A Cognitive-behavioural Approach to Tackling Stress

Michael Neenan and Stephen Palmer

Introduction

Stress has been defined as 'a demand [environmental and/or internal] made upon the adaptive capacities of the mind and body' (Fontana, 1989, p. 3). If the individual's adaptive capacities can meet the demand, then the situation may be perceived as a challenge with the prospect of successful problem-solving. This may be called emotional excitement or emotional prostress (D'Zurilla and Nezu, 1989). However, if the demand cannot be met, then the individual may well buckle under the strain of trying to meet it with inadequate coping resources. When demand has exceeded or overwhelmed capacity, the individual can suffer from physical and mental debilitation that results in burnout, i.e., he or she is emotionally spent and deprived of productive energy; stress has turned into *distress* (Neenan and Palmer, 1996).

Of course, a problem can be viewed simultaneously as both a challenge and a threat, thereby evoking both positive and negative emotions in the same situation. As D'Zurilla (1990, p. 337) observes: 'the emotions that dominate in the situation may depend to a great extent on the amount of attention given to the two potential outcomes (harm/loss vs. benefit/gain)'. So if the individual focuses on the gains to be derived from successful problem-solving, 'instead of concentrating on the harm or loss that might result from *failing* to solve it successfully, then emotional *distress* during problem solving might be minimized' (D'Zurilla, 1990, p. 337).

The costs of detrimental stress are enormous. For example, some estimates suggest 180 million working days are lost annually at a cost of £4 billion to industry through workplace stress (Cooper, 1994). Stress is now the most common cause of workplace absence lasting more than twenty-one days after back pain ('More staff staying off through stress', *Daily Telegraph*, 28 September 1995). Below are listed some of the immediate and longer-term effects of stress (Palmer and Strickland, 1996).

- *Psychological:* anxious, angry, depressed, helpless, guilty, obsessive, no enthusiasm, cynical, lack of concentration, mood swings, intrusive thoughts or images, reduced self-esteem, retreat into daydreams.
- *Physiological:* palpitations, indigestion, muscle twitches, vague aches and pains, skin irritation or rashes, frequent colds, flu or other infections, breathlessness, tiredness, tendency to clench fists or jaw.
- *Behavioural:* accident-proneness, poor work, aggressive or passive behaviour, irritability, increased absence from work, poor time management, increased substance use, change in sleep pattern, impaired speech, withdrawal from supportive relationships.

Cooper (1996) identifies three stages of negative stress. The first stage is behavioural: the individual has difficulty in concentrating and making decisions; she becomes irritable and aggressive, begins to lose her sense of humour. In the second stage, this disturbed behaviour is translated into physical symptoms such as irritable bowel syndrome, stomach upsets, flatulence, constant colds, muscle pains. The third phase in chronic and severe stress can be serious physical illness as the stress can trigger genetic predispositions to, for example, heart disease or cancer.

Some stress-management approaches

1. *Anxiety management.* According to D'Zurilla (1990), this has been the most popular form of stress management for many years (Benson, 1975; White and Tursky, 1982). The focus is on reducing or controlling levels of anxiety through such methods as progressive muscle relaxation, meditation and biofeedback (i.e., autonomic arousal can be monitored to show how individuals react under stress).

2. *Cognitive restructuring.* This approach examines how an individual's thoughts, attitudes and beliefs play an instrumental role in creating maladaptive behaviour and unpleasant affect in stressful situations (Beck, 1984; Abrams and Ellis, 1994; Ellis et al., 1997). By identifying, challenging and changing these stress-inducing ideas, a more adaptive response to such situations can be developed. This approach would include relapse prevention.

3. *Stress inoculation training.* This method 'combines elements of didactic teaching, Socratic discussion, cognitive restructuring, problem solving and relaxation training, behavioral and imaginal rehearsal, self-monitoring, self-instruction and self-reinforcement, and efforts at environmental change' (Meichenbaum, 1985). Stress inoculation training helps individuals to develop coping skills for tackling present and future problems.

4. *Problem-solving training.* This provides individuals with a sequential model of problem-solving (e.g., problem definition and formulation, generation of alternative solutions, decision-making, evaluation of outcome) to increase their coping skills in problematic situations and interpersonal conflicts (D'Zurilla, 1990; D'Zurilla and Nezu, 1982). This model of stress management helps individuals, among other things, to increase their problem-solving ability, self-esteem and satisfaction with life.

5. *Multimodal stress counselling.* The acronym BASIC ID (Behaviour, Affect, Sensory, Imagery, Cognition, Interpersonal, Drugs/Biology) describes the seven discrete but interactive modalities which Lazarus (1989) believes encompasses the entire range of personality.

Problems pin-pointed across the modalities (e.g., traumatic imagery, autonomic arousal, catastrophic thinking) would be tackled with appropriate techniques for those modalities (e.g., respectively, imaginal desensitisation, relaxation, rational coping statements). This model is described as 'transactional' because it provides 'a realistic explanation of the complicated nature of stress as it addresses the inter-relationship between the internal and external world of individuals' (Palmer and Dryden, 1995, p. 4).

Stress research

Pretzer, Beck and Newman (1989, p. 164) suggest that 'stress researchers have gradually approached a consensus on the view that stress is cognitively mediated', i.e., an individual's appraisal of the stressor (external or internal stimuli) and his/her coping responses to deal with it will largely determine his/her emotional and behavioural reactions to the stressor. Two levels of appraisal have been identified: first, assessing the significance of an event (primary appraisal); second, determining the effectiveness of one's coping responses to meet the demands of the event (secondary appraisal) (Lazarus, 1966; Lazarus and Folkman, 1984). For example, a teacher fears an increase in her class size as this will mean greater unruliness from the pupils (primary appraisal); such behaviour from the pupils will push her to breaking point as she is already struggling to impose discipline in her classroom (secondary appraisal). This view of stress reflects the general theoretical model of cognitive-behaviour therapy (CBT) which examines idiosyncratic interpretations of and reactions to events (Beck, 1984).

Fontana (1989, p. 63) states that 'grasping the full significance of the power of our cognitive appraisals over our emotions means realising that we *can* use our thoughts to influence how we feel. This isn't the same as saying it's easy to do so, but it's a vital statement we must understand if we are to develop our power to withstand stress.' Woods (1987a) uses research on the psychophysiology of stress to support the CBT perception that it is our view of events which disturbs us, not the events themselves.

What can be done about stress?

Dr Valerie Sutherland, an occupational psychologist, suggests that by making the workplace a more mentally healthy environment could ensure 'that while stress is inevitable, distress is not' (reported in *The Times*, 1997; see Cooper and Williams (1994) for what companies can do to reduce workplace stress). Abrams and Ellis (1994, p. 39) make the same point about stress and distress but suggest that the answer to why a stressor becomes oppressive 'is largely found within the stressed individual, not in the events'. So one person's response to stress is enhanced performance while another's is potential collapse. Therefore the therapist's task, according to Abrams and Ellis, is to help the stressed individual to identify, challenge and change those patterns of thinking that produce emotional disturbance and problem-solving interference in the face of environmental stressors; this process of cognitive change enables the individual to develop an enduring emotional and practical problem-solving outlook.

CBT stress interventions have been shown to be effective in: decreasing occupational stress levels in working women (Higgins, 1986); providing cost-effective employee assistance programmes for work-based stress (Klarreich, 1987); preventing and coping with stress among safety officers (Kushnir and Malkinson, 1993); treating burnout (Richman and Nardi, 1985); improving occupational mental health (Weinrach, 1980); reducing Type A behaviour, anxiety, anger, and physical illness in corporate employees (Woods, 1987b).

Tackling stress: a case study

Bernard (1993, section 3, p. 1) states that 'in order for you to think clearly and thus effectively handle stressful situations and solve practical problems, you first have to develop emotional control. *Emotional self-management is a vital key to stress management*' (author's emphasis). The first step in emotional self-management is for the individual to become more aware of his/her emotional stress reactions and to understand their self-defeating nature. Counsellors are in an ideal position to help clients with this process:

Client: Since the workforce was reduced, there's been more work for me to do.
Therapist: How do you feel about that?
Client: Pissed off. Every day is pressure, pressure, pressure. I have to work long hours to cope with it.
Therapist: What would a typical day look like to you?
Client: I start about 8.30 a.m. and finish between 6.30 to 7 p.m. Sometimes I have to work through my lunch. I never seem to get ahead. That's why I'm pissed off.
Therapist: You've twice referred to being 'pissed off'. Which emotion do you think is linked to being pissed off?
Client: I'm not sure.
Therapist: How do you behave when you're pissed off?
Client: Tense, can't relax, get headaches, irritable with colleagues, my sense of humour has gone right out of the window, my jaw aches – it always seems to be clenched...
Therapist: Like it is now...
Client: Yes, I know. I feel ready to explode sometimes. I can't get a grip on things.
Therapist: Can you hear any thoughts going through your mind when you're like this?
Client: Apart from the bad language, things like 'I shouldn't have so much work', 'I should be able to cope like most of my colleagues do', 'I can't take much more of this'.
Therapist: Would you say that you're angry?
Client: Yes, very.
Therapist: Does your anger add quality and speed to your work?
Client: I wish it did. No, just the opposite.

Therapist: Does your anger affect your home life?
Client: Absolutely. I'm like a bear with a sore head when I get home and my wife and children suffer because of my moods. I feel angry with myself for being like this and then guilty for my behaviour towards them. Then when I've apologised to them, I start to worry about doing it again. I can't seem to control my moods.
Therapist: So you take your work home in the form of anger, so to speak.
Client: I never seem to get away from work!
Therapist: Does being angry have any benefits?
Client: Well, I suppose that my anger is justified because of the workload and therefore I'm entitled to feel like this. Not much of a benefit though. It doesn't help me work any better or reduce the workload. I'm angry at the company for getting rid of staff and at my boss for dumping this extra work on me. They're responsible for my anger, the way I feel.
Therapist: I'd like to come back to this responsibility issue at a later date if I may, but can I ask you: have you ever thought of leaving your job?
Client: Often, but I want to stay and conquer this problem. Leaving would be running away. That's not an option for me.
Therapist: So, you want to stay and learn a constructive way of handling your workload. Do you think your boss is going to reduce it in the foreseeable future?
Client: No, even though I blame her for my problems.
Therapist: So we need to find another way forward. I would suggest the first thing to do is to keep an anger diary at work for the next seven days so we can get a good idea of the intensity, frequency and duration of your anger.
Client: What's the point of that?
Therapist: Well, that will inform us how much of your time is consumed by anger and how much is actually spent on your workload.
Client: Sounds sensible. What then?
Therapist: On the basis of that information, we'll develop an action plan to tackle your anger and find a healthier way of managing your workload.
Client: Okay. That sounds promising.

Clients usually enter therapy unwilling to give up their anger because they perceive it as justified and believe it is up to others to change in order to make their situation more tolerable. Terjesen, DiGiuseppe and Naidich (1997) suggest that challenging these ideas early in therapy can lead to premature termination; therefore 'successful anger treatment usually entails exploration of the consequences of the client's emotions, and the generation of new alternative reactions. These maneuvers motivate the client to change' (p. 159).

The course of therapy

The client's anger diary was a revelation to him: he counted over ten hours a week being angry (and that did not include his home life). Such a loss of productive energy and the sheer embarrassment of the discovery prompted him to start getting his anger under control. Also, detailed discussions were engaged in on the physical, mental and interpersonal effects of prolonged anger – these effects the client termed 'corrosive'. An imagery exercise that the client found particularly useful was inaction v. action: he was encouraged to visualise as graphically as possible the consequences of not tackling his anger (e.g., a heart attack, family break-up), and then contrasted with doing something about it (e.g., greater efficiency at work, happier family life). The client did this imagery exercise several times a day and over the next few weeks was asked to fade out the inaction imagery.

As the client was making progress in reducing the frequency, duration and intensity of his anger episodes, the therapist began to address the thorny issue of who was ultimately responsible for his anger:

Therapist: You said in the first session that your boss is responsible for your angry reaction.
Client: That's right ... and the company as well.
Therapist: Now you've made some progress in reducing your anger, so who is responsible for that?
Client: I am of course, with your help.
Therapist: If you can reduce your anger, does it follow that you play some part in creating and maintaining it?
Client: I don't see that connection.
Therapist: Why do you think some of your colleagues cope better with the increased workloads?
Client: Because they accepted the changes and kept their noses to the grindstone. They also leave the office earlier than I do.
Therapist: Another incentive to give up your anger. Now I'm not trying to let your company or boss off the hook, but given the grim reality of the increased workload, what was your attitude to it?
Client: Well, I suppose I refused to accept it, it wasn't fair, those bastards ... as if I haven't got enough work to do ... are they trying to drive me into the ground? Those sorts of ideas were banging away in my head.
Therapist: And did this 'banging away' create a pressure cooker atmosphere in your head?
Client: Most definitely.
Therapist: Now, how do you think you would have responded if you had adopted the 'let's get on with it' approach of some of your colleagues?
Client: I know where this conversation is going – you're trying to blame me for my anger.
Therapist: There is an important distinction between blame and responsibility in this kind of therapy: blame involves finger-pointing and fault-finding whereas responsibility acknowledges without censure the significant contribution an individual makes to his/her own emotional problems. So it is the anger-producing ideas we need to examine and not to take you to task in any way for holding those ideas. Does that make any sense?
Client: The way you've put it does. So blaming my boss for my anger is looking at the situation in the wrong way – she gives me the work but it is my choice how I tackle or respond to it.

Therapist: That's right. Some of your colleagues react to the increased workload, which is the same for all of you in the office, in very different ways.
Client: I know they do. Most of them cope better with it than I do.
Therapist: How about conducting a survey among your colleagues to find out their attitudes to work and coping with it and also if they blame the boss like you do?
Client: Okay. That might prove to be very valuable.

The survey method (Burns, 1989) enables clients to test out their ideas in discussions with others as well as gain a variety of problem-solving suggestions. In addition, by subjecting his anger-producing beliefs to the sustained scrutiny of realism and pragmatism the client was able to modify them: realism – 'I keep on demanding every day that my workload should not be this heavy yet it remains the same. This is the way that it is, so I'd better adapt to it and get on with it if I want to keep my job. My anger makes the work harder than it actually is'; pragmatism – 'Where's it going to get me holding on to my anger? I can think of dozens of disadvantages yet struggle to think of one advantage. Even that one, my anger is somehow justified, no longer seems compelling.' On his desk at work he placed the following message, 'Stress does not have to turn into distress unless I let it', to remind him continually of his largely self-induced disturbance.

Reading Paul Hauck's (1980) book on anger control, *Calm Down,* provided more techniques for challenging his stress-creating thinking, as well as reinforcing the principle of emotional responsibility as discussed in the above dialogue. The client was also encouraged to select an activity that would help him to 'unwind' before he got home as well as increase his fitness: the client chose to go swimming twice a week. He also started walking to the railway station every day instead of driving to it and taking the stairs at work rather than the lift. At home, the client decided to take his wife out to dinner every week and once a month he took his family on a weekend break. Therapy lasted a total of ten sessions, the last four being fortnightly instead of weekly.

Therapist: Would you like to sum up what you've learnt in therapy?
Client: The great revelation for me was looking in the wrong direction for the source of my anger – it was her fault, or their fault, but I believed it had nothing to do with me. How wrong I was. Now I see that my boss has got her job to do. It's nothing personal, as most of my colleagues would say. I haven't been singled out in any way.
Therapist: What about the anger itself?
Client: It seems to have vanished. I get irritable sometimes but that's to be expected. It's still a tough place to work in. However, giving up the anger has given me all these extra hours in which to get the work done. Now I'm managing the workload and no longer fear being buried by it. I make sure that I take a lunch break away from my desk and I leave the office every day no later than 5.30 p.m.
Therapist: What about at home?
Client: All that moodiness has gone – my wife says that I'm now more approachable. Her and the kids were always on edge when I got home in case I exploded. I realise now how lop-sided my life was: I was either at work or brooding about it at home. My wife kept pointing this out to me but, of course, I didn't pay any attention to her.
Therapist: Well, I hope you won't make that mistake again.
Client: I hope so too. One concern I've still got is I know we've looked at relapse prevention strategies, but I still wonder if my progress will suddenly fall apart and I'll go back to square one.
Therapist: Well, let's schedule a series of follow-up appointments to see if your progress is still holding. The future won't be all plain sailing but it probably won't revert to square one either if you keep putting into daily practice what you've learnt.
Client: Okay, I look forward to giving you a progress report.

Conclusion

We have tried to show in this article that we are largely in control of our responses to stress in our lives. Cognitive-behavioural therapy emphasises the power of our cognitive appraisals to determine how we feel and behave in the face of stress. We believe that tackling stress successfully is more than just re-evaluating our response to a specific situation; it often calls for a rethinking of our lifestyle and values in order to create a more balanced, healthier and harmonious existence. As Cooper (1996) remarks, 'Nobody on his deathbed has ever been heard to say: "I wish I'd spent more time at the office." '

Michael Neenan *is Associate Director of the Centre for Stress Management, Blackheath, London.*

Stephen Palmer *is Director of the Centre for Stress Management, Blackheath, London.*

Correspondence address: Centre for Stress Management, 156 Westcombe Hill, Blackheath, London SE3 7DH.

References

Abrams, M. and Ellis, A. (1994) 'Rational emotive behaviour therapy in the treatment of stress', *British Journal of Guidance and Counselling*, **22** (1), pp. 39–50.
Beck, A. T. (1984) 'Cognitive approaches to stress' in R. L. Woolfolk and P. M. Lehrer (eds) *Principles and Practice of Stress Management*, New York: Guilford.
Benson, H. (1975) *The Relaxation Response*, New York: Morrow.
Bernard, M. E. (1993) 'Are your emotions and behaviors helping you or hurting you?' in M. E. Bernard and J. L. Wolfe (eds), *The RET Resource Book for Practitioners*, New York: The Albert Ellis Institute for Rational Emotive Behaviour Therapy.
Burns, D. D. (1989) *The Feeling Good Handbook*, New York: William Morrow.
Cooper, C. L. (1994) 'The costs of healthy work organizations' in C. L. Cooper and S. Williams (eds), *Creating Healthy Work*

Organizations, Chichester: John Wiley & Sons.
Cooper, C. L. (1996) 'Overwork could send you to an early grave' (interview), *The Times*, 5 January.
D'Zurilla, T. J. (1990) 'Problem-solving training for effective stress management and prevention', *Journal of Cognitive Psychotherapy*, **4** (4), pp. 327–54.
D'Zurilla, T. J. and Nezu, A. M. (1982) 'Social problem solving in adults' in P. C. Kendall (ed.) *Advances in Cognitive-Behavioral Research and Therapy* (vol. 1), New York: Academic Press.
D'Zurilla, T. J. and Nezu, A. M. (1989) 'Clinical stress management' in A. M. Nezu and C. M. Nezu (eds) *Clinical Decision Making in Behavior Therapy: A Problem-Solving Perspective*, Champaign, IL: Research Press.
Ellis, A., Gordon, J., Neenan, M. and Palmer, S. (1997) *Stress Counselling: A Rational Emotive Behaviour Approach*, London: Cassell.
Fontana, D. (1989) *Managing Stress*, London: Routledge.
Hauck, P. (1980) *Calm Down*, London: Sheldon Press.
Higgins, N. C. (1986) 'Occupational stress and working women: the effectiveness of two stress reduction programs', *Journal of Vocational Behavior*, **29** (1), pp. 66–78.
Klarreich, S. H. (1987) 'Cost effectiveness of an employee assistance program with rational-emotive therapy', *Professional Psychology: Research and Practice*, **18** (2), pp. 140–4.
Kushnir, T. and Malkinson, R. (1993) 'A rational-emotive group intervention for preventing and coping with stress among safety officers', *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, **11** (4), pp. 195–206.
Lazarus, A. A. (1989) *The Practice of Multimodal Therapy*, Baltimore, MD: Johns Hopkins University Press.
Lazarus, R. S. (1966) *Psychological Stress and the Coping Process*, New York: McGraw-Hill.
Lazarus, R. S. and Folkman, S. (1984) *Stress, Appraisal, and Coping*, New York: Springer.
Meichenbaum, D. (1985) *Stress Inoculation Training*, New York: Pergamon Press.
Neenan, M. and Palmer, S. (1996) 'Stress counselling: a cognitive-behavioural perspective', *Stress News*, the Journal of the International Stress Management Association (UK Branch), **8** (4), pp. 5–8.
Palmer, S. and Dryden, W. (1995) *Counselling for Stress Problems*, London: Sage Publications.
Palmer, S. and Strickland, L. (1996) *Stress Management: A Quick Guide*, Doncaster: Folens Publishers.
Pretzer, J. L., Beck, A. T. and Newman, C. F. (1989) 'Stress and stress management: a cognitive view', *Journal of Cognitive Psychotherapy*, **3** (3), pp. 163–79.
Richman, D. R. and Nardi, T. J. (1985) 'A rational-emotive approach to understanding and treating burnout', *Journal of Rational-Emotive Therapy*, **3** (1), pp. 55–64.
Sutherland, V. (1997) 'Office bullies "make their colleagues sick"', *The Times*, 14 May.
Terjesen, M. D., DiGiuseppe, R. and Naidich, J. (1997) 'REBT for anger and hostility' in J. Yankura and W. Dryden (eds) *Using REBT with Common Psychological Problems*, New York: Springer.
Weinrach, S. G. (1980) 'A rational-emotive approach to occupational mental health', *Vocational Guidance Quarterly*, **28** (3), pp. 208–18.
White, L. and Tursky, B. (1982) *Clinical Biofeedback: Efficacy and Mechanisms*, New York: Guilford Press.
Woods, P. J. (1987a) 'Do you really want to maintain that a flat tire can upset your stomach? Using the findings of the psychophysiology of stress to bolster the argument that people are not directly disturbed by events', *Journal of Rational-Emotive Therapy*, **5** (3), pp. 149–61.
Woods, P. J. (1987b) 'Reductions in type A behavior, anxiety, anger, and physical illness as related to changes in irrational beliefs: results of a demonstration project in industry', *Journal of Rational-Emotive Therapy*, **5** (4), pp. 213–37.