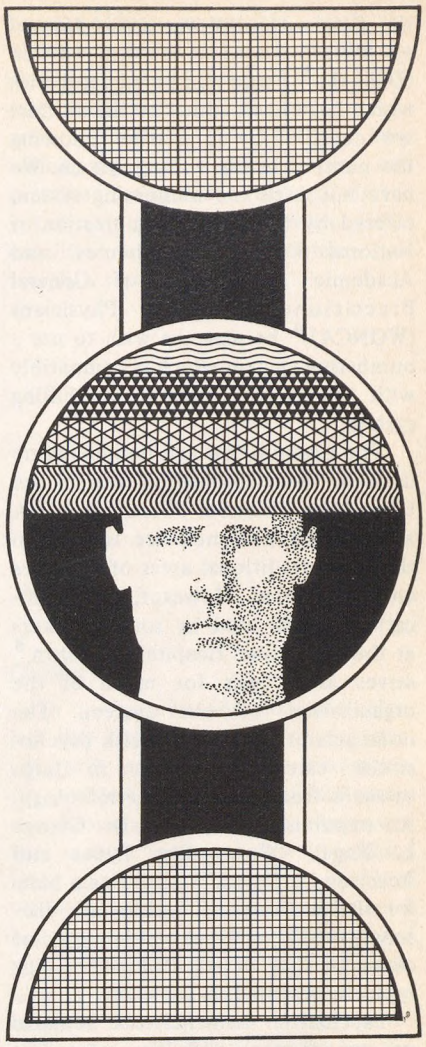
Classification and Coding of Psychosocial Problems in Family Medicine

William M. Cole, MD, Richard M. Baker, MD, and Reva K. Twersky, MSW
Seattle, Washington



Disease and problem classification systems for primary care have recognized that psychosocial problems are integrally related to more traditional medical problems which patients present to physicians. These classification systems remain inadequate for the description of primary care problems, especially as several disciplines interrelate in primary care, such as medicine, nursing, and social work. This paper presents a classification and coding system of psychosocial problems gleaned from a number of existing coding systems. The purpose of presenting it here is to contribute to a dialogue which will result in the establishment of a common psychosocial language for all health professionals. By so doing, progress in research, education, patient care, and administration in the psychosocial area will be facilitated.

Classification systems in primary care have recognized that psychosocial problems are integrally connected with other, more traditional medical problems which present to a physician. The problem-oriented adaptation of the *Royal College of General Practitioners (RCGP) Classification*, published by the Family Medicine Program at the University of Rochester in 1972,[1] reflects this fact. The Family Medical Center at the University of Washington followed this RCGP coding system until September 1, 1974, when a significant management change took place in the office. The FMC began its own billing system, which necessitated the coding of problems in *International Classification of Disease – American*[2] terms for billing purposes.

The ICDA coding system is found wanting in the area of psychosocial codification, in that it follows more traditional medical diagnostic rubrics and omits significant psychosocial problems often dealt with by the physician and social worker alike in the primary care setting. Therefore, a new classification system for psychosocial problems was designed which can serve multiple purposes in the joint physician and social worker realm in the areas of education, practice management, research, and patient care. This paper will present this classification and briefly describe its application in family practice.

From the Department of Family Medicine, University of Washington, School of Medicine, Seattle, Washington. Requests for reprints should be addressed to Dr. William M. Cole, Department of Family Medicine, University of Washington, School of Medicine, RF 30, Seattle, Wash 98195.

Classification of Psychosocial Problems

Table 1 shows a classification and numbering of psychosocial problems proposed for use by health professionals in the family medicine setting. The numbering system used is based on the ICDA eighth revision of

the *Diagnostic and Statistical Manual of Mental Disorders,* second edition (DSM-II).[3] Those numbered categories which have been added by the authors are identified by an asterisk following the number in the coding system. We have not used the numbering system offered by the World Organization of National Colleges, Academies, and Academic Associations of General Practitioners, Family Physicians (WONCA),[4] because we wish to use a numbering system which is compatible with the numbers used in our billing system.

The organization and nomenclature used in the classification system are taken from a number of sources. ICDA and DSM-II nomenclature is used in the more traditional areas of neuroses and psychoses. However, a classification system used by social workers at the Beth Israel Hospital in Boston,[5] serves as a basis for much of the organization of our system. The nomenclature in the high-risk psychosocial categories comes in large measure from the RCGP terminology. An unpublished paper by Dr. George L. Engel, "Personality Types and Reaction to Stress,"[6] serves as a basis for the section on "Problematic Personality Types." A summary of characteristics of selected personality types is presented in Table 2.

Psychiatric nomenclature remains an area of poor definition of terms, especially for the non-psychiatrist. We have tried to provide an acceptable classification by emphasizing behavior, an observable phenomenon, rather than etiology or other vague classifications that can be less well validated. We believe that it is important for health professionals to make appropriate generalizations by behavior and "personality" (behavior pattern). Problematic behavior should be listed so that subsequent care of the patient can be improved, as is the case when medical problems are listed and followed in later visits. Moreover, we believe that behavioral problems should be noted by all members of the health-care team, not just behavioral scientists or the physician. We recognize that our particular listing is not universally understood, but we know of no more commonly acceptable terms.

In synthesizing the sources mentioned, we were guided by responses to the following questions: Is the

Table 1. Classification of Psychosocial Problems

I. ENVIRONMENTAL PROBLEMS

(Meeting Concrete Needs)

317.0*	Vocational (jobs, education)
317.1*	Economic (crisis, indebtedness)
317.2*	Medical coverage
317.3*	Welfare
317.4*	Housing
317.5*	Recreation
317.6*	Nursing home
317.7*	Medical care (home care; other)
317.8*	Improper utilization of health services
317.9*	Legal matters

II. PSYCHOSOCIAL PROBLEMS

Stressful Life Event (Crisis Management)

307	Transient situational disturbance
307.1	Adjustment problem of childhood: jealousy associated with birth of younger sib attention-getting behavior fear of being abandoned peer relationship problems school adjustment problems other
307.2	Adjustment problems of adolescence: irritability and depression associated with: school failure temper outburst brooding discouragement peer relationship problems other
307.3	Adjustment problem of adult life: vocational problem economic problem problem pregnancy separation or divorce death of significant person other
307.4	Adjustment problem of late life retirement isolation
307.5*	Adjustment reaction to acute illness
307.6*	Adjustment reaction to chronic illness
307.7*	Adjustment reaction to terminal illness
	Other

Chronic Limited Functioning

290	Senile and presenile dementia
309	Organic brain syndrome, non-psychotic associated with physical problems
310	Borderline mental retardation
311	Mild mental retardation
312	Moderate mental retardation
313	Severe mental retardation
314	Profound mental retardation
315	Unspecified mental retardation
330.3	Muscular dystrophy
340	Multiple sclerosis
348	Epilepsy
379.1	Blindness
388	Deaf mutism
389.9	Deafness
582	Renal disease
45.7	Kidney transplant

(Other specific diagnoses can be coded by ICDA numbers)

Table 1. Classification of Psychosocial Problems (continued)

Interpersonal Relationship Problems

316.0	Marital conflict
316.1	Culture shock or conflict between loyalties to two cultures
316.2	Employment — occupational maladjustment
316.3	Dyssocial behavior — criminal pursuits
316.4*	Multiple family problems
316.5*	Parent-child problems
316.9	Other social maladjustment, including interpersonal relationship difficulties; extended family problems; broken family (separation/divorce)

Perceived High-Risk Situations

316.6*	High-risk child (includes risk of possible child abuse and neglect)
316.7*	High-risk pregnancy (includes unmarried mother, young adolescent mother, unwanted pregnancy)
316.8*	Other high risk including: accident or violence in household adopted child foster child high risk for suicide or homicide

Behavioral Symptoms

303	Alcohol addiction/habituation
304	Drug addiction/habituation
302	Sexual adjustment difficulties
306.0	Speech disturbance
306.1	Learning disability
306.4	Sleep disturbance
306.5	Feeding disturbance
306.6	Enuresis — of nonorganic origin
306.7	Encopresis
308.0**	Hyperactivity
308.1**	Withdrawing reaction of childhood (or adolescence)
308.2**	Overanxious reaction of childhood (or adolescence)
308.3**	Runaway reaction of childhood (or adolescence)
308.4**	Unsocialized aggressive reaction of childhood (or adolescence)
308.5**	Group delinquent reaction of childhood (or adolescence)
308.9**	Other reaction of childhood (or adolescence)
308.6	Hypochondriacal behavior

Thought and Feeling Disturbances

Neurosis (300)	
300.0	Anxiety neurosis
300.4	Depressive neurosis
Psychosis (295-298)	
295	Schizophrenia
296	Affective psychoses — manic-depressive psychosis, involutional melancholia
297	Paranoid states
298	Other psychoses — psychotic depressive reaction
Problematic Personality Type	
Personality Disorders (301)	
301.0	The paranoid person
301.1	The moody, cyclothymic person
301.2	The schizoid person
301.3	The aggressive person
301.4	The compulsive person
301.5	The hysteric person
301.6	The passive-dependent person
301.7	The antisocial person
301.8	Other problematic personality types passive-aggressive narcissistic primitive-magical depressive

*Code number, added by the authors, used neither in ICDA nor DSM-II
**308 series indicates specific adjustment reactions of childhood and/or adolescence (DSM-II)

terminology acceptable both to physicians and social workers? Will the classification and nomenclature facilitate preparation of statistics in the areas of patient care, resident education, research in primary care, and practice management (billing)? Is the entity common? Finally, is the listed condition a patient problem, not merely a *service* rendered?

Comment

In our own Family Medical Center, we have used the psychosocial classification and code to report monthly the problems seen by our social workers. From an educational standpoint, the reports indicate why physicians refer patients to the social worker. These monthly reports serve as a teaching tool to residents, faculty, and nurses, illustrating the kinds of problems in which the social worker can be involved as a member of the health-care team and what agencies in the community can be called upon to help provide comprehensive patient care.

In addition, the social worker in the Family Medical Center at the University of Washington has begun to charge for services rendered and the coding system is being used to identify problems handled for billing purposes. In the realm of patient care, process and outcome audits of psychosocial problems in the office and evaluations of the performance of health professionals are facilitated. Finally, it is our hope that the expanded coding system will pave the way for research on psychosocial problems, such as a study of the team approach to psychosocial problems. We feel that it is important for all health-care professionals to have a common language of problem classification. Nowhere is this more important than in the psychosocial problem realm. It is our hope that this classification system will be helpful toward this end, and that social workers, physicians, and

Table 2. Characteristics of Selected Personality Types*

Personality Type	Code No.	Characteristics
Paranoid person	301.0	Openly or covertly watchful of others, suspicious of their intentions, prone to laying blame and nursing grievances. Hypersensitive to criticism and slights, fearful of being unexpectedly hurt or taken advantage of, and alert to the negative feelings of others. Easily feel oppressed or even persecuted and are quick to react with self-righteous attack. Illness intensifies these trends by increasing concern about inner weakness and the danger of being dominated. Anxiety and aggression increase, and the patient becomes even more fearful, guarded, suspicious and quarrelsome.
Moody, cyclothymic person	301.1	Subject to recurring fluctuations in mood, usually in fairly regular cycles. May be active, productive, interested, self-confident, and in good spirits for several months, only gradually to become disinterested, inefficient, fatigued, apathetic, self-depreciating, and pessimistic. May involve little more than a regular and predictable fluctuation in interest and efficiency if compensated. Decompensated persons present regularly recurring episodes of depression and hypomania. During the depressed phase the person is appreciably more vulnerable to losses, rebuffs, failures or frustrations, the occurrence of which helps to determine variations in degree of depression with each successive cycle.
Schizoid person	301.2	Uninvolved, detached, remote persons who have experienced a life-long difficulty in relating to others. Tend to gravitate toward activities that demand a minimum of relationships with others. May be frankly eccentric, unconcerned with convention, engrossed with idiosyncratic ideas about food, health, religion, or may lead the life of a tramp or hermit. Incapable of competitive activity or productive work, and may be found in the lowest socioeconomic level unless supported by others. Illness threatens this seclusiveness and hence is denied, minimized, or ignored, often to the point of danger. More likely to be brought to the hospital than to come seeking help. Remain detached and seclusive as patients, participating passively in treatment.
Aggressive person	301.3	Active, angry persons who may be chronically irritable, ready to explode with rage or coldly sadistic. Impatient, constantly on the move, physically active, and usually take pride in physical strength and stamina. Many such persons seek recourse in roles in which aggressive and even sadistic behavior is acceptable, such as sports, law enforcement, military combat, or highly competitive and challenging jobs, while others embrace pursuits in opposition to authority. To be blocked, frustrated, or immobilized constitutes the main source of stress against which these persons respond by intensifying activity, mounting rage, anxiety, and ultimately giving up. They resist the role of patient and struggle against passivity and domination.
Compulsive person	301.4	Orderly, controlled persons ranging from responsible, well-organized, and systematic to rigid, obsessive, and ritualistic. High premium placed on being intellectual and in control of emotions. Try to approach problems and relate to others by thought rather than feeling. They control both the experience and expression of emotion, where pleasurable or painful. Neat, tidy, systematic, punctual, conscientious, frugal, conservative, and concerned with right and wrong. Seek out work roles in which such qualities are an advantage. When more extreme, the personality type is marked by rigidity, obstinancy, compulsive rituals, inability to take action, excessive rumination, indecisiveness. As patients they require more order and control than when well.
Hysteric person	301.5	Dramatizing, expressive and emotionally involved. Respond and communicate primarily through emotions. In everyday life they are labile emotionally. Range from warmly affectionate to provocatively seductive, from openly expressive to blatantly exhibitionistic, from asthetic to histrionic, from vague to dishonest. Often imaginative, sensitive, teasing, flightly, and have an unusual capacity to identify with others. Both men and women have strong needs to be attractive and admired. Hypersensitive to outside opinions and constantly testing the love of others, often responding with emotional upheavals. Charming, lively, colorful, self-indulgent and impulsive, many arouse envy and admiration. As patients they tend to engage the health professional in an eager, warm, and very personal way and expect a similar exclusive response, with jealousy, anger, and disappointment if not forthcoming.

Table 2. Characteristics of Selected Personality Types (continued)

Personality Type	Code No.	Characteristics
Passive-dependent person	301.6	Oriented toward the external environment as the source of support and gratification. Lean on other people and on the social structure and remain well compensated as long as such resources are responsive to their needs. Do not feel capable of functioning on their own. Thus, the extremely dependent person may still be at the parental home or married to a nurturing spouse, or seek a job solely in terms of the security it provides. Often submissive, appealing, ingratiating, seductive, demanding, manipulating, or controlling, but at all times are oriented toward how responsive the environment is to their needs. Anxious, angry, and ultimately helpless if needs not met. The dependent personality is thus particularly vulnerable to any form of loss and may respond by adopting illness behavior or by actually becoming ill.
Antisocial person	301.7	Unless schizoid as described above, these persons are better classified in terms of their interpersonal relationship problem or their behavioral symptoms.
Passive-aggressive person	301.7A	Express strong underlying aggression by being maddeningly obstinate, exasperatingly unresponsive, deceptively compliant, stubbornly uncooperative, callously neglectful, or callously irresponsible. Appease their own consciences by not being actively aggressive, yet at the same time enjoy the helpless frustration of adversaries. As patients they tax the patience of the physician who does not recognize the anxiety and aggression that underlie such behavior. Fearful of injury and retaliation, such a patient needs reassurance and tolerant acceptance to be able to cooperate in his own medical care.
Narcissistic person	301.7B	These superior, vain, grandiose people stand out by virtue of their remarkable self-regard and self-confidence and their patronizing superiority toward others. They show little regard for the opinions and feelings of others. Have difficulty in establishing new relationships except on the basis of their ability to overawe. Vulnerable to challenges to self-esteem. May compete with the physician as an "expert" and often reject advice.
Primitive-magical person	301.7C	May be based on a culture in which such belief systems are dominant or stem from a defect in logical thinking. The culturally determined group is not only well adjusted in its own milieu but often functions well in other settings by not revealing these unacceptable belief systems. Spells, hexes, voodoo, the evil eye, "root work," and many other concepts of black and white magic constitute a basic attitude toward natural events, including illness.

*Adapted from "Personality Types and Reactions to Stress," an unpublished paper by Dr. George L. Engel, University of Rochester, 1965.[6]

nurses alike will contribute to a continuing dialogue and criticism of this proposed classification.

References

1. The Problem-Oriented Adaptation of the Royal College of General Practitioners' Classification (RCGP). Family Medicine Program, University of Rochester, 1972
2. United States Department of Health, Education, and Welfare, Public Health Service, National Center for Health Statistics: International Classification of Diseases Adapted (ICDA). Vol 1, eighth revision. Public Health Service Publication, 1963. Washington, DC, US Government Printing Office, 1972
3. Committee on Nomenclature and Statistics: Diagnostic and Statistical Manual of Mental Disorders (DSM-II.) Washington, DC, American Psychiatric Association, 1968
4. The International Classification of Health Problems in Primary Care. Continuing Education for the Family Physician 3(5):31-38, 1975
5. Phillips B: Facilitating communication. Social work and the problem-oriented record system. In Jackson RC, Morton J (eds): Evaluation of Social Work Services in Community Health and Medical Care Programs. Based on the Proceedings of the 1973 Annual Institute for Public Health Social Workers, San Diego, University of California, 1973, pp 93-111
6. Engel G: Personality types and reaction to stress. Presented at the University of Rochester, unpublished paper, 1965. Adapted from Zinberg, NE (ed): Psychiatry and Medical Practice in a General Hospital. New York, International Universities Press, 1964

Acknowledgement

This work was supported in part by Family Medicine Training Grant Program, Public Health Service No. 10D 70-3001 awarded by the United States Public Health Service, Bureau of Health Resources and Development.