# A farewell to heart sink?

## CHAPTER 4

To sum up what went before: I would like to suggest that the 'heart-sink' patient's behaviour and attitude begin to make sense, and are entirely appropriate and consistent, if we bear in mind the strong possibility of a past history of abuse, in the widest sense of the term: emotional, physical, and sexual. We could decide to see the 'heart-sink' patient as someone for whom things went seriously wrong early on in life: in a relationship of trust, at a vulnerable stage in development.

Our hearts sink for the best of reasons. Feelings are always true and always rational, that is, they are always appropriate and proportional to their original cause. They can therefore be trusted even when it may be impossible to link them to anything in the patient's present circumstances; and even though their original cause remains undiscovered during all our consultations together. Our difficulty in 'getting the picture' may indicate we are dealing with a patient's repressed experience, re-enacted in exact but obscure ways, using the listener/doctor as a ready-to-hand and convenient figure of transference.

Such terms may be of little help for some doctors, or may actively put them off; and perhaps they are not essential. But they are a map, a theoretical ground-plan of where the action is at: I offer them in that light, with examples that may be of use.

### *Repression*

Repression occurs whenever an experience during childhood and development gives rise to feelings that are not fully lived through and assimilated: because these feelings are forbidden/too painful/too confusing for the child, and because there is no one more experienced available to help the child identify and deal with them. Today more experimental evidence is becoming available that supports this hypothesis, for example, in accessible books on the overlap of child psychology and neurophysiology, such as *How Babies Think*.[1] A child without adequate support is unable to cope with such intense conflict as: 'I love my parents/carers but they injure me, physically/sexually/emotionally'. (This applies to the concept of abuse in the widest sense of the word, from the limited to the life-threatening) Having got off to a faulty start in life with such an unmanageable and unassimilated experience, the grown-up child is then disabled from handling feelings aroused by similar abusive situations that come her way in adult life. She will lack empathy or understanding for herself or for others (often her own children) who have been or who are being abused in similar ways. At the same time the mental energy needed to keep the old chaotic and unwanted feelings safely repressed and unconscious, is not available to the patient for more creative purposes and leaves her feeling drained, inadequate, and bad. The sufferer feels non-specifically unwell all the time, and may decide to consult someone about her elusive health problems: someone who may then feel drained, inadequate, and bad, at the end of a dysfunctional consultation … Us!

*Peter has not had a job for more than 10 years, and as his 30s are slipping by, he is beginning to feel desperate. His problem is that he can't leave the house without checking several times that all the doors and windows are secure, and all appliances switched off. On bad days, it can take him 2 hours just to get out of the front door. When he's anywhere away from home, he worries constantly about needing the toilet. He is quite willing to talk about his background; he was brought up in a 'strict but loving' home, and although Peter himself kept his nose clean, as he puts it, his brother Martin was 'a right little devil', who was always in trouble, and was beaten by his father for his bad behaviour.*

What do these compulsions actually do for the sufferer? When he's observed all his self-imposed, rigid rules about locking things up, there must be at least the relief of having done something right, of having warded off the anger and rejection that were always threatened in his early life, if he failed at being good. At the same time, their irrationality and his insistence on them is just provocative enough to the 'normal' observer to express some of the natural resentment he was never allowed to feel. And what about Martin? Does Peter envy his brother's courage, which enabled him to avoid the burden of Obsessive Compulsive Disorder? Or does he feel that he should have done more to protect him?

### *Repetition compulsion*

Repressed experiences are stronger than reason or argument or cognitive therapy; willy-nilly they are enacted again and again in many different ways and in many different settings throughout the patient's life, unless and until the intolerable repressed feelings and their triggering events have been identified, consciously experienced, and reacted to (with sadness, anger or indignation) by the sufferer. The only way this can be done is for the patient to revisit them: if all else fails, alone; but let's hope she can do so in the company of someone willing to listen, during some form of 'talking' therapy, which fortunately may be as informal and ad hoc as an encounter in our surgeries.

*Michael works as a chef in a local restaurant. He is a good-looking young man, asthmatic, slightly built, with a wistful expression. His father seems to have been a violent and unpredictable man who threw him out when he was 18, on discovering that he was gay. Since then Michael has had a succession of partners, who appear at first to be the answer to all his needs; but the relationships always turn out badly. He tells you about Derek, who's just moved in with him; a*

*bit rough, but he's a great bloke — built like a gorilla, Michael says proudly, he used to be a bouncer in a nightclub! Next time he comes for his medication, you notice a bruise on Michael's cheekbone; maybe Derek's roughness isn't just a lack of social skills?*

So why is Michael attracted to the kind of man his father was? A gentle, sympathetic partner wouldn't satisfy him; he has to keep going back to the first man-to-man relationship in his life, hoping that this time at last he can find a way to placate his anger and win love.

### *Transference*

As part of this unresolved repetition compulsion the patient's behaviour towards the listener, and the feelings that arise in the consultation, tell us the patient's story in code and give invaluable clues about how the patient related to important figures in his development: parents, relatives, teachers, people in 'authority', 'helpers' — even nurses or doctors — who have confused and mistreated him, in any sense of the term, while he was very young and dependent on them. During this unconscious re-enactment in the consultation, the patient imposes, or transfers, a past situation or relationship on to the present one. In any given consultation he may allocate the role of the child to himself, casting the listener as the unsatisfactory adult. Or the patient may keep the role of the all-powerful adult for himself and relieve his old feelings of pain, humiliation and incomprehension by attempting to inflict them on the listener, so that the doctor is cast as the former child. The listener's feelings, of anger and irritation, elicited in response to such a consultation, are the feelings the patient may have experienced in a long-past but crucial relationship or situation.

*Clare's high blood pressure came to light during an MOT with her company doctor in the city; she makes it clear that what she wants from you is a quick solution, but unfortunately everything you've tried so far is unsatisfactory in one way or another —ineffective, or the side-effects are unacceptable. She is a tall, smartly dressed woman who dislikes being kept waiting, and receives apologies in silence. Your attempts to make light conversation while checking her blood pressure are not welcomed; she has a way of raising one eyebrow which can be disconcerting. Occasionally she offers a comment about the waiting room facilities, or asks a question about your appearance — 'Tell me, where do you get your hair done?'*

Clare makes you sink — along with your heart — to the level of the 3-year old whose mother finds fault with everything she does. For reasons that originate in her own childhood, a mother like this can't give her daughter support and encouragement; instead, she is in competition with her, and wins every time. Fifty years on, Clare is still under pressure to succeed; perhaps if she can make everybody else look small.

Is all this plausible but imaginary? There is a simple, additional thought experiment we can conduct on ourselves, that may satisfy the most exacting enquirer after truth. It concerns the dialogue in our heads; the often inaudible running commentary we have playing non-stop in the background of our lives. Sometimes it comes intrusively and almost paralysingly to the fore; more often it is muted, although any minor incident may suddenly turn up the volume.

Throughout our lives, we are all pursued by critical voices, reinforcing the sense of inferiority that is there as soon as we realise how small and helpless we are, compared with the grown-ups. From playgroup to focus group, the criticisms never stop:

*Yes, but you've drawn the horse bigger than the house, haven't you! And you've gone over the lines where you've coloured it in.*

*Sarah has made little progress with her piano playing this term. She will never improve unless she spends at least 2 hours a day practising her scales.*

*Well, I taught your kid brother to drive, and I must say he was a natural compared to you. You don't want to change gears like that — you're not meant to be fighting it! And just think what you're doing to my gearbox!*

*I'm not interested what time your childminder turned up. Your job is to get here punctually in the mornings and I don't care how you do it — is that clear?*

*Before we close the meeting I feel I must mention something that's been brought to my attention. Apparently a customer rang just after closing time yesterday and was brushed off quite rudely by one of our reception staff. It was you who took the call, wasn't it, Karen?*

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## REFERENCE

1. Gopnik A, Meltzoff AN, Kuhl P. *How babies think: the science of childhood.* London: Orion, 2001.