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# **OVERCOMING ANXIETY**

*A self-help guide using  
Cognitive Behavioral Techniques*

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Any person with a condition requiring medical attention should consult  
a qualified medical practitioner or suitable therapist.

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## Foreword

Many, perhaps the majority, of those who go to see their family doctor have some type of psychological problem which makes them anxious or unhappy. There may be a fairly obvious reason for this – the loneliness of widowhood or the stresses of bringing up a family – or it may be that their mental state is part of their personality, something they were born with or a reaction to traumatic experiences in their lives. Despite being so common, I soon discovered after starting in general practice over ten years ago that this type of mental disturbance (usually described as a *neurosis* to distinguish it from the *psychosis* of those with a serious mental illness like schizophrenia) is particularly difficult to deal with. What are the options? Well, there are always drugs – minor tranquillizers, antidepressants and sleeping pills. It is certainly easy enough to write a prescription and more often than not the patient feels a lot better as a result, but there is no getting away from the fact that drugs are a chemical fix. Sometimes this is all that is necessary to tide someone over a difficult period, but more usually the same old problems recur when the drugs are discontinued.

The alternatives to drugs are the 'talking therapies', ranging from psychoanalysis to counselling, that seek to sort out the underlying cause of anxiety or unhappiness. Psychoanalysis is out of the question for many, being too prolonged – often lasting for years – and too expensive. Counselling certainly can be helpful for no other reason than that unburdening one's soul to a sympathetic listener is invariably therapeutic. But once the counselling sessions were over, I got the impression it was only a matter of time before the psychological distress reappeared.

Here, then, is one of the great paradoxes of modern medicine. Doctors can now transplant hearts, replace arthritic hips and cure meningitis but, confronted by the commonest reason why people seek their advice, they have remarkably little to offer. And then a couple of years ago I started to hear about a new type of psychological treatment – cognitive therapy – which, it was claimed, was not only straightforward but demonstrably effective. I was initially sceptical as I found it difficult to imagine what sort of breakthrough insight into human psychology should lie behind such remarkable claims. The human brain is, after all, the most complex entity in existence, so it would seem unlikely that someone had suddenly, at the end of the twentieth century, found the key that unlocked the mysteries of neuroses – a key that had eluded human understanding for hundreds of years.

The central insight of cognitive therapy is not, it emerges, a new discovery, but rather is based on the profound observation originally formulated by the French philosopher Descartes that the essential feature of human consciousness

was '*cogito ergo sum*' – 'I think therefore I am.' We *are* our thoughts and the contents of our thoughts have a major influence on our emotions. Cognitive therapy is based on the principle that certain types of thought that we have about ourselves – whether, at its simplest, we are loved or wanted or despised or boring – have a major effect on the way we perceive the world. If we feel unloved, the world will appear unloving, and then every moment of every day our sense of being unloved is confirmed. That, after all, is what depression is all about. These types of thoughts are called 'automatic thoughts' because they operate on the margins of our consciousness as a continual sort of internal monologue. If these thoughts are identified and brought out into the open then the state of mind that they sustain, whether anxiety or depression or any of the other neuroses, can begin to be resolved.

So this type of therapy is called 'cognitive' because it is primarily about changing our thoughts about ourselves, the world and the future. The proof of the pudding, as they say, is in the eating and the very fact that this type of therapy has been shown to work so well, in countless well-controlled studies, is powerful confirmation that the underlying insight that our thoughts lie behind, and sustain, neurotic illnesses is in essence correct.

Nonetheless, some may be forgiven for having misgivings. The concept of cognitive therapy takes some getting used to and it is certainly hard to credit that complex psychological problems can be explained by such an apparently simple concept. There is perhaps an understandable impression that it all sounds a bit oversimplified or trite, that it

fails to get to the root cause of the source of anxiety or depression.

So it is necessary to dig a bit deeper to examine the origins of cognitive therapy, and perhaps the easiest way of doing this is to compare it with what for many is the archetype of all forms of psychotherapy – psychoanalysis. Psychoanalysis claims to identify the source of neuroses in the long-forgotten and repressed traumas of early childhood, so it is less concerned with thoughts themselves than with the hidden meaning which (it claims) underlies them. The important question, though, is whether psychoanalysis does make people better, or at least less unhappy. Many people certainly believe they have been helped, but when Professor Gavin Andrews of the University of New South Wales reviewed all the studies in which the outcome of psychoanalysis had been objectively measured in the *British Journal of Psychiatry* in 1994, he was unable to show that it worked any better than ‘just talking’.

In cognitive therapy, the importance of human thoughts lies precisely in their content and how that influences the way a person feels about themselves, a point well illustrated by one of its early pioneers, Aaron Beck. Back in the 1960s, while practising as a psychoanalyst in Philadelphia, Beck was treating a young woman with an anxiety state which he initially interpreted in true psychoanalytic fashion as being due to a failure to resolve sexual conflict arising from problems in childhood. During one session he noticed that his patient seemed particularly uneasy and, on enquiring why, it emerged she felt embarrassed because she thought she was expressing herself badly and that she

sounded trite and foolish. 'These self-evaluative thoughts were very striking,' Beck recalled, 'because she was actually very articulate.' Probing further he found that this false pattern of thinking – that she was dull and uninteresting – permeated all her relationships. He concluded that her chronic anxiety had little to do with her sex life but rather arose from a constant state of dread that her lover might desert her because he found her as uninteresting as she thought herself to be.

Over the next few years, Beck found that he was able to identify similar and quite predictable patterns of thinking in nearly all his patients. For the first time he realized that he was getting inside his patients' minds and beginning to see the world as they experienced it, something he had been unable to do in all his years as a psychoanalyst. From that perspective he went on to develop the principles of cognitive therapy.

Compared to psychoanalysis, cognitive therapy certainly does appear much simpler, but we should not take this to mean that it is less profound. The central failure of the founders of psychoanalysis was that they did not recognize the true significance of thoughts in human neurosis. Once that significance was grasped by those like Aaron Beck, then human psychological disorders became more readily understandable and therefore simpler, but it is the simplicity of an elegant scientific hypothesis that more fully explains the facts. It can't be emphasized too strongly the enormous difference that cognitive therapy has made. Now it is possible to explain quite straightforwardly what is wrong in such a way that people are reassured, while

allowing them to be optimistic that their problems can be resolved. Here, at last, is a talking therapy that works.

Professor Gavin Andrews in his review in the *British Journal of Psychiatry* identified cognitive therapy as 'the treatment of choice' in generalized anxiety, obsessive compulsive disorders and depression. It has in addition been shown to be effective in the treatment of eating disorders, panic attacks and even in the management of marital and sexual difficulties, in chronic pain syndromes and many emotional disorders of childhood. Its contribution to the alleviation of human suffering is remarkable.

*James Le Fanu, GP*

## **Introduction**

### **Why cognitive behavior therapy?**

Over the past two or three decades, there has been something of a revolution in the field of psychological treatment. Freud and his followers had a major impact on the way in which psychological therapy was conceptualized, and psychoanalysis and psychodynamic psychotherapy dominated the field for the first half of this century. So, long-term treatments were offered which were designed to uncover the childhood roots of personal problems – offered, that is, to those who could afford it. There was some attempt by a few health service practitioners with a public conscience to modify this form of treatment (by, for example, offering short-term treatment or group therapy), but the demand for help was so great that this had little impact. Also, whilst numerous case histories can be found of people who are convinced that psychotherapy did help them, practitioners of this form of therapy showed remarkably little interest in demonstrating that what they were offering their patients was, in fact, helpful.

As a reaction to the exclusivity of psychodynamic therapies and the slender evidence for its usefulness, in the 1950s and 1960s a set of techniques was developed, broadly collectively termed 'behavior therapy'. These techniques shared two basic features. First, they aimed to remove symptoms (such as anxiety) by dealing with those symptoms themselves, rather than their deep-seated underlying historical causes. Second, they were techniques, loosely related to what laboratory psychologists were finding out about the mechanisms of learning, which were formulated in testable terms. Indeed, practitioners of behavior therapy were committed to using techniques of proven value or, at worst, of a form which could potentially be put to test. The area where these techniques proved of most value was in the treatment of anxiety disorders, especially specific phobias (such as fear of animals or heights) and agoraphobia, both notoriously difficult to treat using conventional psychotherapies.

After an initial flush of enthusiasm, discontent with behavior therapy grew. There were a number of reasons for this, an important one of which was the fact that behavior therapy did not deal with the internal thoughts which were so obviously central to the distress that patients were experiencing. In this context, the fact that behavior therapy proved so inadequate when it came to the treatment of depression highlighted the need for major revision. In the late 1960s and early 1970s a treatment was developed specifically for depression called 'cognitive therapy'. The pioneer in this enterprise was an American psychiatrist, Professor Aaron T. Beck, who developed a theory of depression which

emphasized the importance of people's depressed styles of thinking. He also specified a new form of therapy. It would not be an exaggeration to say that Beck's work has changed the nature of psychotherapy, not just for depression but for a range of psychological problems.

In recent years the cognitive techniques introduced by Beck have been merged with the techniques developed earlier by the behavior therapists to produce a body of theory and practice which has come to be known as 'cognitive behavior therapy'. There are two main reasons why this form of treatment has come to be so important within the field of psychotherapy. First, cognitive therapy for depression, as originally described by Beck and developed by his successors, has been subjected to the strictest scientific testing; and it has been found to be a highly successful treatment for a significant proportion of cases of depression. Not only has it proved to be as effective as the best alternative treatments (except in the most severe cases, where medication is required), but some studies suggest that people treated successfully with cognitive behavior therapy are less likely to experience a later recurrence of their depression than people treated successfully with other forms of therapy (such as antidepressant medication). Second, it has become clear that specific patterns of thinking are associated with a range of psychological problems and that treatments which deal with these styles of thinking are highly effective. So, specific cognitive behavioral treatments have been developed for anxiety disorders, like panic disorder, generalized anxiety disorder, specific phobias and social phobia, obsessive compulsive disorders, and hypochondriasis (health

anxiety), as well as for other conditions such as compulsive gambling, alcohol and drug addiction, and eating disorders like bulimia nervosa and binge-eating disorder. Indeed, cognitive behavioral techniques have a wide application beyond the narrow categories of psychological disorders: they have been applied effectively, for example, to helping people with low self-esteem and those with marital difficulties.

At any one time almost 10 per cent of the general population is suffering from depression, and more than 10 per cent has one or other of the anxiety disorders. Many others have a range of psychological problems and personal difficulties. It is of the greatest importance that treatments of proven effectiveness are developed. However, even when the armoury of therapies is, as it were, full, there remains a very great problem – namely that the delivery of treatment is expensive and the resources are not going to be available evermore. Whilst this shortfall could be met by lots of people helping themselves, commonly the natural inclination to make oneself feel better in the present is to do precisely those things which perpetuate or even exacerbate one's problems. For example, the person with agoraphobia will stay at home to prevent the possibility of an anxiety attack; and the person with bulimia nervosa will avoid eating all potentially fattening foods. Whilst such strategies might resolve some immediate crisis, they leave the underlying problem intact and provide no real help in dealing with future difficulties.

So, there is a twin problem here: although effective treatments have been developed, they are not widely available;

and when people try to help themselves they often make matters worse. In recent years the community of cognitive behavior therapists have responded to this situation. What they have done is to take the principles and techniques of specific cognitive behavior therapies for particular problems and represent them in self-help manuals. These manuals specify a systematic program of treatment which the individual sufferer is advised to work through to overcome their difficulties. In this way, the cognitive behavioral therapeutic techniques of proven value are being made available on the widest possible basis.

Self-help manuals are never going to replace therapists. Many people will need individual treatment from a qualified therapist. It is also the case that, despite the widespread success of cognitive behavioral therapy, some people will not respond to it and will need one of the other treatments available. Nevertheless, although research on the use of cognitive behavioral self-help manuals is at an early stage, the work done to date indicates that for a very great many people such a manual will prove sufficient for them to overcome their problems without professional help.

Many people suffer silently and secretly for years. Sometimes appropriate help is not forthcoming despite their efforts to find it. Sometimes they feel too ashamed or guilty to reveal their problems to anyone. For many of these people the cognitive behavioral self-help manuals will provide a lifeline to recovery and a better future.

*Professor Peter Cooper  
The University of Reading*

## Preface

This book is in the form of a self-help program for dealing with problem worries, fears and anxieties. Its aim is twofold: first, to help the reader develop a better understanding of the problem; and then to teach the reader some basic coping skills. Part One explains the origins and development of problem worries, fears and anxieties, while Part Two is a practical, step-by-step guide to overcoming these problems. Part Two is based on a self-help programme which has been developed in clinics and doctors' surgeries over the last ten years, using the comments of clients to adjust and improve it.

The self-help section introduces the coping strategies of:

- controlled breathing and applied relaxation to ease physical discomforts;
- thought management to combat worrying thoughts;
- graded practice and problem-solving to help you face fears;
- assertiveness training to assist with interpersonal stresses;

time management to limit the stress caused by procrastination and poor organization;  
sleep management to help you get a better night's rest;  
and coping in the long term to help you keep up the good work.

It is a good idea to read the entire guide before embarking on the programme so that you get an overview – this means that you can then plan your own program realistically, taking into account your personal requirements and thus avoiding disappointment. You can then work through Part Two, taking a section at a time and rehearsing each technique thoroughly. You need to be familiar with all the techniques in the book if you are to be able to judge which suit you, and the techniques need to be practised if they are to become second nature to you.

Managing your problems will be achieved through the investment of time, setting realistic goals for yourself and gradually building up your self-confidence. Maintaining your achievements will come through keeping your coping skills up to scratch and knowing how to learn from set-backs.

This is not a program that you have to carry out alone, unless you choose to do so. You can enlist the help of family and friends, particularly in the practical tasks, and I recommend that you do so. If you decide to do this, encourage them to read this book so that they might better understand the difficulties that you are trying to overcome and the ways in which you are tackling your problems. If your family or friends are going to be able to help you, they also

need to appreciate that anxiety management requires time and careful planning.

There is nothing to lose by working through this book; it will equip you with basic coping skills. However, some readers might find that self-help alone is insufficient to meet their needs, and in these cases the reader is advised to consult a family doctor, medical practitioner or specialist therapist who can offer extra support. If you find that you do need to seek more help, this is not an indication of failure, but a recognition of the complexity of your difficulties.

## **PART ONE**

# **Understanding Worry, Fear and Anxiety**



# 1

## The stress response

Worries, fear and anxieties are common to us all. They are not physically or mentally damaging and, on most occasions, these responses are reasonable or even vital to survival. They are the normal reactions to stress or danger and only become a problem when they are exaggerated or experienced out of context. For example: I hear an approaching bus; I worry that it might hit me; I fear for my life and I experience the sensations of anxiety. This is a perfectly normal, helpful response if I am crossing the road, but an exaggerated and unhelpful reaction if I am resting in the park and the bus is in a nearby lane.

### Normal responses to stress

*It couldn't have been more idyllic. A peaceful summer's day in the country, just me and my young son. Then I heard the bull and saw that it was running towards us. I felt a whoosh of adrenaline and my heart jumped into my throat. The hair on the back of my neck bristled, my body tensed and all I could think of was my son's safety. I had to get him to safety. I scooped him up and*

*ran. I forgot his toys, I forgot the camera, I was so focused on the gate at the edge of the field and our escape. I don't know where the energy came from but I found the strength to carry him and I was able to get to the gate before the bull reached us. Afterwards, I felt jittery and exhausted but this eased off with time.*

Worry, fear and anxiety are crucial to our survival because they prepare us for coping with stress or danger. They trigger the release of a hormone (adrenaline) which promotes physical and mental changes which prepare us for either taking on a challenge or fleeing from a dangerous situation. Once the stress or danger has passed, these temporary changes subside.

Our ancestors were faced with very tangible threats to their safety, such as a wild animal or a hostile neighbour, so for them this *fight-flight* response was highly appropriate. The stresses which we face today tend to be more subtle: delays, ongoing domestic problems, deadlines, job loss. Nonetheless, we experience the same bodily, mental and behavioral changes as did our ancestors.

### **The bodily changes**

*. . . I felt a whoosh of adrenaline and my heart jumped into my throat. The hair on the back of my neck bristled, my body tensed . . .*

The bodily responses that we are likely to experience include heightened muscular tension, increased breathing rate, raised blood pressure, perspiration and digestive changes.

All of these reactions increase our readiness for action and explain many of the bodily sensations that we associate with anxiety, such as tense muscles, panting, racing heart, sweating, 'butterflies'. This is the ideal state for someone who has to react with a burst of energy: the athlete who is about to run an important race, for example. Without these physical changes, he would be sluggish rather than primed for action.

### **The psychological changes**

*. . . all I could think of was my son's safety. I had to get him to safety. I scooped him up and ran. I forgot his toys, I forgot the camera, I was so focused on the gate at the edge of the field and our escape . . .*

The psychological changes associated with stress include changes in the way we think, and sometimes in the way we feel, which, again, help us to cope under stress. When faced with danger or stress, our thinking becomes more focused and there can be an improvement in concentration and problem-solving. This is an ideal state of mind for anyone facing a serious challenge – a surgeon carrying out an operation, a stockbroker making a swift decision about an investment, a parent restraining a child who is about to walk into the road. Without the stress response their reactions might be too careless.

We can also experience a range of emotional responses to stress, such as increased irritability or even a sense of well-being. Imagine the stressed father becoming short-tempered with his children, or the executive who becomes

exhilarated as she gets closer to meeting her stressful deadlines, or the excited teenager watching a horror film.

### **The behavioral changes**

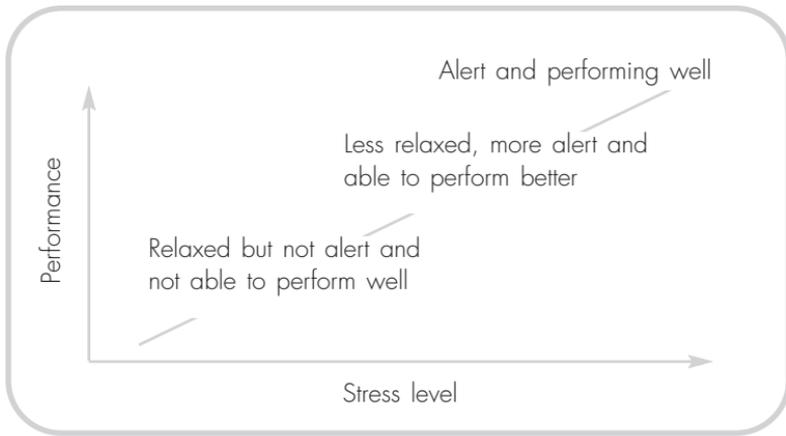
*. . . I don't know where the energy came from but I found the strength to carry him and I was able to get to the gate before the bull reached us . . .*

The behavioral responses to stress or danger are usually forms of escape or vigilance (i.e. flight or fight). If I see a tree branch falling towards me, I get a burst of energy and jump out of the way in order to escape. If I am driving and go into a skid, I become particularly determined to correct this and I find the strength to hold on to the steering wheel. Again, these are vital reactions: without such changes in behavior I would find myself trapped under a branch or caught up in an uncontrolled skid.

Thus, the bodily, mental and behavioral responses to stress are normal, helpful and often vital; and, up to a point, our ability to cope with stress improves as we undergo more stress. This is shown in Figure 1.1. At the bottom of the curve, we are relaxed but physically and mentally ill-equipped to deal with danger because we are not primed for action when we are in this state. As our tension rises, our body and mind become increasingly able to confront stress.

### **Long-term stress**

*I used to be positive about myself and had energy and ideas, but I've lost all that since we started to go through*



**Figure 1.1** Stress and performance

*a crisis with the business. Now I really have to push myself to do routine things because I feel so tired and dull. Even when I do get things done, I get no enjoyment from it and so everything feels like a chore. It doesn't end there because I go home worrying about the business and about my performance. I can't get these things out of my mind so I don't even bother to try to be sociable any more. Sometimes I feel quite ill with it all and I haven't slept properly in months. I can't understand how I can push myself and not seem to get anywhere.'*

Clearly, the changes brought about in the stress response are helpful in the short term because they prepare our bodies for physical action and focus our minds on the immediate problem. However, they evolved as an immediate and temporary response to stress which was switched off as soon as the danger passed. Problems can arise if these

reactions are not switched off, that is, if the stress response becomes chronic or excessive. If this happens, we pass our peak and performance begins to deteriorate: see Figure 1.2, which illustrates the stress-performance curve.

### The bodily changes

The bodily sensations now become more unpleasant. The muscular tension, so important for fight and flight, can develop into muscular discomfort throughout the body. This might be experienced as headaches; difficulty in swallowing; shoulder, neck and chest pain; stomach cramps; trembling and weak legs. With prolonged or extreme stress, a person can become aware of the heart pounding and, as blood pressure rises, begin to experience light-headedness, blurred vision, ringing in the ears. As breathing rate increases one might feel dizzy, nauseous and short of breath. If the digestive system is affected by prolonged stress, sickness, diarrhoea and stomach pain can result. Finally, sweating

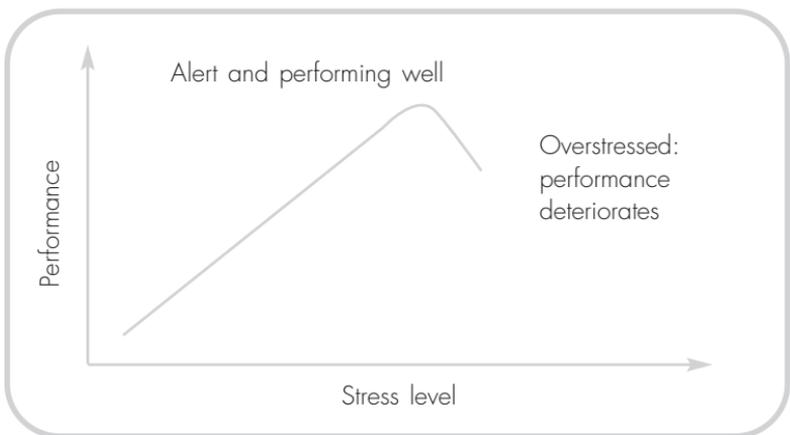


Figure 1.2 The stress-performance curve

can become excessive and, although this is not harmful, it can cause embarrassment.

### **The psychological changes**

The psychological reactions, if sustained, cause thinking to become far too focused on worrying so that a person always fears the worst, worrying that a problem is insoluble and generally thinking negatively. Such negative thinking can form a vicious cycle with the bodily changes during stress if physiological reactions trigger worries such as: 'Pains in my chest. There's something wrong with my heart!' or 'This feeling is unbearable and there's nothing I can do about it.' This will keep stress levels high and prolong the physical discomfort and, therefore, the worrying.

The emotional changes which can occur because of ongoing worry and anxiety are typically those of irritability, constant fearfulness and demoralization. When any of us is feeling like this we find it much more difficult to cope with stress, and when our coping resources are low the stress is much more likely to get on top of us.

### **The behavioral changes**

The changes in behavior, if persistent, can also give rise to difficulties. Constant fidgeting and rushing around becomes exhausting, making one tired and less able to handle stress. Increased comfort eating, smoking or drinking can cause physical and mental problems and take a toll on one's health and sense of well-being. The most common response to fear

is running away, or avoiding the situation or object which triggers fear. However, the relief obtained from avoidance is often only temporary and leads to a loss of self-confidence so that the situation soon becomes even more difficult to face.

You can see that the response to stress can itself become distressing. This might be because the physical changes are alarming, or because the worrying and the emotional changes impair one's ability to cope, or because a loss of self-confidence makes it difficult to face fears and overcome them. Whatever the reason, when the natural stress response causes more distress, a cycle has been created which is difficult to



**Figure 1.3** The stress–distress cycle

control (see Figure 1.3). This cycle, which maintains the stress response after it has been triggered, is the common factor in all forms of *problem* worry, fear and anxiety.

### What triggers the stress response?

The actual trigger for the stress response might be a real or an imagined threat. For example, a man with a snake

phobia would experience distress on seeing a real snake or on coming across a picture of a snake. He would have the same response if he *believed* that he had seen a snake or if he *believed* that he was likely to come into contact with a snake in a zoo, for example. A woman who was fearful of public speaking would feel panicky as she stood to give a speech at a wedding, but she might feel just as afraid if she *believed* that she would be asked to stand up and speak without warning.

Whatever the trigger, the keys to persistent problems are the *maintaining cycles* of worry, fear and anxiety. These will be explored in the next chapter.