

FOR BOTH HEART AND MIND

We talk about the importance of psychoeducation for heart patients with **Anna Mierzyńska** and **Karolina Jurczak** of the Cardinal Stefan Wyszyński Institute of Cardiology in Anin.

ACADEMIA: What sort of psychological support is offered to cardiac patients? Does your work involve following defined general guidelines, or is each patient treated on an individual basis?

ANNA MIERZYŃSKA: Psychological support in cardiac rehabilitation is tailored to the needs and problems of the individual patient. Certain steps, however, are common to all patients, and they are part of what's known as secondary prevention of cardiovascular diseases. In short, they involve psychoeducation on the risk factors related to lifestyle, recognizing emotional tension, stress management, relaxation training, and solving problems related to motivation to undergo treatment and achieve goals consistent with the objectives of cardiac treatment.

More intensive psychological counseling, and other forms of psychological interventions, are directed at people who have adjustment disorders, or have difficulty adjusting to the new situation. These patients show signs of increased tension, stress, and anxiety associated with the life-changing event of being diagnosed with, and undergoing treatment for chronic cardiac disease. It doesn't matter whether the mental disorders observed in these patients were there before, or appeared only as a result of cardiac disease and treatment.

What is "psychoeducation," and how is it conducted?

A.M.: Cardiology is a field of medicine that has a lot to do with lifestyle. The way one deals with everyday challenges and stress, lack of balance between different areas of life, such as professional and personal life, or between work and relaxation, can be risk factors for cardiovascular diseases. On the other hand, proven effective strategies to cope with these difficulties can also be a useful resource for getting back to health. Psychoeducation is a process during which we provide patients with tools to help them change their

lifestyle and adapt to the recommendations related to the treatment.

It is also a way to regain control. Illness often triggers a feeling of helplessness caused by what is happening to the body. The problem may also lie in the chosen form of treatment, such as the cardioverter-defibrillator implant, for example, which takes over control of the heart's rhythm. Our role as psychologists is to help patients get used to the change, understand the benefits, and adapt to this new situation.

Patient education is a common theme in medicine, not just in cardiology. However, convincing the patient to follow the doctors' recommendations, and making him understand the limitations imposed on him by the illness, seem to be a problem.

A.M.: You have touched on two parallel issues. One is something called functional health knowledge, which is the ability to acquire and analyze information related to the health condition, treatment and side effects. Imparting this knowledge to patients so that it's understandable, but at the same time reliable, is a big challenge. While we expect that poorly educated individuals may have difficulty understanding complex medical information, it turns out that highly educated people can also sometimes have problems assimilating information regarding their treatment. A separate issue altogether is the autonomy of patients, and proper recognition of their life priorities, which will help establish rapport with them. It is important to have joint treatment goals, priorities from the point of view of psychologists, doctors, and therapists, along with the goals of the person you are helping. Such cooperation is a long process.

People sometimes perceive illness as something separate from them. They think: "One of my



JAKUB OSTALOWSKI

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Anna Mierzyńska is the Head of the Laboratory for Clinical Psychology at the Institute of Cardiology. In 2005 she graduated from the Faculty of Psychology at the University of Warsaw, and in 2014 received the title of Specialist in Clinical Psychology. Her main areas of professional interest are medical psychology, psychological issues associated with heart failure and transplantation, as well as Solution-Focused (Brief) Therapy.

organs isn't working well, but I will heal, and everything will be like before." Only after some time they realize that there are some activities in which they can no longer participate.

A.M.: It's a matter of adapting to the new situation. Few people are capable of cognitive and emotional acceptance, in a relatively short time, of the fact that their life has turned upside down, and that's how they see heart disease. Most of our patients go through all the steps involved in adapting to a new life situation, from shock, through denial and bargaining, to vari-

ous attempts at change in the hopes of stopping the events that have already taken place. If this process is successful, it ends up with acceptance of the situation, otherwise problems arise. We try to help patients go through this process.

What techniques do you use in your work?

A.M.: In the case of somatic patients the cognitive-behavioral approach is the most effective. It is based on the assumption that changing the patient's beliefs and thoughts related to the situation in which he found

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himself affects his emotions and approach to the situation, and as a result helps change his behavior. In addition, we use our own experiences, as well as those of other patients, in instrumental ways of dealing with problematic situations.

How do you work on developing the motivation to exercise after surgery? This is usually more difficult than just regularly taking medication.

KAROLINA JURCZAK: Physical therapy is difficult, especially for patients after cardiac surgery. They often don't have the physical strength and they lack motivation. Recently I have been visiting one of our post-transplant patients during his rehabilitation and I've been motivating him together with the physiotherapist.

A.M.: When working with a patient, the role of the psychologist is to observe the patient's strengths and point out new successes, even small ones. Some of our patients had never been physically active, and the need for daily physical activity as part of the post-surgery rehabilitation process is a big challenge for them. Pointing out their progress is a great motivator, which our therapists are very good at. A psychologist should in turn show them how they're getting closer to the goal they have set for themselves. The goal is usually to return home to their families.

So, on one hand, we have minor everyday successes, small steps, and then we have milestones, that the patient determines himself. A milestone could be something mundane, like going to the bathroom alone, but it's an important step in getting home.

How can you help maintain this motivation after the patient leaves the hospital?

A.M.: To help him fight temptations, such as skipping his walk or not taking his medication, we work on

building a sense of self-efficacy. We make every effort so that he leaves here with a sense of success, confident that his systematic work and our joint effort has led him to this. Patients remember their worst condition, they don't want to return to it and respect what they were able to achieve with their hard work. This is very strong motivation.

A few weeks or months at a clinic doesn't seem like enough time to radically change someone's attitudes and life habits.

A.M.: It may seem this way from the point of view of a healthy person who is trying to make a similar change. But a person who is ill begins the process from a different cognitive perspective. Our patients want, as much as possible, to return to the pre-diagnosis state, or the condition they were in before their illness progressed, which they remember well.

K.J.: Equally important is the issue of having a potentially life-threatening condition. Patients realize that if they don't change their habits, their health could greatly deteriorate. This especially means giving up alcohol and smoking, which are major risk factors and can aggravate the symptoms of the disease. But it is also harmful to avoid physical activity, skip medications, or not maintain a healthy diet.

A.M.: The psychologist's code of ethics places great stress on the autonomy of the patient. In healthcare, however, there is a tendency to act in an authoritative way, believing that we know better. We try to convince patients that they can take the initiative and change old habits for behaviors which are now good for them.

But there is another side to this: the patient's autonomy means that he has the right to choose an option other than the one recommended in the clinic.

Prof. Ryszard Piotrowicz, Head of the Department of Rehabilitation and Noninvasive Electrocardiology



INSTITUTE OF CARDIOLOGY

What exactly is the role for a psychologist at a cardiology clinic?

Indeed, this type of association is quite rare in our country, but psychological support should be included in comprehensive cardiac rehabilitation on par with other types of aid. The prognosis for a patient after a cardiac event depends not only on the actions of a cardiologist, but also on the work of physiotherapists and psychologists. By combining

medication with psychological support and physical therapy, we can reduce the risk of re-hospitalization after cardiac surgery. The mental state of the patient significantly affects his prognosis: studies show that a person suffering from post-MI depression or anxiety will live shorter than the patient with no such burdens.

Psychological support is especially vital in the first days after a cardiac incident. Sometimes when I visit a patient after surgery, he or she seems fine from a somatic perspective,

but for some reason doesn't want to get out of bed. This improves only after several visits by a psychologist. That is why in our clinic we have the laboratory for psychology, although our center is unique in this regard.

How often do cardiac patients experience depression?

We see it in 40-60% of cases. This may seem surprising as the quality of life after surgery is constantly improving due to technological progress. But paradoxically, this progress becomes

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A.M.: Some patients do indeed choose another option. There are situations in which the patient receives everything: information, tests, medications, treatments, physiotherapy, rehabilitation, psychological care, and after leaving the hospital they go back to their previous lifestyle. Our job is to provide him with the tools to change and show how he can succeed.

When a patient refuses help and goes back to old habits it is very frustrating for the entire team. Fortunately, it's quite rare for a patient to completely give up treatment. In this case, the psychologist must make sure that this is a conscious decision, that the patient is able to properly assimilate the information, and isn't acting under pressure. If that's the case, we have to respect his or her choice, even if we disagree with it. Such situations occur rarely, usually because patients wait some time for an appointment at the Institute, and when they come here they agree to follow our instructions.

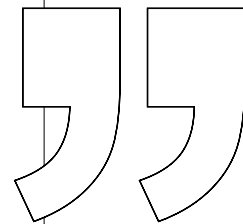
Does psychological support in helping patients alter their lifestyle also include their immediate surroundings, especially family?

K.J.: We also work with the patient's family, especially in the case of a transplant, where the changes affect many aspects of a patient's life. After this type of surgery their loved ones help maintain discipline: regularly taking medication, check-ups, changing habits. I have observed that the more support the patient receives, the faster their recovery, and the swifter their physical and mental state improves.

A.M.: The family can indeed help in very practical terms, such as renovate the home to adapt it to the needs of the returning patient. Equally important is the close emotional relationship with family members, which is a great motivator to get patients to fight for themselves every day. Patients say many wonderful

things about the role of family and its support. This is confirmed by studies, which clearly show that among the psychosocial risk factors for diseases of the cardiovascular system depression and social isolation play a crucial role. The lack of close ties with other people often makes patients not see any sense in further action, or in making the effort to change.

In the psychoeducation process we provide patients with tools to help them change their lifestyle and adapt to the recommendations related to their illness.



Can the family also have a negative impact on the adaptation process, for example expecting that after the operation the patient will function as before?

A.M.: The family may have difficulty understanding the situation, just like the patient. Ideally, the doctor and the psychologist communicate the same information to both the patient and someone from his circle. Then both the family and the patient will receive the same message from two sources. They learn that at the clinic we work together as a team and have common goals, and that once the patient is discharged, they and their family are the ones responsible for achieving these goals. We welcome questions from family members as we want them to feel important in this process.

at the Institute of Cardiology

a cause of depression: patients with an implantable cardioverter-defibrillator that saves their lives live in constant fear that it will discharge. Sometimes this tension is so severe that, in extreme cases, it causes suicidal thoughts. The role of psychologists is to prevent this from happening.

Does such a discharge really cause severe damage?

This is mainly a psychological issue, and the accompanying physical pain is not very strong. The new cardioverters do

give patients a certain jolt, but it is not something they can't handle, especially since this equipment is saving their lives. If this is how we present it to patients, it is easier for them to accept it.

Does this attitude change, and the knowledge of what will happen, give patients a sense of control over their illness?

Most cardiac disorders, such as atherosclerosis, are incurable, and medicine can only slow their progression. If a patient suffers from

a milder illness, he often doesn't realize that his situation will continue to worsen. Only those patients who return to us begin to understand that as the illness progresses things will no longer be as before, but will be getting worse. The solution is a transplant, which requires enormous self-control of a patient, taking immunosuppressive medications, and adhering to instructions and restrictions, which is made easier when working with your doctor and psychologist who help motivate the patient. ■

Does a patient's temperament influence the course of treatment, rehabilitation and prognosis?

A.M.: Temperament determines our daily functioning: how quick we react to stimuli, to stressful situations or changing conditions, how quickly we adapt, and to what extent we seek new sensations. It is an important risk factor for diseases of the cardiovascular system, which is confirmed by research. Although there are few studies which directly investigate the influence of temperament on the process of treating cardiovascular diseases, I think it certainly is important. There is a difference in working with a lively, active person, and dealing with a person with low resilience who is susceptible to stress.

in this case can he reconcile trust in the doctor with his own experience?

K.J.: Yes, it sometimes happens that a patient feels fine, comes in for treatment, and suddenly starts to feel worse than before. In addition, treatment is often long and burdensome. When it comes to cancer, some people don't want to undergo chemotherapy because they doubt whether such drastic measures make sense. Others agree to it but have mixed feelings about it. It's the same with patients who need the cardioverter-defibrillator implant. They are fully aware that this device is saving their life, but the discharge hurts and sometimes causes loss of consciousness. This makes the patient feel he has no control.

A.M.: Anxiety associated with discharges that occurred in unexpected circumstances may turn into anxiety disorders. Patients may be unwilling to perform activities that preceded the discharge, or may avoid situations that they associate with it. In addition to pain and loss of control they may also experience feelings of helplessness. This is true for the medical staff as well. Unfortunately, sometimes patients have difficulties in smaller facilities, where the team has no experience in helping people with a cardioverter-defibrillator.

This condition requires intensive therapy. We work on the patient's fear, usually by applying the cognitive-behavioral interventions, adapting it to the specific case. Another important aspect is to convince the patient that the cardioverter discharge is the result of arrhythmia, so it can't be triggered by the patient's own actions.

K.J.: Another problem is the fear that the device may break.

A.M.: The complexity of the mental state of patients with cardioverters is that they receive a lot of contradictory information. They are in a life threatening situation: these devices are implanted in people who experience cardiac arrest, but in some patients the risk was determined only by tests, and they have not yet had this experience. It may therefore happen that someone has a cardioverter, but the arrhythmias are not severe enough to cause a discharge. The patient may then consider it unnecessary. Then there are the inadequate discharges, which occur due to circumstances other than arrhythmias, such as alcohol abuse. Patients have to deal with this turmoil, hence the current guidelines of the European Society of Cardiology recommend psychological counseling prior to implanting cardioverter-defibrillators, and psychological help for those who have experienced inadequate discharges. Their aim is to help the patient adapt to the situation, and help the team care for him during his treatment. We hope that these recommendations will soon become routine practice.

Both family and patient receive the same message from two sources. They learn that at the clinic we work together as a team and have common goals.

What other psychological factors play a role?

K.J.: Experience in being ill. Young people who have only experienced illness for a short time adapt to the condition very differently than people who have struggled with it for much longer or return to us again.

A.M.: In psychology there is the concept of the locus of control, the belief of a person in having power over what is happening to him. In psychology we talk about the health locus of control and this concept is important in clinical work. There is a difference in how a person who claims to suffer the consequences of their decisions and choices adapts to the treatment process, as opposed to the patient who is convinced that his health depends on the actions of medical staff, and he has doesn't have much say in the process. Both of these attitudes have their advantages and disadvantages, and we try to highlight the benefits and discuss with the patient what good we can do for him based on his attitude to treatment. There is another group of patients who claim that health depends on random factors. We work differently with this group and try to convince them that they can indeed influence the course of events.

When a patient is diagnosed at an early stage of the disease, he often doesn't feel its symptoms, which appear only after he begins therapy. How

INTERVIEW BY OLEK MICHALSKI

GLOSSARY

Implantable cardioverter-defibrillator (ICD)

– a device used in patients who are at risk of sudden cardiac death. The electronic system along with the generator are placed under the chest muscles. The heart rate is monitored by means of electrodes introduced into the chamber through the vein. The device interrupts ventricular fibrillation or ventricular tachycardia by delivering low-energy or high-energy shocks, and can restore normal operation if an abnormal rhythm is detected. ICDs have been used since the 1980s. According to data from the National Health Fund (NFZ), there were about eight thousand implantations performed in Poland in 2015.