A Psychological Systems Review

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The family physician needs a systematic means for understanding and dealing with his patients' emotional and social problems as an essential element in the provision of comprehensive care. The Psychological Systems Review is offered as a potentially useful tool in this process.

The PSR provides a systematic means of evaluating the patient's emotional status, life situation, and personality. It is geared to real-life presenting situations of patients and families in distress and can be adapted efficiently to the needs of the situation and to the physician's style of practice. The review provides for the early diagnosis of emotional and social problems and also for identification of patient resources for coping with these problems over a period of time. This essential diagnostic information establishes a basis for deciding upon appropriate treatment, including possible referral.

The family physician has need of a systematic means for developing a psychological data base for understanding the patients and families he serves. In the provision of comprehensive primary care there are constant demands placed upon the physician to assist patients and their families in coping with problems in living and with the impact of illness. An accurate early diagnosis of an emotional or social problem enables the physician to help the patient deal with the primary problems that are troubling him.

The family physician has some training in psychiatric syndromes, interviewing and mental status exam, and in the importance of gathering a good social history. But how to put it all together? The problem-oriented record, including the patient profile, represents one step in the direction of system and integration. However, the physician needs a person-oriented and situation-oriented record as well as a problem-oriented record. The Psychological Systems Review (PSR) is one method of systematically generating such a record. It is designed to enhance the physician's ability to prepare a psychosocial profile of his patients.

We have identified three major areas of the PSR: (1) emotional status, (2) life situation, and (3) personality (Table 1). The primary focus of the PSR is on the patient's present status and situation, with extensions into history as indicated. The underlying assumption is that, in the psychological area, the point of departure must be a clear understanding of how the patient is currently feeling and functioning. Problem areas of emotional distress, life stress, and social maladjustment are of major concern. However, of equal importance is an understanding of the patient's overall personality, major life situations, and adaptive operations. The focus is as much on the person and his situation as on his symptoms and problems. This is a crucial integration to make in understanding the whole person.

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Use of the PSR

The physician may use elements of the PSR or obtain an overall survey, depending on the situation and his style of practice. When the patient is in obvious distress it is sensible to begin by inquiring into the nature and source of the distress; in a more routine situation, the physician may begin by asking about work, family relationships, etc, and subsequently learn of any emotional distress.

An essential attitude is the physician's willingness to view the patient's presenting symptoms and signs as possible indicators of emotional distress as well as of organic disease *at the outset.* The physician should "listen beyond the words" of the presenting complaint in order to determine the patient's actual reason(s) for coming at this time. One upset patient may present the physician with somatic symptoms which serve as an "admission ticket"; another is convinced that aches and pains are indicators of serious or fatal illness; yet another's somatic complaints are a manifestation of underlying depression.[1]

By simply taking a good look at the patient – his physical appearance, style of dress, facial expression, and body posture – and by considering what this says about the kind of person he is and how he is feeling at the moment – the physician can begin to sense whether the PSR is indicated. The PSR may also be included as part of a complete history and physical examination.

In obtaining a PSR, two questions must be addressed. First, what are the main areas to be explored? and second, how does one skillfully and efficiently collect this data?

The latter question falls in the realm of the art of interviewing.[2] A

Table 1. Psychological Systems Review

General	Problems	Resources
Emotional Status	Distress	
Life Situation	Stresses	Support Systems
Personality	Conflicts, Maladjustment	Coping Skills

physician's ability to readily establish a relationship with his patients is an important step in developing the review. To achieve this relationship, an adequate physical setting where both the physician and the patient may be comfortable and free of distractions is essential.

Some of the variables which facilitate the data-gathering process are:

– using general to specific questions to allow the patient to tell his own story,
– communicating interest through eye contact, body posture, and tone of voice,
– using appropriate therapeutic silences and pauses, and
– reflecting feelings and summarizing issues.

Through these means, the physician can convey the fact that he hears and understands and accepts the person. This is crucial to the helping relationship.[3]

In interpreting the meaning of the information a patient is relating, the patient's non-verbal behavior is very important. It has been estimated that from 65 to 90 percent of the social meaning of a message is conveyed by non-verbal behavior, ie, facial expression, tone of voice, body language, etc.[4] In fact, a patient's distress and concerns are revealed more by his non-verbal behavior than by his words.

In using the PSR, the physician should observe and inquire into: (1) how the patient is feeling, (2) what he is concerned about, (3) the nature of his overall situation, (4) how he interprets events that are of concern to him, and (5) his personal outlook and expectations. The patient's objective situation and his subjective interpretations are both important to understand.[5,6]

The three "systems" – emotional status, life situation, and personality – must be understood in relation to each other. The central point here is that the three systems describe interrelated aspects of the whole person.

Emotional Status – Distress

The PSR begins with emotional status because, of the three systems, this is the most observable initially and the most accessible to inquiry. In evaluating the patient's emotional status and possible distress, the physician needs to understand what kinds of feelings the patient is experiencing, their degree of intensity, how they affect the patient's functioning, and how long-standing or chronic they are (Table 2).

Distress may be reported spontaneously by the patient, elicited by questioning, or suggested by the patient's non-verbal behavior. Simple questions from a concerned physician such as, "Tell me how you are feeling. You seem to be . . . upset, sad, very tense," are often adequate to help the patient begin his story. Non-verbal cues are very important, especially for those patients who are suppressing negative feelings and using denial as a means of coping. The patient's walk, how he sits, the position of his arms and legs, the expression on his face, his tone of voice, and the ways he says the words and integrates sentences all give cues to his emotional status.

It is important to appreciate not only subjective distress but also the degree to which the patient's distress is interfering with his ability to function. Evidence of decreased functioning at home or work, of loss of emotional control, or of inappropriate behavior should be carefully evaluated. These considerations provide an overall estimate of severity of distress and need for major help.

It is essential to discriminate acute, reactive distress from long-standing, chronic anxiety or depressive patterns. Reactive distress related to life crises requires more immediate intervention on the part of the physician. Emotional distress is most often related to current events in the patient's life which should be explored by the physician.

Life Situation – Stresses – Support Systems

Depending on the patient's emotional status, the physician can begin searching for "what's wrong?" in critical areas or begin with a general survey of major life situations and subsequently identify problems. Emotional distress is commonly related to disturbance in a key relationship. The physician must determine *who* and *what* is the nature of the disturbed relationship or situation.[7] The seven major areas of adjustment which most people confront and may have trouble with are as follows: work, marriage (intimacy, sexual relationship), parenting, friendship, recreation, religion, and health (Table 3).

The physician should inquire into these situations, ask about the patient's functioning in these areas, and inquire about his level of satisfaction or frustration. The following questions may be asked: "How are things going at home? at work? at school? with husband/wife?" One very useful method of understanding the patient's world and how he operates within it is to ask him to briefly describe a typical day in his life. Feelings are also obviously expressed in the telling. Marriage and family relationship problems may be more quickly understood by asking early, "Who is in the family?" and by listing or diagramming the family members including names and ages.

Change, loss, and *threat* are key concepts in understanding problematic situations. A myocardial infarction suffered by the breadwinner of the household results in a serious life change and fear of loss. The promotion of the husband or wife to a more time-demanding position results in a loss of time shared with the spouse, which may threaten the marriage. The birth of a child, the coping with adolescence, the threat of retirement, the death of a loved one, all represent stresses and potential crises.[8]

It is crucial to understand the personal meaning of the present situation to the patient and his family. These events should also be understood in comparison to the past situation. Finally, the patient's expectations for future outcome must be assessed. Allowing the patient to express his concerns and feelings about these matters is essential. It is through

this process that the physician assists patients and families to better cope with their difficulties.

As we identify stresses for the patient, his support systems also need to be identified. Such supports as the spouse, relatives, job, friends, religion, and the physician himself are important factors in assessing the overall impact of the stressful situation on the patient. The quality and extent of the support systems are one measure of the coping ability of the patient and family in times of stress.[9] The primary question for the patient here is "Whom do you talk to when you need help?"

Personality — Conflicts/Maladjustment — Coping Skills

Life stresses alone do not provide an adequate explanation of the patient's distress and dysfunction. The role of his personal style in contributing to his problems and his methods of coping must be understood in order to decide what kind of help he needs. Personality evaluation involves more than a symptomatic classification of a patient as "depressed, neurotic, psychopathic, or schizophrenic."[10] *Personality is best understood as the person's subjective view of himself in relationship to his environment, plus his characteristic ways of coping and adapting.*[11,12] Each individual acts according to his beliefs about other people and himself. In general, the psychological issue we all confront is the problem of our own value. Many of the patients who present with emotional symptoms are basically discouraged human beings who have low self-esteem and who feel incapable of influencing others in a positive way.

The physician's task here is to look beyond symptoms toward understanding the person's outlook on life and his view of himself in relation to his environment. The physician may get a sense of the patient's personal style regarding:

optimism	sociability
competence	independence
dominance	conformity
expressiveness	self-esteem.

Personality information emerges as the patient tells of his distress, describes the stresses he is facing, and tells how he is coping. He may display a fearful, pessimistic, indecisive attitude, or he may present as dominating and dogmatic; he may be defensive, manipulative, or he may "smile until it hurts" although he is obviously in distress.

Beyond the observation of the patient's behavior with the physician, it is essential to appreciate how the patient functions in everyday life situations. We can learn a great deal about an individual from the manner in which he handles key roles, eg, worker: reliable, hard-working to casual, inconsistent; avoidant to superconscientious, driven. We must also understand the person's competencies, ie, intelligence, special abilities, and accomplishments.

Recognizing that the patient's behavior is based on his subjective interpretation of events, the physician will also need to inquire into his "outlook on life," including his evaluation of life, other people, work, and himself (Table 4). A person's outlook consists of two elements: his beliefs or expectations regarding "the way it is" and his values and goals regarding "the

Table 2. Emotional Status

- Nature of feelings
  - Comfortable, positive mood, no apparent distress
  - Depressed, "sad"
  - Anxious-fearful
  - Angry, resentful
  - Confused, "mixed up"
  - Flat, affectless
  - Malaise
- Depth of feeling
  - Subjective degree — intensity
  - Preoccupation with feelings — frequency
  - Interference with functioning — sleeping, eating, working, socializing, sex
  - Emotional control
    - Defenses against acting upon feelings in ways that are destructive to self or others
    - History of suicide attempt, aggressive behavior, running away
- Chronicity ("How long have you felt this way?") — duration
  - Acute, reactive vs chronic
  - Traits of emotionality — anxious or depressive style, emotional impulsiveness, emotional inhibition
- Emotional outlook
  - Discouragement — feelings of being unable to meet life's demands, to gain acceptance from others, to establish self-esteem
  - Expectations for the future — hopeless, pessimistic to optimistic

Table 3. Life Situation

What is the situation?	*Stresses?*	Is the situation one of . . .
How is the patient doing?		
at *Home* in *Marriage?*	*Functioning?*	*Change?*
with the *Children?*	*Level of Satisfaction (Frustration)*	
at *Work?*		*Loss?*
with *Friends?*		
at *Recreation?*	*Expectations?*	
with *Religion?*		*Threat?*
with *Health?*	*Support Systems?*	

Table 4. Personality — Outlook on Life

Beliefs — Expectations		Values — Goals	
"The way it is"		"The way it should be"	
Environmental Evaluation			
Life is . . .	"dangerous, grim, good"	should be . . .	"beautiful, exciting, easy"
People are . . .	"no damn good, worthwhile"	should be . . .	"generous, completely understanding"
Women are . . . (My wife is . . .)	"vain, emotional, capable"	should be . . .	"pleasing, kind, self-sacrificing"
Men are . . . (My husband is . . .)	"bossy, selfish, capable"	should be . . .	"powerful, stoic, heroic"
Work is . . .	"very hard, useless, fun"	should be . . .	"a duty, a necessity, rewarding"
Self Evaluation			
I am . . .	"weak, stupid, bad, crazy, O.K., a loser, a loner, a pleaser, no good"	should be . . .	"intelligent, strong, attractive, successful, rich, generous, number one"

way it should be." Most human conflicts involve conflicts between an individual's beliefs and values or between two individuals' values. These discrepancies and conflicts must be understood if the patient's behavior is to make sense to the physician.

Finally, the physician should understand the patient's ways of coping with his problems. Is he actively working or struggling toward solutions, defensive and denying of their existence, passively resigned to his fate, overwhelmed, distorting reality, striking out against others, etc? Use of alcohol or drugs as another means of coping should be routinely investigated.

The answers to these questions provide the physician with a dual perspective of the patient's personality, including his outlook on life and how he is coping. Appreciating the patient's behavior provides a picture of the person in action, in terms of both self-defeating behaviors and coping skills. This understanding provides the physician with a basis for empathy, for gauging doctor-patient rapport, for medical decision-making, and for anticipating cooperation with needed treatment.[13]

Discussion

The Psychological Systems Review provides a systematic means of evaluating complex and potentially confusing patient problems. This assessment of the patient's emotional status, life situation, and personality, along with the physical assessment, presents a comprehensive view of the patient's functioning. The PSR can be adapted efficiently to the needs of the situation and to the physician's style of practice. The review provides for the identification of emotional and social problems and also for identification of patient and family resources for coping with these problems over a period of time. This critical diagnostic information establishes a basis for deciding upon appropriate treatment, including possible referral.

The format of the review provides a patterned framework for inquiry and also serves as an outline for generating an essential element of the patient's record (Figure 1). The amount of time necessary to touch upon each of the three systems need not exceed 20 to

Figure 1. Psychological Systems Review – Summary

Date March 27, 1975

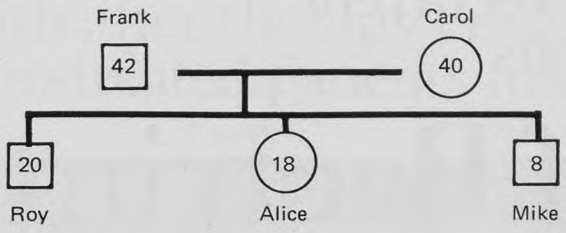
Name: Frank M. **Age – Sex:** 42, male

Race/Nationality: white, German **Education:** High School, Vocational

Work: electrician, 1952 **Marital Status:** Carol, 1954

Number of Children: 3 **Religion:** Lutheran

Family Diagram



Presenting Complaints:

"tired, dizzy spells, need a checkup"

Emotional Status – Distress:

Appears tense, reports difficulty relaxing, is mildly depressed, has difficulty expressing feelings.

Present Life Situation: (stresses, support systems)

Job dissatisfaction (work unrewarding).
Marriage: "Not going so good lately. Lot of arguing – fighting about kids, money." "My wife is always complaining."
Children: daughter fighting with dad about independence, oldest son recently engaged.
Support Systems: has good friends, especially old army buddies (V.F.W.), an uncle, strong religious commitment, finances are good.

Personality: (problems, coping resources)

Capable, reasonably confident, hard-working, somewhat rigid and compulsive, relatively non-expressive except for anger, independent. Sees life as a struggle; people as not terribly supportive or trustworthy; work as hard, unrewarding, but a duty; himself as O.K. when productive and in charge of events. Is puzzled, angry when others do not see things his way.
Coping techniques: structure, routine, hard work, beer with the boys, overeating.

Problem List:

Hypertension; overweight; tense, depressed (angry); marital problem; children; life style – compulsive, no recreation.

Treatment Plan:

Physical exam, lab studies, medication, diet, blood pressure checks, discussion with couple regarding marriage and children, encourage recreational activity.

Patient Profile (Summary):

Mr. M. is a 42-year-old German male, married (Carol) for 21 years with 3 children: Roy (20), Alice (18), and Mike (8). Frank has been an electrician with the Jacobs Company for 23 years with adequate financial rewards. His primary supports are his work, spouse, uncle, V.F.W. friends and Lutheran religion. Frank's temperament is relatively reserved and non-expressive except when he gets angry. He likes structure and conformity from others. Very little recreational activity other than being an avid sports fan. Basic attitude toward life is one of work and a struggle to "get ahead" and to be able to maintain what one has.

30 minutes. Naturally, this will vary with the chronicity of the problem, nature of the situation, and degree of emotional distress. Several return visits may be scheduled to obtain a more complete understanding of the patient and his situation. Other health professionals may be used by the physician to assist in gathering this data.

The process of identifying problems and resources with the patient is often therapeutic in itself. Further, it may provide a basis for engaging in short-term supportive psychotherapy.[7,14] If the physician feels that his efforts at understanding the patient and his situation and at providing support are not yielding the desired results or are too time-consuming, he should seek consultation and consider referral. In any case, the PSR should contribute to the development of trust and to the patient's acceptance of some form of treatment.

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