SPECIAL ISSUE

Identifying and Treating Stress in Primary Care Medical Patients

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Recent life stress is a major factor affecting physical and emotional illness and medical utilization. This paper describes several ways of assessing risk for stress-related disorders in a family practice population. A model for a brief group intervention is summarized. In a small study, 2 sessions of relaxation and problem solving were associated with a significant decrease in reported anxiety, but no changes in utilization.

Introduction

A significant number of medical visits to the primary care physician (PCP) can result from stress in the patient’s life and the psychophysiological consequences of difficult life circumstances. Increased stress leads not only to patient distress (particularly worry, stress, and tension) and a lower quality of life, but also to increased medical utilization (Lynch, McGrady, Alvarez, & Forman, 2005). One identifiable source of stress for patients is the number of recent events in their lives.

Life changes may be followed by physical or emotional illness, due in part to the adjustments necessitated by these events (Rahe, Myer, Smith, Kjaer, & Holmes, 1964; Miller & Rahe, 1997). The High Risk Model of Threat Perception (HRMTP) (Wickrama, 1995), which was developed to identify patients with somatoform disorders, suggests that in addition to physical illness, life changes may act as a trigger to produce physical symptoms reflecting a somatization process. McGrady, Lynch, Nagel, and Wahl (2003) tested this hypothesis in a sample of primary care medical patients, finding that recent life events in combination with other predictor variables (such as negative affect, lack of social support, and avoidance coping) were associated with more somatoform symptoms and greater medical utilization.

Identifying patients who are experiencing significant stress might be helpful to the PCP in assessing and treating patient symptoms. Group-administered stress management interventions may be used in a primary care setting to ameliorate the negative effects of stress. This paper is devoted to describing a method for identifying patients in family medicine who are troubled by high stress and one intervention to teach primary care patients stress management skills.

Identifying Patients at Risk for Stress-Related Illness

Spitzer and his associates (1995) developed the Primary Care Evaluation of Mental Disorders (PRIME-MD) for use in the primary care medical setting. It involves a 2-step method consisting of a brief screening inventory completed by the patient; if indicated, this is followed by a structured clinical interview to determine a psychiatric diagnosis. While this approach is helpful, it has the goal of diagnosis of psychiatric disorders and, for this reason, goes beyond merely identifying patients with significant stress. Simply asking the patient about level of stress may be the most straightforward method of assessment. In the Medical Outcomes Study (Stewart et al., 1989), a simple Likert-type item was used for determining subjects’ perceived level of stress, along with a number of other variables. For some patients, the experience of stress is translated into physical symptoms that may wax and wane with increasing and decreasing demands for coping with stress. However, patients often do not connect their difficulties in coping with stress to physical symptoms. When asked, they may not be aware of the level of stress and its possible relationship to their symptoms. Some patients are ill-prepared to discuss emotional issues with their physicians and may respond to questions about anxiety or depression with vague answers that say more about their level of discomfort with the topic than about their experience of sad mood or constant worry. For these patients, simply asking may not provide useful information.

Application of the assessment methods used in the HRMTP could be helpful with such patients, especially since the model is intended to identify patients with somatoform symptoms. However, administering and scoring the lengthy battery of assessment instruments used with the HRMTP would not be economical or time efficient, particularly in a primary care setting.
One precipitant of stress, recent life events, has shown significant correlations with measures of stress, somatoform symptoms, and higher medical utilization. McGrady, Lynch, Nagel, and Zsembik (1999) McGrady et al. (2003) evaluated the elements of the HRMTP and found a relationship to medical utilization. Moreover, recent life events alone, as measured by the Social Readjustment Rating Scale (SRRS) (Holmes & Rahe, 1967), also predicted medical utilization. Given the ease of administration and scoring of the original SRRS and its recent updated version (Miller & Rahe, 1997), it could be used as a screening instrument at the time of the yearly health assessment conducted by the PCP. If the patient scores above 300 (the suggested cut-off score), the PCP can continue with more detailed questioning regarding distress and possible physical correlates. Behaviors that the patient has been using to cope with the adjustment to life changes can also be assessed. Positive coping (exercise, relaxation, use of social support) as well as negative coping strategies (smoking, fatty diet, substance abuse) should be monitored as well.

Our setting is the Family Practice Center (FPC) of the Medical University of Ohio. We developed a group intervention for patients who experienced many life changes during the past year and were thus at risk for stress-related disorders. All patients visiting the FPC were asked to complete the SRRS. Excluded were patients younger than 18 years of age, those unable to read about and/or understand the study, and those in the medical practice for less than a year. A total of 268 patients completed the form, and those receiving scores above 300 (the highest 1/3) were invited to participate in the group intervention. Of those invited, 33 enrolled and 23 completed the program. There were 17 women and 6 men, and the average age was 53 years. Participants were randomly assigned to either an experimental group or a wait-list control group.

The intervention consisted of simple relaxation techniques and problem solving. Skill building was emphasized to participants with verbal statements that they were going to learn several useful tools to manage stress. Empowerment was implied but that word was not specifically used. Two 90-minute sessions were held 2 weeks apart. Besides the educational component of the intervention, interaction among participants was encouraged to enhance the group support benefits. Sessions were held in the early evening for the convenience of those with daytime responsibilities such as work or child care.

**Relaxation**

Progressive and passive relaxation strategies (Davis, Eshelman, & McKay, 1995) were presented and practiced. Progressive relaxation was emphasized as a useful tool to differentiate muscle tension from relaxation with the goal of gaining voluntary control of level of tension. Participants verbalized understanding of the importance of relaxation and the effects of stress on their physical and emotional state. They recalled what their physicians had told them about how tense their muscles were to the touch and that stress was increasing their blood pressure or raising their blood sugar. The credibility of the program was enhanced by the congruence between our introductory remarks and what patients had been told by their physicians. However, despite patients’ belief that reducing stress, exercising regularly, and eating balanced meals was important, patients had the least understanding of how to improve stress management. None thought that they had adequate skills to manage stress or even begin the process of relaxation.

Autogenic relaxation with deep breathing assisted participants in quieting their minds and decreasing the impact of intrusive thoughts. Several participants reported frequent worry about job, family, and personal issues. Some verbalized that these thoughts impeded concentration and distracted them so that they were more forgetful and accomplished fewer tasks. The autogenic exercise was presented as a method for improving focus; repetition through practice was emphasized so that relaxation could steadily, over time, counteract the multitude of times that the stress response had been activated. Participants were given audiocassettes to take with them and use to reinforce what they had learned during the sessions. The audiocassettes included elements of autogenic training, progressive relaxation, and simple imagery.

**Problem Solving**

The problem solving approach developed by Nezu, D'Zurilla, Zwick, & Nezu, (2004) was presented at the first session. This model involves orienting the patient to the relationship between problems and emotions, helping them define a particular current problem, brainstorming about possible solutions, choosing the most promising solution and finally applying the solution to see how effective it is. The 5 steps of this approach were identified, along with the concrete examples of how this could be applied to real-life situations. Participants were encouraged to apply the approach to problems in their own lives, to use the solution that they worked on dur-
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The session, and to report on their progress at the second session. It was suggested but not required that the identified problem be one of the items on the SRRS. The Beck Anxiety Scale (Beck, 1990) was administered to participants at the beginning and the end of the intervention. Medical charts and the office database were examined for information about medical utilization. Statistical analysis showed a significantly greater reduction in anxiety in the intervention group in comparison to the wait-list controls but no significant difference in medical utilization. Informal feedback from the participants and their physicians was uniformly positive.

Conclusion

This paper presents ideas for identifying high-stress patients as well as describing an intervention to help patients manage stress. The decrease in anxiety scores in the intervention group is encouraging for further applications of group stress management in family practice. Since drop outs were common in our program, anticipating this factor and attempting to design programs with this in mind is recommended.

References


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