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Dear Dr Miller,

I thought you might be interested to see a monograph, which has just been published in five parts in the British Journal of General Practice. This is a journal for family doctors. It was written by Dr Gwenda Delany, who died last year. She was enormously influenced by your work, and the monograph describes how she used your insights in her work as a family doctor. I wrote the appendix at the end in which I attempted to summarise your thoughts. I do hope you think I have expressed them reasonably.

Best wishes, Judith Burchardt

> **AM: Thank you so much for sending us the article and for having written the excellent Appendix. I hope that some of the GP will open their ears and check what they have read with their own patients. But for doing so they should overcome (at least a bit) their own fear of their childhood pain. Unfortunately, doctors like this are rare; most of them think that they have to DO something (prescribe drugs) to feel powerful and do not to listen. They don't know that listening gives them much more knowledge, also about themselves, which means to gain true strength for themselves instead of playing the powerful one.**
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> ***A Farewell To Heartsink?***
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> ***by Dr Gwenda Delany***
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> Prefatory note.
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> This is a testament of 26 years lived in General Practice. I completed the testament after some years' gestation, when I retired from work at the end of 2005, with disseminated breast carcinoma and a prognosis of weeks. The references to my evidence base are therefore entirely inadequate, though I have indicated the areas where some may be found. But as this is primarily narrative medicine, I feel my small testament may stand as it is, and go, in Beethoven's words, from the heart to the heart; with not a sink in sight. The word 'she' or 'he' is short for 'he' or 'she' wherever it crops up in the text: the writer is a bona fide 'she' who finds conventions such as 's/he' obtrusive and jarring.
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> Being a doctor myself, I have the incorrigible tendency in what follows to refer most often to doctors in connection with heartsink encounters. These are of course not limited to doctors, or even to medical professionals; as humans, we all encounter them in our daily lives; we all get the chance to do something about them, and to make a difference. The illustrations, which are entirely fictional, were provided by a non-medical collaborator who has had much to do with medical professionals in the course of her life, and hopes in her turn to make a difference to them.

Is ‘heartsink’ a term of abuse? I don’t think so: speaker and listener may truly bring a sunk heart to their meetings. That this is a sign of life and hope, is what I aim to demonstrate: if anyone comes to see it in the same light as a result of reading this monograph, I shall have achieved my aim.

A Farewell to Heartsink?

Chapter 1

Scrolling through this morning’s appointment list, I see A is coming to see me. In a cruder era a few years ago A might have been labelled a ‘heartsink patient’: a patient whom I just can’t seem to help, and who all too frequently comes to remind me of the fact.

Every consultation with A leaves me aware of a turmoil in myself out of all proportion to the presenting problem. Turmoil made up of many feelings on my part: Anger, misery, irritation, fear, rejection, blame, manipulation, exploitation, contempt, hopelessness, helplessness, uselessness, confusion. So much confusion in fact, that I hardly know where in all of this my feelings towards A begin or A’s towards me end.

It’s a consultation we’re all familiar with: we all know A. Some of us might defend our own negative feelings towards A as entirely justified; others would prefer to bundle them hurriedly out of sight, ashamed of a supposed lack of professionalism and compassion. But we could adopt a more practical approach, and treat these difficult feelings as part of the objective history and examination. They are as present in the consulting room as any other physical sign might be: a cough say, or impetigo - or bursting into tears.

Monica asked to be taken on your list 18 months ago, after “misunderstandings” with her previous GP, in a practice on the other side of town. She has tried everything for recurrent bouts of IBS, which she is convinced stems from a food allergy; she’s even attempted an exclusion diet a couple of times, but neither of you felt that it proved anything. She often responds to your suggestions with a sigh, opening her eyes very wide; then silence. As she lives on the edge of your practice area, she has difficulty arriving punctually for appointments. It’s impossible not to feel irritated yourself by Monica’s behaviour; you are being challenged to discover the secret source of her irritation, in every sense…

Of course, A can be 20, 30, 40 or older; male or female; of any or of mixed ethnic origin. Dominating all the feelings A has ushered into the consulting room, there is a sense of ill-usage, on the part of both patient and doctor. Both appear to experience the consultation in terms of: ‘I don’t deserve this’ and ‘Why are you doing this to me?’ Where does all this come from, and what does it mean? Could it literally be telling us that we are dealing on some level with a history of ill-usage, of maltreatment - of some kind of abuse?

What is abuse? The term is generally reserved for harm inflicted on children by adults or by older children: inflicted by those in a position of power and/or trust, on someone more powerless and defenceless than themselves. The abuse may be overt or may have come

in disguise, as love, as discipline, as protection or ‘good parenting’ even.

Most of us would have no difficulty in acknowledging the criminal end of the spectrum where physical or sexual abuse are concerned, and would expect the victim to be deeply and lastingly scarred.

Jake is 19, in his first year as an art student, still living at home; he seems a shy young man, who moves awkwardly. He has presented quite frequently in the past few months with headaches and trouble sleeping. None of the remedies you suggest seem to help much. Examining him for a shoulder injury, you discover that his arms are heavily scarred. He has little to say about this, except “I do it when I feel bad.” Nobody in his family is aware that he cuts. When you find time to look back over his early notes, you see that he was on the At Risk Register for possible abuse when he was ten; shortly afterwards, his father spent two years in prison.

Many ‘heart-sink’ patients will turn out to have suffered such gross and overt abuse; though feelings of confusion, intolerable shame and self-blame may still be preventing them from disclosing, or even from consciously remembering it.

There are other forms of ill-treatment: as well as less extreme physical and sexual abuse, there is a whole spectrum of gross and subtle emotional damage. If, as I propose, we’re right in linking ‘heartsink’ behaviour in the consulting room to an origin in a ‘major’ or ‘minor’ abusive experience, then A, without knowing it, has already given us a map to a troubled and largely unexplored interior. Here be dragons, belonging to A’s past, but not of A’s making.

Geraldine is a woman in her late fifties who relies heavily on laxatives. She is overweight and, you suspect, a more than moderate drinker. She claims to have suffered chronic constipation “ever since I was at boarding school, really,” and is reluctant to give details of her diet. In her presence, you have the sense of things being held back…from a long way back…

All these examples are of patients who can’t tell their stories openly. The origin of their pain is hidden, even from themselves.

Chapter 2

Emotional abuse is a concept that lays itself wide open to - well – abuse. But perhaps it can really be put very simply. To have experienced emotional abuse A must have heard or interpreted words like these early on in life:

You’re not the way I want you to be.
It’s your own fault.
Everybody else knows how.
If you really wanted to, you’d do it for me.
I’d be a good parent (teacher) if it weren’t for a child like you.

Did anyone in A’s life really say these words - or consciously imply them? Might they have been spoken/implied by someone unaware of their power to annihilate, someone no

longer capable of hearing how they would strike a child? Someone so damaged by their own childhood that they themselves had never come to realise how such an attack would strike a child in his self-image or worth? In emotional abuse, the child's love, trust and attachment are used to warp the course of the child's development in the (un)conscious interests of the adult, who is lashing out with unresolved damage of her own.

For an 11 year old boy, Russell already has an impressive accumulation of notes. A very premature baby, his parents were worried that he might be a slow learner; but by the time he started school, he seemed to be of average ability, if a bit small for his age. His mother –or sometimes his grandmother, who lives with the family –turns up with him at the surgery every few weeks, with suspected ear infections, chest infections or tonsillitis; demanding antibiotics, and wondering if he ought to be taking fish oil or extra vitamins? Shouldn't he be referred to a specialist?

You get the feeling that Russell is an unsatisfactory child, who needs to be put right; and if only you were a good doctor, you'd see that he's all wrong... a child like this has to live in an atmosphere of constant criticism which amounts to emotional abuse.

Emotional abuse inevitably accompanies physical and sexual abuse and may also occur where there is:
Rigid 'discipline' at home or in school, in deference to values of past generations and unrelated to the child's real needs
Harsh or intolerant religious/cultural indoctrination
Excessive demand for achievement
Excessive demand for conformity to questionable standards
Role reversal where the child is expected to be strong or considerate or self-effacing beyond his years, for the sake of the fragile adult(s)
Deception surrounding adoption or parental disappearance
Unpredictable and deficient parenting associated with alcoholism/drug abuse/ untreated mental illness. Etc, etc - for further examples, we need only consult our patients.

Mary is fourteen, the eldest girl of a large family, and a great help at home; her mother says she is a little saint, the way she looks after the younger ones, making all their breakfasts before she goes to school. Her father is away a lot in his job as a drug company rep; when he is home, he often relieves his stress by going out drinking, but her mother says that Mary still adores her Daddy and won't hear a word against him. However, lately Mary has been having a lot of stomach upsets and seems to be off her food; after glimpsing her daughter in the shower, her mother is worried that she is getting dreadfully thin.

Mary's developing anorexia is telling us something about the unacknowledged problems in her family. Seeing her mother struggling with a difficult marriage and an impossible workload, Mary has found a way of fending off the demands of womanhood; she goes on being the good girl who is loved and approved of –sustaining, even if it kills her, the apparently vital illusion that all is well.

What these parents have in common is that they provide an insecure environment for the developing child, where she learns not to trust herself or others; where she is expected to strive after goals which entail giving up much of her own spontaneity and creativity to others' demands. This is likely to leave its lasting mark in depriving her of self-esteem

and self-confidence, and leave her with feelings of anger and outrage she may not even be aware of. All the same, they are painfully eating away at her, and are making her feel worthless; even if she is busy establishing what appears to be a fulfilling life, with a successful career and happy family. Unknown to her, inside him, a cry has been waiting to be heard since childhood.

I am that I am
I love you T-H-I-S much
I know I don't give you what you want
I keep trying to because I love you
I can't help myself
I'm mad at you, I hate you
I hate myself
You made me the way I am but I can't face it that you did this terrible thing to me
When I grow up I'm going to be depressed – no- workaholic – or
I'm going to get my own back and become a delinquent addicted paedophile serial killing suicide bombing heartsink patient - and – and – and - you'll be SORRY

Simple as that. King Lear said it first:

- I will do such things -
What they are yet I know not, but they shall be
The terrors of the earth.

As for an example, do we need to look very far? In our own hearts?

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 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 abuser; and 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/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 or rubbishing 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 disabled son and a part-time job; 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 towards 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, but so far, you've never actually had to reach for the panic button.

Somewhere in John's early life, he learnt 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 A'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 her. We can remain firmly on her side, welcoming her communication with interest and respect, experiencing no need to deflect it or to control it in self-defence. We become open to his real and sad history, one we wouldn't wish on our worst enemy; and in our efforts to improve our relationship with him, we start to become supported by the admiration we develop for his grit in enduring and surviving appalling times. The question arises: in his place, would we have come out so well?

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, sexual. We could decide to see the 'heartsink' 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, i.e. 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 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; e.g. in accessible books on the overlap of child psychology and neurophysiology, such as "How babies think." 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 ten years, and as his thirties 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 two 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 though 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 and 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 eighteen, 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, irritation etc, 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 BP 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, though any minor incident may suddenly turn up the volume.

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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 two 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?

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, self-diagnosis etc., 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 him all about it: better not, better if the patient is given the space to find the answer for himself.)

Transference: the patient's 'heart-sink' 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 herself 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.

Dr 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.

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. If however 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. The 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 antagonize 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 counter-productive 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). 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 consciously recognize her anger 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.

General practitioners 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.

Dr Judith Burchardt