**Stress,**

1. *In a patient presenting with a symptom that could be attributed to stress (e.g., headache, fatigue, pain) consider stress as a contributing factor.*

20-25% of Canadians >15yrs rate daily life as “quite a bit” or “extremely” stressful.

Acute Stress

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| Physical Response | Emotional Response |
| *  ACTH, epi + norepi, glucocorticoids and endorphins * Insulin+ reproductive hormones (est, prog, test) * Cognition + memory * Pain sensation * Energy stores mobilized, heartrate, metabolic rate, bp, resp rate | * Denial (defense mechanism) * Disbelief * Shock * Anger * Anxiety * Restlessness * Confusion * Self-doubt * Forgetfulness * Fear, anger and excitement |

Chronic Stress

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| Physical Response | Emotional Response | Behavioural Response |
| Gl upset  Sleep disturbances  Headaches  Lethargy  Muscle + Back pain  libido  Immune response  risk developing mood disorder (GAD, MDD)  serum cholesterol  blood pressure  platelet aggregation  risk of cardiovascular events  risk of DM related complications and metabolic syndrome | Mental blocks  Hopelessness, frustration  Boredom  Reduced feelings of empathy  Chronic fatigue  Anger, cynicism, pessimism  Depression  Nervousness  Self-hate  Guilt | Mistakes or judgment errors  Impulsiveness  Inappropriate or aggressive communication  Apathy  Increased drug or alcohol use  Withdrawal, isolation  difficulty maintaining healthy life style (diet, exercise, sleep)  Disordered eating |

1. *In a patient in whom stress is identified, assess the impact of the stress on their function (i.e coping vs. not coping, stress vs. distress)*

**Stress**: any demand on the body, mind and spirit to perform. Function is maintained and coping is adaptive.

**Distress:** Coping and adaptation processes fail to return an organism to physiological and/or psychological homeostasis.

**Coping:** Behavioral response to reduce stress in non-detrimental way. Function maintained.

**Not coping**: Appreciable decline in social, work, economic, family functioning and/or maladaptive coping (ETOH, substances, smoking, social withdrawl, etc)

A) Assess function (all domains): school, family, relationships, work, health behaviors (exercise, diet, sleep), substance use, sexual function, psychological health

B) Identify maladaptive/deleterious coping strategies/behaviors

3 main ways people cope with stress (can be adaptive or maladaptive)

**Task-oriented**: analyze situation and take action to deal directly with situation.

**Emotion-oriented**: address feelings and find social supports.

**Distraction-oriented**: use activities or work as distraction.

1. *In patients not coping with stress, look for and diagnose, if present, mental illness (e.g. Depression, anxiety, disorder)*

Stress has high comorbidity with anxiety, depression and psychoses

Screen for following:

a. MDD

b. Eating disorders

c. GAD

d. Panic Disorder

e. Phobias

f. Acute Stress disorder (symptoms of PTSD with onset before 4 weeks and duration < 4 weeks) g. PTSD

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| **Diagnostic Criteria for Post-traumatic Stress Disorder**   |  |  |  | | --- | --- | --- | | A. The person has been exposed to a traumatic event in which both of the following were present: | | | |  | 1. The person experienced, witnessed, or was confronted with an event or events that  involved actual or threatened death or serious injury, or a threat to the physical integrity  of self or others. | | |  | 2. The person's response involved intense fear, helplessness, or horror. | | | B. The traumatic event is persistently re-experienced in one (or more) of the following ways: | | | |  | 1. Intrusive distressing recollections(young children, repetitive play) | | |  | 2. Nightmares | | |  | 3. Flashbacks/hallucinations | | |  | 4. Intense psychologic/physiologic distress at exposure to cues resembling the event. | | |  |  | | | C. Avoidance of stimuli associated with the trauma + numbing of general responsiveness | | | | D. Persistent symptoms of increased arousal (irritable, hypervigilant,  startle, [ ] | | | | E. Duration is more than one month. | | | | F. Causes clinically significant distress or impairment in function. | | | |  |  |  | |

**Prognosis:** Spontaneous improvement, lasts 36 months (treatment), 64 months (no treatment), > 1/3 never fully recover

**(+) prognosis if:** Rapid engagement of treatment, early/ongoing social support, avoidance of retraumatization,good premorbid function, and absence of psychiatric disorders or substance abuse.

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| ***Comorbidity*** | ***Men (%)*** | ***Women (%)*** |
| Alcohol abuse or dependence | 51.9 | 27.9 |
| Drug abuse or dependence | 34.5 | 26.9 |

**Treatment:**

NO! Exposure therapy and psychotherapy to relive experiences =(BAD)

**Behavioural and cognitive therapy** (enroll families in therapy as well)

**SSRI** (sertraline, Fluvoxamine, paroxetine)  numbing, avoidance, hyperarousal

**Clonidine/Risperidone** may intrusive recollections, nightmares, hypervigilance and outbursts of anger

Benzos: anxiety but no impact on core symptoms ( substance abuse = avoid benzos)

1. *In patients not coping with stress in their lives,*
2. *clarify and acknowledge the factors contributing to the stress*
3. *explore their resources and possible solutions for improving the situation.*

Stress Reduction Therapies:

Exercise!!!

Control manageable issues

Counseling/ CBT

Encourage peer social support

Massage

Breathing exercises + Progressive muscle relaxation

Mediation (mindfulness, transcendental, guided imagery)

Acupuncture

1. *In patients experiencing stress look for inappropriate coping mechanisms (drugs, eTOH, eating, Violence)*

Screen for:

Substance use

ETOH

Overworking

Eating disorders

Anger/aggressive behavior

Smoking