OR: 0.88, 95% CI: 0.63–1.24) not to be diagnosed with CVD prior to cardiovascular death, compared to individuals without SMI. Almost all (98%) individuals with SMI and undiagnosed CVD had visited primary or specialized somatic health care prior to death, compared to 88% among the other individuals who died of CVD.

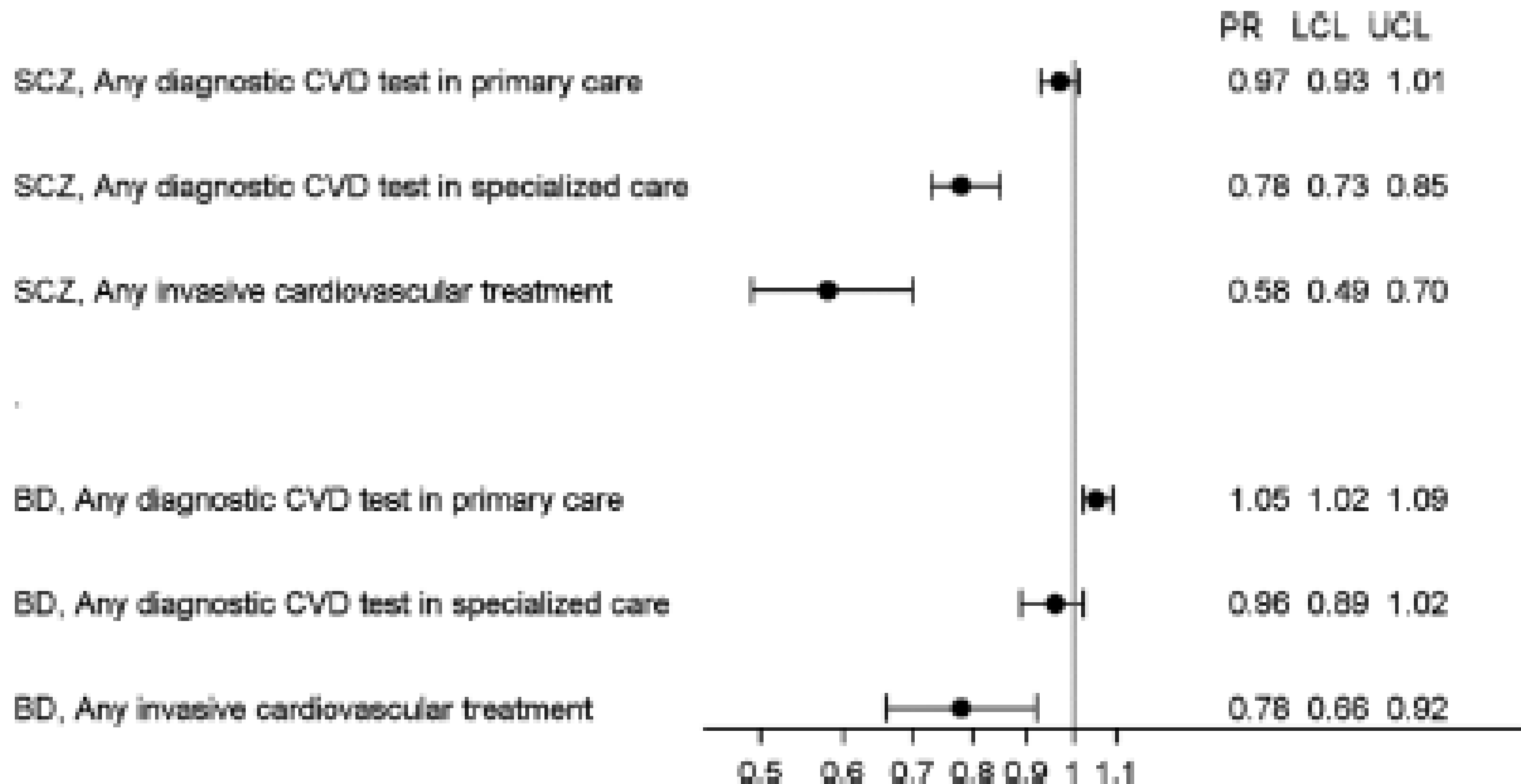
Conclusion: Individuals with SCZ and women with BD are more likely to die due to undiagnosed CVD, despite increased risk of CVD and many contacts with primary and specialized somatic care. Strengthened efforts to prevent, recognize, and treat CVD in individuals with SMI from young age are needed.

I. H. Heiberg[1], **B. K. Jacobsen**[1,2,3], **L. Balteskard**[1], **J. G. Bramness**[4,5], **Ø. Næss**[6,7], **E. Ystrom**[8,9,10], **T. Reichborn-Kjennerud**[6,8], **C. M. Hultman**[11,12], **R. Nesvåg**[5,13], **A. Høye**[1,5,14]

[1]Center for Clinical Documentation and Evaluation (SKDE), [2]Department of Community Medicine, UiT – The Arctic University of Norway, [3]Centre for Sami Health Research, Department of Community Medicine, UiT – The Arctic University of Norway, Tromsø, [4]Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Innlandet Hospital Trust, Hamar, [5]Department of Clinical Medicine, UiT – The Arctic University of Norway, Tromsø, [6]Institute of Clinical Medicine, University of Oslo, [7]Institute of Health and Society, University of Oslo, [8]Department of Mental Disorders, Norwegian Institute of Public Health, [9]Department of Psychology, University of Oslo, [10]PharmacoEpidemiology and Drug Safety Research Group, School of Pharmacy, University of Oslo, Oslo, Norway, [11]Department of Medical Epidemiology and Biostatistics, Karolinska Institutet, Stockholm, Sweden, [12]Icahn School of Medicine, Mt Sinai Hospital, New York, NY, USA, [13]Norwegian Medical Association, Oslo, and [14]Division of Mental Health and Substance Abuse, University Hospitalof North Norway, Tromsø, Norway

Heiberg et al., Acta Psychiatr Scand 2019

Færre får behandling hos hjertespesialist



Heiberg et al., Acta Psychiatr Scand 2020

Årsaker til ulik behandling?

- Systemnivå
- Behandlernivå
- Pasientnivå

Negativ pragmatisme

Fra Anne Høye, UiT

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Livsstil og psykiske lidelser

WHO setter fokus på somatisk helse i psykisk helsevern

- Psykiske lidelser med i NCD
- Kartlegge somatisk helse
- Endre levevaner
- Endre holdning/stigma i
  - Tjenestene
  - Samfunnet

World Health Organization, 2015

Livsstilsfaktorer og psykiske lidelser

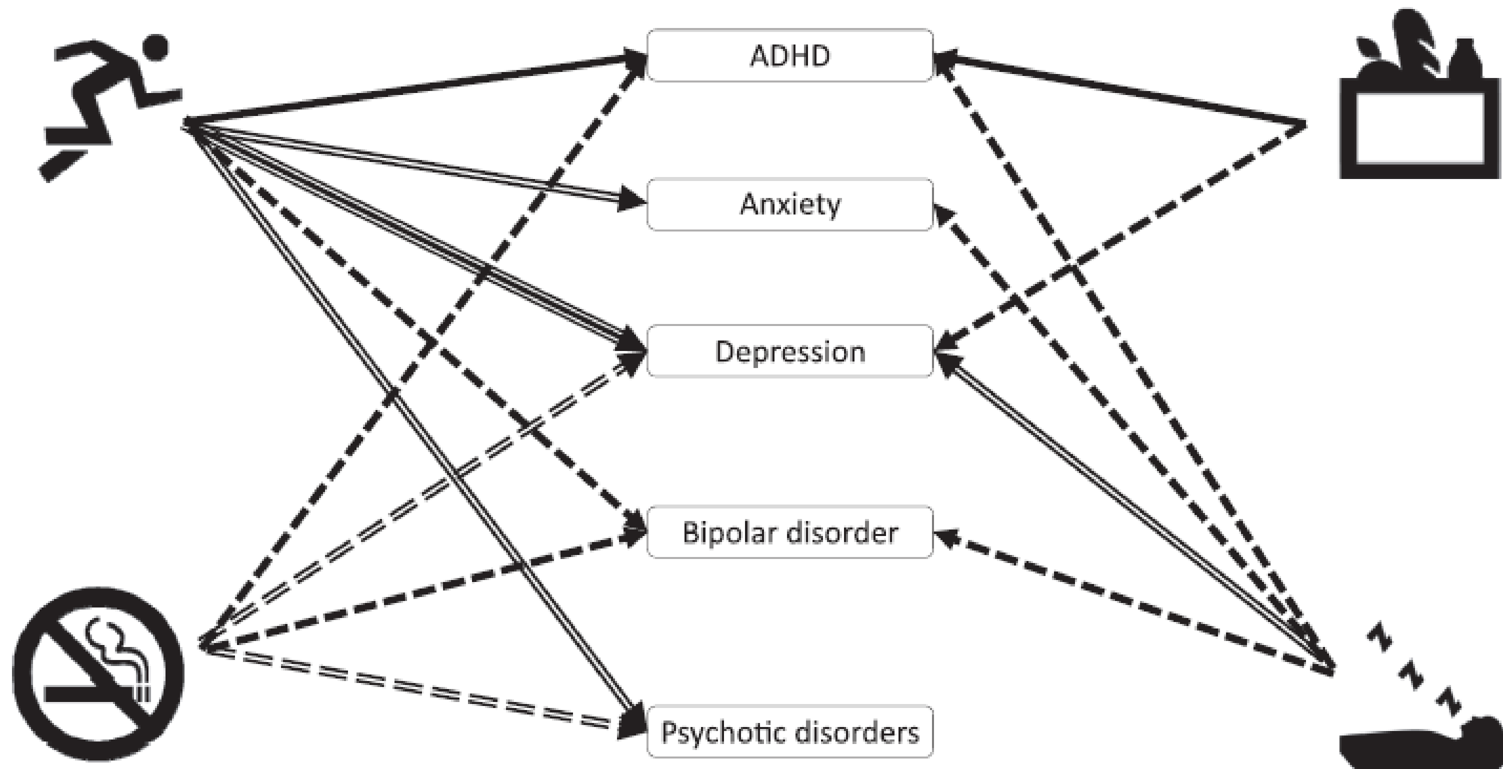

Figure 1 Lifestyle factors in the prevention and treatment of mental illness. The dashed line indicates evidence for protective benefit from either prospective meta-analyses (P-MAs) or Mendelian randomization studies (MRs). The double-dashed line indicates evidence for protective effects from both P-MAs and MRs. The solid line indicates evidence for efficacy in treatment of mental illness from MAs of randomized controlled trials (RCTs). The double solid line indicates convergent evidence from MRs or P-MAs with MAs of RCTs. The treble solid line indicates convergent evidence from all three (P-MAs + MRs + MAs of RCTs). ADHD – attention-deficit/hyperactivity disorder.

Firth et al., World Psychiatry 2020

Oppsummering

- Hva med dikotomien «Psykisk og fysisk helse»?
  - Ja takk, begge deler
- Pasienter med kroppslige helseplager har ofte psykiske vansker
- Pasienter med alvorlig psykisk lidelse har ofte kroppslige sykdommer
- Livsstilsfaktorer har sammenheng med psykiske lidelser
- Fysisk aktivitet, kosthold, søvn og røykeslutt er gode tiltak for å forebygge og til en viss grad behandle psykiske lidelser

Takk for oppmerksomheten

Takk til Thomas S. Nilsen og Marianne Abel Hope for analyser og tolkning av data fra NHUS

Ragnar.nesvag@fhi.no