UNIT NO. 5

STRESS MANAGEMENT AND COUNSELLING

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ABSTRACT

The concept of "stress", remains elusive to attempts made to define its precise meaning. Nevertheless, as a concept, stress encompasses the overlapping domains of stressors, manifestations, and mediating factors. A comprehensive assessment of these domains enables the clinician to understand the various factors contributing to stress as it applies to the individual patient. This then allows for optimal planning of interventions that target the cause and effects of stress. Broaching the topic of stress helps the patient to recognize the symptoms of stress and its link to psychosocial stressors. Communication skills in stress management are to direct attention to the topic of stress, encourage patients to talk about the events and factors, as well as sensitive enquiry into behavioural changes. Counselling skills needed in stress management include the skills of educating the patient and psychological intervention such as cognitive behavioural therapy. Pitfalls to avoid are over-investigation, failure to distinguish between psychiatric illness and adjustment disorder, viewing stress as always deleterious, and failure to consider the need to refer the patient for further management.

STRESS, HEALTH AND DISEASE

The concept of 'stress', despite its extensive use in lay and medical language, remains elusive when attempts are made to define its precise meaning. Stress is often seen to be exerting a negative effect on one's general well-being. In medical practice, the focus is on the deleterious effects it has on health. Research has implicated stress to play a significant aetiological role in various illnesses, ranging from cancer[1,2] and the common cold, to heart disease[3] and irritable bowel syndrome[4]. Table 1 lists a variety of medical disorders where stress has been identified to have a major role. Understanding the psychosocial factors as they impact on these illnesses is crucial to their optimal management. Stress also has a major role to play in psychiatric disorders and indeed, the term 'stress' is often considered to be the generic equivalent of emotional distress of all sorts, including anxiety, depression, and other psychological symptoms. The onset and experience of medical illness is invariably experienced as stressful and distressing by both the sufferer and his/her family, and is yet another reason why clinicians need to familiarize themselves with stress and how to manage it.

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CLINICAL ASSESSMENT OF PATIENTS WITH STRESS

As the concept of stress encompasses a number of overlapping domains, a clinical assessment of stress in patients requires enquiry into various areas, including:

- the causes of stress (stressors) (Table 2)
- its manifestations (physical and psychological symptoms and behavioural changes) (Table 3); and
- the mediating factors (personality, coping and social supports) (Table 4).

One easily identifies with the inventory of life stressors which provoke stress, but there is also a realisation that the impact of the stressor is mediated to a large extent by the individual's personality, coping, available supports etc. Medical practice focuses to a large extent on its symptomatic manifestations. In the primary care setting, physical symptoms of stress, which may often be diverse and non-specific, may pose a diagnostic challenge.

Table 1. Common Stress-related Illnesses

Cardiovascular Disease e.g. Ischaemic Heart disease, hypertension
Immune System Disease e.g. SLE, Rheumatoid arthritis
Digestive Disorders e.g. IBS, peptic ulcers
Dermatological conditions e.g. psoriasis
Headaches and Migraines
Menstrual symptoms
Psychiatric Disorders e.g. depressive disorder, anxiety disorder

Table 2. Common Causes of Stress (Stressors)

Major Life Events
o Unemployment, retirement
o Marriage
o Bereavement
o Relationship problems (separation, divorce)
o Illness (serious or life-threatening illness, disability/disfigurement, major operation)
Daily Hassles
o Child-rearing (in the absence of supports)
o Relationship discord
Chronic Stressors
o Financial hardship
o Work-related (worked, unclear role, shift-work, performance demands, hazard, uncertainty)
o School and academic pressures
o Changes in lifestyle and relationships due to illness/disability

Table 3. Common Symptoms & Manifestations of Stress

Physical	
	o Muscle tension, easily startled
	o Insomnia
	o Poor appetite
	o Fatigue
	o Sweating, shaking
Psychological	
	o Feeling overwhelmed, upset
	o Low mood
	o Poor concentration
	o Anxiety
	o Irritability
	o Dissatisfaction, self-critical
Behavioural	
	o Smoking, drinking
	o Anger & aggression
	o Poor work performance, absenteeism

Table 4. Mediating Factors in the Individual Experiencing Stress

o Personality e.g. Type A, pessimism/optimism
o Coping Styles e.g. emotion-focused, problem-focused
o Social supports – family, social network, community
o Environmental factors e.g. housing

Comprehensive assessment. A comprehensive assessment of the domains of stressors, manifestations, and mediating factors enables the clinician to understand the various factors contributing to stress as it applies to the individual patient. This then allows for optimal planning of interventions that target the cause and effects of stress.

Broaching the topic of stress. Although stress has an important recognized role in clinical care, yet, doctors and patients may not readily broach this topic during a routine consultation. This often stems from reluctance on the part of both doctors and patients to engage in discussion about emotional issues. Many patients prefer to focus on physical symptoms and may even amplify somatic manifestations and actively avoid mention of emotional symptoms. Age, gender, personality, educational level, culture or past experience, are factors that may influence one's willingness to discuss emotional symptoms. Various other factors contributing to this reluctance are listed in Table 5. Both doctors and patients may be complicit to thsi tendency to 'side-step' issues relating to stress and emotions. Research attests to the fact that the majority of local patients does not perceive of their doctor as an appropriate person to discuss emotional distress with, and is primarily seen as a physical healer[5].

Another reason that it is useful for clinicians to broach the topic of stress with patients is because it offers an acceptable 'idiom of distress'[6] that allows for a 'safe' avenue to explore the psychosocial factors that affect physical and psychiatric illness. Most patients intuitively understand the concept of stress when it is referred to and consider it more 'acceptable' to talk about stress rather than 'anxiety' or 'depression' which may be considered pejorative or inappropriate to endorse. Some people of our local cultures would consider the open expression of emotional distress to be a sign of weakness and a 'loss of face'.

COMMUNICATION SKILLS IN STRESS MANAGEMENT

Given that a discussion about stress is not readily entered into during a clinical encounter, despite the important role it plays in disease management, special attention may have to be paid to how this can be facilitated through the use of communications skills and strategies. Examples of some useful techniques are listed in Table 6.

Direct attention to the topic of stress. Since patients may not spontaneously report that they are stressed, it is important to remain alert to indicative cues. Some patients may need prompting, direct inquiry or explicit 'permission' from the doctor to talk about emotional matters. An effective strategy to use for patients who manifest obvious signs of distress but remain reticent, is to identify and acknowledge the observation of that emotion and allow time for the patient to respond. Making normalizing statements to reassure that such symptoms are common, may further help put patients who are uncomfortable at ease.

Table 5. Reasons for Reluctance to Dealing with Stress and Emotions during a Clinic Consultation

Doctors	
	o Taking too much time
	o Lack of skill/training
	o Doubts about its value/usefulness
	o Fear of difficult questions/issues being raised
	o Fear of patients becoming distressed
	o Fear of emotional closeness with patients
	o Fear of harming the patient psychologically
	o Lack of support for oneself
Patients	
	o Thinking that stress/distress is inevitable and can't be alleviated
	o Fear of being labeled as 'neurotic' or 'unstable' or 'weak'
	o Perception that its not legitimate to mention non-physical problems
	o Desire to 'protect' the doctor and not 'bother' him/her

Table 6. Communication Skills when talking about Stress

1.	Picking up Cues Verbal: "I'm very frustrated…" "I've been so upset." Non-verbal: sighs, frowns, physical tension, shifting of moods
2.	Use Open-ended Questions "How have you been feeling lately?"
3.	Use Normalizing Statements "A lot of my patients who go through similar stress experience low moods. Do you feel like that sometimes?" "I think almost anyone would feel like that in your position..."
4.	Clarifying Statements "You mentioned that things have been bad at home lately. What has that been like?"
5.	Ask about a Specific Example "When was the last time you felt like that? Tell me about what happened when you felt like you lost control."
6.	Make Empathic Statements "I can see you've been having a really difficult time at work recently…"
7.	Acknowledging Emotions "You look quite upset ... (followed by an appropriately long pause)"
8.	Appropriate Screening Questions "How have things been with you and your wife lately?" "Do you think you have been drinking a lot more nowadays?"
9.	Eliciting Personal Beliefs "What have you thought might be causing all of this?"

Encourage patients to talk about stress. For patients who acknowledge they are stressed, it is ideal to encourage them to provide an account of the causes and manifestations of stress as they themselves perceive it to be. Patients usually highlight the issue that is of greatest concern to them, (which may be quite different from what the clinician suspects) and specific detailed enquiry can then follow. In trying to understand the personal context and impact that stress has on the individual, it is also useful to ask for the patients own perspective on what he believes to be the reason(s) for his present predicament.

Even when patients seem very defensive and do not acknowledge the role of stress in their medical presentation, it may be useful to continue on a systematic inventory of life events, work and family issues etc, without necessarily labeling them as 'stressful'. There may often be an apparent temporal link even though there is no acknowledgement of a connection by the patient.

Sensitive enquiry into behaviour changes. Stress is commonly associated with a range of behavioural changes including excessive smoking, drinking or illicit drug use, domestic violence or marital discord. A complete assessment may necessitate direct and sensitive enquiry without being intrusive or putting the patient on a defensive.

COUNSELLING SKILLS IN STRESS MANAGEMENT

Skills in educating the patient. Helping patients acknowledge the presence of stress and the link it may have to symptoms and disease is the important first step to intervention. Educating patients about the nature of stress, the physiological manifestations (which translate into symptoms) and its mediators operating, is in itself quite reassuring to patients.

Increasingly, GPs are also recognizing the important role they have as counselors. Like stress, 'counseling' also defies simple definition, but essential components comprise providing:

- help and support
- an understanding, empathic listening ear
- a climate of acceptance and safe environment to talk about feelings
- an opportunity to gain insight and understanding to enable helping oneself and mobilization of available resources.

Cognitive Behavioural Therapy. The Cognitive Behavioural Therapy (CBT) approach offers a useful model that has been successfully applied to general practice settings for treatment of various psychological conditions. The goal of CBT is "cognitive restructuring" i.e. changing patterns and habits of thinking. More specifically, CBT for patients experiencing ill effects of stress attempts to change the way patients think and act in stressful situations that result in damaging or unpleasant consequences.

The "cognitive" component of CBT focuses on thoughts and how they may be distorted and lead us to develop inaccurate perceptions of what's going on in the world around us. For example, a stressed patient may be experiencing anger or anxiety for no outwardly apparent reason, due to their own – perhaps distorted – impressions of events. The "behavioral" component of CBT focuses on actions and how these are linked to thoughts. Integrating the two components allows the therapist to work toward weakening the connections between faulty "automatic" thoughts and certain behavioral responses.

The following examples illustrate distorted thought patterns coupled with damaging responses which perpetuate ill effects of stress:

- Someone in a meeting at work suggests an improvement to a project your patient submitted. Even though this individual expressed a positive impression of the work and no criticism was intended, patient feels attacked and has an automatic "anger response." On her way back to her desk she picks up a doughnut and a soft-drink and wolfs them down, fuming.
- While shopping in a clothing store, the sales person erroneously guesses your patient needs a size larger than her usual clothing size. She feels unattractive and buys more new clothes and shoes, but soon regrets as it is way beyond her budget.
- It's Saturday evening and your patient is home alone. Even though he is tired from the work week and could use some down time, he feels bored and lonely, and is worried that he'll spend the rest of his life like this. Anxious, he reaches for his cigarettes.

In all of these examples, a distorted or faulty reasoning, led to a negative action. In the first case, the dysfunctional thought is that "my work has been criticized and I have been personally attacked". Coupled with this thought is an inappropriate emotional response (anger) that leads to a negative behavior (bingeing on junk food).

The goal is the identification and alteration of dysfunctional thoughts and the damaging behaviors that result from them. CBT for stress management involves identification of stressful situations and alteration of "automatic" or destructive behavioral responses to these situations. Over time, the thought-behavior response cycle is modified to reinforce healthy, rational thinking and appropriate behavioral responses.

PITFALLS TO AVOID

Avoid over-investigation. Stress can be manifest in many different ways some of which are subtle or 'masked', for example by physical complaints and symptoms. Somatic manifestations of stress are important to carefully assess, as unnecessary or excessive medical investigations or interventions may be carried out in pursuit of a medical/surgical problem which is really a manifestation of stress.

Distinguish between psychiatric illness and adjustment disorder. It is difficult to distinguish the boundaries between psychiatric disorders like anxiety and depressive disorder and distress that individuals experience in coping with stress (adjustment disorder). Patients may prefer to focus on the entity of stress without acknowledging emotional symptoms and have an underlying depression or anxiety disorder undetected and untreated. A commonly-held misperception is that just because the individual's emotional reaction is 'understandable' given the highly stressful nature of a life event e.g. diagnosis of a serious illness or bereavement, it does not amount to a disorder or warrant any treatment. Where symptoms persist for a long time, distress is extreme and significant social and occupational dysfunction results, even in the face of on-going stressful circumstances, it is important to exclude a psychiatric disorder.

Consider the need to refer. In those cases where stress symptoms seem disproportionately severe or prolonged, consider the need to refer for further management. Many of those who suffer from stress may benefit from treatment by a psychologist who has expertise in cognitive behaviour therapy, for example. It is also important to recognize that stress may be the external manifestation of psychiatric illness (e.g. depression or anxiety) or bring into focus personality dysfunction which had previously been covert. In these cases psychiatric help should be considered.

Do not view stress as entirely deleterious. It must also be qualified that although we have concentrated mainly on the potentially harmful aspects of stress, in reality, stress is a part of life, and we will all experience stress throughout our lives in varying degrees, just as we experience joy, contentment, disappointment, sadness, and other emotions. Indeed, many kinds of stress are beneficial and contribute to our interest in and enjoyment of life. Even more compelling is the notion that experiencing stress and learning to cope with present adversity, builds up individual resilience and enhances self-esteem and self-efficacy to enable successful coping in the face of subsequent stress. In that sense, the clinician is in a privileged position of being able to help facilitate the personal growth and development of their patients.

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LEARNING POINTS

- **The concept of stress encompasses the overlapping domains of stressors, physical. psychological and behavioural manifestations, and individual mediating factors. A comprehensive assessment of these domains need to be done for each patient.**
- **Broaching the topic of stress helps the patient to recognize the symptoms of stress and encouraging the patient to talk about the causes and manifestation as they themselves perceive it to be. Key communication skills can be employed to help facilitate this type of discussion.**
- **Sensitive enquiry into behavioural changes should not be forgotten.**
- **Counselling skills needed in stress management include skills in educating the patient about stress and its manifestations and psychological treatments such as cognitive behavioural therapy.**
- **Referral of those whose symptoms seem disproportionately severe or prolonged should be considered.**