CPD Article

Stress and its implications for family practice

Spangenberg JJ, MA(Psych), MA(Clin Psych), DPhil
de Villiers A, MA (Clin Psych)
University of Stellenbosch

Correspondence to: Dr J Spangenberg, E-mail: spangenberg2@telkomsa.net

Abstract

An underlying component of stress that manifests in physical symptoms is present in a high percentage of patients visiting the family practitioner, who is expected to help them cope with stress. In this article the transactional model of stress is briefly explained. Guidelines are given for assessing the role of stress in physical symptoms and for consulting with stressed patients. Subsequently, some stress moderators are discussed and guidelines are given for implementing these in practice. Lastly, primary, secondary and tertiary stress interventions in primary health care are briefly discussed.

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Introduction

It is estimated that an underlying component of stress that manifests in physical symptoms is present in up to 90% of visits to physicians.[1] The stress hormones adrenaline and cortisol are functional in producing the "fight or flight" response when the individual needs to confront physical or psychological danger.[2] However, when stress persists so that sympathetic nervous system activation becomes chronic, stress can become a contributory factor in various diseases such as hypertension, stroke, coronary heart disease, ulcers, migraine, tension headaches, rheumatoid arthritis, backache, bronchial asthma, gastrointestinal disturbances, and skin disorders.[3,4]

The rationale for this article is that patients are increasingly turning to family practitioners (FPs) to help them cope with a range of stressful life experiences and conditions.[5,6] However, FPs often avoid or evade patients' cues to the existence of emotional problems.[5] This may cause unintentional iatrogenic harm.[5,7] The objectives of this article are therefore to briefly explain a useful theoretical model of stress and to present guidelines for assessing the role of stress in physical symptoms, conducting consultations with stressed patients, implementing stress moderators and utilizing stress interventions.

The transactional model of stress

Lazarus and Folkman's transactional model of stress is the most influential of the psychological stress theories and has generated the most research. According to this model, stress is primarily the result of one's perception of risk factors in the environment and one's assessment of whether personal resources will enable one to meet the environmental challenges or whether, on the other hand, one will become overwhelmed by environmental threats.[8] Coping with stress, in terms of the transactional model, consists of the individual's constantly changing cognitive and behavioural efforts to manage external and/or internal demands that are appraised as taxing or exceeding his/her resources.[8,9] The ways in which people cope with stress can either reduce or amplify the effects of adverse life events and conditions on emotional distress and short-term functioning as well as on the development of chronic physical and/or psychological disorders.[9]

Assessing the role of stress in physical symptoms

When symptoms lack an adequate physical explanation, even after a proper physical investigation, the FP should evaluate the potential contribution of life stress.[10] Sudden stressful life changes are not the only source of stress; subtle and longstanding life situations can be a source of severe stress because of their persistence.[10,11] Special attention should be paid to:[10]

- Possible grief reactions to losses, including the loss of a loved one, relationship, career, body part or bodily function
- A history of physical and/or sexual abuse
- Perception of environmental demands as exceeding personal resources
- A possible temporal relationship between stressful life events and symptom onset or relapse

The possible latency between stress accumulation and symptom onset (of which the patient may be unaware) should be kept in mind, e.g. symptomatic worsening during weekends or holidays.[10] A simple questionnaire for assessing stress in primary care is available.[12] A self-rating questionnaire could also give valuable information.[13]

How to approach consultations with stressed patients

Four nonspecific ingredients that are shared by most therapeutic relationships also characterize a therapeutic doctor-patient relationship. These are:[10]

- The FP's full availability during the specified times
- The patient's opportunity to ventilate thoughts and feelings
- An emotionally involved, confiding relationship
- A plausible explanation of symptoms
- A procedure that involves the active participation of both patient and FP that is believed by both to be the means of restoring the patient's health

Practical guidelines to establish such a relationship are:[6,7]

- Adopt a friendly, relaxed attitude to put the patient at ease.
- Enquire in a tactful and sensitive manner what the patient's worries are, using open-ended rather than closed questions.
- Listen attentively and respect the patient's views.
- Taking the educational level of the patient into consideration, provide understandable, personalised information about the possible link between somatic and psychological symptoms (e.g. abdominal pain and anxiety).
- Give opportunity for discussion and clarification.
- Suggest a management plan.
- Ascertain what the patient's expectations are. If they cannot be met, explain why in an empathic manner and discuss possible referral to a psychologist, psychiatrist, or social worker as part of the management plan.

Moderators of the effects of stress

To help the FP to obtain some insight into the patient's strengths and weaknesses, some of the most important stress moderators are briefly discussed. Guidelines are given to help the FP to implement these in practice.

Coping strategies

People develop predispositions to cope with stress in particular ways and these, like most other personality traits, remain stable from post-adolescence throughout adulthood.[8,14] Macro-level analysis has led to a distinction between problem-focused and emotion-focused coping. Problem-focused coping comprises cognitive problem-solving efforts and behavioural strategies aimed at managing the ***problem*** that causes stress, while emotion-focused coping comprises cognitive and behavioural efforts aimed at managing or reducing the negative ***emotions*** caused by the problem.[8,15] Problem-focused coping strategies have been found more effective in circumstances that are perceived as amenable to change, while emotion-focused coping strategies, such as acceptance of the situation or seeking social support, have proved more effective in circumstances perceived as unchangeable.[14,15]

Guideline:

Enquire which coping strategies used so far have proved useful or not. Make the patient aware of instances of successful coping. Point out psychological strengths and ask elicit the patient's ideas about possible solutions to the problem.

Attributional style

According to attribution theory, people are constantly in the process of forming causal attributions (cognitive explanations) for the causes of successes and failures. A person's attributional style is his/her overall tendency to ascribe events to specific types of causes.[16] People with a negative attributional style tend to explain negative events as having internal, stable and global causes. For example, the cause of one minor failure is explained as internal ("it's all my fault"), stable ("I am always at fault") and global ("I will always be at fault in everything I do"). People with a negative attributional style are especially vulnerable to stress and subsequent depression when faced with uncontrollable life stressors.[17] A negative attributional style has also been linked to poor immune functioning.[18]

Guideline:

Listen for inappropriate self-blaming and ask questions to elicit other factors that could have contributed to the current problem or stressful situation. If a negative attributional style seems ingrained and not amenable to change, referral to a psychologist is recommended.

An optimistic disposition

People with an optimistic disposition hold generalized positive expectations for the future and expect good things to happen to them, while pessimists expect the opposite. Thus, optimists tend to believe that adversity or stressful life events can be handled successfully, whereas pessimists tend to anticipate disaster.[19] Optimists use more engaged coping strategies (such as problem-solving), whereas pessimists use more disengaged coping strategies (such as avoidance or denial).[20] An optimistic disposition has been associated with more effective coping and a reduced risk for illness.[19] Research has shown that individuals who measured high on optimism tended to show signs of more adaptive immune functioning and exhibited less extreme cardiovascular reactivity during the course of their daily lives than those who measured high on pessimism.[21]

Guideline:

The pessimistic patient is easily recognized through expressions of helplessness, hopelessness and demoralization. If the pessimism does not seem pathological, bibliotherapy can be a valuable recommendation.[22] Otherwise, referral to a psychologist is advisable.

Social support

Social support comprises the certainty that one is loved, cared for and valued by significant others.[23] Sources of social support may include a spouse, partner, relatives, friends, community resources such as churches or clubs, or even a devoted pet.[24] Social support enhances physical and psychological well-being by facilitating feelings of predictability and stability, maintaining positive affective states and providing social recognition of self-worth.[25] Research has confirmed that positive social support is an important stress buffer.[26] The formation and disruption of social relationships had important cardiovascular, immunological and endocrinological sequelae.[27]

Guideline:

Tactful enquiry will soon reveal whether the stressed patient experiences a lack of social support. Establish which current or previous interpersonal relationships or community support systems could provide a buffering role against stress. If necessary, assist the patient in mobilizing social support. Should serious marital or family discord be revealed, refer the patient to a psychologist or social worker.

Spirituality and religion

A resurgence of interest has recently developed in the buffering effect of spirituality and religion in coping with stress and maintaining health.[28] The beneficial effect of religion as a stress buffer seems to stem from, firstly, a belief system and a way of thinking about adversity that enables people to find meaning and purpose in inevitable life stress and, secondly, the fact that organized religion often provides a network of supportive individuals who share the same beliefs.[29] Research has shown that people with strong religious faith experienced greater life satisfaction, greater personal happiness, and fewer negative consequences of traumatic and stressful life events than those without religious involvement.[30]

Guideline:

If applicable, if the stressed patient is amenable and if spirituality is in accordance with the FP's own value system, the FP should not hesitate to discuss this important stress buffer with the patient and, if necessary, refer the patient to his/

her minister or a clinical pastor as part of the management team.

Stress interventions in primary health care

Primary intervention

1. The FP's main primary intervention is lifestyle modification by providing practical advice regarding diet, exercise, relaxation, constructive leisure activities, alcohol and drug use.
2. Excessive or unnecessary stressors can be eliminated by means of environmental adjustment,e.g. reducing workload.[18] FP's are often approached for a "sick note" or medical boarding. "Stress" is an easy target for the patient who simulates symptoms for financial or other gain. Many FPs do not have experience with patients who malinger and the signs are often subtle. Brief tests which measure faking of both behavioural and cognitive symptoms are available. These tests effectively identified malingerers in research.[31,32]
3. The intensity of the stress response can be reduced by adjusting the level of the moderator, e.g. increasing social support.[18] Guidelines in this regard were given in the previous section.

Secondary intervention

This involves reducing the severity of already existing stress symptoms before they lead to more serious physical and/or psychological pathology. Stress management programmes fall into this category. Basic information about stress management programmes, which are offered in individual or group format by some psychologists, is presented here to help the FP decide whether a patient would benefit from such a programme. For the self-reliant and sophisticated patient, the FP could suggest a self-help manual as an experimental intervention.[33,34] The aim of stress management is not to eliminate stress entirely, but to enable people to control their stress so that they can maintain the optimum level of arousal that is needed for effective performance.[4]

Effective stress management programmes are holistic and incorporate physical, emotional, cognitive and behavioural components. The programme usually commences with relaxation techniques such as progressive muscle relaxation, imagery-based relaxation, breathing techniques, visualization and meditation. Other components include problem solving, time management, communication skills (including assertiveness and conflict management), and cognitive restructuring to develop a healthy self-esteem, psychological hardiness and resilience.[33,34,35,36]

Tertiary intervention

Tertiary intervention involves treatment aimed at alleviating advanced stress symptoms. It includes pharmacological treatment (by the FP or a psychiatrist) and/or psychotherapy by a psychologist. These two modalities are often most effective when used in conjunction. Cognitive behaviour therapy aims to uncover and modify stress-inducing cognitions through a variety of techniques.[37,38] The patient's stress resistance is thus enhanced through more realistic cognitions. Close co-operation and feedback between the FP, psychologist and psychiatrist is essential to enhance effective treatment.

Conclusion

Family practitioners often constitute the primary helpline when patients suffer from stress or when stress underlies physical symptoms. Guidelines for a stepwise approach are:

1. Assess the presence and role of stress empathically, considerately and constructively.
2. Establish which of the following stress moderators can be activated on primary level: coping strategies, attributional style, optimism, social support and spirituality/religion.
3. Employ primary interventions such as lifestyle modification and elimination of unnecessary stressors.
4. If primary intervention proves insufficient, proceed to secondary intervention by referring to a psychologist for stress management.
5. If advanced stress symptoms such as severe anxiety or depression are present, employ pharmacological treatment by the FP or a psychiatrist, in combination with psychotherapy by a psychologist. When referring, maintain a team approach through co-operation and feedback.

See CPD Questionnaire, page 43

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