Psychologically Integrating a Physically Repaired Heart:
A Clinical Case Study
(excerpt / public version)

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Abstract

The present study aims to understand anxiety states in patients with congenital heart defect. This is done by presenting an excerpt of the psychotherapy process with the patient experiencing anxiety after the repaired atrial septal defect. The clinical case belongs to the unrecognized patients with the defect being discovered due to the sudden heart failure in the adult years of the patient; this carried a specific psychological dynamic after the heart was physically healthy again. The main content of the case is divided into the four phases of treatment. Each phase is influenced by the particular theme of the therapy process related to the congenital heart disease. The belonging comment of each phase addresses closer clinical insights of the relevant theme including psychotherapeutic technique and the approach used. The discussion proposes general clinical perspective based upon the individual perceptions and social aspects of the patients with congenital heart defect.

Keywords: congenital heart defect, anxiety, heart failure, psychotherapy

Die vorliegende Studie versucht zum Verständnis von Angst bei Patienten mit angeborenem Herzfehler beizutragen. Zu diesem Zweck wird der psychotherapeutische Prozess eines Angst-Patienten mit behandeltem Vorhofseptumdefektvorgestellt. In diesem Fall wurde die Herz-Erkrankung des Patienten erst nach einem plötzlichen Herzversagen im Erwachsenenalter entdeckt; dies schlug sich in einer spezifischen Psychodynamik nieder, die über die physische Gesundunghinaus anhielt. Der Fall wird anhand der vier Phasen der Therapie geschildert. Jede Therapiephase widmet sich einem spezifischen Thema mit Bezug zur angeborenen Herzschwäche. Der Kommentar zu jeder Phase soll das klinische Verständnis des jeweiligen Themas vertiefen und behandelt auch psychotherapeutische Techniken. Eine allgemeine klinische Perspektive basierend auf individuellen Perspektiven und sozialen Variablen von Patienten mit angeborenem Herzfehler, soll zur Diskussion gestellt werden.

Schlüsselwörter: angeborene Herzfehler, Angst, Herzversagen, Psychotherapie

Introduction

Technological advances in the cardiovascular medicine and surgery significantly contributed in prolonging the life expectancy of people born with the most common defect present at birth - congenital heart disease (CHD). As a result, CHD in adults is now more prevalent than ever. Two of the most common types of heart diseases involve septal defects ('halls in the heart'): ventricular and atrial septal defect, each with the highest prevalence rate respectively. In general, two distinct groups of adult population with CHD are to be recognized -- patients who have been treated and followed-up during pediatric and subsequently adult years, and, de novo – previously unrecognized adults who may or may not be symptomatic at the time of diagnosis. In such respect, psychological states accompanying congenital heart defect can have a different dynamic. Having been recognized and treated for CHD, patients belonging to the firstly mentioned group face physical, psychological and/or social burdens from the very early age, all throughout adult life. By contrast, milder heart malformations equate to higher treatment success rate, yet due to the missing or weak accompanying physical symptoms, probability for the defect to remain unnoticed until the patients' adult years carries the risk of a *sudden heart failure* in previously healthy human beings; this very circumstance can cause significant implications on the resulting mental health in relation to the concerned physical condition.

As the growth rate of adults with CHD is increasing rapidly a need to develop more *personal and humanized processes*, systems and institutions has been recognized (Callus, Quadri, Passerini, & Tovo, 2015). A research study investigating illness perceptions of patients with CHD found this to be a significant predictor of patients' quality of life, cardiac anxiety and depression one year after the heart intervention (O'Donovan, Painter, Lowe, Robinson, & Broadbent, 2015). Based on these results, the same study proposed a future research investigating whether an *intervention to discuss patients' perceptions about their CHD* would improve mental health and quality of life. The present research follows a direction of formerly acknowledged goals. Embracing people as cognitive subjects, rather than objects of examination, qualitative research and psychotherapeutic treatment have the same possibility to access the inner images and relationship fantasies of a person (Moertl, Buchholz, & Lamott, 2010). This study will present the clinical case involving psychotherapy process of the patient with developed anxiety after repaired atrial septal defect (ASD) that has not been recognized until the heart failure in the adult years of the patient. Based on the themes that emerge during the treatment with persistence of the patient's focus in respect to

the heart defect, it is possible to gain reference related to the specific concerns and needs of a person with treated heart disease, both physically and psychologically, along with the appropriate psychotherapeutic interventions of use. In difference to the standard case studies, however, in addition to the interpretations closely related to the particular case, by incorporating means of the qualitative text analysis, this research will present observations that go beyond the immediate relevance.

Method

The present case, amounting to approximately one hundred sessions, begins with the anamnestic data (including the problem presenting, biography, diagnostic features). The main content is divided into the four phases of treatment. Each phase revolves around the particular *theme* of the therapy process with the focus remaining on the congenital heart defect and appropriate issues of significance in that respect[1]. This is followed by the belonging comment which aims to provide *closer clinical insights* into the aforementioned (therapeutic observations and/or therapeutic technique/approach), thus is specifically tied to the psychotherapeutic treatment. The guiding idea pursues the use of clinical case study as the dominant research method of traditional psychoanalysis[2], due to its usefulness as a method of identifying psychodynamic phenomena which can be further studied and theorized upon (Jarvis, 2004).

Given the complexity of a psychotherapy process with diverse, rich information that can be approached from various aspects, thinking behind the selection of themes for the treatment phases was influenced by the qualitative text analysis, as it conveniently combines openness to the material (required in the psychotherapeutic process itself), yet at the same time, provides a support for the meaningful systematic assessment of the complex and extensive material (Moertl et al., 2010). Such an approach allowed for the additional possibility of generating ideas and interpretations that are part of the *general clinical perspective* and is, therefore, presented in the discussion.

[1] The present case is an excerpt of the longer psychotherapy process, with the primary focus on the circumstances related to the congenital heart disease (CHD). As such, it does not aim to present a detailed in-depth analysis of the patient or the dynamic specifically characteristic for the psychoanalytic treatment.

[2] Given the psychoanalytic background of the author, cited literature is mainly psychoanalytically oriented. However, the present study aspires to offer the psychotherapeutic contribution on the topic in its wider meaning; that is, when agreeable, terms such as 'psychoanalysis, psychoanalyst' should be understood in the context of 'psychotherapy, psychotherapist'.

The Clinical Case Study

Anamnestic Data:

Presenting the Problem

Three months prior to seeking psychotherapy (in August 2012), during a casual walk while on a vacation with girlfriend in Italy, the patient had experienced a heart failure. Upon arrival to the hospital, the condition on his heart (atrial septal defect) was confirmed. This required a medical intervention, yet any procedure had to await until he was stabilized and back to Vienna. Once admitted to the medical centre in Vienna (AKH), the patient was explained that atrial septal defect implied an opening between the left and right atrium of heart which, contrary to ordinary, had not closed after his birth. Thus, the patient had such opening (defect) all his life, yet learned about it only at the age of thirty-three. Additionally, he was informed on the possibility to leave the heart as it was – in which case one would never know, when another attack, similar to the one he had in Italy might happen again, or to undergo a routine medical intervention in which the opening is closed (with a patch/'an umbrella'). The patient opted for the procedure which he had undergone the following month. Everything went by exactly as predicted hence as a result 'his heart was as in any healthy, living person'.

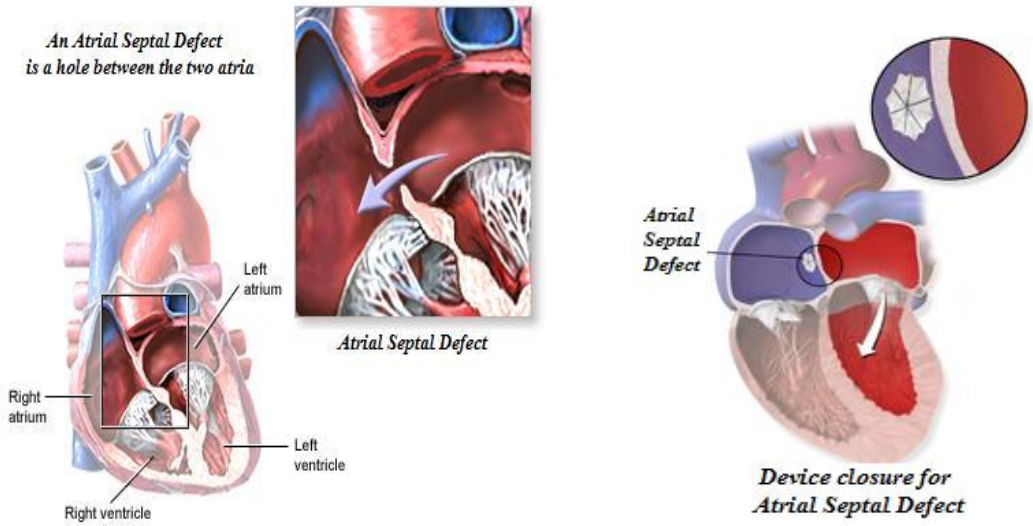

Figure 1. Images of heart with atrial septal defect and device used for closure. Source: Adapted from *the U.S. National Library of Medicine.*

Nevertheless, after the procedure, the patient started to concern himself excessively with the heart (and health in general); he would notice the smallest buzzing or tremor in the chest and due to the anxiety that would follow – he would go to AKH for the additional checkup. After several such visits which confirmed perfectly well-healed heart and health state, he was informed on the possibility to be referred to the psychiatric department. A friend of his, being one of the rare people who was acquainted with his anxiety states, suggested psychotherapy to which he had agreed.

When in an initial interview asked whether there was any previous history of heart-related or similar conditions in the family, the patient vaguely responded how his paternal grandfather had some difficulties with the heart, yet as he became increasingly nervous on the mentioning of the topic, he readily changed it. In respect to reported burdens (anxiety states), patient said that prior to the heart intervention he had not experienced neither similar states nor health-related concerns of such kind.

Biography (public version – left out)

The Psychotherapy Process (public version – left out)

Phase One *(Sessions 3~10)* **- *Living with the Feeling of 'Damage' within Oneself***
Phase Two *(Sessions 10~50)* **- *"The Fixed Part of My Heart Might Unseal"***
Phase Three *(Sessions 51~90)* **- *Unacknowledged Pain from Childhood***
Phase Four *(Sessions 90~100)* **- *Illness as Shame***

Discussion

Research in the psychosomatic field traditionally had to deal with the difficulty related to the "specificity hypothesis" or, more precisely, with "nonspecificity". As demonstrated by the previous research in the area, despite the importance which psychic factors have in the genesis and course of an illness, in the *multifactoral constellation* of conditions that cause illness, psychic factors carry a *nonspecific role* (Thomae & Kaechele, 1992). Although the somatopsychic field has faintly different dynamic in that respect, the present case tackled a similar disadvantage through the diagnostic features of anxiety that may result after an organic illness and the following medical intervention. The difficulties consist in determining precisely the part attributed by the very illness and, the part evoked by the personality structure with the personal history of the patient, due to their interchangeable character.

Within the specific somatopsychic field related to the congenital heart disease, once taking into consideration each person's limit beyond which his mental apparatus fails in its function of mastering the quantities of excitation which required to be disposed of (Freud, 1926, p. 148), the fact that the disease is *congenital* involving such crucial organ for keeping one's life, can easily challenge a previously defined limit. It is then hardly to be wondered that mental disorders such as depression and anxiety are among the most frequent after-effects in the life of people who are born with the heart defect (O'Donovan et al., 2015). Particularly predisposed are the patients with severe heart malformations that have been recognized and treated from the very early age, due to the inexorable accompanying stress for both the patient and the family (environment). Even though de novo patients are not associated with previously acknowledged dynamic from an early age, they are faced with the danger of unexpected heart failure later in life, and consequently, with an equally damaged perception of themselves as formerly physically healthy persons. It is certainly the case that both of these dynamics invariably influence personality development and mental health state of affected people and as such, should be further researched.

Among the general population, anxiety is found to be the fundamental phenomenon and the main problem of neurosis (Freud, 1926). At the same time, it takes on the psychic component in the genesis and course of a somatic illness (Thomae & Kaechele, 1992). In addition to the previous two factors, symptoms of neurotic anxieties commonly refer to one's heart (i.e.): arrhythmia, tachycardia, breathing disturbances, cardiac palpitation et cetera. Given the present research interest of a heart defect already present at birth, it becomes a peculiar query regarding the inner state of a person who learns about one's condition, even when regularly repaired and with no (physical) contraindications; what does it do to the *individual perceptions* of oneself including possibly (anxiety-prone) experiences that would otherwise remain quiet, and, what happens to the *social aspect* involving the environment? It goes without saying that only after including assessment of both, physical and psychological part involving one's heart, can the person be considered healthy and genuinely recovered. As demonstrated by the case study, a physically healthy state of one's heart per se does not mean a healthy person; the psychological side is not to be underestimated, hence, in the proceeding will be elaborated in the terms of individual and social aspects.

Even though a particular personality structure and personal history indicate whether and how the person will experience and cope with the intervention around one's heart defect, psychotherapeutic practice allows insight precisely into the psychic processes accompanying

physical care of this kind. In the present case, *individual perception* of oneself in relation to a defect was perceived in the terms of '*damage*' and '*weakness*', which evoked a further idea of a '*wound*' in one's heart – experiences of which were preferably concealed from others. The fact that this was communicated rather early in the therapy implies perhaps the universal yet immediate need of a person who has undergone a heart intervention -- reflecting on a wound within oneself assists the person to integrate the image and experience of oneself related to the heart disease.

With the focus remaining in the realm of individual perceptions yet specifically related to anxiety, a given context creates significant clinical implication including various aspects. The dynamic of anxiety, in general, involves an increase in the awareness of psychic or physical sensations to a degree that makes it impossible for the *real or imagined danger* to be avoided, as in such states there is a constant danger signal together with the incapacity for active coping (Waelder, 1960). In the context of a heart defect, as learned from the presented case, what seemed to have additionally contributed to the previously defined anxiety dynamic, is precisely the fact that the person was with an inborn, yet until adulthood unrecognized, and then repaired defect (thus, the problem somehow being there, but not there at the same time) continuously played with and provoked anxiety between real and imagined. Hence firstly, *approaching private theories* of a patient becomes an important aspect in respect to the psychological part of the complete heart impairment. In such a way, the therapist is in a position to rather favorably deal with the possible states accompanying heart defect (in this case, anxiety), precisely by lighting (differentiating) between the 'real' and 'psychic' in respect to one's heart. In doing so, one is immediately surrounded by the *fantasies (images and ideas)* around the patient's illness which usually significantly contribute to the health state of a person. It is worthy to be noted at this point that the very work with (mental) images, being the meeting point of all psychotherapy methods, allows for the handling technique that is appropriated in accordance to each of its respective methods achieving closely beneficial results.

All the previously mentioned presents an overture into the second, and perhaps more significant, clinical aspect. Studies examining physical health from the psychological perspective have understandably relied on the relationship/attachment styles of a concerned person (Maunder & Hunter, 2008), with the experiments implying that physiology is regulated by factors that are neither strictly internal nor maternal – but rather *relational* (Hofer, 1995). In the context of (discussed) anxiety, Sullivan (1953) pointed to the centrality of the need for 'interpersonal' by recognizing that the relaxation in the tensions of anxiety

seeks the experience not of satisfaction but of *security* (p. 42). As presented by the case study, while discussing images regarding one's state of heart, through the fantasies and personal ideas one builds around his private understanding of an illness, one is at the same time involved in creating the safest ambience for the impaired heart, and thus intervening precisely on the psychological aspects that may accompany medical interventions involving congenital heart diseases (equally, in mild and severe cases). In my view, this stands for both – reactive and/or neurotic anxiety – yet in the context of the latter, the patient needs a further psychotherapeutic work in respect to the instances from his personal history where the anxiety was transformed into the object-related fear.

At this point, it is convenient to pause and reflect on the previously discussed individual's/patient's perspective due to a rather interesting phenomenon that could be observed. As already mentioned in the first phase of the case, one of the first and foremost discussed topics by the patient were his ongoing ideas and perceptions regarding health or, repaired heart in particular. Yet interestingly, this was communicated mainly *in relation to other (close) people* who did not know about this, thus were missed by the patient. That is, in the anxiety of this form (triggered by the heart defect), individual and social aspects invite each other and seem to be overlapping. Reasonably, one may argue that any neurotic anxiety has something to do with "losses, being left alone" (Haefner, p. 198), yet it is conceivable that being born with the defect of an organ which is almost an engine of one's life, does something to the ego of a person; it influences physical-self (at least), which by its nature fluctuates throughout life. The role of a psychoanalyst (or, psychotherapist in general) is precisely to provide an auxiliary ego to the patient in these circumstances, as elaborated in the above passages. At the same time, the role of 'others', that is, the environmental circumstances, support and/or contribution to the patient's health state, are not to be undervalued, as they can assist in sealing the repaired heart in one's mind.

Given formerly stated, it is convenient to turn to the *social perspective* involving heart defect. By social I am referring mainly to the patient's immediate surrounding with an inclusion of any person who fulfills the role of an attachment figure. In the present case, the family belief system regarding health had a profound effect on the psychological development of the patient, hence, played an unfortunate role in stirring up deeply seeded fears and disarming his coping strategies after the heart failure. In a similar manner, the opposite is true – the more understanding an environment has about the CHD and of the previously discussed *needs* of a person recovering from the disease, the more benign experience about it one may expect.

Two significant factors are to be recognized here. One has a sabotaging effect which may stand as true for any mental or health-related condition, thus as such, should be acknowledged – *the feeling of shame*. This can be observed in the therapy experiences with both the children and adults, regardless of the culture, profession or 'status' and often even despite their education. There seems to be something slightly disagreeable on the fact that one needs the assistance of some form, and of psychological in particular, and this can have its implications once a disease is congenital. Approaching such issue on an individual level in psychotherapy is possible, yet once the environment is needed for the prosperous outcome, it can be challenging. For the therapy methods that work with more than just a patient (such as systemic family) this becomes a theme of the process, yet, for the primarily individually oriented approaches a technique relies on working with the patient in a manner that influences both the person, his perception and approach to the surrounding (thus very often, the surrounding itself), as it had occurred with the presented case.

The second factor is advantageous, already tackled in the individual aspects of the disease yet at present, applies to a wider context and refers to - *relating*. A mere knowledge or formal delivery of information on the heart defect by the professional does not necessarily mean a proper support to the environment and if done in an untactful manner can have a negative effect (causing additional worry or concern for the patient and/or his family). Along the same line of thinking, a study on the improvement factors of diabetic patients demonstrated better results among those who had rated their patient-provider communication as 'good' compared to those who rated it as 'poor' (Ciechanowski, Hirsch, & Katon, 2002). Importantly, these differences were large enough to be associated with long-term micro-vascular and macro-vascular complications in the heart, kidneys, eyes and with earlier mortality (Ciechanowski et. al, 2002). In the context of CHD, a specialized therapist working with the patients who do experience psychological after-effects associated with this condition would be in a position to also 'medico-educate' the patient and his surrounding, yet this so, in a therapeutic way.

In respect to the previously elaborated throughout the study, by recognizing that physical treatment of the heart is completed only after securing the psychological component related to the disease, an invitation for the cooperation between cardiology and mental health professionals naturally follows. Notwithstanding the fact that technological advances have significantly improved modern medicine and healthcare -- the main causes of congenital disease remain mainly unknown (or speculated upon). The opportunity, thus, remains on the advances that can be achieved in a human form -- by healthcare professionals working together in order to *alter the internal support* of the concerned patients and their families.

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