A farewell to heart sink?

CHAPTER 5

Investigations and management

Examining feelings of past abuse is intensely painful for the sufferer, a pain matched only by that of keeping feelings repressed by heartsink strategies. But there is no true healing without uncovering the past. The patient has to set the pace, must never be forced, and must be allowed to remain stuck if that's all she's ready for at the time. The listener is in no position to disapprove of her for this, and can remain therapeutic simply by being aware that this is the stuff of old trauma; by accepting the patient's verdict on how far (if at all) to go with any exploring; and by remaining solidly on the patient's side while genuinely being undaunted by the re-enactment that's going on. The re-enactment is not a personal attack on the listener, no matter how much it feels like one.

Julie has turned up quite a lot recently, with suspected cystitis and problems with discharge; all tests have proved negative. She is a plump, pretty girl in her late teens; she wears tight strappy shoes and clothes that always look too small for her, while her scraped-back hair and heavily plucked eyebrows give her a pained expression. She offers giggly anecdotes about her numerous boyfriends and nights out drinking with the girls, and lately has been hinting at recreational drug use too. When you ask whether she thinks her lifestyle might be causing some of her health problems, she comes right out and tells you, 'Sometimes you sound just like my Mum!'.

It may be hard for the overworked health professional to feel liking for Julie, who doesn't really like herself much and isn't having as much fun as she wants you both to believe. But she does keep coming to see you. What is she trying to show you, if it's not the succession of elusive sexually transmitted infections? Is there any way of getting in touch with her insecurity and unease about herself? Every professional working with heartsink patients will have his own successful approach based on temperament and experience, and will sense how to adapt this to every individual patient's needs. If we can accept our own discomfort when presented with the riddle of the patient's heartsink behaviour, and if we can signal that this behaviour doesn't throw us but keeps us interested and happy to try and help, then we have no need for an 'expert' to spell out to us 'how to do it'.

But it may be useful to consider some of the therapeutic tools:

- Liking (aka 'unconditional positive regard', in the phrase coined by Carl Rogers) is one of them: it comes easily when we remember that the patient's feelings and behaviour are appropriate responses to hidden (repressed) stimuli, and that the patient is a survivor of experiences that would have defeated many of us.
- Face-saving: we can apply the ancient Chinese wisdom of helping one's interlocutor to maintain his dignity (as we would all wish our own vulnerability to be respected) by welcoming the patient's suggestions, explanations, and self-diagnosis, and by exploring them together in discussion; if necessary, concluding together, for the time being, that the patient's tentative interpretations don't quite seem to fit the picture, don't quite seem to get us there, and that the mystery remains as yet unsolved (even if we feel sure that we ourselves have hit upon the explanation long before the patient is ready to do so, and even if we are bursting with impatience to tell them all about it. Better not, better if the patient is given the space to find the answer for himself.)
- Transference: the patient's heartsink treatment of the listener may be used to form hypotheses about the patient's treatment of, and by, other significant figures in his life, especially during childhood/development. These hypotheses may be put, cautiously and with an open mind, to the patient for confirmation/rejection, or may simply be filed away by the listener as useful ideas to be checked out at a later stage when it feels more helpful to do so.
- Transparency: All the above has to be a genuine exploration, by two equals, of uncharted territory. The listener has no tricks up his sleeve, no answers ready to pounce with, no directions to give. There is no technique, only a willingness for the doctor to be shown how it is and how it was for the patient.

Conclusion

The care of the 'sinking heart' patient is easy if we let it be. In fact, until the patient himself gives us the go-ahead, we don't need to do anything about it. We don't need to come up with advice, recommendations, or treatment. We can afford to admit our ignorance. The patient has the answers, all we can do is wait for them in an atmosphere of optimism and confidence, knowing the answers are there, even if we don't know what they are. There is, as yet, a limited, but growing, evidence base. Meanwhile, a qualitative/narrative approach, empirical experience, and intuitive assent constitute a provisional one rich enough to be getting on with.

Further reading

I am totally indebted to the writings of Alice Miller, which helped me to make sense of heartsink consultations, and to formulate the ideas summarised in this monograph. Her books are highly recommended, especially:

The Drama Of Being A Child
For Your Own Good
Thou Shalt Not Be Aware

Similar conclusions, in an educational rather than a therapeutic setting, are reached and set out in A S Neill's *The New Summerhill*.

How Babies Think: The Science of Childhood by Alison Gopnik, Andrew Meltzoff, and Patricia Kuhl describes experimental evidence concerning the development of children's minds.

Dibs In Search Of Self by Virginia Axline describes one way that theory may be put into practice.

Gwenda Delany

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APPENDIX

The psychological thought of Alice Miller

Alice Miller is a psychotherapist. She is interested in the importance of emotions in understanding seemingly irrational behaviour. Her thesis is that our emotional life governs our behaviour. Seemingly irrational behaviour becomes explicable once one understands a person's emotional life.[1]

Miller believes that our emotions are formed in early childhood. If we have happy childhoods then our emotions develop naturally and we behave in a rational way. However, if our childhoods have been unhappy, as a result of physical, sexual, or emotional abuse, our emotional world is damaged. Emotionally damaged adults may harm themselves or others or suffer with psychosomatic illness. Why is this?

Children who are being abused are in a frightening and dangerous situation. Children need to believe that their parents love them. If they react in a natural way to the abuse, by showing their anger and outrage, they risk further abuse from their parents or carers. An abused child, A, represses her anger and outrage and does not feel it consciously. This is a healthy response to abusive parents as it optimises A's wellbeing while she is dependent on them. By repressing her anger and convincing herself that everything is OK really, A does not antagonise her parents and so maximises the chance that they will continue to give her the good things they can, such as food, shelter, and a home. She also helps herself to cope with an intolerable situation. When A grows up the situation changes. The repression of her anger is no longer necessary and is, in fact, counterproductive for A's wellbeing. Sadly, because A is herself unconscious of the anger it will probably remain repressed. She lives with the unconscious anger inside her and is compelled to express it in some way. The anger may be expressed towards herself (as in depression, self-harm, or psychosomatic illness), her children (as child abuse), or towards others over whom she has power (as in violence or bullying).[2] Conversely, she may re-experience her own anger by developing relationships with other people who will abuse her.

This unconscious anger is usually maladaptive in adult life. It causes harm to A, her children, and other people. It no longer plays any useful function. If A is able to recognise her anger consciously and express it directly then she may be able to free herself from the compulsion to harm herself and others. Miller believes that people like A can be helped by communicating with people who understand her experience. This is the aim of psychotherapy.

GPs meet many patients who have suffered some form of abuse and express this in the form of depression, self-harm, or psychosomatic illness. A may make our heart sink if we try to understand her behaviour on a superficial rational level. However, if we are able to sense the emotional experiences lying behind A's behaviour then this may be therapeutic.

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REFERENCES

1. Miller A. *For your own good; The roots of violence in child-rearing*. London: Virago Press, 1987.
2. Miller A. *The drama of being a child; the search for the true self*. London: Virago Press, 1995.