"Mona Lisa" or "Don't Worry, Think Systems!" — Dr J De Kroon

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Curriculum vitae

Jan De Kroon obtained his Artsexamen in 1985 at the University of Nijmegen, the Netherlands. He served for two years as Medical Officer in the Royal Netherlands Ground Forces, and in 1987 he and his wife started to work as Medical Officers at the Siloam Hospital in Venda, where they left in March 1991. At present he is enjoying his work as Senior Medical Officer at Ceza Hospital (Kwa Zulu) and is busy with his part-time M Prax Med programme at Medunsa. In November 1991 he became a member of the Academy of Family Practice. They have three children who provide them with a rich and variable source of practical experience in family life. Jan likes to paint in watercolours if he can find time to do so.

Summary

The history of a difficult patient is presented to demonstrate the reward of making a three stage diagnosis, and using a family approach in order to find the deeper issues behind the presenting illness behaviour. Applying the principles of family medicine in a transcultural health care situation was found to be essential for good patient management and professional satisfaction. It is recommended that family practitioners familiarise themselves with basic theoretical and practical aspects of family therapy.

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Introduction

Fortunately, most of us like our work and, in general, we derive much satisfaction from daily interaction with patients. However, a small proportion of our patients might give us nightmares by merely appearing in the consultation room. These patients are often investigated and leave us either feeling irritated, hopeless or depressed because nothing we try to do for them has ever given them, or us, any relief.

These patients are not dealt with in medical textbooks, or if they are, the standard suggestion is referral to a psychiatrist. Recently in this journal, RE Kirkby[1] described a practical approach to the management of such patients.

I would like to present the case of Miss Mona Lisa to demonstrate a way to discover the real issue behind the illness behaviour.

Mona Lisa:

A 17 year old African girl entered my consultation room (in a busy rural hospital) with her well-known spectrum of complaints: fatigue, headache, dizziness, chest pain, palpitations, heart pain, nausea and painful legs. She only spoke Venda and our communication depended on a nurse interpreter and my own observations of her body language.

Often she had a faint smile as she explained her symptoms. At other times, her expression was neutral or distant as if she was not emotionally involved with her illness. This was the 7th time she was seeing me. Until then she had been treated strictly according to the biomedical model. As a result, her bedletter was fat (see figure 1).

Diagnoses made over this time included post rheumatic mitral valve disease, neurosis, anxiety syndrome, fracture of the L-hand, and gastro-enteritis. Frequently no diagnosis could be made and she was sent home with some tablets. In 1989, an echocardiographic assessment revealed no abnormalities. Despite this, her complaints persisted. Fortunately, by that time, I had been introduced to some interesting ideas about family medicine during my M Prax Med programme. Until then some important principles[2] had been neglected, including:

1. Personal commitment to the patient and

... Don't worry, think systems

Figure 1 Patient Bedletter

	OPD-visits	Different doctors	Admissions	Visiting specialists	Referrals
1983-87	9	4	0	0	0
1988	13 (2 x seen by me)	7	1 (gastro)	0	0
1989	22 (5 x seen by me)	9	1 (psych)	2	1

2. Continuity of care. No patient will open-up adequately to an unpredictable and ever-changing group of doctors. The minimal requirement to allow my patient to open up is a good doctor-patient relationship. This cannot be built in a haphazard, rushed way by 10 different doctors.
Step 1 towards adequate management, I decided was to assume personal responsibility for my patient. Her bedletter then read in red letters on the front cover: "For Dr de Kroon, if available".

These patients leave us irritated or hopeless or depressed

3. Her social context had never been explored. No notes about her family appeared in her bedletter.
4. Nothing was known about her personal beliefs, ideas, hopes and fears concerning her illness. I had seen her 7 times but she never volunteered personal information.
Steps 2 and 3 towards better management were to collect social and personal information, and to integrate this with information from her clinical record. In other words, to make a three stage diagnosis.

The problem was, how to gather that information.

Since I had little time I decided to refer her to our psychiatric nurse with the question: "Are there any psychosocial stressors?" This revealed that she failed standard 7 three times due to her illness. Her father had to find another school for her because she was rejected by the principal for another term.

End of report

Maybe her mother could tell us more?

Another psychiatric nurse saw them a few days later. Again I was not present during the interview. The mother told them that her daughter had become seriously ill soon after birth. She had been admitted several times to our hospital during her childhood with unknown conditions. Old records could not be found. She failed sub A once, standard 6 once, and standard 7 three times. A genogram revealed a family of father, mother, two married daughters (living elsewhere) and two sons, older and younger than Mona Lisa.

They often get referred to a psychiatrist

According to mother and daughter, relationships at home were good. They denied problems at school, despite the fact that the teacher used physical punishment if a pupil failed.

With such a history I found it difficult to believe that she had no problems at school, but it seemed the psychiatric nurses could not find the true story.

I then decided to see mother and daughter myself. Mother was an asthmatic patient, collecting her medicines from our hospital, receiving a disability grant due to her asthma. Mother confirmed that Mona was the only other chronically ill family member at home. No other relevant information could be obtained. I felt frustrated. As before, nothing helped: seeing her alone or together with her mother, allowing her plenty of time to reveal her story, asking many open-ended questions

... Don't worry, think systems

about all possible issues of concern to an adolescent girl, but no success. Balint[3] suggests that a patient often opens-up when offered an opportunity by a "listening" doctor. But Mona remained quiet and distant, hiding her secrets behind her faint smile!

Balint says: "If you ask questions you get answers and hardly anything else".[4] But if the patient offers no information, you just have to ask questions! I was frustrated! My only option was to foster a warm doctor-

Personal commitment to the patient is essential

patient relationship[5] in the hope that this would pay-off in the long run. I wrote a letter to her school principal, but he only confirmed that Mona was failing in school because she was too often absent. The same day I referred mother and daughter to our social worker with the complete bedletter and a request: "Kindly explore the family situation".

Two hours later they came back with the report: "Family relations are good, no problems at home". Home visit is not possible due to lack of transport.

I felt helpless!

Step 4, towards improved management was to know the potentials and methods of our consultants. Fortunately, by this time, I had been introduced to a new way of thinking about patients and their problems, in a book, called: "Family Systems Theory in Medical Practice".[6] After devouring this book, I decided to give it a go, and arranged for a family encounter. The chance of success was small. I had only read one book about family systems theory, I had no experience with family meetings, no special training in group discussions or interview techniques, I was working through a nurse-interpreter, who also had no special training in psychology. Despite all this, I felt this was my last chance to find out what was going on.

And this time it worked!

All family members came to the hospital. They only knew that the doctor wanted to see them to discuss Mona's illness. I asked each of them to express their view about her illness. I tried to find out how and when the illness started. Why was she the only one who was ill? How did that affect her position in the family? At school? What were the reactions of the family members when she feels weak? By probing and letting all

Continuity of care is necessary

members give their opinions and views, deeper issues slowly became clear. What follows is a summary of my findings.

At birth Mona was very ill. She survived but was always regarded as a vulnerable child, needing continuous protection by her mother. The older siblings were instructed not to be angry with her or upset her. She was never physically punished by her parents, even when she was very disobedient. If she did become upset or angry, she was treated as an ill person, comforted and put to bed. At school however, her mother could not protect her. Mona received physical punishment and started to fail due to illness. As long as she was ill, she could remain safe at home. Thus a cycle of failure-punishment-illness was developed. Her problems

Mona remained quiet and distant, hiding behind her faint smile

became more severe when one of the teachers fractured the second metacarpal bone in her left hand. She failed standard 7 three times because she could not go back to this teacher. Her illness also prevented her from working or even visiting her friends. Her parents accepted her illness behaviour because they believed she had a "weak constitution". This was it: abnormal family dynamics! Mona cannot cope with aggression, and her maladaptive behaviour was supported by her family. I felt relieved and stimulated. At long last (I thought) I understood Mona and her illness enough to be able to help her.

Step 5 in better management now became: Don't worry! Think Systems, and try the family approach.

In my inexperienced enthusiasm, I proceeded during the same meeting to share my insights with the family. Initially, the family members reacted with surprise, but gradually they began to recognise the patterns I tried to describe to them and they confirmed my hypothesis.

... Don't worry, think systems

How now to change life for Mona? Mona and her family had no idea. I decided to give them some suggestions:

- from now on, treat Mona as you would treat the other children,
- express love and concern for her by stimulating her to become an independent and responsible person,
- treat her as an adult as much as possible.

I reassured Mona that she was a perfectly healthy person and that being emotionally upset is frequently accompanied by the symptoms which she thought were due to illness.

I suggested to them that this was not Mona's problem alone, but that it involved the whole family. They should not expect quick results because this situation had developed over a period of 17 years.

The family seemed relieved and satisfied with this outcome; Mona seemed satisfied with the new direction life had taken for Mona. She was missing less of school and she helped more often with household duties. Mona did not want to go back to the old days.

Then one afternoon she presented to our OPD with the story that her father had arrived at home with a young woman. He announced that this was to become his second wife.

If you ask questions, you get answers and hardly anything else

even showed a real smile! This session took 2½ hours and left me exhausted, but satisfied; a breakthrough had been achieved.

A Happy End?

During the next months I saw Mona and her mother together when the mother had to come to fetch her anti-asthmatics. Mother and daughter

Try the family approach!

Mother reacted furiously and stormed out of the house, wheezing. It appeared that over the past few months her parents were having marital conflicts in increasing frequency. "What is really happening?" I thought. By encouraging change in the status of Mona I probably had deranged the family homeostasis. Concerns for Mona might have had a peace keeping function in her parents' marriage. Mona's "recovery" removed a major distraction from their smoldering conflicts. Thus, they were forced to face each other directly, with open fights as a result. Unacknowledged marital discord had to be acknowledged after my intervention.

I asked myself: is this a negative development? I would argue: Not really. Open conflicts may be solved more easily than unacknowledged disagreements. During the following months, family life slowly settled down again (without the second wife). But, I agree, all the work has not yet been done. Every action has consequences; the goal is to anticipate them, and not to be taken by surprise.

So to my last discovery, *Step 6*, towards better management: familiarise yourself with basic family therapy techniques.[7]

Your families are worth it!

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