

THE
SKELETON
CUPBOARD

The making of a
clinical psychologist

TANYA BYRON

MACMILLAN

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Introduction

MY GRANDMOTHER'S FRONTAL LOBES

Frontal lobe *n.* (*pl. frontal lobes*) **1.** Each of the paired lobes of the brain lying immediately behind the forehead, including areas concerned with behaviour, learning, personality and voluntary movement. **2.** A region of the brain that influences higher mental functions often associated with intelligence, such as the ability to foresee the consequences of actions, planning, comprehension and mood.

I first became fascinated by the frontal lobes of the human brain when I saw my grandmother's sprayed across the skirting board of her dark and cluttered house. I was fifteen.

A young woman – eight months pregnant, I discovered much later, and a heroin addict – had battered her about the head with an iron fire poker. She was an ex-tenant of my grandmother's. This woman knew that her former landlady, a German Jewish refugee recently converted to Christianity, had treasures and cash galore stashed among the chaos of her large house, the top two floors of which she rented out.

A few blows to the head, a quick rifle through purses and drawers, and the woman was off, cash in her pocket to pay

off her dealer and secure her next hit. My grandmother lay on the carpet of her front room, bleeding from a large head wound. I don't know whether she was conscious or not. I do know exactly how she died: by slowly asphyxiating, choking to death on her own blood.

Asphyxiation: that was the problem, of course. If only she'd died instantly from the head trauma, the crime would have been treated as murder. If only she hadn't been a stubborn, wilful woman – a woman who had fled Nazi Germany pregnant with my father, a woman who had lost many of her family in concentration camps, a woman who never took anything lying down, except when she was beaten with an iron fire poker.

There she lay, refusing to die, until she choked on her blood. The woman who had beaten her was sentenced to only three years for manslaughter with diminished responsibility. She had her baby in prison and was out within eighteen months.

OK, to be honest, I am not entirely sure that my grandmother's brains *were* on the skirting board when I went into her house that day at the age of fifteen. Is that a direct memory or something I told myself later on? In fact, I'm not sure I remember much of that day at all except two things: a massive bloodstain on the carpet and my father making a noise like an animal caught in a trap.

In that moment I became the rational cop. My darling father howled, but I just shut down and began to try and understand how and why.

Had she died in pain? Did she know she was dying before she died? What had compelled her murderer to smash her head in? Had the woman planned it? Did she

want to kill my grandmother or merely maim her so she could plunder?

All these questions about the shit end of life, at a time when I should have been unthinkingly hedonistic. At fifteen years old, my frontal lobes were in a post-pubertal stage of reorganization, which meant I should have been taking my own risks and thinking bugger all about the consequences.

But on that March morning it was only and all about frontal lobes: my grandmother's on the skirting board (perhaps), her murderer's – clearly under-functioning – and mine, clicking into a precocious place of calm rationality that I now believe began my journey into the profession of a mental health practitioner.

This book tells the story of my clinical training. It takes place over the course of three years from 1989 to 1992, when I was in my early twenties, during which I underwent a series of placements in different mental health settings and worked with several distinct kinds of patient: troubled children; families in crisis; men and women dealing with the encroaching effects of dementia; those struggling with drug dependency, eating disorders, sexual dysfunction and terminal illness and, in one case, a sociopath.

After completing my BSc in psychology at the University of York, in the north of England, I had moved back to live in a flat in London, the city in which I grew up. My childhood had been busy, creative and exciting. My father was a successful TV, film and theatre director – a brilliant, highly emotional, inspiring man. My mother was a senior nursing theatre sister and occasional model. My sister, Katrina, only fifteen months younger than me, and I grew up surrounded by art and culture – which I loved – and went to a highly

academic all-girls school – which I hated. Life was full of interesting people coming through our house; dinner conversations were always lively and passionate; my mother was a calm, steady presence in the busy, sometimes manic world of the creative people who worked with my father.

I never intended to be a mental health practitioner; I wanted to work in film and TV, making documentaries about social issues. Quite unexpectedly, I managed to get onto a postgraduate clinical training course and decided that a further three years would allow me to make authentic films and TV programmes about mental illness. I wanted to demystify and destigmatize it.

Almost twenty-five years on, I still practise clinically alongside writing, journalism, broadcasting and policy advising. Best of all, I am the mother of two fantastic teenagers, Lily and Jack.

Although I have written books about child development and parenting, I have never felt able, until now, to write more fully about the experiences of working in mental health. It's taken this long to distil the experience of working with some of the most amazing people I have ever known – people who trusted me enough to tell me about their lives.

I am going to start at the beginning and tell the stories of my training as a well-meaning but inexperienced young woman. I had to learn on the job: half the week at University College London, receiving lectures and training in models and approaches in mental health, writing essays, case reports, a dissertation and taking exams; the other half of the week on a series of six-month placements, attempting, with regular supervision, to apply this learning.

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The training took place within the National Health Service, and I spent time in hospitals, clinics, mental health units and GP surgeries. I saw patients referred to me by many different specialists in health and mental health – people struggling with acute, chronic and at times profoundly debilitating mental health difficulties. Some were mildly impaired, others dealing with long-standing difficulties. Occasionally there were patients who presented such a degree of risk to themselves or others that they had been sectioned under the Mental Health Act.

Over three years I was given six six-month placements, structured to provide a complete training experience across the age span and full spectrum of mental health issues by the time I qualified.

There is no other way to narrate the training of a clinical psychologist than to tell the stories of those I encountered, so the book is inspired by the cases I worked and my experiences treating people as a new and naive mental health practitioner. However, because confidentiality is a core principle of my profession, while all I describe is drawn from real clinical practice, the characters I write about are not modelled on real individuals. They are constructs, influenced by the many incredible people I had the privilege of meeting during my training.

I dedicate this book to them.

Tanya Byron
London, April 2014

One

THE EYES HAVE IT

I sat in my office, the first office that I had ever had. The word 'office' might have been an overstatement. George, the friendly elderly porter who had welcomed me to the outpatient psychiatric department – 'Welcome to our happy home' – had pointed out that up until five months ago the space I was sitting in had been a storage cupboard.

'Storage for what?' I asked. I was thinking about asbestos.

'Storage for everything: dressings, commodes, the old drug trolley. It was only when the department had to take on more fresh blood that we converted it – some kind of regulation, I think.'

'What kind of regulation allows a windowless office?'

George smiled. 'Fresh blood see the jumpers.'

'Jumpers?'

'The ones that go straight for the windows.'

Why on earth had I thought I could do this?

Alone in my office, I put my head in my hands – perhaps it wasn't too late to accept the researcher job at that TV production company. Christ, I was twenty-two, in my own flat, living in arguably the best capital city in the world. I

could have glamour, a better wage, less responsibility. What the hell was I trying to prove here?

The other people on my training course seemed much more competent. To begin with, I was the youngest out of our group of twenty. Most of them had come from research or other clinical backgrounds and I felt intimidated, even though I'd only just met them; they seemed to know 'stuff'. I wasn't looking forward to our university time together. I would obviously be the dunce of the class, just like I was at school.

Shit. I knew absolutely nothing.

Feeling sorry for myself, I looked around my cupboard; it smelt musty, a complete contrast to the glass, marble and chrome atrium I had walked through downstairs less than an hour before. This was a flagship hospital. It had been like entering another world – calm and clean. Even the signs advising against physically attacking the staff were printed in gentle sans serif, muted and almost apologetic for the crassness of their message.

The staff down at the reception were friendly too – all smiles and uniforms and endless leaflets about patient rights and complaints procedures. It was not a hospital; it was a Trusthouse Forte hotel lobby.

I had taken the lift up to the eighth floor with several hassled-looking members of staff, none of whom had been even remotely interested in the fact that I had just joined the team. I looked at my new staff identity card and made sure it was facing outwards. 'Clinical psychologist in training.' No one noticed; no one gave a damn; and in that moment I felt like the new kid on the first day of school.

It had taken me five minutes of circling the four-sided

eighth floor before I'd located the outpatient psychiatric department – I had dismissed it on circuits one to three because it looked like the entrance to some sort of supply room. Nothing here reflected the opulence of the hospital downstairs.

The grumpy, round-faced woman who had greeted me when I finally got to the psychiatric outpatients reception managed to thrust me my room key, point to the cupboard door and say, 'You see them in there,' all without once lifting her eyes from *Woman's Own* magazine.

'Is everything all right?'

Seeing Chris standing over me, with a man just behind her, jolted me back into the room.

'Oh, yes. Hi. Gosh. Sorry.' I'd been slumped over the desk, lost in thought.

I scrambled to my feet.

Dr Chris Moorhead was renowned for being a brilliant supervisor but one hard-core, fiercely intelligent, no-nonsense woman. I remembered her from my interview for the clinical training course. She didn't smile. She didn't make small talk. She asked the most difficult question: 'Why do you deserve a place on this training course any more than all the other people who want it?' When we were told who our training supervisors were to be, I noticed a number of my fellow trainees sighing with relief when my name was matched with hers. A few second- and third-years laughed and patted me on the back. 'Good luck,' said one of them.

Chris, a tall, slim, angular woman who had the unnerving habit of maintaining unbroken eye contact, gestured to the man standing just behind her.

‘This is Professor Horace Winters, head of the outpatient psychiatric department. Professor Winters, this is my trainee. She’ll be here two and a half days per week for the next six months.’

The prof offered his hand, making zero eye contact. His words sounded as if they’d been worn smooth by repetition.

‘Welcome to the department. I hope you enjoy your time here. I’m always at your disposal. I’m looking forward to the valuable contribution you will make to my team.’

With a flourish the prof then walked out. I wanted to giggle, but Chris clearly wanted further words.

‘They very rarely take unqualifieds in this department, but I told them you’d do good.’

‘Chris, that’s so great of you. Thanks.’

‘Don’t thank me. Just don’t let me down.’

After Chris left, I found a way to wedge some old and slightly damp prescription pads under the tilt mechanism to keep my chair from tipping over. Welcome to the NHS.

As I was rearranging my cupboard office, I heard the sound of singing – a small voice growing in volume and then, just as the melody was decipherable, getting fainter again. I could have sworn it was a song from *The Sound of Music*.

Maybe I was hallucinating. No – it got louder again:

*‘How do you solve a problem like Maria?
How do you catch a cloud and pin it down?
How do you find a word that means “Maria”?
A flibbertigibbet! A will-o’-the wisp! A clown!’*

It was extraordinary – a little voice, but one with such purity and clarity that it cut through the growing noise of the busy outpatients reception area outside my door.

Why is no one else hearing this?

I left my room and looked around. I had two hours before my first appointment, I was alone, and I wanted to know who was singing that song. But when I stepped out into the waiting area, I was stunned by what I saw and the song – although still lilting in the background – became peripheral.

If my mother had been there, she would have instructed me not to stare.

When George appeared with two mugs of tea, I was able to tear my gaze away.

‘Gender Identity Clinic.’

He sat down on a waiting-room chair and gestured me to join him, which I did. The sugary orange brew calmed me and brought me back to a clinical state of mind. I inhabit a non-judgemental space, I reminded myself.

‘Gender Identity Clinic?’ I asked.

‘Yep. The boys come in because they want to be girls. Prof Winters is their man. They get assessed, and if they can live for five years as the gender of their choice, then they get the op, the deportment classes, the whole works.’

‘The works?’

‘Adam’s apple shaved, make-up classes, how to dress to suit your shape – you can cut off a penis, but you can’t rebuild a brick shithouse.’

I looked around and had to agree, as much as I hated the indelicacy of George’s language. There were some who could only be described as pantomime dames. There were also some incredibly good-looking men/women here.

There was one mesmerizingly beautiful oriental-looking woman. Slight and delicate, she had the most incredible curtain of straight, shiny black hair hanging down to her waist. She certainly knew how to dress to suit her shape – ‘classy not brassy’, as my girls, my three best friends, would say. She even gestured in a manner that, despite the slight exaggeration of movement and eyelash flutter, was all believable, in a sort of hyper-feminized way.

I felt challenged. My clothes – a charity shop man’s suit with crisp white shirt, tight vintage Dior belt and Doc Marten shoes – made me feel frumpy.

How can a man look a better woman than me?

I was rescued from this thought by the appearance of two other people coming out of the women’s toilets. The smaller of the two was startling. She was wearing the sort of dress that my late grandmother would put on for a family occasion: good material, generously cut, but staid in its blue navy, with a tight, thin red belt, plunging neckline and cheeky sailor-striped T-shirt subtly covering the décolletage. She held a tiny red clutch bag in her enormous man-hand and tottered on blue wedge heels made out of the material that allows room for bunions – the sort of shoe that can be purchased from a Sunday-supplement catalogue that also sells lawn-aerating sandals, ladies’ turbans and slow cookers. Her wig was of the brightest yellow perm – she was Bette Midler, at a bar mitzvah, in the late seventies, playing a man in drag.

The other woman was more challenging – nowhere near as gorgeous as the lovely oriental ladyboy, but much more sexy. How could that be? At well over six foot, she was broad, with calves the size of tree trunks and well-defined

arms to die for. She was dressed in a tight black dress, lap-dancing shoes with Perspex platforms and vertigo-inducing stilettos, and sported a straight, brown, honey-highlighted Mary Quant bobbed wig with serious attitude.

She was the Adam/Felicia character in *Priscilla, Queen of the Desert*, or Tony Curtis as Josephine in *Some Like It Hot*. The smaller woman, however, only managed Terence Stamp and Jack Lemmon – Bernadette and Daphne.

I was mesmerized by 'Josephine'. She caught my eye, winked her giant eyelashes, poked the end of her tongue out from between her red, shiny lips and smiled. I felt hot and looked away.

Someone flew past me singing and then disappeared behind the central lift shaft.

*'How do you solve a problem like Maria?
How do you catch a cloud and pin it down?'*

'That's Edith,' George explained. 'She's an RDP.'

'A what?'

'A revolving-door patient.'

'And that is?'

'She comes in on a section and is taken into the inpatient ward on the other side of this floor. She is stabilized. She takes her meds independently. She is discharged. Care in the community take over. There is no care in the community. She drops off her meds, frightens the neighbours, so she comes back in. Revolving door.'

I looked thoughtfully at George. He was in his seventies, I reckoned, perhaps ex-military, with his white cuffs visible a precise and equal distance under a pristine black jumper.

‘Hello, Edith,’ said George, looking up at the person whose beautiful voice I’d heard.

‘Well, hello, George. And who might this pretty lady be?’

Edith had wandered into the outpatient department and I found myself taking the hand that had been offered by the smallest, darkest woman that I had ever seen.

‘Edith Granville, please say hello to our fresh blood.’

‘Hello, my dear. How are you this blessed day?’

Edith was so small and so smiley and had eyes so sparkly that I was almost too enchanted to reply. This tiny and compact black woman had a crisp white pillowcase pinned to her head. The pillowcase, I soon realized, was an attempt at a nun’s wimple. Edith was Mother Superior.

‘I know what you thinking, girl, and you’s wrong.’

‘What am I thinking, Edith?’

‘You’s thinking that I Julie Andrews!’ Edith cackled. ‘Oh, Georgie Porgie! She think I Julie Andrews!’

George was wheezing, bent over double, and coughing up many years of Player’s Navy Cut.

‘Oh, Edith, no, I don’t think you are Julie Andrews. No, not at all!’

‘Well, good for you, girlie, because:

*‘When I’m with her, I’m confused,
Out of focus and bemused.
And I never know exactly where I am.
Unpredictable as weather,
She’s as flighty as a feather. She’s a darling!
She’s a demon—’*

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‘*She’s a lamb!*’ I sang out as hard as I could. Bugger clinical training – there was nothing that an entire childhood of Christmas showings of *The Sound of Music* couldn’t prepare me for.

Edith clapped her hands together, as George beamed and I bowed.

‘This your first day here, girly?’

‘Yes, Edith, it is.’

‘So what you think?’

‘I think I don’t know what to think.’

‘George, you say she fresh blood?’

‘Yes, Edith, that is what I would say she is.’

Edith threw her arms around me and held me tight. ‘Oh, sweetheart, you just joined. So new. Let Edith help you in.’ Edith took me by the hand, linked arms with George and skipped us all into my cupboard.

‘Ah, we called this “the Shithole”. Commodes, medication – all the shit was here. Yes, indeed, I think it were better when it were a cupboard.’

Over the next forty minutes, as I perched gingerly on my chair and George brought us all another brew, Edith initiated me into the realities of my training by telling me her life story.

Born in Tobago in a small village by the Caribbean Sea called Black Rock, Edith was the second-youngest child and the youngest daughter of nine children. Her father, a Baptist minister, was a man of compassion to his flock, but not, it seemed, to his children. Father – that was his name – travelled far across the width of the island from Plymouth to the capital, Scarborough, and the length from Charlotteville to Sandy Point. Father held Bible meetings in Roxborough

and Parlatuvier on the beach, and performed miracles in Moriah and on Cinnamon Hill. Father saved lives, and when he was away, the family was also at peace.

When he wasn't away ministering, Father would struggle to contain the sin in his home. Edith told of the 'whoopin's' and 'beltin's' and beatings that were part and parcel of childhood. Especially for a young girl prone to daydreaming – a sin, said Father, when in church – and to singing – a sin, said Father, when not a hymn.

Poor Edith – the youngest of the sisters and the favourite of her mother, she was the first to be sent to live with her father's sister, Aunt Charisma, in Shepherd's Bush. It was there that Edith was to really understand how undesirable she was. At this point in the story, Edith broke into song again:

*'She'd out-pester any pest,
Drive a hornet from its nest.
She could throw a whirling dervish out of whirl.
She is gentle!
She is wild—
She's a riddle,
She's a child
She's a headache!'*

Edith suddenly stopped singing, and as her head fell backwards, her eyes simultaneously rolled up until I could only see the whites. This seemed serious; I tried not to panic.

'Who's a headache, Edith? Tell me.'

Edith's eyes closed and screwed up, and tears trickled down her cheeks. Mouth open, she began a low moan, before beginning to sing again:

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*'She is wild—
She's a riddle,
She's a child
She's a headache!
She is wild—
She's a riddle,
She's a child
She's a headache!
She is wild—
She's a riddle,
She's a child
She's a headache!'*

Between bouts of singing, Edith told scrambled stories. 'Stinging' was a key word. 'Stinging' and 'down there'. The 'downstairs department'. Aunt Charisma and scrub, scrub, scrubbing. No dreaming. Bad dreaming. No singing. Bad singing. Only scrub and sting and Lysol.

'You lie, you Lysol. You lie, you Lysol.'

In my mind, I tried to sing ahead, to remember the words, as Edith kept repeating the lyrics, her needle stuck in the groove:

*'She is wild—
She's a riddle,
She's a child
She's a headache!
She is wild—
She's a riddle,
She's a child
She's a headache!'*

TANYA BYRON

*She is wild—
She's a riddle,
She's a child
She's a headache!*

I got it and belted out:

*'She's an angel!
She's a girl . . .'*

Then there was a complete stop. Not a pause but a stop. Silence. No song. No moans. No lies or Lysol.

The small woman stood with dignity and straightened the pillowcase on her head. She looked me directly in the eyes, and despite the streams of tears still coursing down her mahogany cheeks, she extended a hand. 'A pleasure speaking with you.'

'And a pleasure meeting you, Edith.'

'Please call me Maria.'

And Maria walked out of the cupboard and across to the other side of the lift shaft, where the inpatient psychiatric department welcomed her with its familiar revolving door.

Seeing her go, I felt really sad. I began thinking about some recent lectures exploring diagnosis and ethnicity. It had shocked me to learn that there were disproportionately high levels of psychiatric diagnosis and hospital admissions among black and ethnic minorities living in the UK compared to the rates found within their own indigenous populations, with African Caribbean people up to five times more likely to be diagnosed with schizophrenia. Poverty, racism and culturally rigid definitions of mental illness

all played a part, and I wondered whether Edith was herself a victim of this and now, after many years cycling through the revolving door, her diagnosed illness had become a self-fulfilled prophecy.

‘As I say,’ said George, breaking the moment, ‘welcome to our happy home.’

Alone in my cupboard once more, I shut the door and started to try and get the space to look more like a consulting room. As it was, I worried it might be slightly insulting for anyone who came in to see me.

‘Welcome to the outpatient psychiatric department. We have designed your treatment environment to match the way you feel about yourself.’

I tidied up: old prescription pads, patient leaflets about fifteen years out of date, a guide to electroconvulsive therapy. The thought sent shivers down my spine. I opened a small cupboard next to my desk and shoved the whole lot in.

The chairs needed replacing, so I wandered across the department to see what I could get. In an empty lecture room, I found a couple of low chairs. They would do nicely: no disparity in height between my patient and me. I dragged them back past the reception desk without anyone looking up or asking me what I was doing; I probably could have stripped the place entirely and taken it home piece by piece, and no one would have noticed.

Chairs in, positioned at forty-five degrees, it looked better. A few damp hand towels removed some of the visible dust, and then I was on the hunt for a pot plant, which proved more tricky. While considering whether to steal one from a more plush doctor’s office, I eventually came upon a

bunch of plastic flowers in a small vase in the ladies' toilet. After a rinse and buff with yet another hand towel, they looked rather sweet. I got a coffee table too, and then stood in the middle of my office, pleased with my work.

Nothing to do now but wait for my first patient.

After three years taking an undergraduate psychology degree, fierce competition to get onto a clinical training course, all the stress of moving back down to London, renting a flat in the north of the city and getting myself set up, this was the moment I'd been waiting for. But I felt like running away.

The placement at the hospital was two and a half days a week, with the rest of the week and the odd evening lecture at uni. Effectively, I was seeing patients without any real knowledge of what I was seeing them about: my lectures, the learning I'd need to treat those patients, were happening concurrently. Is this what medics in training also went through? Imagine being operated on by someone who has never before put a scalpel into living human flesh.

George brought in another brew: orange, builder's, strong and sweet – perfect. He also dumped a pile of notes on my desk.

'Here you go – your first sets of patient notes. Have a read through.'

I sat there looking at the notes; now everything began to feel real.

There had been a long debate among my clinical year group about whether 'they' should be called 'patients'. The psychodynamic lot were against it: it demeans the individual, reduces them to a medical stereotype, colludes with the limited but prevailing medical model of mental health. They

believed it was better to use the term ‘clients’. The behaviourists were very much for it: they are here for us to treat; they require our intervention; they need the clarity of the well-defined parameters of the relationship between them and us. The psychoanalysts as usual were nowhere and everywhere: why did we want to call them ‘patients’? What did it defend us against in terms of our own unowned pathology? And equally, what projection did the label ‘patient’ represent in terms of our *over-identified* pathology?

Oh bloody hell, I thought. They are so not my clients – I’m not a solicitor or a prostitute. They are patients and may Sigmund strike me down with the full weight of my unowned fucked-upness. They are *patients*!

However, as I edged myself into training over the next few weeks, I soon realized that they were neither patients nor clients; they were people, real people, with lives and stories – vulnerable, sometimes deeply unhappy, interesting people.

My first few clinical sessions were alongside qualified staff running anxiety-management groups, which helped me deal with my own anxiety as much as anything else. I then started working with an emetophobic woman who was trying to get pregnant and terrified of the prospect of vomiting with morning sickness, a young man who was struggling with depression after a serious accident, a woman who had begun to have panic attacks on the Tube and in confined spaces, and an elderly man recently bereaved after many years being his wife’s sole carer. I loved it. I felt I was helping.

A couple of months passed. I discharged my claustrophobic lady, who was now back riding on the Tube. One morning I

was sitting in my cupboard, flicking through the notes for a man I was about to see for the first time. It seemed pretty straightforward: anxiety and panic attacks. We had had quite a few lectures about those, so I didn't feel as though I was going in totally blind. But a few lectures, some rather self-conscious role plays with my co-trainees and my one discharged patient still didn't allow me to feel quite adequate somehow. What if I made a mistake, made him worse? What if I had a panic attack myself?

A knock at my door and there he was: Ray Robards.

'Good afternoon, Mr Robards.'

'I'm Ray.'

We sat opposite each other in the low chairs. We shook hands and then settled into a good mirror position; I felt pleased with the session's progress so far.

'Here's the thing,' said Ray. 'I'm a bit freaked seeing you – a head doctor and all. Like, I'm not a nutter, OK. That's the first thing we need to get clear, OK. I'm not a mental case.'

'Why would I think you were?'

'When I came in, not only was I sitting among a bunch of tranny freaks in wigs, but I also saw some black bird singing something from *The bloody Sound of Music*. She's fucking insane. I'm not. Let's get that clear.'

'I make no judgement, Ray.'

'That's not what I'm looking for.'

'Mr Robards – Ray. Sorry, Ray. I am clear that you are not insane.'

One-nil to the patient.

'OK, if you're crystal on that, then we're fine. So what do you want me to tell you?'

‘What do you want to tell me, Ray?’

He looked blank.

OK. This is going nowhere. Too much to and fro – get a clinical grip. Get going.

‘Well, Ray, why don’t we start from the beginning? Why don’t I tell you what I know and we can take it from there?’

‘Sounds good to me. By the way, did anyone ever tell you you’ve got beautiful blue eyes?’

Two–nil to the patient. Don’t blush. Shit, too late. Focus. Carry on. Maintain eye contact.

As I felt the familiar feeling of heat and colour spread upwards from my neck, I turned away to pick up Ray’s patient file from my desk. I turned back. Ray was leaning back in his chair, arms spread behind his head, smiling at me.

‘You had a series of unexplained dizzy spells at work. Quite worrying by the sounds of it. Can we start from there?’

‘Whatever you say, Doc.’

Ray sat forward, his gaze never once leaving me. ‘I used to collect rubbish. I worked the trucks and emptied bins. That’s what I did – did it for years with the same team.’

I smiled and nodded. Ray wasn’t smiling anymore.

‘Due to circumstances outside my control, however, I had to change jobs. I was gutted. But a man’s gotta work and so I started doing security, working the doors, that kinda stuff.’

‘You’re a bouncer?’

‘Spot on, Doc. Clever girl.’

‘Do you miss doing the dustbins?’

‘Doing the dustbins?’ Ray laughed, mimicking my accent

as if I were the Queen. 'Yeah, but as I say, circumstances outside my control.'

I was curious, but something stopped me asking for further information.

'Anyway, Doc, it was' – Ray was counting on his fingers – 'about eight months ago, when I first got pains in my chest. Freaked the fuck outta me – excuse my French.'

'So you thought you were having a heart attack?'

'No, love, I thought I was coming.'

Where were we now? Four-nil to the patient?

'Of course – sorry.'

'Apology accepted, my beautiful blue-eyed girl.'

This time I had no excuse to turn away and so I decided to front it out. I felt uncomfortable – this wasn't going well.

'To cut to the chase, my old man dropped dead of a heart attack when he was fifty-seven. He did the bins like me. He was an arsehole but didn't deserve to die at fifty-seven. He smoked, drank, the usual, but nothing more than the next bloke. Apparently he had a faulty valve or something.'

'So this is when you went to see the cardiologist?'

'Right. They wired me up, got me running on one of them treadmill things. I had a what-d'you-call-them?'

'ECG?'

'ECG and every bloody test, but apparently' – Ray thumped his chest hard with his fist – 'strong as a bloody ox.'

'That must have reassured you.'

'No, sweetheart, it didn't. Not at all. 'Cos I kept having these bloody attacks, as I call them, and they were coming more often and lasting longer and like a bloody nancy boy I started fucking fainting. On the job.'

'How did the frequency of the attacks change?'

‘In English, please.’

‘Sorry. How many more were you experiencing? Did they become daily?’

‘Yeah, but I could cope with those. The boys would see them coming and take me off the door until they passed. Problem was, also I’d get them sometimes in my sleep.’

‘That must have been really frightening.’

‘Bloody terrifying.’ Ray rubbed his face with his hands. The mask was slipping, the bravado disappearing. ‘I can only explain it like you’re drowning. You wake up and you can’t breathe – like you are trying to get to the surface but know your chest will explode before you do. I’d get to the window and open it and try and breathe, but nothing would go in – it was like my lungs had just packed up.’

Ray stopped abruptly. Beads of sweat appeared on his forehead. I could see his breaths becoming faster and shallower. His large hands gripped the arms of the chair. Ray was beginning to panic.

Thank God for my few weeks sitting in on the anxiety-management group. I began to feel in control. Perversely, that felt good, despite the obvious discomfort of the man sitting opposite me.

‘Ray, I want you to breathe slowly.’

‘I fucking can’t breathe.’

Ray was rasping, his pupils dilating. I leaned forward and took his hands in mine.

‘Ray, look at me. Look at me. OK, now listen to me. I am going to count and you are going to count with me. OK? Here we go. One ... two ... Count with me, Ray. Three ... four ... That’s it. Good. Five ... six. Slow it down.’