A farewell to heart sink?

CHAPTER 3

So let's say then for the sake of argument that 'A', our 'heartsink' patient, may well have experienced some form of abuse — physical, sexual, or emotional — early in life. Why take it out on us, in our consultations? Or even in our myriad social, familial, and domestic encounters?

With the best will in the world, there is a power imbalance between patient and doctor in a medical consultation: one that easily recalls the original power imbalance between child and adult, the emotions that went with it, and the expectations that follow from it. If these experiences involved abuse of any kind, then on some level, however unconsciously, the patient may see the doctor, the 'figure of power' in charge of the consultation, as an abuser. The doctor's offers of help may then be seen as deceit, seduction, or attack; or grossly wanting in some other way. This state of affairs in turn will require the 'once bitten, twice shy' patient to be ready with tactics and strategies for repulsing and outwitting the hapless doctor; to go on the defensive, or on a 'pre-emptive' offensive, often both. The patient, self-perceived as victim, gives in and appears to comply, prompted by old fears of powerful parent figures, only later to give way to old anger by rejecting the help that is offered.

Jennifer, in her late forties, wants you to help her lose weight. She is a chatty, sociable woman who copes alone with a part-time job and a son who has a disability. But all those girls' nights out, which she says cheer her up, have contributed to a weight problem that's making her breathless and uncomfortable. There is a very good group run by the practice nurse, but Jennifer is adamant; only you will do. At first all goes well, and she rapidly loses a stone; you praise her efforts; but then the lapses begin. When you have to tell her gently that she is gaining again, she bursts into tears: 'It's all right for you, isn't it? You've obviously never been tempted by a chocolate biscuit in your life!'.

You started off as the good parent, helping her to deny herself for her own good, and now you've become the bad parent, critical, and hostile, depriving her of everything that gives her life sweetness.

And that's just for starters. A's natural and unmet needs for a good relationship with a generous and protective 'figure of power' may lead her to place impossible expectations and demands on someone who asks, professionally: 'What can I do for you?'. When that someone who asks is us (us, for heaven's sake!) she is bound to be disappointed. Impossible, unconscious dreams of undoing the traumas of the past come up against the shortcomings of adult reality in our consulting rooms. For the patient, this is a disillusion too far; likely at first to reinforce her heartsink defences and behaviour toward the idealised parent figure of the doctor, who once again has let her down and made light of her hopes.

The good news is: it's nothing personal. Nothing to do with us. All we have to remember is that we are dealing with a simple case of mistaken identity. The patient in our presence, without consciously realising it, is relating to and confronting her abuser, the sometimes hated, often loved, and always powerful figure whose influence still rules her life. (Reminder: I am not necessarily talking of major, criminal, abuse here, but of any degree of more subtle abuse.) The patient's 'heartsink' behaviour tells us with great accuracy how that relationship was in emotional terms, how she felt and feels about it, how she copes with it, and covers it up; even as she goes on telling another story, one of (not so) passive aggression, attention-seeking, or clowning; of mental illness, alcoholism, or addiction. Right here in our consulting room.

John is 29, a tall, burly young man who is obviously emotionally disturbed. He sits in the waiting room with arms folded, muttering under his breath, and there are always empty seats on either side. What he has to show you are injuries: he dropped a hammer on his foot, he burnt his hand on the electric ring. Once he turned up with horrific bite marks. He'd been in a fight, hadn't he? He speaks angrily and tends to thrust the injured limb in your face. So far, you've never actually had to reach for the panic button.

Somewhere in John's early life, he learned to be afraid. Now, for a change, he can do the frightening, and you can find out what it's like to be the one who fears.

Of course, we are not John's abuser, all the while he's treating us as if we were, and giving us whopping great insights into his life. But he and his emotions are so powerful that we are in danger of forgetting, and of actually, here and now, turning into his abuser. We may end up punishing him for the difficult feelings he presents us with, by becoming angry, rejecting, or self-righteous — just like his original parents or authority figures — so helping to perpetuate a vicious circle of abuse that seems beyond anyone's control.

But if we remember, and stay with our realisation, that the patient is undermining someone we merely stand for, an old figure of power rather than our hapless personal self, we find we can stay unfazed with very little effort. We are freed up to note the anger and defeat we feel in the presence of this patient, without being in danger of taking our own sense of inadequacy out on him. We can remain firmly on the patient's side, welcoming communication with interest and respect, experiencing no need to deflect it or to control it in self-defence. We become open to the patient's real and sad history, one we wouldn't wish on our worst enemy. In our efforts to improve our relationships with the patient, we start to become supported by the admiration we develop for the patient's grit in enduring and surviving appalling times. The question arises: in his place, would we have come out so well?

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