Remettre le coronarien au travail
Le stress professionnel
Que faire ?

Jean-Pierre Houppe
Centre cardiovasculaire Cœur de Lorraine
57100 THIONVILLE

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Pullman Paris Centre Bercy

Collège National des Cardiologues des Hôpitaux

DÉCLARATION DE RELATIONS PROFESSIONNELLES

Je n'ai aucun lien d'intérêt à déclarer pour cette présentation

Factors predicting working status after aortocoronary bypass surgery

NICOLAS DANCHIN, MD
PAUL DAVID, MD
MARTIAL G. BOURASSA, MD
PIERRE ROBERT, PH D
BERNARD R. CHAITMAN, MD

The working status of 1165 patients aged 59 years or less (mean 49.8 years) was evaluated 7 to 77 months (mean 36 months) after aortocoronary bypass surgery. Although 76% of the patients eventually returned to work, only 56% were working 6 months after their operation. The proportion of patients working peaked at 2 years after the operation (at 66%) and decreased progressively to 56% at 4 years and 53% at 5 years without ever reaching the proportions that applied 12 and 6 months before the operation (84% and 69% respectively). Multivariate analysis identified three socioeconomic and three clinical variables as predicting the working status at 6 months and at yearly points during the first 4 years after the operation. Of the socioeconomic variables analysed, preoperative unemployment of long duration, a preoperative occupation that required strenuous physical effort and a low level of education were, in that order, the strongest predictors of postoperative unemployment. Among the clinical variables, associated noncardiovascular illness and the severity and duration of angina pectoris independently influenced the patients' postoperative working status. The authors conclude that modification of some of these variables should be attempted both before and after aortocoronary bypass surgery to see whether the rate of return to employment after the operation can be improved in selected patients.

socioéconomiques analysés, un non-emploi de longue durée avant l'opération, un emploi préopératoire exigeant un effort physique important et un faible niveau d'éducation étaient, dans l'ordre, les plus forts indices prévisionnels d'un non-emploi postopératoire. Parmi les facteurs cliniques une maladie noncardurée de l'angine de poitrine ont influencé l'occupation des patients après l'opération. Les auteurs concluent qu'il y a lieu de tenter de modifier certains de ces facteurs avant et après l'opération de pontage aortocoronarien afin de voir si le pourcentage des sujets qui retournent au travail peut être amélioré chez les patients choisis.

Although complete or partial relief of angina pectoris is noted in 75% to 90% of patients after aortocoronary bypass surgery,[1] recent reports[2-11] indicate that a relatively large proportion of patients do not return to gainful employment after undergoing this procedure. These reports also identify some clinical and socioeconomic variables that may influence the postoperative working status of patients. Most of the reported data are limited to the first year after the operation; the long-term work profile of these patients was not described.

We therefore determined the percentage of 1320 men who returned to work after this operation and analysed variables that may predict their employment status in the early and late postoperative periods.
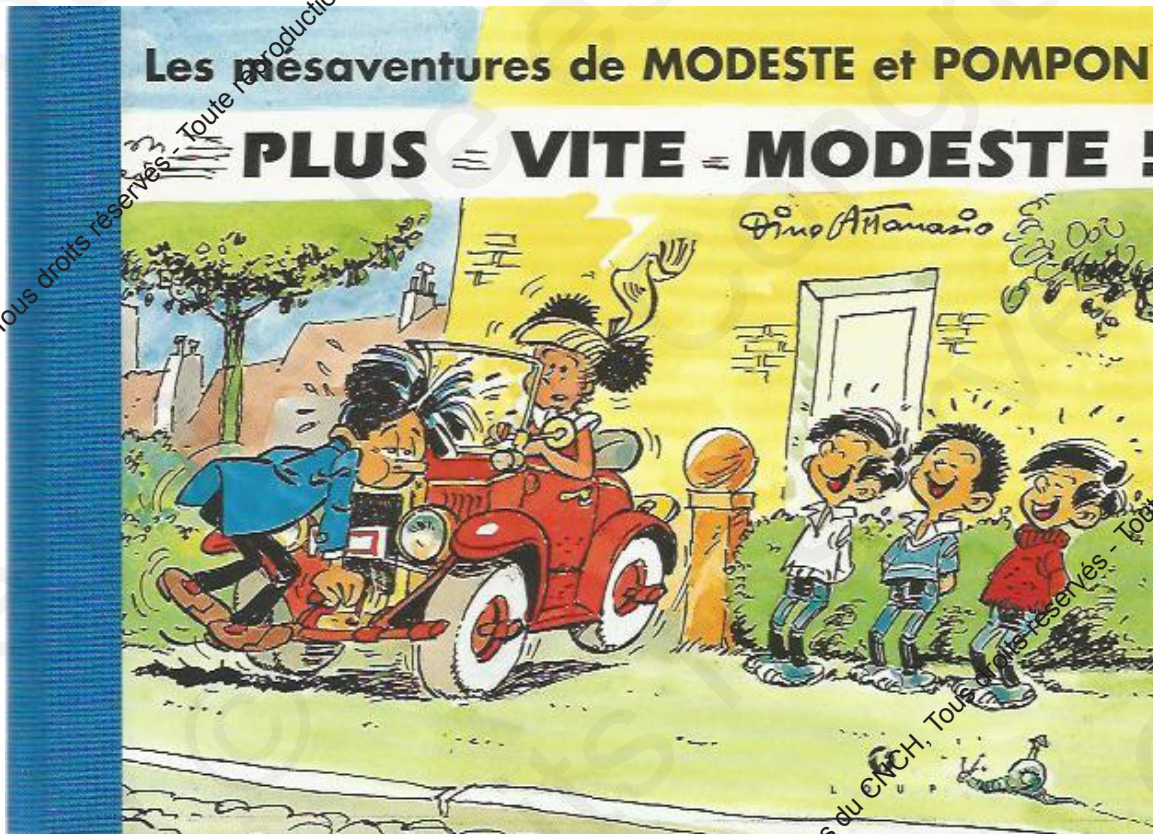
« Il n'y a aucune solution »

Un peu de modestie…

Les mésaventures de MODESTE et POMPON
PLUS = VITE = MODESTE !

Ce que nous ne pouvons pas faire…

Temps de travail et productivité

Working Hours/Year
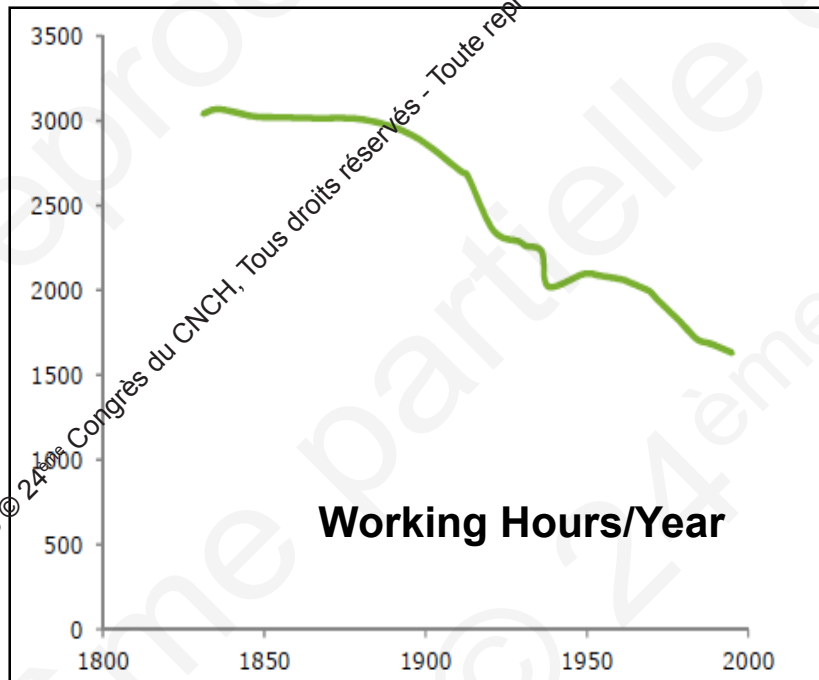
1830: 3050 Heures/An
1990: 1630 Heures/An
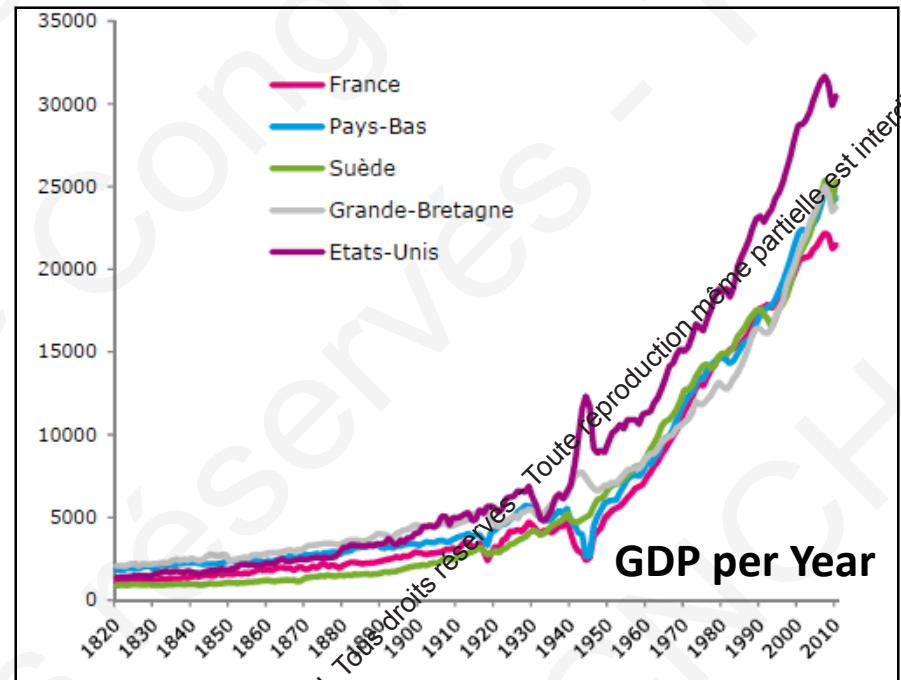
- France
- Pays-Bas
- Suède
- Grande-Bretagne
- Etats-Unis

GDP per Year

1830/1990
PRODUCTIVIE X 25

Stress et Travail

Qui ne gare pas assez vite sa voiture

Rate son TGV

Rate sa réunion

Rate son augmentation

Rate sa carrière

Rate sa vie

Le stress professionnel ...Que faire ?

4 questions

- **Pourquoi faire ?**
- **Que faire ?**
- **Comment faire ?**
- **Pour quels résultats?**

Intérêts de la question?

- **Stagnation du taux de reprise**
- **Facteurs cardiaques objectifs: 40%**
  - **Cliniques**
  - **Paracliniques**
- **Poids des facteurs psychosociaux**
  - **Pour la reprise du travail**
  - **Pour le pronostic cardiovasculaire**

Retour au travail

Psychological and clinical predictors of return to work after acute coronary syndrome

Mimi R. Bhattacharyya*, Linda Perkins-Porras, Daisy L. Whitehead, and Andrew Steptoe

Department of Epidemiology and Public Health, University College London, 1-19 Torrington Place, London WC1E 6BK, UK

Aims Resumption of paid employment following acute coronary syndrome (ACS) is an important indicator of recovery, but has not been studied extensively in the modern era of acute patient care.
Methods and results A total of 126 patients who had worked before hospitalization for ACS were studied with measures of previous clinical history, ACS type and severity, clinical management, and sociodemographic characteristics. Depressed mood (Beck Depression Inventory) and type D personality were measured 7–10 days following admission. Among them, 101 (80.2%) had returned to work 12–13 months later. Failure to resume work was associated with cardiac factors on admission (heart failure, arrhythmia), cardiac complications during the intervening months, and depression scores during hospitalization. It was not related to age, gender, socioeconomic status, type of ACS, cardiac history, acute clinical management, or type D personality. In multivariate analysis, the likelihood of returning to work was negatively associated with depression, independently of clinical and demographic factors [adjusted odds ratio 0.90, CI 0.82–0.99, $P = 0.032$].
Conclusion Depressed mood measured soon after admission is a predictor of returning to work following ACS. The management of early depressed mood might promote the resumption of economic activity and enhance the quality of life of cardiac patients.

Facteurs corrélés à la reprise du travail

- **Facteurs cliniques**
  - Durée d'hospitalisation
  - Sévérité clinique: angor, dyspnée
  - Index GRACE (Age, IC,TA,FC,ECG,IR)
  - Types de procédure (angioplastie versus chirurgie)
  - Participation à la réadaptation
  - Interruption de la réadaptation

- **Démographiques**
  - Age
  - Sexe : Femmes

Facteurs corrélés à la reprise du travail

- **Facteurs Psychiques**
  - Dépression
  - Stress, anxiété, hostilité.
  - « Locus contrôle» externe
  - Estime de soi, « self efficacy »
  - Perception de la maladie: Handicap
- **Sociologiques**
  - Niveau éducatif
  - Support social
  - Relation de couple
  - Type de travail: Libéral/salarié et Ouvrier/employé
  - Soutien de l'employeur
  - Satisfaction au travail
  - Conditions économiques

Une bombe à fragmentation…
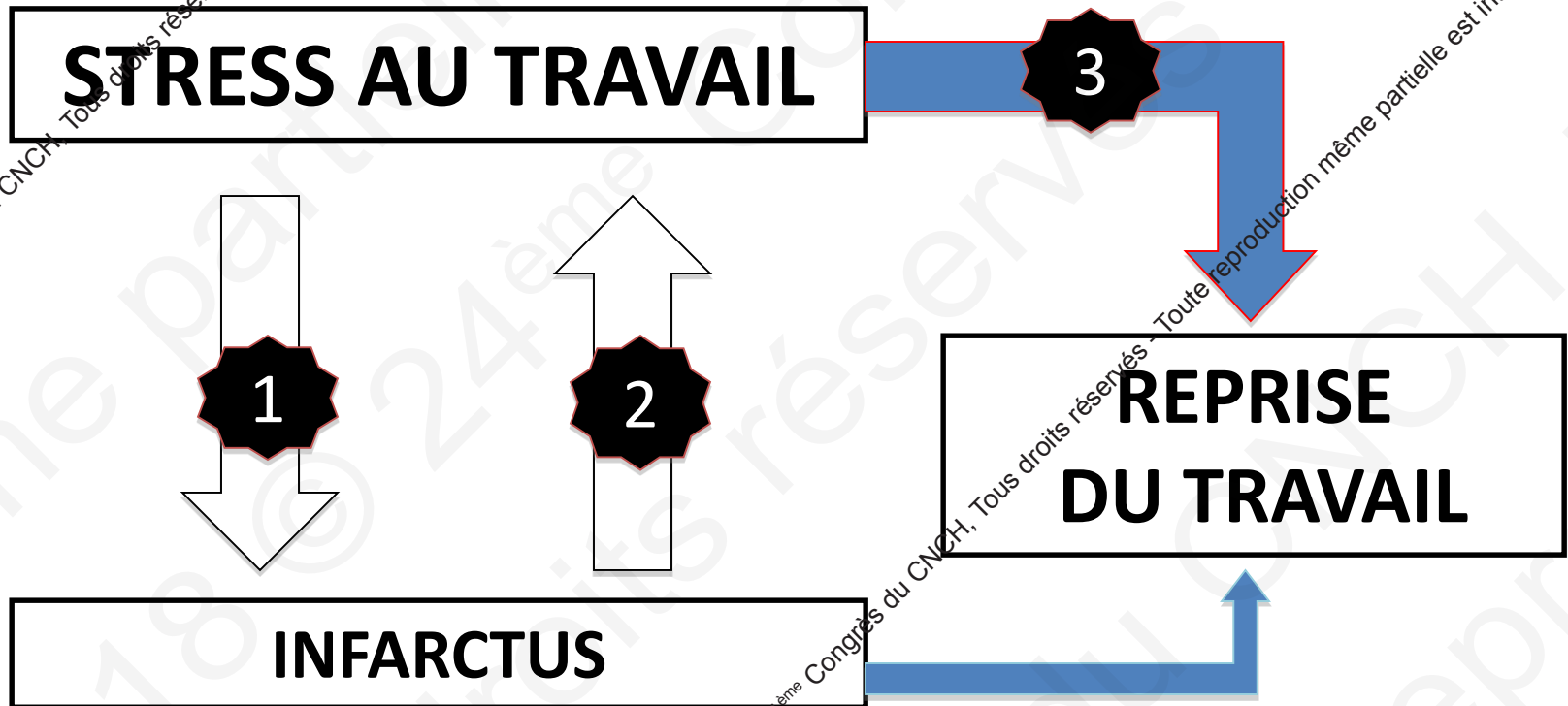
STRESS AU TRAVAIL

3

REPRISE DU TRAVAIL

1

2

INFARCTUS

Un triple aspect

1. **Un métier stressant**

2. **Le stress de la maladie**

3. **Le stress de la reprise**

Stress et Travail

Quelques Chiffres éloquents …

- **20 à 60 % des Salariés sont touchés selon l'OMS**

- **44% de la population , 65% des cadres en France selon la CGC**

- **30% des arrêts de travail selon le BIT**

- **3 à 4 % du PIB en Europe (certains disent 10%)**

- **1200 euros par an et par habitant en Suisse (source SECO)**

- **20 à 50 milliards d'euros par an en France (source BIT et CGC)**

Barometre Stress. Ed Harmattan. 2005.
Rapport Ramaciotti et Perriard. SECO. 2003.
Bejean. Revue de affaires sociales. 2004

Travail , stress et coronaires

JOB STRAIN

STRESS FULL EVENT

SOCIAL SUPPORT

CAD

UNEMPLOYMENT

OVERTIME WORK

JOB INSECURITY

BURN-OUT

SHIFTWORK
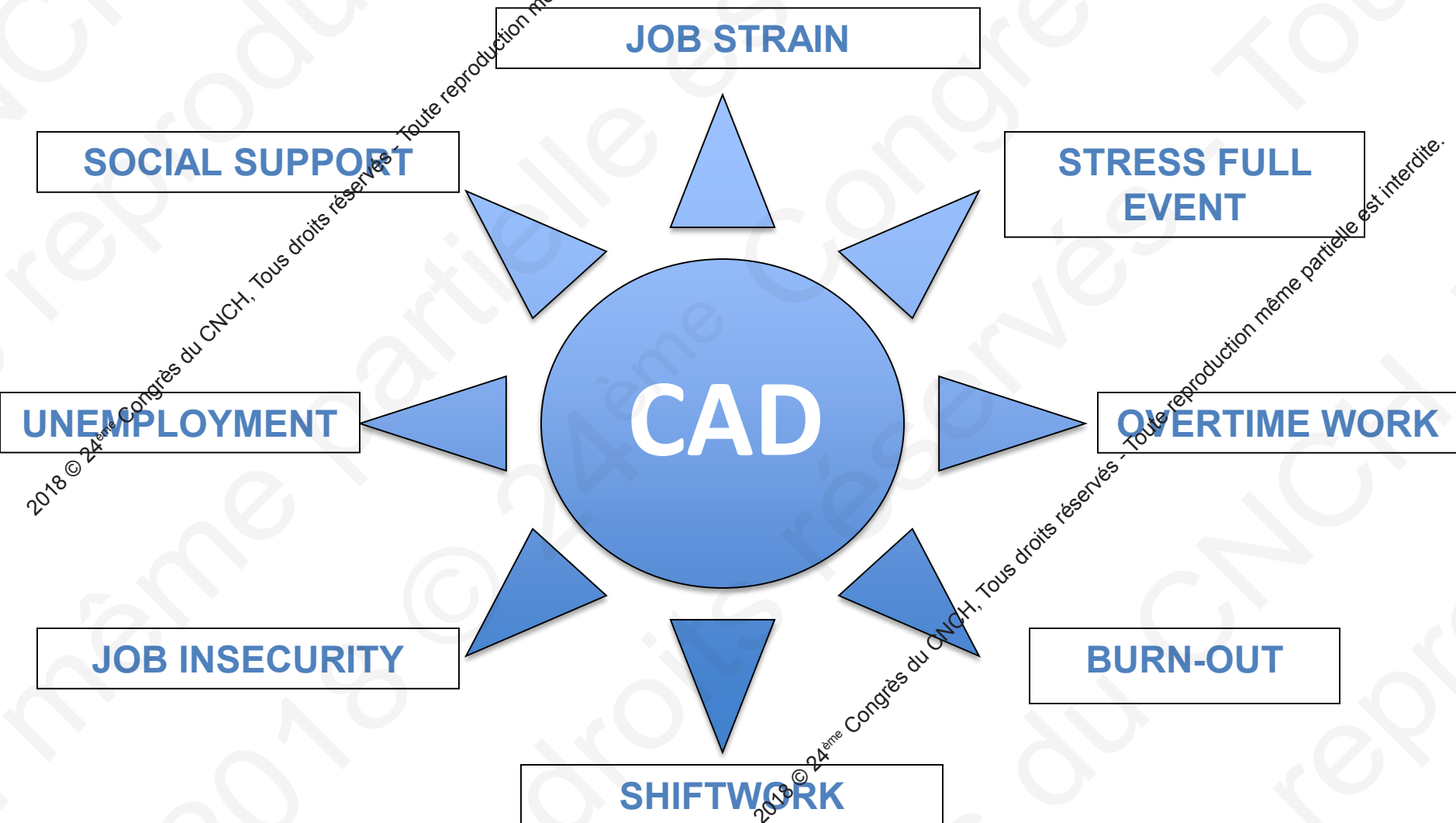
Work Stress as a Risk Factor for Cardiovascular Disease

Mika Kivimäki[1] · Ichiro Kawachi[2]

KivimakI M . Current cardiol .2015;17:630
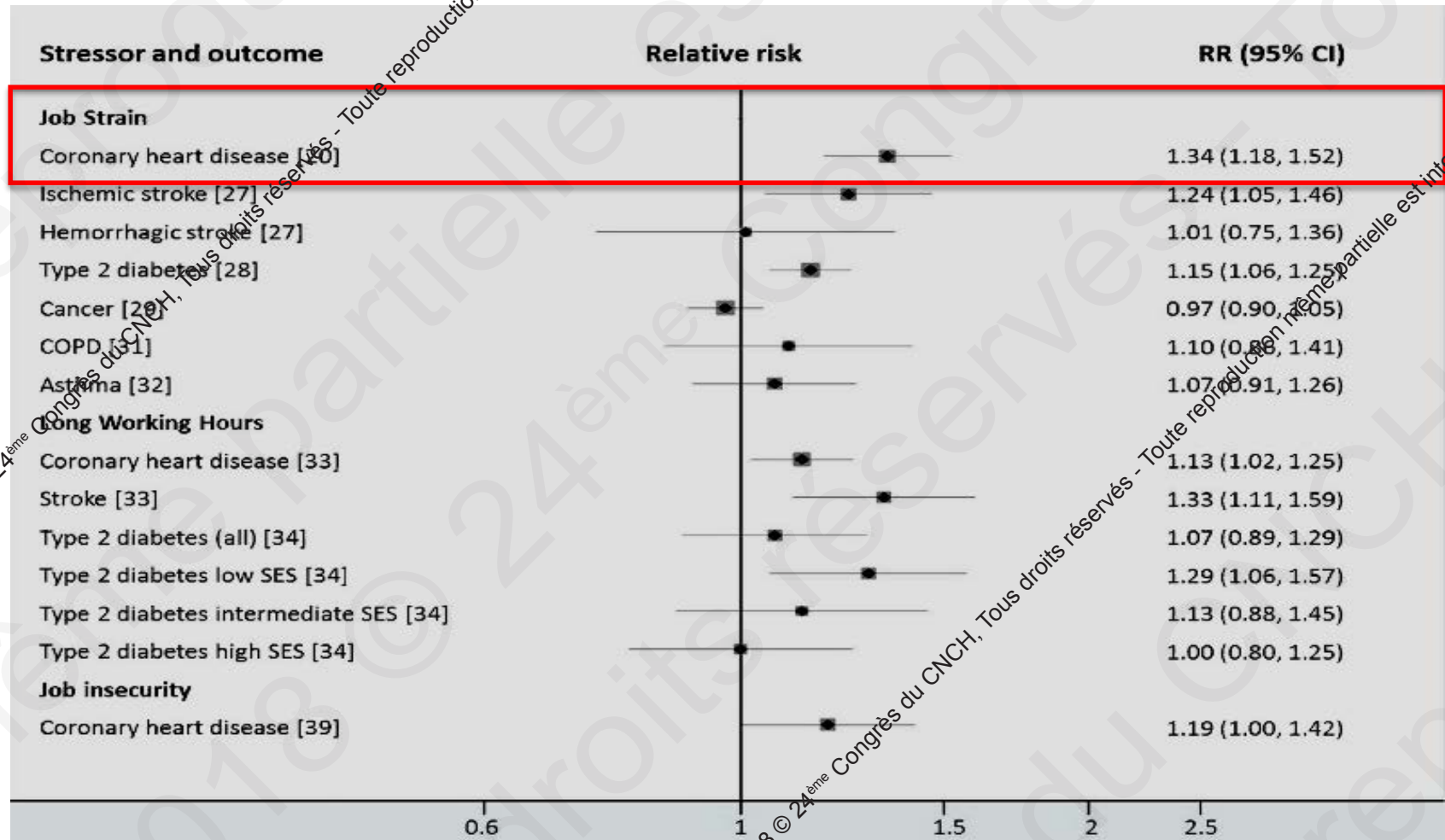
Surcharge de travail

Overtime work and incident coronary heart disease: the Whitehall II prospective cohort study

Marianna Virtanen[1]*, Jane E. Ferrie[2], Archana Singh-Manoux[2,3,4], Martin J. Shipley[2],

Exposure: overtime work/day	Fatal CHD, non-fatal myocardial infarction, or definite angina pectoris					
	No. of events	No. of Participants	Person-years	Rate/1000 person-years	Model A, HR (95% CI)[a]	P-value
All	369	6014	67543.9	5.46		
No overtime	189	3256	36331.7	5.20	1.00	Ref.
1 h	69	1247	14185.4	4.86	1.01 (0.76−1.34)	0.94
2 h	60	894	10115.8	5.93	1.28 (0.95−1.74)	0.11
3−4 h	51	617	6911.0	7.38	1.60 (1.15−2.23)	0.005

3-4 Hours Overtime work per day = 1.60-fold increased risk of CHD

Burnout : Facteur de risque independant

HR: 1.79

Burnout and risk of coronary heart disease: a prospective study of 8838 employees.

Toker S[1], Melamed S, Berliner S, Zeltser D, Shapira I.

⊕ Author information

Abstract

OBJECTIVE: Burnout is a negative affective state consisting of emotional exhaustion, physical fatigue, and cognitive weariness symptoms. This study was designed to evaluate prospectively the association between burnout and coronary heart disease (CHD) incidence and to test the possibility that this association is nonlinear.

METHODS: Participants were 8838 apparently healthy employed men and women, aged 19 to 67 years, who came for routine health examinations at the Tel Aviv Sourasky Medical Center. They were followed up for 3.4 years on average. Burnout was measured by the Shirom-Melamed Burnout Measure. CHD incidence was defined as a composite of acute myocardial infarction, diagnosed ischemic heart disease, and diagnosed angina pectoris.

RESULTS: During follow-up, we identified 93 new cases of CHD. Baseline levels of burnout were associated with an increased risk of CHD, after adjustment for various risk factors (hazard ratio = 1.41; 95% confidence interval = 1.08-1.85). In addition, we observed a significant threshold effect of burnout on CHD incidence. Participants who scored high on burnout (scores in the upper quintile of the Shirom-Melamed Burnout Measure scores distribution) had a higher risk (hazard ratio = 1.79; 95% confidence interval = 1.05-3.04) of developing CHD on follow-up compared with others.

CONCLUSIONS: Burnout is an independent risk factor for future incidence of CHD. Individuals with high levels of burnout (upper quintile) have a significantly higher risk of developing CHD compared with those with low levels of burnout.

TOKER S. Psychosom Med. 2012; 74: 840-847

Horaires décalés

Original Contribution

A Prospective Cohort Study of Shift Work and Risk of Ischemic Heart Disease in Japanese Male Workers

TABLE 2. Relative risks of shift work associated with cause-specific mortality, Japan Collaborative Cohort Study for the Evaluation of Cancer Risk, 1988–2003

	Age adjusted					Multivariate*		
	Person-years (no.)	Deaths (no.)	Relative risk	95% confidence interval	p value	Relative risk	95% confidence interval	p value
Total deaths								
Daytime worker	195,280	1,138	Referent			Referent		
Fixed-night worker	11,751	81	1.13	0.90, 1.42	0.290	1.06	0.85, 1.34	0.593
Rotating-shift worker	26,838	144	1.00	0.84, 1.19	0.973	0.98	0.82, 1.17	0.835
Circulatory system diseases								
Daytime worker	195,280	235	Referent			Referent		
Fixed-night worker	11,751	21	1.41	0.90, 2.21	0.131	1.29	0.82, 2.03	0.270
Rotating-shift worker	26,838	48	1.62	1.19, 2.21	0.002	1.59	1.16, 2.18	0.004
Ischemic heart disease								
Daytime worker	195,280	63	Referent			Referent		
Fixed-night worker	11,751	5	1.28	0.51, 3.17	0.601	1.23	0.49, 3.10	0.658
Rotating-shift worker	26,838	18	2.27	1.34, 3.84	0.002	2.32	1.37, 3.95	0.002

Fujono Y. Am J Epidemiol. 2006;164:128-135

Chomage et coronaires

The Cumulative Effect of Unemployment on Risks for Acute Myocardial Infarction

Matthew E. Dupre, PhD; Linda K. George, PhD; Guangya Liu, PhD; Eric D. Peterson, MD, MPH

+63%

Cumulative No. of job losses		
0	1 [Reference]	1 [Reference]
1	1.19 (1.02-1.39)	1.22 (1.04-1.42)
2	1.24 (1.03-1.50)	1.27 (1.05-1.54)
3	1.47 (1.18-1.83)	1.52 (1.22-1.90)
≥4	1.62 (1.28-2.05)	1.63 (1.29-2.07)
Cumulative time unemployed, y		
0	1 [Reference]	1 [Reference]
>0 to 1	1.35 (1.07-1.69)	1.27 (1.01-1.60)
2 to 4	1.08 (0.89-1.31)	0.96 (0.79-1.17)
≥5	1.05 (0.87-1.28)	0.90 (0.74-1.09)

Cumulative time unemployed: 0 y; >0 to 1 y; 2 to 4 y; ≥5 y. Rate of Age-Specific AMI vs Age, y. $P < .001$
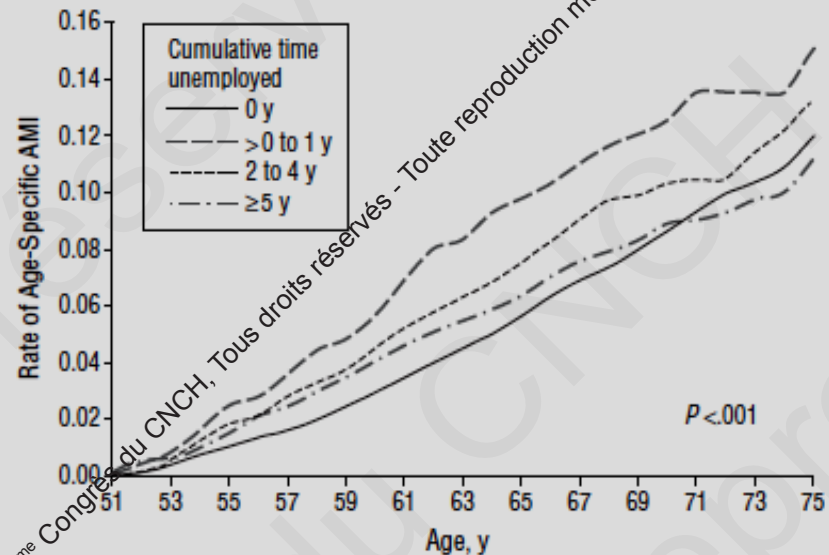
Arch Intern Med. 2012;172(22):1731-1737.

STRESS PSYCHOSOCIAL

PSYCHOLOGIE | SOCIOLOGIE | SOCIO-ECONOMIE

Facteurs de risque
Comportement
Observance

Activation Inflammatoire
Activation Coagulation
Dysfonction endothéliale
Baisse Variabilité Sinusale

Génétique

MALADIE CORONAIRE

MODES D'ACTIONS DU STRESS PSYCHOSOCIAL

Un triple aspect

1. Un métier stressant

2. **Le stress de la maladie**

3. Le stress de la reprise

Un bouleversement déstabilisant

NAISSANCE → Sens de la vie...Valeurs de vie.....Buts de vie → **MORT**

MALADIE CHRONIQUE
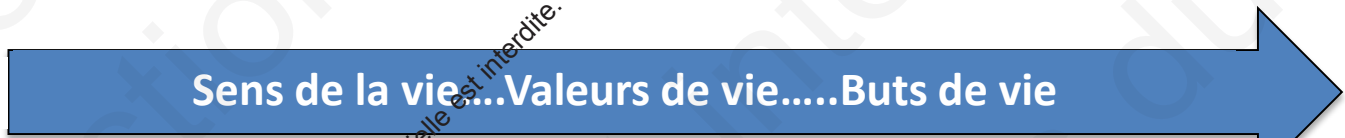
DEUIL
- Immortalité
- Santé

PEURS
- Mort
- Abandon
- souffrance
- Dégradation

COPING

- Locus of Control

- Coping émotionnel
- Coping cognitif

- Coping Actif
- Coping passif

Perturbation des buts de vie
- Limitation physique
- Peur
- Croyances

Nouveaux buts de vie

Schéma d'adaptation à la maladie chronique

Jean Cassanas

Je reviens d'un infarctus

Mon voyage entre deux mondes

Préface du docteur
Jean-Pierre Houppe

frison
roche

Trop fréquent pour être ignoré

- **Déni: ??? (Jugement extérieur)**
- **Anxiété:**
  - 30% à la phase aigue
  - 20% à 1 an
- **Dépression**
  - Dépression caractérisée: 20%
  - Traits dépressifs: 40%
- **SSPT:**
  - de 15% à 30%

Bouleversement émotionnel : 100%

STRESS PSYCHOSOCIAL

PSYCHOLOGIE · SOCIOLOGIE · SOCIO-ECONOMIE

- Facteurs de risque / Comportement
- Activation Inflammatoire / Activation Coagulation / Dysfonction endothéliale / Baisse Variabilité Sinusale
- Génétique

MALADIE CARDIO-VASCULAIRE

MODES D'ACTIONS DU STRESS PSYCHOSOCIAL EN CARDIOLOGIE

Mental health status and risk of new cardiovascular events or death in patients with myocardial infarction: a population-based cohort study

Tine Jepsen Nielsen,[1] Mogens Vestergaard,[2] Bo Christensen,[1] Kaj Sparle Christensen,[3] Karen Kjær Larsen[2]

+ 50 %
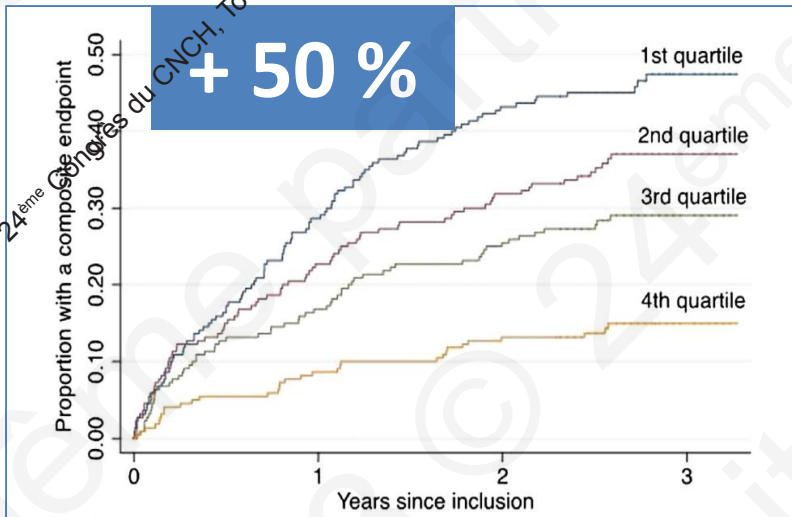
**Mortalité globale
Évènements CV(SCA et AVC)**

CONCLUSION

We found that low mental health status following MI was associated with an increased risk of new cardiovascular events or death. The association was explained partly by cardiac disease severity, physical activity, depression and anxiety, but low mental health status remained an independent prognostic risk factor. Further research is needed to disentangle the pathways that link mental health status following MI to prognosis and, in continuation hereof, to identify interventions that can improve mental health status and prognosis.

**MCS : Mental Score Component
Vitalité, émotions, Relations sociales
Sensations Physiques de bien être**

Créer une alliance thérapeutique

On n'éduque pas un adulte souffrant

Jean-Daniel Lalau

Anne Lacroix

Alain Deccache

Michel Wawrzyniak

Comprendre les personnes

« On n'éduque pas un adulte souffrant »

Un triple aspect

1. **Un métier stressant**

2. **Le stress de la maladie**

3. **Le stress de la reprise**

Le stress de la reprise

Psychologic Distress in Postmyocardial Infarction Patients Who Have Returned to Work

CHANTAL BRISSON, PhD, RICHARD LEBLANC, PhD, RENÉE BOURBONNAIS, PhD, ELIZABETH MAUNSELL, PhD, GILLES R. DAGENAIS, MD, MICHEL VÉZINA, MD, BENOÎT MASSE, PhD, AND EDELTRAUT KRÖGER, MSc

Objective: To assess the prevalence of psychologic distress in women and men returning to work after a myocardial infarction (MI) and to compare this prevalence with the prevalence observed among men and women of the general working population. **Methods:** The study population was composed of 990 post-MI patients (106 women and 884 men) recruited in 30 hospitals who had returned to work after their first MI. Psychologic distress was measured with the French version of the Psychiatric Symptom Index (PSI). Adjusted mean PSI score and prevalence of psychologic distress were compared with those observed in 8829 other workers (3823 women and 5006 men), representative of the general working population. **Results:** Mean PSI score was higher in post-MI women (30.3) than in post-MI men (20.3). This score was also higher in the post-MI population than in the general working population, both for women (30.3 compared with 17.0) and men (20.3 compared with 14.1). Psychologic distress was more prevalent in post-MI women than in post-MI men (prevalence ratio [PR], 1.62; confidence interval [CI], 1.27–2.07). This score was also higher in post-MI women and post-MI men than in the general working population (PR, 2.18; CI, 1.75–2.71 and 1.76; CI, 1.48–2.08, respectively). **Conclusions:** Among the presumably fittest post-MI patients, namely those who had returned to work, psychologic distress was significantly more prevalent than in the general working population, particularly among women. Further research is needed to shed light on prognosis in post-MI workers experiencing psychologic distress and on adequate intervention before and after their return to work. **Key words:** psychologic distress, post-MI patients, return to work.

PR = prevalence ratio; CI = confidence interval; MI = myocardial infarction; PSI = Psychiatric Symptom Index.

Femmes: 2,18
Hommes: 1,76

Brisson C .Psychosom Med. 2005; 67:59-63

QUE FAIRE ?

Guidelines...OUI

European Heart Journal (2016) **37**, 2315–2381
doi:10.1093/eurheartj/ehw106

JOINT ESC GUIDELINES

2016 European Guidelines on cardiovascular disease prevention in clinical practice

The Sixth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (constituted by representatives of 10 societies and by invited experts)

Developed with the special contribution of the European Association for Cardiovascular Prevention & Rehabilitation (EACPR)

Guidelines.. NON

ESC GUIDELINES

2015 ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation

Task Force for the Management of Acute Coronary Syndromes in Patients Presenting without Persistent ST-Segment Elevation of the European Society of Cardiology (ESC)

clinical practice guidelines

Primary breast cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up[†]

E. Senkus[1], S. Kyriakides[2], S. Ohno[3], F. Penault-Llorca[4,5], P. Poortmans[6], E. Rutgers[7], S. Zackrisson[8] & F. Cardoso[9], on behalf of the ESMO Guidelines Committee*

[1]Department of Oncology and Radiotherapy, Medical University of Gdańsk, Gdańsk, Poland; [2]Europa Donna Cyprus, Nicosia, Cyprus; [3]Breast Oncology Center, Cancer Institute Hospital, Tokyo, Japan; [4]Department of Pathology, Centre Jean Perrin, Clermont-Ferrand; [5]EA 4677 Université d'Auvergne, Clermont-Ferrand, France; [6]Radboud University Medical Center, Nijmegen, The Netherlands; [7]Department of Surgery, Netherlands Cancer Institute, Amsterdam, The Netherlands; [8]Department of Diagnostic Radiology, Lund University, Malmö, Sweden; [9]Breast Unit, Champalimaud Clinical Center, Lisbon, Portugal

Mais « position paper »

Psychosocial aspects in cardiac rehabilitation: From theory to practice. A position paper from the Cardiac Rehabilitation Section of the European Association of Cardiovascular Prevention and Rehabilitation of the European Society of Cardiology.

Pogosova N[1], Saner H[2], Pedersen SS[3], Cupples ME[4], McGee H[5], Höfer S[6], Doyle F[5], Schmid JP[7], von Känel R[8]; Cardiac Rehabilitation Section of the European Association of Cardiovascular Prevention and Rehabilitation of the European Society of Cardiology.

⊕ Collaborators (9)

⊕ Author information

Abstract

A large body of empirical research shows that psychosocial risk factors (PSRFs) such as low socio-economic status, social isolation, stress, type-D personality, depression and anxiety increase the risk of incident coronary heart disease (CHD) and also contribute to poorer health-related quality of life (HRQoL) and prognosis in patients with established CHD. PSRFs may also act as barriers to lifestyle changes and treatment adherence and may moderate the effects of cardiac rehabilitation (CR). Furthermore, there appears to be a bidirectional interaction between PSRFs and the cardiovascular system. Stress, anxiety and depression affect the cardiovascular system through immune, neuroendocrine and behavioural pathways. In turn, CHD and its associated treatments may lead to distress in patients, including anxiety and depression. In clinical practice, PSRFs can be assessed with single-item screening questions, standardised questionnaires, or structured clinical interviews. Psychotherapy and medication can be considered to alleviate any PSRF-related symptoms and to enhance HRQoL, but the evidence for a definite beneficial effect on cardiac endpoints is inconclusive. A multimodal behavioural intervention, integrating counselling for PSRFs and coping with illness should be included within comprehensive CR. Patients with clinically significant symptoms of distress should be referred for psychological counselling or psychologically focused interventions and/or psychopharmacological treatment. To conclude, the success of CR may critically depend on the interdependence of the body and mind and this interaction needs to be reflected through the assessment and management of PSRFs in line with robust scientific evidence, by trained staff, integrated within the core CR team.

Que peut faire le cardiologue?

- **Avoir conscience de la problématique**

- **Evaluer le niveau de stress psychosocial**

- **Déterminer la part du SPS dans la survenue de la maladie**

- **Evaluation psychique:**

    – **« Et psychiquement vous allez comment? »**

- **Prendre le temps de laisser la parole: Temps gagné sur le futur**

- **Prise en charge globale**

QUELLE TYPE DE PRISE EN CHARGE?

La prise en charge avant l'accident

- **Les Modalités**
  - **Primaire: structure**
    - **Réflexion et élaboration d'une structure de travail non stressante**
  - **Secondaire: éviter**
    - **Améliorer la gestion individuelle**
    - **Pas de secondaire sans primaire**
  - **Tertiaire: traiter**
    - **Burn-out**
    - **Dépression**
    - **SSPT**

Pourquoi après l'infarctus ?

- **POURQUOI?**
  - **Troubles psychosociaux: absentéisme, accidents du travail**
  - **Pronostic cardiovasculaire**
    - **Dépression : risque x 3**
    - **Anxiété: risque x 2.5**
    - **SSPT: risque X 2**
- **Situations cliniques très diverses**
- **Situations psychosociales diverses**
  - Réadaptation et ETP faites et ...parfaites
  - Aucune prise en charge

Tully PJ.Psychosom Med. 2010
Székely A.Psychosom Med. 2007
Frasure-Smith N, Lesperance F. Can J Psychiatry. 2006.
Nicholson A, Kuper H, Hemingway H. s.Eur Heart J. 2006

Faut-il évaluer et comment ?

- **Diagnostic Psychosocial**
  - **entretien libre +++**
  - **Questionnaires d'évaluation**
- **Evaluation Emotionnelle**
- **Perturbation des buts de vie**
  - **Valeurs de vie et Buts personnels**
  - **Perturbation vis à vis de l'entourage (famille, amis)**
  - **Perturbation pour le travail**
- **Evaluation Sociale**
  - **Activités Sociales**
  - **Support Social**

Statut socio-économique	1. Quel est votre niveau d'études ? 2. Etes-vous travailleur manuel ?
Stress Familial et professionnel	1. Avez-vous une possibilité de contrôler votre demande de travail ? 2. Estimez-vous être normalement récompensé pour votre investissement au travail ? 3. Avez-vous des problèmes sérieux dans votre relation de couple ?
Isolement Social	1. Vivez vous seul ? 2. Avez-vous une personne à qui vous confier?
Dépression	1. Vous sentez-vous triste, déprimé ou sans espoir ? 2. Avez-vous perdu de l'intérêt et du plaisir à vivre ?
Anxiété	1. Vous sentez-vous souvent nerveux, anxieux ou « a cran » 2. Etes-vous souvent incapable de mettre fin ou de contrôler une préoccupation?
Hostilité	1. Vous mettez-vous souvent en colère pour des choses banales ? 2. Etes-vous souvent irrité par le comportement des autres ?
Personnalité de type D	1. Etes-vous généralement, anxieux, dépressif ou irritable ? 2. Evitez-vous de partager vos idées et vos émotions avec les autres ?

Questionnaire d'évaluation du Stress psychosocial adapté du modèle de L'ESC

Validité du questionnaire ESC ?

Validity of the European Society of Cardiology's Psychosocial Screening Interview in patients with coronary heart disease - The THORESCI study.

van Montfort E[1], Denollet J, Widdershoven J, Kupper N.

⊕ Author information

Abstract

AIM: To examine the validity of the European Society of Cardiology (ESC) psychosocial screening instrument.

METHOD: 508 acute (67%) or elective (33%) percutaneous coronary intervention (PCI) patients (mean age=63 years, SD=10; 81% male) completed the ESC screening interview and established questionnaires for psychosocial risk markers, i.e., depression (PHQ-9), anxiety (GAD-7), Type D personality (DS14), hostility (CMHS-7), and marital/work stress (MMQ-6, ERI) during or close after hospital admission. At 1-year follow-up angina and cardiopulmonary symptoms were assessed.

RESULTS: Prevalence estimates of psychosocial factors based on the ESC screener were as follows: depression (18%), anxiety (33%), negative affectivity (11%), social inhibition (41%), work stress (17%), marital stress (2%), hostility (38%). Analysis of correspondence with validated questionnaires revealed fair to moderate agreement (depression [Kappa=.39], anxiety [Kappa=.23], Type D personality [Kappa=.21]), regardless of PCI indication. For work and marital stress, there was poor to fair performance (Kappa range: .04-.24); agreement for hostility was poor (Kappa=-.27). A positive ESC screen for depression, anxious tension and Type D personality was associated with more angina and cardiopulmonary symptoms at follow-up (ORs ranging between 1.85 (95%CI 0.84-4.08) and 8.01 (95%CI=2.35-27.35).

CONCLUSIONS: The ESC screener contributes to the search for a multidimensional and easy-to-use psychosocial screening instrument for cardiac patients. Although the screener, in its current form, may not be sufficiently valid to reliably detect all predefined psychosocial factors, screening scores for depression and anxiety might be useful in clinical practice. Our findings can be used for the further refinement and validation of the screener.

Comment et pour qui?

- **Prise en charge Multidimensionnelle**
  - **Patient**
  - **Entourage familial**
  - **Entourage professionnel**
  - **Stress de l'employeur**
  - **Stress du médecin du travail…**

Travail d'équipe: Interfaces
  - **Patient**
  - **Psychologue, infirmières, Kiné, ergothérapeutes**
  - **Cardiologues, Psychiatres,**
  - **médecin du travail , Employeur**

- **Qualité relationnelle ++++**

Quelles Méthodes de prise en charge ?

Traitements psychotropes

- ## Anxiolytiques
  - Phase aigue, **Traitement bref**
  - Dépendance
  - **Aucune étude en cardiologie**

- ## Antidépresseurs
  - **Etudes: SADHART,ENRICHD,CREATE , MIND-IT**
  - **Connaissances:**
    1. **Les IRSS agissent sur les dépressions majeures.**
    2. **Les IRSS sont inutiles pour les autres dépressions**
    3. **L'usage de IRSS est possible**
    4. **Peu d'efficacité des IRSS sur la morbi-mortalité cardiovasculaire**

ACTIVITE PHYSIQUE

- **METHODE EFFICACE**
  - FIGHT or FLIGHT
  - FREEZE

- **EFFETS BIOLOGIQUES**
  - Moindre production d'interleukines en cas de stress chez les sportifs
  - **Facilite la production de VGF au niveau de l'hippocampe**
    - Améliore la neuroplasticité
    - **Action antidépressive et anxiolytique.**
    - Augmente la résistance au stress

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PSYCHOTHERAPIES

PSYCHANALYSE

COHERENCE CARDIAQUE

SOPHROLOGIE

HYPNOSE

RELAXATION

TCC

METHODES PSYCHOLOGIQUES

METHODES CORPORELLES

MEDITATION

JACOBSON

EMDR

TRAINING AUTOGENE
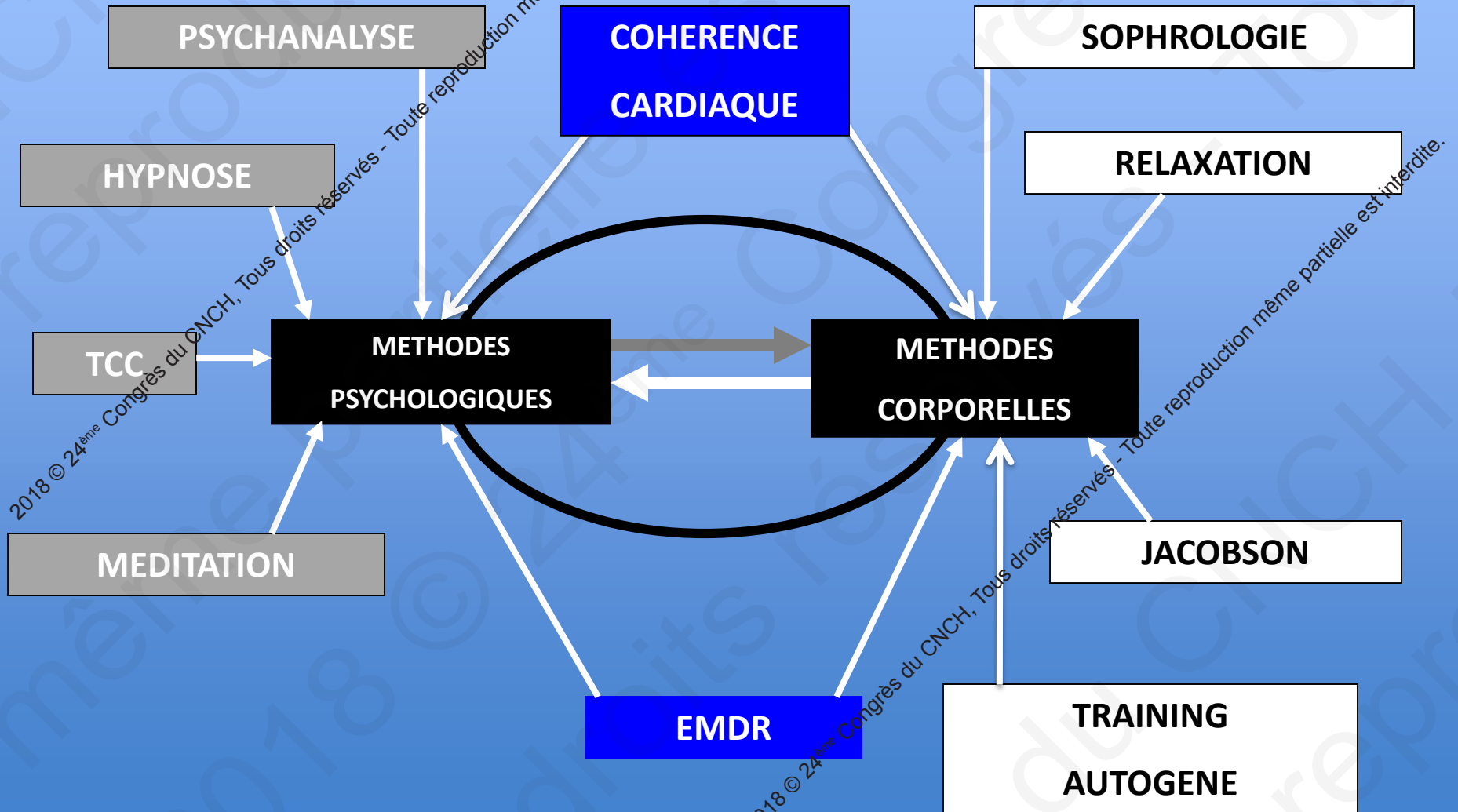
Quelles techniques employer?

- **Prévention et techniques en autonomie**
  - Activité physique
  - Relaxation psychocorporelle
  - Sophrologie
  - Cohérence cardiaque
  - Méditation en pleine conscience
  - Apprentissage à communication (analyse transactionnelle)

Quelles techniques employer?

- **Prise en charge curative avec un thérapeute**
  - Traitement médicamenteux
  - Thérapies cognitivo-comportementales
  - Hypnose
  - EMDR
  - Thérapies d'acceptation et d'engagement

Randomized Controlled Trial of Cognitive Behavioral Therapy vs Standard Treatment to Prevent Recurrent Cardiovascular Events in Patients With Coronary Heart Disease

Secondary Prevention in Uppsala Primary Health Care Project (SUPRIM)

Mats Gulliksson, MD, PhD; Gunilla Burell, PhD; Bengt Vessby, MD, PhD; Lennart Lundin, MD, PhD; Henrik Toss, MD, PhD; Kurt Svärdsudd, MD, PhD

Récidive à 9 ans

- 45 %

**Background:** Psychosocial factors are independently associated with increased risk of cardiovascular disease (CVD) morbidity and mortality, but the effects of psychosocial factor intervention on CVD are uncertain. We performed a randomized controlled clinical trial of cognitive behavioral therapy (CBT) to measure its effects on CVD recurrence.

Methods: The study included 362 women and men 75 years or younger who were discharged from the hospital after a coronary heart disease event within the past 12 months. Patients were randomized to receive traditional care (reference group, 170 patients) or traditional care plus a CBT program (intervention group, 192 patients), focused on stress management, with 20 two-hour sessions during 1 year. Median attendance at each CBT session was 85%. Outcome variables were all-cause mortality, hospital admission for recurrent CVD, and recurrent acute myocardial infarction.

Results: During a mean 94 months of follow-up, the intervention group had a 41% lower rate of fatal and non-
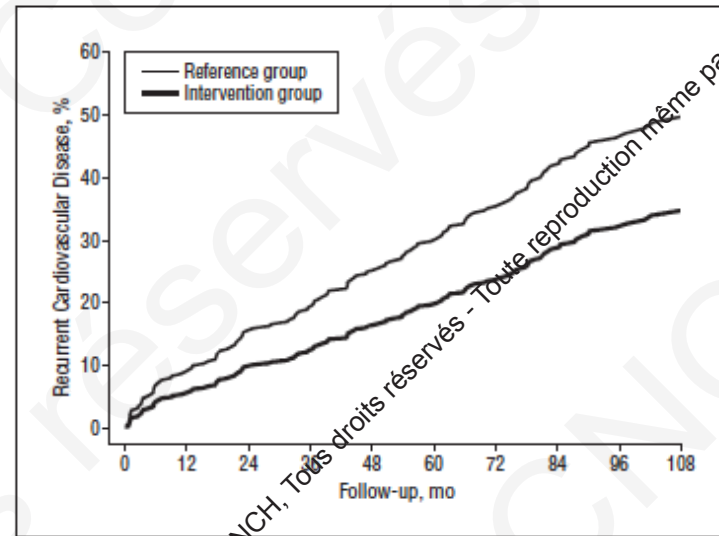
Figure 2. Cumulative first recurrent fatal and nonfatal cardiovascular events during 9 years (108 months) from baseline, adjusted for the influence of age, sex, marital status, education, smoking habits, comorbidity (number of previous acute myocardial infarctions, angina pectoris, hyperlipidemia, hypertension, heart failure, diabetes mellitus, asthma/chronic obstructive pulmonary disease, and stroke), peripheral artery disease, and 2-year mean systolic blood pressure, serum cholesterol, and serum triglyceride level, and scores for vital exhaustion, coping ability resources, and credence in the future, by treatment group.

CONCLUSIONS

1. **Place centrale de la réadaptation**
2. **Pilier de la reprise et de l'évolution secondaire**
3. **Implique toute la filière cardiologique**
4. **Triple aspect (maladie, travail, reprise)**
5. **En pratique**
   1. **Faire le bilan psychosocial**
   2. **Prendre en charge**
      1. **Activité physique**
      2. **Psychothérapies**
   3. **Développer des interfaces**
   4. **Prolonger la prise en charge…**

Intérêts de la prise en charge psychosociale en réadaptation

- **Prévention coronarienne**
- **Amélioration de la reprise du travail**
- **Amélioration du sevrage tabagique**

PSYCHOSOCIAL FACTORS

| SMOKING RELAPSE | CV RISK | RETURN TO WORK |

PHYSICAL ACTIVITY → - **25%** (5,6)

OR:1,84 (3)

OR:1,98 (1,2)

STRESS MANAGEMENT → - **45%** (4)

Q.O.L

CARDIOVASCULAR   MORTALITY
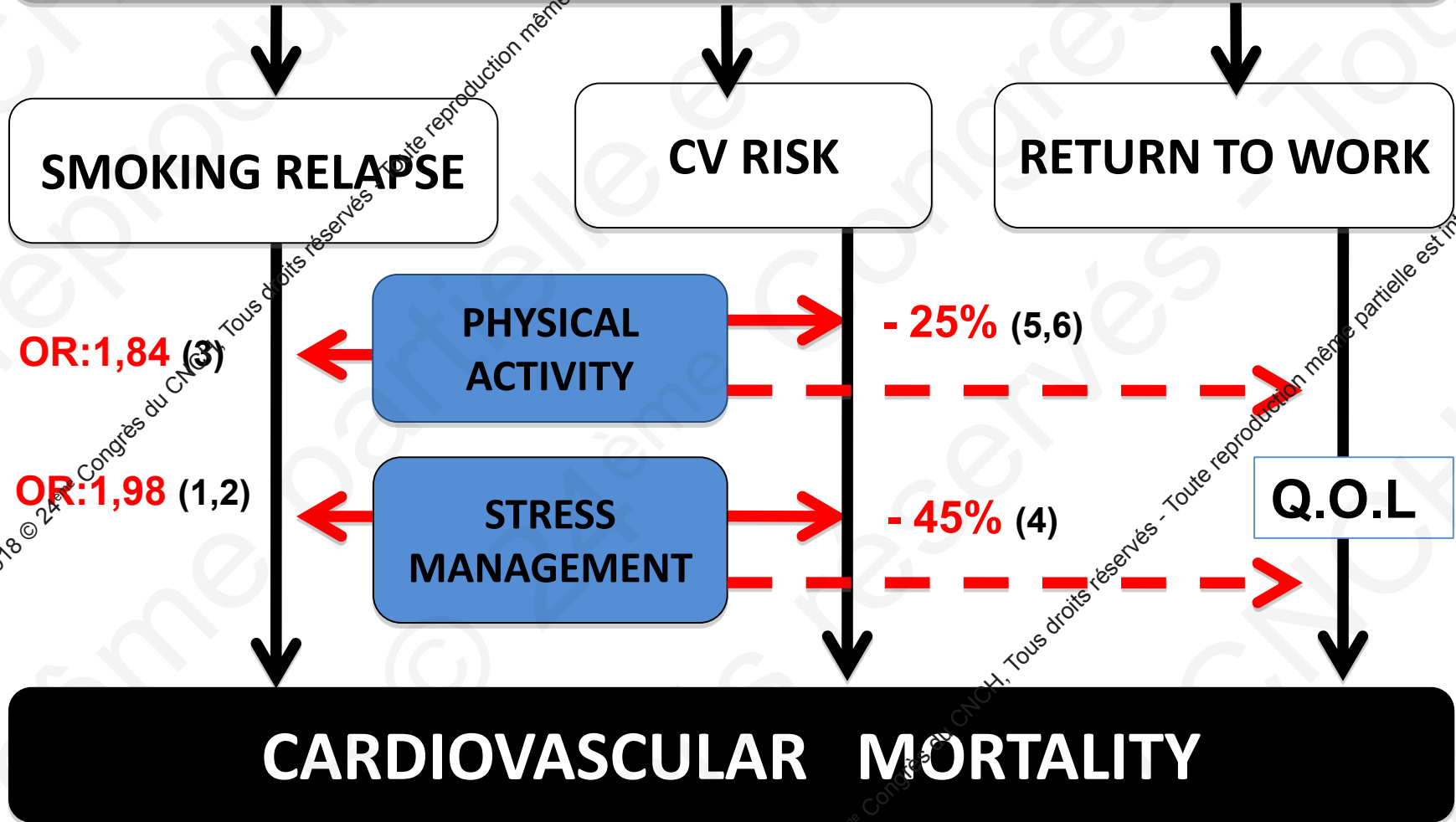
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La maladie est biopsychosociale

Le paradigme biopsychosocial

1. **Maladie biopsychosociale**
2. **Prise en charge biopsychosociale**
3. **Réadaptation biopsychosociale**
4. **Education thérapeutique biopsychosociale**

Behavioral Cardiology

Current Advances and Future Directions
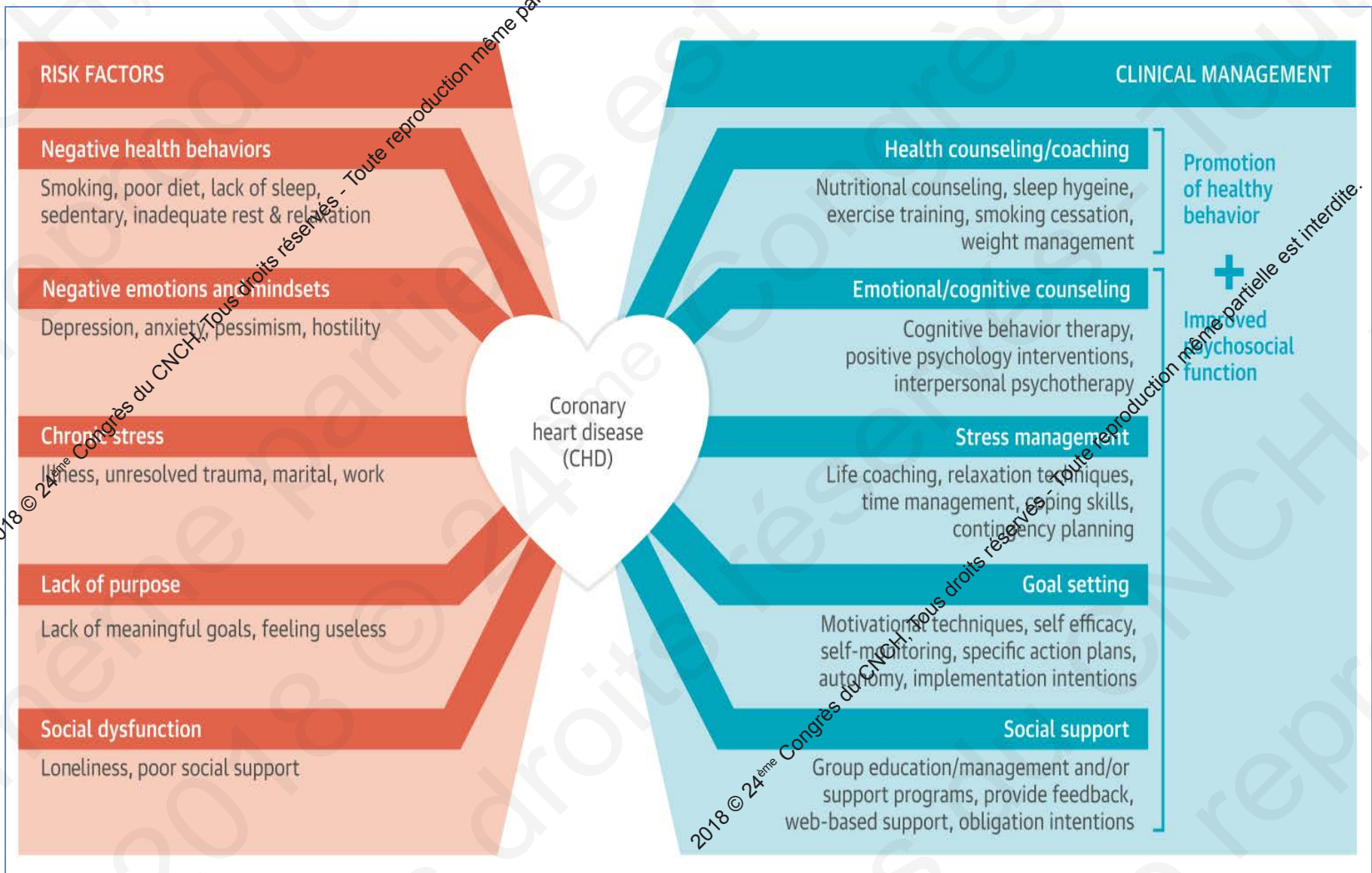
Alan Rozanski, MD

ABSTRACT

Growing epidemiological evidence identifies key domains relevant to behavioral cardiology, including health behaviors, emotions, mental mindsets, stress management, social connectedness, and a sense of purpose. Each of these domains exists along a continuum, ranging from positive factors that promote health, to negative factors, which are pathophysiological. To date, there has been relatively little translation of this growing knowledge base into cardiology practice. Four initiatives are proposed to meet this challenge: 1) promulgating greater awareness of the potency of psychosocial risks factors; 2) overcoming a current "artificial divide" between conventional and psychosocial risk factors; 3) developing novel cost-effective interventions using Internet and mobile health applications, group-based counseling, and development of tiered-care behavioral management; and 4) in recognition that "one size does not fit all" with respect to behavioral interventions, developing specialists who can counsel patients in multidisciplinary fashion and use evidence-based approaches for promoting patient motivation and execution of health goals. (J Am Coll Cardiol 2014;64:100–10) © 2014 by the American College of Cardiology Foundation. Open access under CC BY-NC-ND license.

Prise en charge globale

RISK FACTORS

Negative health behaviors
Smoking, poor diet, lack of sleep, sedentary, inadequate rest & relaxation

Negative emotions and mindsets
Depression, anxiety, pessimism, hostility

Chronic stress
Illness, unresolved trauma, marital, work

Lack of purpose
Lack of meaningful goals, feeling useless

Social dysfunction
Loneliness, poor social support

Coronary heart disease (CHD)

CLINICAL MANAGEMENT

Health counseling/coaching
Nutritional counseling, sleep hygeine, exercise training, smoking cessation, weight management

Emotional/cognitive counseling
Cognitive behavior therapy, positive psychology interventions, interpersonal psychotherapy

Stress management
Life coaching, relaxation techniques, time management, coping skills, contingency planning

Goal setting
Motivational techniques, self efficacy, self-monitoring, specific action plans, autonomy, implementation intentions

Social support
Group education/management and/or support programs, provide feedback, web-based support, obligation intentions

Promotion of healthy behavior

+

Improved psychosocial function

Conclusion

Quelques minutes d'écoute empathique permettent d'économiser beaucoup de temps, beaucoup de complications et beaucoup d'argent