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RESEARCH ARTICLE

PSYCHOLOGICAL EXPERIENCE AFTER MYOCARDIAL INFARCTION

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ABSTRACT

The author describes the problems that the patient has to face and compare them to experiences of vulnerability which can be particularly intense and lead to a serious coercion of the resumption of living, far beyond and reasonable limitation imposed by objective conditions. Depression is also biggest untreated risk factor in heart disease after heart attack.The depressive elaboration of the situation after the heart attack can enable the individual to reorganize his\her investments starting from the upset caused by the eruption of death anguish.

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INTRODUCTION

Any disturbance of a condition of psycho-physical-social well-being (irrespective of the role played by emotional elements act the starting moment of the disturbance) causes a complex series of consequences, on the emotional and relational levels, through the establishment of defensive attitudes which reflect the strength or the weakness of the self and, as far as possible, to relieve the patient from anxiety, from the sense of frustration and from all the unpleasant sensations which derive from the menace to one's own identity. The heart attack has some peculiar characteristics in this general ambit: first of all, abrupt, dramatic breaking of the previous balance. A sudden, quick beginning, often with no relevant premonitory signs, an impressive, prolonged symptomatology, a state of intense alarm of the patient and his\her family, the urgent hospitalization in a coronary unit: all this represents a sudden breaking of the health conditions and becomes even more dramatic when new consider the incidence of this problem among young people, at the height of their working age, which psychological investigation describes as being particularly linked to an image of the efficient self and unprepared for the frustato deriving from the modification of this image, after the illness. Put in an emergency situation, the individual tries a series of defenses, among which negation has the function of screening anguish.

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Obviously, if the victim of a heart attack, from the very first moment, was overwhelmed by terror because of the gravity of his\her state and the danger of death that he \his is experiencing at the moment, this perception would not be of any help to him\her and would further decrease the prognosis of survival in the first hours after attack. We were called by Giuseppa, 67, hospitalized because of ischemic cardiopathy with acute myocardial attack. The negation of the heart illness worked less in the woman, so that the anguish of death started and sometimes became intolerable. A pharmacological aid was required to soothe the increasing anxiety with was at its worst in the afternoon and at night. The lasting of a rigid attitude of negation can create adaptation problems to the limitations and to the rules imposed by the condition of post-heart attack and to the probable program of rehabilitation; in this case the negation ends up by no longer and the feelings of narcissistic wound which occur after the first phases of the heart attack, to elaborate these feelings positively and to undertake a realistic work of emotional re-investiment starting from the new condition. If the negation has something to do with the truth of things and thoughts (what is denied is not the event in itself, but the range of emotional reactions which it causes), the denial has to do with the existence itself of things, that is with their reality. Rosalia, 76, was moved from the clinic for nervous diseases to the coronary unit because of a myocardial attack. She was upset, she wasn't aware of her heart conditions and tried to get up to go back to the department where she had come from. Ideas of injury and slight confusion were attributed to panic, fear and were treated with promazine. The following day the patient (better oriented) kept on denying the heart problem saying: "By bringing me here, they have upset my

plans!". After six days, she appeared calm even if she was not taking any psychotropic drugs and was prepared to talk about her life. The sensation of attack on one's own body can be projected outside (Giuseppe, 70, hospitalized in intensive therapy, presented a restless mood with increasing anxiety until the evening when a subdelirant situation exploded: being convinced the a mortal accident has happened to his son, he interpreted any element is a Distorted way; he was upset and tried to go out to be reassured about his fears) and\or be attributed to the doctors (that is what happened to a 48 year old woman who was always suspicious of treatment: on day she said that the injection she had been given had "reached her throat!"). Another area of intensive emotional movements, often raised by a heart attack, are the feelings of strong regressive dependence which, when they are limited and temporary, allow the functioning parts of Self to get reorganized around the projects of co-operation within therapy; if the are uncontrolled and massive, instead, they can imply feelings of defeat and desperation, facing the collapse of the illusions of omnipotent and invulnerability.

The strongly regressive climate, linked to being hospitalized, cases the development of the patient's welcoming fantasies in a sort of total dependence from an exclusively good entity, but it is necessary to identify and increase the value of the autonomy elements against the tendency to de-responsibilisation. Sometimes this tendency is activated, at the moment of getting back home, by hyper protective attitudes towards the patient who is also treated as a child: this shows a sort of difficulty on the parent's side to accept and elaborate a basically passion position - with a projection of this position on the patient who is reinforced this way in his\her dearest traits and "made passive" in the condition of child to be controlled. When the victim of a heart attack goes back home, he\she is asked to elaborate the narcissistic wound the the heart attack has provoked in the image of self, to adapt to limitations (probably imposed) with a realistic attitude, to restructure his\her own relational world, in conditions of comparative weakness. The success or the failure of the psychological adaptation to a heart attack depends on the elaboration of this depressive position and by the type of defends put in progress against the anguish with corresponds to it. Freud asks himself, in "Mourning and Melancholy": "What is the role played by mourning?" His answer is that it is a difficult, slow job which implies an extremely painful interior process of gradual desertion.

Freud refers to the mourning we wear when somebody we love dies. But we could wear mourning also for the loss of what we once had or were or hoped it would have been, because there is an end, an end ti everything we have loved. However, there can also be an end to mourning; on this point Freud warns: It is remarkable that even though mourning involves serious shifting from a normal way to face life, we never think about considering it as a pathological state and entrusting the victim to medical treatment. We are confident that the mourning will be overcome after a certain period of time and we think that any interference is inappropriate, or even harmful. The process of mourning does not always follow a normal course. It can be excessively intense, or it could happen that we remain trapped in a condition of continuous sorrow, holding to our grief, incapable of going on with our lives. Actually, a heart attack is felt as a moment of dramatic break of a vital Balance. The victims are often young people with a personality profile "which comprises an excessive push to competition, aggressiveness, impatience and the exasperated fear of losing time. The type A individuals seem to engage in a chronic, endless and often vain fight against themselves, other people, circumstances, time and, sometimes, life itself. Frequently, they also show open but rationalized hostility and, almost ever, deep uncertainty". It is obvious that an event such as a heart attack implies looking at the precariousness of life and at the immanence of death and proposes an unavoidable moment of mourning upon the result of which the ability to achieve a follow-up re-adaptation depends extensively.

Samuel Taylor Coleridge (cfr. "The Rime od the Anciente Mariner"):

"Like one, that on a lonesome road,
Doth walk in fear and dread,
And having once turned round walks on,
And turns no more his head;
Because he knows, a frightful fiend
Doth close behind him tread." - Part VI, vv.446-451

In a personality with a narcissistic structure, an attitude of negation can be perpetuated with the re-activation of pre-attack behavioral patterns. This the case of Mario, 50, criminal lawyer, who, after a heart attack, filled his life his typical frenzied activity, with scars predisposition to relaxation, with active research of responsibility and deep commitment in his job, so that he neglected others aspects, feeling and family.Less than two years later he had another serious cardiac ischemic attack. Another case is that of Maria, 48, single woman, working as a manager. During an interview she said:"I couldn't have kept on thinking about this thing all the time". Against a mourning-grief that somehow she was not able to conclude and re-elaborate, she opposed a "hyperactive defense" which was rather anomalous if related to her pre-attack personality traits: she often worked overtime and started drinking a lot. This is the maniacal behavior of the those people who "keep themselves in movement", both psychologically and physically, to defend themselves from the depression which is felt as imminent.

As Pascal said: "Having been unable to cure death , misery and ignorance, men have decided not to think about them so that they can live happily". Too rigid personalities can settle on a projective emotional register, instead of one of depressive restoration. A 60-year-old-man, after a heart attack, developed a delusion of infidelity that, in the psychic economy of the indigo, worked as an operculum: it "bolted" mourning and became the only narcissistic proof of existence and identify, his only support, his only, even if frail, anchorage to the world, to the surrounding reality and to his own interior reality. Personalities with scarse capacities to tolerate the loss can also express a withdrawal made passive and renunciatory. Enzo, 62, pediatrician, says: "Every morning, waking up, the uselessness of everything grips my throat like a hand". Eight months ago, he had a heart attack. Today he has a deep, silent and unavoidable depression. He is already thinking about asking for early retirement due to disability. There is not a thought of a fuller appropriation of life - starting from the new condition as a victim of a heart attack, while a narcissistic, destructive attachment emerges, "in the dying life". This is what happened to a patient whom we are going to call Carlo. He is a 56-year-old who has a fast, successful career as a computer operator. He has an elder brother and an elder sister. His father, who died of a heart attack, was an authoritative managing director;

Carlo, too, has shown personality traits of strong competitively with a sense of urgency of time and too much importance given to external reality. He had a heart attack five months ago. As far as his heath is concerned, he would like to recapture the same mastery which he had when he was working ("I was able to anticipate any mistakes in projects elaborated by other people in my group") and it is intolerable to him to think about adapting to the limits and the rules imposed by his condition after the attack. The preoccupation about the sensation weakness felt at his first attempt to start his job again, has forced him to stop. The impotent misery of his soul and a tormenting sensation that nothing will ever change is what's left. Now he is asthenical and sleepless. A month before the acute myocardial attack his younger son had been hospitalized in the Neurosurgical Department because of crania-encephalic trauma. He had to interrupt his studies and his father was extremely upset because he had always treated him as an example of obedience and scrupulousness for the leder son who was, instead, transgressive and careless. Carlo had been very frightened by the news of the accident to his son who was in the Neurosurgical Department for two weeks for diagnostic tests.

In the ten days after the news of his son's hospitalization, Carlo has night angina; after ten days, in her turn, Carlo's daughter was hospitalized because of an acute abdomen problem: a twisted ovarian cyst on the peduncle was to be diagnosed, but in the meantime the heart attack had occurred. While remembering these events Carlo, deeply needing to have his feelings under control, has a lump in his throat, but not even a tear comes out of his eyes. In this case the role played by the real events could seem very important but, as Epictetus wrote in Manuale V: "Men are troubled and upset not by things, but by the opinions that they have about those things" (translated into Italian by G. Leopardi). The following of the events seems to be less important in Carlo than their resonance in a system of representations to which he is attached in a narcissistic way - what torments him is the fact of seeing his trust in his younger son as betrayed, that is the value which he attributes to an ideal image of self and of other people: the more demanding, the more fragile. The rationality, the logic, the foretelling which characterizes Carlo's professional activity - giving him the sensation of foreseeing and controlling every element with the gratifying experience of dominating the world, contrast with the events of his own life - unexpected, unpredictable, felt with a sense of importance ("The heart attack of Self" as Cassem and Hackett say) and which shun every possibility to modify them. Carlo cannot show the anguish which submerges him through his body; this incapability, together with a practical sense and with a practical sense and which the need for realism which characterizes his life-style, are possible causes of coronary risk - together with familiarity (now related to genetic alteration of ACE, genotype DD:deletion-deletion). The psychiatric has conducted a tireless fight to find a pharmacological treatment to depression. There are a lot od groups of medicines with diverse chemical structures and different mechanisms of action. Tricyclic medicines require particular attention in their clinic application, because of their on a wide range of receivers. In fact, as a consequence, this has a series of anticholinergic and cardio-vascular collateral secondary effects.

The common characteristic of serotoninergic antidepressant (SSRI) is the ability to inhibit the re-absorption of serotonin selectively at a synaptic level, with a different power in relation to the single molecules. The blocking action of the receptive spectrum, unlike the action of tricyclic medicines, is much reduced. At a clinical level this implies a drastic reduction of disturbances of anticholinergic type and a scarse effect on the cardiovascular system, on the same therapeutic efficacy. However, the depressive elaboration of the situation after the heart attack forces us to take loss feeling into consideration at a psychological level. It is a suffered process which can be activated and sustained thanks to psychotherapeutic intervention. It is upon the mature outcome of this process that the quality of the patient's improvement depends. After a myocardial attack, one of the authors' University colleagues started to move out of the field of power: "I don't give a damn if I can't finish my manuscript so that I can publish it in a certain issue of scientific magazine, or if I can't use it as a conference paper… I strongly feel the importance of caring about my life and the people who stand by me."

Conclusions

In a general hospital a psychopathological development can be easily observed as a reaction to heart disease which de-structures the existential order re-activating the most radical levels of anguish. The possibility that, in the medical services, there is a more careful and understanding attitude towards the subjective aspects of somatic suffering presupposes that the treating team gives up the massive use of defensive mechanisms which make the relationship with the patient more difficult. Both the explorative, scientific function, which is typical of medicine, and the listening, welcoming function, typical of clinical psychology are indispensable. The co-operation between various specialists can also be the moment in which such functions are carried out by different people. Certainly, this diversity makes the common work tiring and difficult, but, potentially, this heralds a new health culture which is less inaccurate and more useful to the patient.

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