Sexologies (2012) 21, 109—112

Disponible en ligne sur
SciVerse ScienceDirect
www.sciencedirect.com

Elsevier Masson France
EM|consulte
www.em-consulte.com

ORIGINAL ARTICLE

The Consultation-Liaison Psychiatry, an effective process between heart and sexuality☆

A. Sauvaget*, M. Guitteny

Consultation-Liaison Psychiatry Unit, Addictology and Psychiatry University Department, University Hospital of Nantes, 85, rue Saint-Jacques, 44093 Nantes cedex 1, France

Available online 27 February 2012

KEYWORDS
Consultation-liaison psychiatry;
Erectile dysfunction;
Cardiovascular disease;
Comorbidity;
Multidisciplinary;
Complexity

Summary Erectile dysfunction (ED) is now considered as a marker of vascular diseases. Psychiatric disorders and psychosocial factors may increase ED. Therefore, the latest recommendations prescribe to look for these factors. There is definitely some evidence connecting psychosocial factors, ED and vascular diseases. However, the role of these factors and their relationship in the emergence of depressed mood and ED is still debatable. Consultation-Liaison Psychiatry contributes to an integrative and comprehensive health care approach for patients with cardiovascular diseases. Moreover, Consultation-Liaison Psychiatry intervention takes place in both primary and secondary prevention. Consequently, Consultation-Liaison Psychiatry is used to perform an in-depth assessment of the in-patient psychiatric status, in a dimensional approach or a categorical approach. Typical issues to consider during the interview might include: major psychiatric disorder, side effects of toxic and medical/surgical conditions or treatments, specific personality traits, psychological functioning. Then the consultation-liaison psychiatrist can supply appropriate diagnostic and therapeutic information to medical colleagues. However, these propositions highly depend on the somatic conditions and psychological functioning and coping strategies of the patient. We consider that there is a need for special expertise, provided by the consultation-liaison psychiatrist, in the management of complex problems involving psychological and physical issues. Thus, Consultation-Liaison Psychiatry is a great medical speciality, which enables the medical and psychosocial approaches to improve bio-psychosocial outcomes of the patients. A multidisciplinary and collaborative approach is highly recommended for ED, a prototype of the case complexity. Integrating the sexuality theme in the care programs for patients with cardiovascular disease, for example therapeutic education could be very useful for the patients, as well as the promotion of the multidisciplinary works.

Introduction

Erectile dysfunction (ED) is now considered as a marker of vascular diseases. There is some strong evidence linking ED and endothelial dysfunction (Jackson et al., 2006). Psychiatric disorders and psychosocial factors may increase

☆ Également en version française dans ce numéro : Sauvaget A., Guitteny M. Entre cœur et sexualité, la place du psychiatre de liaison.

* Corresponding author.
E-mail address: anne.sauvaget@chu-nantes.fr (A. Sauvaget).

1158-1360/$ - see front matter © 2012 Elsevier Masson SAS. All rights reserved.
doi:10.1016/j.sexol.2012.01.007

ED. Therefore, the last recommendations prescribe to look for these factors (Lewis et al., 2010). This article aims at highlighting the role of Consultation-Liaison Psychiatry (C-L Psychiatry) in both the evaluation and care management for patients suffering from cardiovascular disease and an ED. A multidisciplinary and collaborative approach is highly recommended for ED, a prototype of the case complexity.

What are the links between psychiatric disorders, psychosocial factors, erectile dysfunction and cardiovascular disorders (CVD)?

Epidemiological links between depression and heart disease are evident. The prevalence of heart disease in patients with depression is high (Kent and Shapiro, 2009). Depression is widely considered a significant risk factor in patients with coronary heart disease and has been related to adverse outcomes in patients with established heart failure (Pena et al., 2011; Sherwood et al., 2011). Moreover, depression is associated with greater cardiovascular mortality (Win et al., 2011). Treatment of depression may improve cardiovascular outcome. Negative affects, as depressive symptoms, anger and hostility are supposed to be linked with heart disease (Kent and Shapiro, 2009).

There is definitely some evidence connecting psychosocial factors, ED and vascular diseases. Psychiatric disorders, mainly anxiety and depression, are strongly associated with ED for men, and with orgasmic dysfunction and dyspareunia for women. Cumulating evidence confirm the association between depression, antidepressant drugs and sexuality. Furthermore, ED is positively correlated with sexual performance anxiety and phobic disorder.

The psychological ED risk factors include trait factors (i.e. personality). ED is a marker of vascular disease and trait factors may be a risk factor for vascular disease (arterial hypertension and heart attack). The dimensional approach identifies different trait factors involved in interactions between psychological factors and physical health: Type A behaviour pattern, Type D personality and hostility (Friedman and Rosenman, 1959).

The type A behaviour pattern has been described as striving to do as much as possible in the shortest possible period of time, as competitive, and as aggressive (sense of time urgency, competitiveness, and aggressiveness). This trait factor is actually considered as a risk factor to the vulnerability for stress. Personality trait factors may be either a protective or a risk factor depending on the health status of the person (sick or healthy). Hostility is one of the most studied trait factors and has proved to be a risk factor for CVD. Hostility is also a main trait of the paranoid personality.

The type-D pattern is defined by high levels of negative affectivity and high levels of social inhibition. In recent years, the type-D construct has been established as a predictor of cardiac prognosis in patients with CVD. The type-D personality is very close to the avoidant personality. So, there could be a strong correlation between patients with, ED, CVD and personality traits (Consoli, 2006; Lemogne et al., 2008). Type A and Type D patterns may be a risk factor for depressive mood and ED. However, the role of these factors and their relation ship in the emergence of depressed mood and ED is still debatable.

The definitions for sexual disorders do not generally separate organic- from psychogenic-caused dysfunctions. These two categories of organic and psychological dysfunctions are not mutually exclusive (Lewis et al., 2010). Diabetes mellitus, cardiovascular disease, psychiatric/psychological disorders are all common risk factor categories associated with sexual dysfunction for men and women. In women, some more specific risk factors have been highlighted: anxiety and depression, adverse effects of antidepressants, which delay the orgasm, past history of emotional, physical, and sexual abuse. In men, cumulating evidence confirms the association between metabolic syndrome, cardiovascular diseases and ED (Levy, 1994). Research findings show that a detectable psychiatric condition is present in more than 60% of the patients suffering from ED, including depressive disorders in 25.2%, anxiety disorders in 11.7%, depression-anxiety co morbidity in 6.8% and personality disorders in 5.8% (Lemogne et al., 2008; Mallis et al., 2005).The guidelines about sexual dysfunction recommend searching for a psychiatric morbidity potentially associated to the ED. The assessment of a psychiatric disorder and its adequate treatment must be managed by a psychiatrist. When ED is associated to a cardiovascular disease, the first psychiatric evaluation occurs during the management of the cardiovascular disease mostly by the consultation-liaison psychiatrist.

Consultation-Liaison Psychiatry in cardiology

Consultation-Liaison Psychiatry

Epidemiological studies have underlined the prevalence of psychiatric comorbidities of medical and surgical inpatients. Psychiatric comorbidity in somatic patients is recognized as a major risk factor for impaired somatic treatment outcomes, longer length of stay and increased rehospitalization. The role of C-L Psychiatry is significant in the management of somatic patients with psychiatric comorbidity, specifically in case complexity. According to a bio-psychosocial model, C-L Psychiatry contributes to an integrative and comprehensive health care approach. Furthermore, C-L Psychiatry is involved in academic areas such as research and teaching. ''Consultation-liaison psychiatry is a subspecialty of psychiatry that incorporates clinical service, teaching, and research at the borderland of psychiatry and medicine'' (Lipowski, 1983). The theoretical references of C-L Psychiatry are based on psychiatry in the medically ill, psychosomatic medicine, and medical psychology. ''Consultation'' and ''liaison'' are two closely linked parts of each intervention of consultation-liaison psychiatry. Consultation is frequently carried out with the individual patients and aims at giving feedback to the requesting team. The liaison part of the work aims to raise awareness of the medical staff about the psychiatric or emotional aspects of delivering medical care. Liaison psychiatry involves many different ways of working (Consoli, 1995; Mayou, 2007).

There are course the classical interventions but also combined medical and psychiatric consultations are performed by C-L Psychiatry in the cardiology department at the university hospital of Nantes (France).

Psychiatric intervention in cardiovascular disease

ED in cardiovascular disease is insufficiently investigated and under-diagnosed. Sexual problems are frequently overlooked or neglected by clinicians. Taking on a sexual history is a sensitive task. It may be difficult for patients and sexual partners to complain about sexual dysfunction so a C-L Psychiatry consultation can be an opportunity for in-patients after a cardiac event such as myocardial infarction to talk about sexual problems. Basically, in the field of cardiovascular disease, psychiatrists will act in two different ways. On the one hand, the patient is referred to a psychiatrist for a psychiatric disorder. Some of psychiatric disorders are considered as risk factors for cardiovascular disease (coronary heart disease): affective disorders, anxiety disorders, addictive disorders, and psychotic disorders. This status requires a close monitoring of cardiovascular parameters. On the other hand, psychiatric symptoms or disorders may occur after a cardiac event or with cardiovascular predisposing factors such as major depressive disorder, adjustment disorder, panic disorder, and cognitive impairment. They require integrated care management, including psychological and/or psychiatric intervention.

There is a need for special expertise, provided by the consultation-liaison psychiatrist, in the management of complex problems involving psychological and physical issues. This approach involves collaboration and coordination between cardiology, primary care, sexology, and psychiatry.

Consultation-Liaison Psychiatrist and assessment in cardiologic wards

After a first psychosocial screening carried out by physicians and nurses, the consultation-liaison psychiatrist will perform an in-depth assessment of the in-patient psychiatric status. Typical issues to consider might include:

- is there a major psychiatric disorder, according to Diagnostic and Statistical Manual (DSM IV-TR) (APA, 2000) and International Classification of Disease (ICD-10) (WHO, 1992)? Affective disorders, addictive disorders with somatic complications, chronic psychoses, and anxiety disorders will be investigated;
- are there side effects of toxic and medical/surgical conditions or treatments? Side effects on sexuality (antidepressants), metabolic adverse effects (antipsychotics) and psychiatric side effects of medications (corticosteroids, interferon) will be explored (Guitteny-Collas et al., 2011);
- are there specific personality traits or premorbid personality?;
- psychological functioning will be assessed from specific issues such as coping strategies, alexithymia, type-A/type-D personality, anger/hostility;
- the patient will be asked about the sexual disorder: context of the onset, impact on psychological and psychiatric status.

The clinical interview may be completed by self-rated or physician-administered questionnaires in a dimensional approach or a categorical approach. The INTERMED method is designed to facilitate integrated patient-oriented health care for complex patients (Huyse et al., 1999; Stiefel et al., 1999). It stimulates interdisciplinary communication and seems helpful in the field of cardiovascular disease.

Then the C-L psychiatrist communicates appropriate diagnostic and therapeutic information to medical colleagues and other hospital staff members. To conclude, the C-L intervention contributes to an integrated approach, specifically for complex patients.

How the consultation-liaison psychiatrist manage in the cardiovascular event process (in the case of a heart failure [HF])

Psychiatrist's action apart from a heart failure

The psychiatrist is responsible for the diagnostic, the treatment and the follow-up of the psychiatric disorders. Psychotropic drug treatments, especially antipsychotics, potentially bring out adverse metabolic and cardiovascular effects, including weight gain, metabolic syndrome, type 2 diabetes mellitus, dyslipidaemia, hypertension, long QT syndrome. Such effects are prevalent and complex, but can be managed clinically when recognized. Management strategies for weight gain and metabolic syndrome mainly consist in critical assessment of benefits versus risks of psychotropic drugs and lifestyle changes (diet habits and physical activities). Management strategies need a strong and close coordination of psychiatric and general medical care to improve long-term health of psychiatric patients.

Psychiatrist's action after a heart failure

HF is associated with several psychological symptoms: mainly depressive symptoms and anxiety, but also suicidal ideas, delusion, insomnia, and care refusal. When such symptoms appear, the patient has to be evaluated by the C-L psychiatrist, in order to be treated. Then, the C-L psychiatrist may propose strategies for improving long-term health of cardiovascular patients, by taking into account existing general medical care.

Psychiatrist's action for patients with coronary heart disease

For patients with coronary heart disease, psychiatrists are mainly involved in the secondary prevention. Growing evidence indicates that depression and psychological stress factors are important primary and secondary risk factors for coronary heart disease. Thus, the main goal of the secondary prevention is to reduce depression and stress factors. The psychiatrist can use either psychotherapy such as cognitive behavioural therapy, psychodynamic therapy, supportive individual psychotherapy or pharmacological interventions. These interventions aim at improving the coping style and quality of life, mostly sexual quality of life for patients with coronary heart disease and ED. The psychological and pharmacological strategies are always managed with the other specialists, especially cardiologists.

Conclusion

ED and overwhelmingly sexuality is largely under investigated for patients with CVD. There is evidence that ED adversely affects the quality of life. ED is known to have complex and multiple psychological and physical aetiologies. Empirical evidence suggests a strong relationship between cardiovascular diseases, sexual functioning and psychological symptoms. Therefore, it is highly necessary to take into account psychosocial factors in the care management for patients with ED and CVD. ED has to be treated in a global and multidisciplinary perspective. The C-L Psychiatry is essential to assess the psychological state of these patients and to propose psychological/pharmacological interventions if necessary. Integrating the sexuality theme in therapeutic education in the care programs for patients with CVD could be very useful for the patients and for their partners. The C-L Psychiatry is also a great medical speciality, which enables the medical and psychosocial approaches to join together, in order to improve bio-psychosocial outcomes of the patients.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

References

APA. Diagnostic and statistical manual of mental disorders. 4th ed. Washington, DC: Author; 2000, American Psychiatric Association. Text revision.

Consoli SM. Maladie endothéliale, risque cardiovasculaire, dysfonction érectile et personnalité. Marseille: Communication AHIUS; 2006.

Consoli SM. « Psychiatrie de liaison ». Thérapeutique psychiatrique (Senon JL., Sechter D., Richard D). Paris: Hermann; 1995 [955—979].

Friedman M, Rosenman RH. Association of specific overt behavior pattern with blood and cardiovascular findings; blood cholesterol level, blood clotting time, incidence of arcus senilis, and clinical coronary artery disease. J Am Med Assoc 1959;169(12): 1286—96.

Guitteny-Collas M, Berramdane M, Volkaert M, Ricoux A, Hamidou M, Vanelle JM, Sauvaget A. Corticosteroid-induced hypomanic episodes observed in consultation-liaison psychiatry: which are the predictive factors? J Psychosomatic Res 2011;70:594.

Huyse FJ, Lyons JS, Stiefel FC, Slaets JP, de Jonge P, Fink P, Gans RO, et al. ''INTERMED'': a method to assess health service needs. I. Development and reliability. Gen Hosp Psychiatry 1999;21(1):39—48.

Jackson G, Rosen RC, Kloner RA, Khostis JB. The second Princeton consensus on sexual dysfunction and cardiac risk: new guidelines for sexual medicine. J Sex Med 2006;3:28—36.

Kent LK, Shapiro PA. Depression and related psychological factors in heart disease. Harv Rev Psychiatry 2009;17(6):377—88.

Lemogne C, Ledru F, Bonierbale M, Consoli SM. Erectile dysfunction and depressive mood in men with coronary heart disease. Int J Cardiol 2008.

Levy J. Impotence and its medical and psychosocial correlates: results of the Massachusetts male aging study. J Urol 1994;151:54—61.

Lewis RW, et al. Definitions/epidemiology/risk factors for sexual dysfunction. J Sex Med 2010;7:1598—607.

Lipowski ZJ. Discussion: liaison psychiatry and the quest for new knowledge. Gen Hosp Psychiatry 1983;5(2):111—4.

Mallis D, et al. Psychiatric morbidity is frequently undetected in patients with erectile dysfunction. J Urol 2005;174(5):1913—6.

Mayou R., The development of general hospital psychiatry, in Lloyd G.G. and Guthrie E., Handbook of Liaison Psychiatry, Cambridge University Press, 2007.

Pena FM, Modenesi Rde F, Piraciaba MC, Marins RM, Souza LB, Barcelos AF, et al. Prevalence and variables predictive of depressive symptoms in patients hospitalized for heart failure. Cardiol J 2011;18(1):18—25.

Sherwood A, Blumenthal JA, Hinderliter AL, Koch GG, Adams Jr KF, Dupree CS, et al. Worsening depressive symptoms are associated with adverse clinical outcomes in patients with heart failure. J Am Coll Cardiol 2011;57(4):418—23.

Stiefel FC, de Jonge P, Huyse FJ, Guex P, Slaets JP, Lyons JS, et al. ''INTERMED'': a method to assess health service needs. II. Results on its validity and clinical use. Gen Hosp Psychiatry 1999;21(1):49—56.

Win S, Parakh K, Eze-Nliam CM, Gottdiener JS, Kop WJ, Ziegelstein RC. Depressive symptoms, physical inactivity and risk of cardiovascular mortality in older adults: the Cardiovascular Health Study. Heart 2011;97(6):500—5.

World Health Organization. International Classification of Diseases (10th ed). Geneva: WHO, 1992.