**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

|  |  |
| --- | --- |
| 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

|  |  |  |
| --- | --- | --- |
| Physical Response | Emotional Response | Behavioural Response |
| Gl upsetSleep disturbancesHeadachesLethargyMuscle + 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 blocksHopelessness, frustrationBoredomReduced feelings of empathyChronic fatigueAnger, cynicism, pessimismDepression NervousnessSelf-hateGuilt | Mistakes or judgment errorsImpulsivenessInappropriate or aggressive communicationApathyIncreased drug or alcohol useWithdrawal, 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**

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| --- |
| 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. |
|  |  |  |

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**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.

|  |  |  |
| --- | --- | --- |
| ***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