



KNOWLEDGE SPACE

SURVIVAL IS NOT HEALING

The post-infarction reality of life between medicine, psyche, and biography

*Healing does not mean returning to the person one was before.
It means integrating the experience into one's own life.*

KNOWLEDGE SPACE NO. 6 — EXPANDED EDITION

Long-form article on the presentation · English

I. THE SAVED HEART

◆ 1. The Triumph of Acute Medicine and the New Reality That Follows

The heart attack is no longer the inescapable death sentence it once was — but with survival comes a new task.

A heart attack is one of the most profound ruptures a person can experience. Within minutes, a reality that seemed self-evident just before is transformed. Modern cardiology has achieved extraordinary progress over the past decades: blocked coronary arteries can be reopened within the shortest possible time, severe narrowings treated with stents, or bridged through bypass surgery. Medication and structured rehabilitation significantly improve prognosis, and what was once frequently fatal is today, in many cases, a survivable, treatable event.

Yet this very medical progress has created a new reality that is spoken about comparatively rarely: more and more people survive a heart attack — and then learn to live with its physical, psychological, and social consequences. The real challenge, therefore, does not end with discharge from the hospital. For many, it begins there, in a life that continues outwardly while having changed inwardly.

This knowledge space follows that movement in three steps: from the saved heart, through the unsettled person, to a life that does not suppress its experience but takes it in.

This knowledge space therefore does not understand recovery as a mere return to an earlier state. It describes a multidimensional process in which physical stabilization, psychological processing, social reintegration, self-efficacy, and the renewed development of trust interweave.

◆ 2. Discharge — From the Organized Hospital into the Unstructured Everyday

From the outside, much appears to carry on as usual. For those affected, the real challenge often begins only here.

While acute medicine focuses on saving life — organized, measured, secure — the gaze of those affected turns, after discharge, increasingly toward a different question: how does one go on living after a heart attack? Not theoretically, but in ordinary daily life, between grocery shopping and doctor's appointments, between work and family, between hope and uncertainty.

This period is frequently underestimated. Surgical scars heal, follow-up examinations show satisfactory results, and rehabilitation conveys the impression of a step-by-step return to one's former life. For outsiders, the picture of an overcome illness easily forms. For many patients, however, this phase feels considerably less clear-cut, because the hospital offered a framework that is now absent: monitoring, medical staff within reach, a structured daily routine. With discharge, their own responsibility takes its place — the responsibility to interpret a condition that is constantly changing and whose meaning is not always obvious.

◆ 3. Two Levels of the Same Reality

“The heart looks fine” and “It doesn't feel fine” can both be true at the same time.

Between objective findings and subjective experience, a gap often opens that is difficult for outsiders to understand. The examinations are unremarkable, pumping function is stable, lab values are satisfactory — and yet the person affected describes symptoms that dominate their entire daily life. Medicine describes the pump: blood flow sufficient, function stable, findings unremarkable. The person describes the anchor: the loss of deep trust in the reliability of their own body.

Both statements can be true at the same time. They simply describe different levels of the same reality — and precisely here lies one of the greatest challenges of follow-up care. Whoever acknowledges only one level risks overlooking the other. And whoever keeps both in view recognizes why a healthy heart alone does not yet amount to a healed life.

II. THE UNSETTLED PERSON

◆ 4. The Loss of Taken-for-Grantedness

It is not the pain of the heart attack that remains most formative in memory, but the loss of a quiet certainty.

Before the infarction, a person simply has a body. It functions largely unnoticed in the background of life: the heartbeat is not an object of attention, climbing stairs is simply locomotion, tiredness is tiredness and nothing more. After the infarction, this relationship can shift fundamentally. The person begins to monitor their body instead of simply inhabiting it. The heartbeat becomes an object of consciousness, climbing stairs becomes a silent stress test, and every instance of tiredness raises the question of its cause.

What changes is not necessarily only the body — it is the relationship to the body. Looking back, many survivors describe not the pain of the heart attack as the most formative experience, but precisely this loss: the quiet conviction that their own body would reliably carry them through everyday life had, until then, been so self-evident that it was not even perceived as trust. Only its absence makes visible how much it had been carrying.

“Before the infarction, I had a body. Afterward, I began to watch it.”

Terms such as body trust, interoception — the perception of internal bodily signals —, hypervigilance, and safety behavior describe this shift more precisely. They name no weakness, but a changed form of attention that, after an existential event, initially appears entirely logical and only over time can become a burden in its own right.

◆ 5. The Dilemma of Nonspecific Signals

The symptom alone does not reveal its cause.

A feeling of pressure in the chest or dizziness can be the result of a perfectly normal healing process: scar healing from surgery, muscle tension, a change in posture, or blood pressure fluctuations caused by new medication. Yet the very same sensations can also indicate a renewed, life-threatening reduction in blood flow to the heart muscle. For the individual, this distinction is almost impossible to make in daily life, and even trained staff sometimes need examinations, not just a conversation, to tell the two apart.

For those affected, this creates a contradiction that is almost impossible to resolve: they are told to take warning signs seriously while remaining calm, to listen attentively to their bodies without overreacting to every sensation. This balancing act cannot simply be learned once and then set aside. It must, in essence, be found anew every day.

◆ 6. Silent Hypersensitivity — the Vigilance Cycle

This heightened vigilance is not simply "imagined," but can be understood as an intelligible protective response following an existential threat.

After a heart attack, the perception of one's own body often changes fundamentally. The brain attempts to learn from an existential experience and focuses its attention more intensely on the region of the body from which the threat originated. This creates a cycle of four steps: a normal bodily reaction — for example, a slightly faster heartbeat after exertion — triggers a trauma-informed evaluation that asks whether this could be a new heart attack. This evaluation activates the autonomic nervous system and, with it, the release of stress hormones, and the resulting physical reaction — such as a rise in heart rate or blood pressure — can additionally confirm the original worry, even though it was at least partly intensified by the stress response itself.

In this way, the brain tries to detect future dangers as early as possible. Understanding this mechanism makes it easier to interpret, rather than mistaking it for a sign of psychological instability.

◆ 7. The Paradox of Attention

A person is meant to learn to listen to their body — and at the same time to learn not to listen to it constantly.

After a heart attack, attentiveness is medically sensible: whoever overlooks serious symptoms puts themselves at risk. At the same time, permanent attentiveness can itself become part of the problem. Every form of follow-up care moves between these two poles, and so does each individual day of someone affected: when does attention protect? When does it bind? When does taking one's blood pressure become orientation — and when does it become a safety ritual that itself generates unease?

The same question arises today, sharpened by wearable technology. A smartwatch can help keep heart rate and activity within a healthy range. But it can just as easily prolong the constant preoccupation with one's own heart, turning a reassured glance into continuous monitoring, and transforming a device meant to provide security into a further instrument of surveillance. Between mindfulness and surveillance there is no fixed point, only a boundary that every person — ideally in conversation with medical and psychological professionals — must recalibrate for themselves.

◆ 8. When Well-Meant Words Are No Longer Enough

Between these perspectives, a conversation emerges in which no one feels consciously misunderstood — and yet everyone is talking past one another.

Hardly anyone experiences a heart attack alone. Partners, children, friends, colleagues, and also doctors search for words meant to convey security and hope — and do not always find the right ones. "You have to think positively now. You were lucky" often carries, for the person affected, the silent translation: an expectation to become the old self again, faster. "When will you be fully fit for work again?" translates into an expectation of visible performance, while overlooking invisible exhaustion. And "From a cardiological standpoint, everything is fine" rarely answers the actual question of why the body still feels unfamiliar.

Perhaps follow-up care needs less reassuring language and more shared orientation: the knowledge that uncertainty, an altered sense of the body, and fluctuating resilience can be known reactions to such an event — not signs of weakness or of ingratitude for the time that was regained.

◆ 9. The Family Experiences a Different Heart Attack

A heart attack happens to one person — and shakes an entire social fabric at the same time.

The usual view focuses almost exclusively on the person affected. Yet partners, children, and those close to them experience, in this same moment, their own, independent loss of control. While the person affected mainly asks whether they can still trust their body, the partner asks whether they can leave them alone, and a child may wonder whether Mom or Dad could die again. These questions are rarely spoken aloud. Yet they work in the background of every shared meal, every walk together, every brief goodbye at the front door.

Out of these silent fears, very different dynamics can arise: overprotection, constant checking-in, a well-meaning control that nonetheless confines, or the avoidance of shared activities out of caution. Equally possible is the opposite reaction — the expectation that, with discharge from rehabilitation, “everything is fine again now,” paired with a lack of understanding for persisting fear or exhaustion. What results are, in effect, two parallel recovery processes: that of the person affected, and that of the social system around them. When only one is accompanied, the other remains invisible — and can considerably complicate the return to a shared life.

◆ 10. Between the Will to Live and Awareness of Death

A zest for life and an awareness of death are not mutually exclusive after a heart attack — they coexist.

A heart attack confronts a person with an experience that usually seems far removed from everyday life: their own mortality. Many survivors speak of the moment they realized that their own life could actually have ended — an experience that often changes one's outlook on life more profoundly than the illness itself.

From this experience, many people develop a new kind of mindfulness: a shift in priorities, a greater appreciation for small moments, more conscious time with family. The challenge is not to lose the memory of one's own vulnerability, but to regain trust in life despite it.

◆ 11. The Lost Future

A severe event changes not only the present. It can also change one's inner sense of the future.

Before an existential event, a person often thinks, quite naturally, in open timeframes: next year, in five years, once I'm older. After a heart attack, the future can suddenly become conditional: if everything goes well, if nothing else happens, if my heart cooperates. An open expectation becomes an expectation held under reservation.

This is more than a linguistic nuance. A heart attack interrupts not only a lived life course, but possibly also an anticipated biography — that quiet, usually unconscious narrative a person carries about their own continuing life. Finding this narrative anew, without denying it or losing oneself in worry, is among the quietest yet most consequential tasks of recovery.

◆ 12. The Heart Attack as a Biographical Rupture

“A heart attack is not forgotten; it becomes part of the biography.”

At some point, for many of those affected, a clear before and after emerges: before the infarction, after the infarction. The event becomes a biographical time marker, against which other memories are measured — “that was still before my heart attack,” “that was already afterward.” At first, such an event often occupies the entire identity. For a while, it overshadows nearly every other experience, every other topic, every other conversation.

The truly interesting question, then, is this: how does an event that initially binds all attention eventually become an experience within a larger life story? This question forms a bridge between medicine, psychology, and that deeper, philosophical level that asks what a person makes of what has happened to them.

♦ 13. Identity: Am I a Heart Patient Now?

How can an illness become part of one's own biography without becoming the entire identity?

After a serious illness, it is not only body perception that can change, but self-image. A person may medically become a “heart patient” — yet the question of precisely when they are one cannot be answered unambiguously. At the cardiologist's, certainly. During rehabilitation, surely. While taking daily medication, probably. But forever, in every circumstance, as the defining feature of the whole person?

This question touches directly on the loss of taken-for-grantedness already discussed. Where the body previously simply belonged to life, it now threatens to become the defining feature of one's identity. An illness can occupy a firm, honest place within one's own biography without beginning to govern every other trait, every other role, and every other chapter of life. Precisely here lies a considerably deeper form of self-efficacy than one described by physical capacity alone.

♦ 14. Work, Livelihood, and the Expectation of Functioning Again

A true return means not only being able to work again, but rediscovering one's place in life.

For many patients, discharge from rehabilitation marks the beginning of a phase that appears unremarkable from the outside yet is among the most challenging stages of the entire illness. Societal expectations often seem clear-cut: those successfully treated are expected to gradually return to their previous lives. For many, this transition goes surprisingly well; others find that while their bodies make progress, their confidence returns far more slowly.

Added to this are existential questions that extend far beyond the workplace: inability to work, sick pay, gradual reintegration, or socio-medical evaluations. This is precisely where an often-overlooked form of rehabilitation lies — one that aims not only at restoring physical function but also at regaining self-confidence and self-efficacy.

♦ 15. Closeness, Sexuality, and Intimacy

The return to a lived life also includes questions that are rarely spoken about.

After a heart attack, questions can arise that people discuss far less often than exercise tests or medication: is sexual activity safe again? What happens if the heart races during intimacy — is that arousal, or is it danger? Is the partner afraid of causing harm, or of losing the other? Does one's body image change after a sternotomy or other procedures, after a visible or invisible scar?

These are not peripheral questions. Desire, physical closeness, and vulnerability stand in close relation to one another, especially when one's own body is suddenly experienced primarily as endangered. What remains unspoken here does not disappear — it continues to work in silence, often more powerfully than an open conversation ever could. Follow-up care that omits intimacy and sexuality leaves an essential part of the return to a lived life unaddressed.

◆ 16. Medication as a Daily Reminder

The pill means protection and a reminder of vulnerability at the same time.

After the hospital, the heart attack does not vanish entirely from daily life. Medication can serve as a reminder every morning. For some, this daily routine quickly becomes second nature; for others, it remains a small, recurring moment in which the illness re-enters awareness before the day has even begun. Much the same applies to follow-up appointments, blood pressure monitors, scars, medical letters, or the next cardiology visit.

Recovery, therefore, does not necessarily mean that the illness disappears from daily life. Rather, its meaning within daily life eventually changes: from a constant threat to a part of the routine, from a daily disruption to a quiet, almost incidental gesture of self-care.

◆ 17. The Rhythm of Recovery

Progress is rarely experienced as a straight line, but as a series of steps forward and setbacks.

The objective medical healing usually progresses steadily upward. Subjective trust in one's own body follows a different rhythm: good days alternate with setbacks triggered by minor symptoms, until the two lines gradually converge. For many patients, progress is therefore experienced not as continuous development, but as a constant back and forth, in which trust must be earned anew, step by step.

"Life does not follow a schedule of check-ups."

III. THE REGAINED LIFE

◆ 18. The Unrecognized Gap in Care

There is a lack of a reliable place for symptoms that cannot be fully explained medically but still feel very real.

On one side stands acute care and rehabilitation: it saves lives, stabilizes physical performance, monitors heart function and medication. Cardiac rehabilitation can already combine medical, exercise-based, psychological, and socio-medical elements. Still, the transition of this support into long-term daily life does not succeed equally well for everyone affected. On the other stands the new life: returning to work, managing family life, regaining self-efficacy and trust, and coming to terms with identity, closeness, and the future.

Between them lies a biographical, social, and existential space that the current healthcare system addresses only inadequately. It is here that it is often decided whether a life that has been saved becomes a life that is truly lived.

◆ 19. Psychocardiology — the Bridge

The cardiovascular system and psychological experience cannot be viewed independently of one another.

Psychocardiology steps in where medicine focused exclusively on the organ reaches its limits. It does not mean hastily attributing physical symptoms to psychological causes. Rather, it recognizes that anxiety affects the heart rate, that prolonged stress alters blood pressure and sleep, and that physical symptoms in turn can intensify anxiety and insecurity. It unites biology and psyche instead of pitting them against each other, and it integrates experience by carefully distinguishing between normal trauma processing and a narrowing state of alertness that has taken on a life of its own.

Above all, though, it mediates between two truths that are both valid: the real danger that came from the heart attack, and the equally real experience that the acute threat is over. This is precisely why psychocardiological perspectives should be a natural component of holistic cardiac medicine; where support is needed, reliable access to psychocardiological or psychotherapeutic care must exist. Not everyone after a heart attack needs psychotherapeutic treatment — but the psychocardiological perspective should be available.

◆ 20. Trust, Unfolded More Precisely

Trust is the guiding theme of this knowledge space — and yet it is not a single, uniform quantity.

Whoever speaks of trust after a heart attack usually means several different forms at once, without distinguishing between them. Body trust means that one's own body carries one. Situational trust means that exertion does not automatically mean danger. Self-trust means being able to cope with symptoms and uncertainty. Medical trust means knowing when and where help can be found. Social trust means that one's environment takes one seriously without reducing one to the role of a patient. Trust in the future means being able to begin planning again. And finally, as the most comprehensive form: trust in life — the quiet certainty that vulnerability and life do not exclude one another.

These seven forms rarely develop simultaneously or at the same pace. A person may have long regained medical trust and still lag behind in body trust. They may be socially supported and yet wrestle alone with the question of whether they may trust their own future again. Whoever recognizes this distinction perceives more precisely what a given recovery is actually still working

on — and will not prematurely conclude that a person is “not yet healed” simply because one of these seven forms is still missing.

♦ 21. What We Must Expect from Follow-Up Care in the Future

Treating only the organ leaves part of the illness unaddressed.

	So far	In future
Central question	How is the heart functioning?	How is the person living?
Success metric	Survival rates and open vessels	Prevention through self-efficacy and quality of life
Handling symptoms	Medical evaluation as an endpoint	Shared interpretation that creates orientation
Role of psychology	A specialty for a few	A natural part of holistic cardiac medicine

Modern follow-up care should therefore not ask only how the heart is functioning. It should also ask how the person is living: how are they sleeping? What concerns do they carry? Do they dare to leave the house alone again? Can they feel joy again? Does anyone talk with them about closeness, about fear, about their changed sense of the future?

♦ 22. Conclusion — The Real Turning Point

After a heart attack, healing does not mean returning to the person one was before the infarction.

A heart attack is one of those experiences after which life does not simply pick up where it left off. Even when medical treatment succeeds and daily life gradually returns, the memory remains of the moment one's own life stopped being a given. For many, this is where a quiet process of reorientation begins — one that no EKG, lab result, or imaging test can measure: a reorientation of body trust, of identity, of relationships, of the future.

Over time, many people develop a new form of trust — not trust in invulnerability, but a trust that knows its own vulnerability and is nonetheless willing to look forward again. Modern cardiology can save lives today like never before. The challenge of the coming years will be not to treat survival as the endpoint of medical care, but as the beginning of a quiet path of its own: away from returning to the person one was, toward integrating an experience that may become part of the biography — without remaining its center forever.

“In the end, what matters is not only that a heart beats again, but that a person trusts their life again.”

♦ Survival describes the end of an acute threat to life. Healing begins where a person rediscovers their place in life — not despite the experience of the heart attack, but with it, as an integrated part of a biography larger than this single event.

∞ Further Reading

Those who wish to explore these questions further will find related depths within the WISSENSRÄUME series:

- Knowledge Space No. 5 — System Breakdown at 8:30 PM
- Knowledge Space No. 9 — Burnout in the Shadow of the Perpetual Motion Machine
- Knowledge Space No. 10 — Depression as a Blocked Transition

◇ Sources & Lines of Thought

This knowledge space does not understand itself as a scholarly treatise. The following sources mark the professional and scientific lines of thought that its central statements connect to — above all those of Chapters 1, 4, 5, 6, 9, 15, 18, and 19.

- I. Kindermann et al.: *Bedeutung von psychosozialen Faktoren in der Kardiologie – Update 2024 [The Significance of Psychosocial Factors in Cardiology – 2024 Update]*. Die Kardiologie (2024). Position paper of the German Society of Cardiology; basis for the psychocardiological perspective.
- D. Edmondson et al.: *Posttraumatic Stress Disorder Prevalence and Risk of Recurrence in Acute Coronary Syndrome Patients: A Meta-Analytic Review*. PLoS ONE 7(6) (2012), e38915. Evidence base for psychological distress and hypervigilance after an acute coronary event.
- R. Eisenberg, K. Fait, R. Dekel, N. Levi, H. Hod, S. Matezki, N. Vilchinsky: *Cardiac-Disease-Induced Posttraumatic Stress Symptoms (CDI-PTSS) Among Cardiac Patients' Partners: A Longitudinal Study*. Health Psychology 41(10) (2022), 674–682. Basis for the independent burden carried by partners and family.
- G. N. Levine et al.: *Sexual Activity and Cardiovascular Disease: A Scientific Statement From the American Heart Association*. Circulation 125(8) (2012), 1058–1072. Basis for questions of closeness and sexuality after a heart attack.
- German Society for Prevention and Rehabilitation of Cardiovascular Disease (DGPR) / AWMF: *S3 Guideline on Cardiac Rehabilitation in the German-Speaking Region (LL-KardReha)*. Registration No. 133-001, 2020. Basis for the scope and limits of cardiac rehabilitation.

*Knowledge that is shared
loses none of its depth.*

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