# Stress Management for Everyday Life

THE TALKING THERAPIES UK SELF-HELP SERIES



# Stress Management for Everyday Life

An eight-module programme for understanding stress, reducing its grip on the body and mind, and building a sustainable way of living that absorbs pressure without breaking under it

A self-help workbook · 8 modules · about 8 weeks

**TALKING THERAPIES UK**

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

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First edition, 2026.

This workbook accompanies the Stress Management for Everyday Life programme on the Talking Therapies UK self-help platform. Its text is drawn from the programme and is kept current with it: whenever the programme changes, the workbook is set again.

Revision 11. This printing was set on 15 November 2026 from the programme as it stood that day.

A note on using this workbook. It offers self-help based on established psychological approaches for difficulties of mild to moderate severity. It is not a substitute for assessment or treatment by a qualified professional and is not designed for use in a crisis. The examples in it are fictional; no real person appears in them. If you are worried about your safety, or your difficulties are getting worse, the page headed “When self-help is not enough” says where to turn.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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# How to use this workbook

Stress is part of being a person in a busy life, not a sign that anything has gone wrong with you. The problem is when the pressure does not let up, when the body is running on adrenaline for weeks at a time, when sleep stops being restorative, and when the small irritations of an ordinary day start landing harder than they should. The result is the recognisable pattern of modern chronic stress: physical tension, irritability or low mood that fluctuates with workload, difficulty switching off, sleep that is unrefreshing, and a sense of running closer to capacity than feels sustainable. This eight-module programme works with the practical reality of modern stress rather than the clinical caricature. It explains what stress actually is at the level of the nervous system, helps you map your own specific pattern of stressors and responses, gives you concrete tools that work on the body and on the mind, and ends with a personalised plan you carry forward into the rest of your life. The approach is grounded in the cognitive-behavioural and stress-management research and is suitable for self-directed work at NHS Talking Therapies Step 2 equivalent. Understanding the stress response. The body's stress response is not a defect, it is a precisely engineered short-term performance system. The problem in chronic stress is not that the system fires, but that it stays on for weeks and months at a time without the recovery periods it was designed to alternate with. The first modules cover what the autonomic nervous system is actually doing during a stress response, why the symptoms feel the way they feel, and what 'recovery' means in physiological rather than abstract terms. Mapping your own stress pattern. Chronic stress is not a single thing. Some people are dealing primarily with high-volume cognitive load that does not get resolved by sleep or weekends; others have a smaller volume of more emotionally charged stressors that the system has not adapted to; others have stressors with no clear endpoint, where the stress is about the absence of a foreseeable resolution. The work matches your specific pattern rather than applying a generic template. You build a stress map that identifies your main load sources, your usual response patterns, your recovery resources, and your warning signs that the system is approaching overload. Body-side tools. A substantial part of the programme is dedicated to body-level stress regulation, because cognitive techniques applied to a heavily activated nervous system tend not to take. Paced breathing, progressive muscle relaxation, the deliberate use of brief recovery periods through the day, sleep hygiene, the role of movement, and the often-overlooked importance of where your attention is resting when you are not actively working. These are not relaxation techniques in the meditation-app sense; they are nervous-system interventions calibrated for someone who is currently spending too long in sympathetic activation. Cognitive tools. Some stressors are amplified by cognitive patterns that turn ordinary pressures into existential ones: the should-and-must thinking that converts a tight deadline into an identity threat, the all-or-nothing patterns that turn a single difficult interaction into a referendum on the whole relationship, the catastrophising that runs ahead of the actual evidence. The cognitive modules teach you to identify these patterns as they happen and apply the same evidence-testing approach used in CBT for depression and anxiety, calibrated specifically for stress-related thinking rather than mood-related thinking. Boundaries, demands, and saying no. For many adults the structural driver of chronic stress is not the absolute volume of demands but the difficulty saying no, delegating, postponing, or declining. The programme covers the practical communication skills for managing demands, including specific scripts for the

conversations that have to happen with managers, colleagues, family, and friends when stress has crossed into territory that requires changes to the surrounding environment rather than just internal coping. The maintenance plan. The final module is a personalised stress maintenance plan: the early warning signs that your stress is creeping back towards overload, the specific recovery actions that work for you at each level of intensity, the structural changes you have identified as necessary, and the conditions under which stepping up to therapist-led care or medical input is the right move. Who this is for and what it is not. The programme is suitable for adults experiencing chronic stress, work-related burnout in its earlier stages, or persistent low-grade overload that has started affecting sleep, mood, or relationships. It is not a substitute for individual therapy where stress sits alongside more serious mental-health symptoms such as moderate-to-severe depression, an anxiety disorder, or post-traumatic stress; the final module covers when and how to step up to clinician-led care. If you are in crisis, please contact Samaritans on 116 123, text SHOUT to 85258, or NHS 111 option 2.

This workbook is the written form of the Stress Management for Everyday Life programme on the Talking Therapies UK self-help platform. It follows the programme module by module: each part of the book is one module, and each chapter is one piece of the module's teaching, set in the order the programme presents it.

Read the chapters of a part in order, then turn to the worksheets that follow them. The worksheets are the part of the work that changes things, so give them the time they ask for and come back to them as the weeks go on. You may copy or print the worksheets for your own use, as often as you need.

Most people work through one module a week, which takes the whole programme about 8 weeks. Go at the pace that suits you: a module done properly is worth more than two done quickly.

The check-in questionnaires let you see how things are changing. Complete each one when you reach it, note the date and your total, and compare it with the last.

### When self-help is not enough

- If you are in danger now, or have seriously harmed yourself, call 999 or go to your nearest accident and emergency department.
- If you need help urgently but it is not an emergency, call NHS 111 or contact your GP surgery.
- Samaritans are there day and night, every day of the year: call 116 123 free from any phone.
- If you would rather not talk, text SHOUT to 85258 for free, confidential support at any hour.
- If your difficulties are getting worse as you work through this book, or you find yourself thinking about ending your life, stop and speak to your GP or a mental health professional. A workbook can be a good start, and some difficulties need more help than a book can give.

### What this workbook will help you to do

- By the end of this module you will:
- Understand stress as an evolved response system rather than a personal weakness
- Know the difference between acute stress, chronic stress, and burnout
- Have a working sense of allostatic load and why prolonged stress costs the body

- Have set three goals for what you want this programme to change
- Have a complete inventory of the stressors currently active in your life
- Understand the distinction between internal and external stressors and between controllable and uncontrollable ones
- Know which stressors are amenable to direct intervention and which need a different kind of response
- Have prioritised two or three stressors as the focus of the rest of the programme
- Recognise the somatic signs that stress is active in your body, before they become symptoms

PART 1

# Understanding Stress

*What stress actually is, why it exists, and the difference between pressure that helps and pressure that harms*

CHAPTER 1

## Welcome to the programme

This is an eight-module programme for understanding stress and learning to live with it more skilfully. The phrase managing stress is everywhere, but the underlying message is often unhelpful. It implies that stress is a personal failing, that other people seem to handle pressure better than you, and that if you would just be more disciplined or more meditative or more resilient the problem would resolve itself. None of that fits the actual research on stress, and none of it fits the experience of most people who feel they are running too hot for too long.

The programme starts from a different premise. Stress is what the human body does when it perceives a demand that exceeds the resources currently available. The response is biologically ancient, finely tuned, and largely automatic. Your stress system is not faulty. It is doing the job it was designed to do, in a modern environment that often presents demands the system was not designed for. Long-running deadlines, financial uncertainty, family responsibilities that overlap with work, the constant low-level pressure of always being reachable, the cumulative weight of small daily decisions that never resolve into rest, all of these activate the same system that evolved to deal with predators and short-term threats to survival. The system was never meant to run for years. The cost of running it for years is what we call chronic stress, and the cost is real.

This first module sets out what stress is, what it is not, and why the difference matters for what you do next. Modules two and three move into the practical work of mapping your own pattern of stressors and noticing what stress is doing to your body. Modules four through seven introduce the cognitive, behavioural, lifestyle, and recovery skills that make a measurable difference. Module eight closes by helping you build a personal stress-management plan that you carry forward. By the end you will have both a clearer understanding of what is happening when you feel overwhelmed and a working set of tools for changing the picture.

A note on what this programme is not. It is a self-directed step-2 programme, similar in scope to those offered by NHS Talking Therapies, and is designed for stress that is interfering with daily life but has not yet tipped into a clinical mental-health condition that needs individual therapy. If your stress is bound up with serious depression, severe anxiety, post-traumatic symptoms, or thoughts of self-harm, the programme can still be useful, but it should sit alongside a conversation with

your GP or with one of our therapists rather than instead of one. The final module covers when and how to step up.

CHAPTER 2

# What stress is, in physiological terms

The stress response is what your body does when a part of the brain called the amygdala detects a threat or demand and signals the rest of the system to mobilise. Within seconds, the sympathetic nervous system fires, adrenaline floods the bloodstream, the heart speeds up, breathing quickens, blood is redirected from the digestive system to the large muscles, the pupils dilate, the immune system shifts, and a cascade of hormonal changes prepares the body for fight, flight, or freeze. This is the acute stress response, and it is wonderfully effective when there is a short-term challenge to handle.

About fifteen minutes after the initial activation, a slower system called the HPA axis releases cortisol. Cortisol is the body's longer-acting stress hormone. It mobilises energy, suppresses functions that are not immediately needed, and sustains the alertness the system needs to handle the demand. In a healthy stress cycle, the demand is met, the system stands down, cortisol returns to baseline, and the body recovers. The cycle is normal, useful, and not harmful in itself.

What causes problems is when the cycle does not complete. The deadline is met but the next deadline arrives the same day. The argument with the partner ends but the underlying tension never resolves. The work week finishes but the weekend brings its own demands. The body never gets the signal to stand down, cortisol stays elevated, and the system that was designed for short bursts of high demand is now running on a continuous low simmer. This is chronic stress, and over months and years it has measurable effects on cardiovascular function, immune competence, sleep architecture, digestion, cognition, and mood.

The technical name for the cumulative wear-and-tear of running the stress system longer than it was designed for is allostatic load. The concept matters because it explains why people who are technically not in crisis at any single moment can nevertheless be deeply unwell. The damage is not from any one stressful event; it is from the absence of recovery between events. People with high allostatic load develop more illnesses, recover from them more slowly, sleep less restoratively, and find their threshold for distress drops over time. The smaller stressors that they would have shrugged off two years ago start to land harder, which itself feels like evidence that they are weakening, when in fact it is evidence that the underlying system has been under-recovered for too long.

A woman in her forties is a senior manager at a public-sector organisation. Her week looks like this. Monday begins at half past six with a difficult conversation about her son's school refusal that runs into her commute. By the time she arrives at her office her cortisol is already elevated. The first meeting of the day is at nine; it concerns a budget shortfall that has been running for three months and has no clear resolution. The meeting ends at half past ten with no decision and another meeting scheduled for Thursday. She spends the rest of the morning catching up on emails that arrived during the meeting. Lunch is eaten at her desk. The afternoon contains four further meetings, none of which closes the loop on anything. By six she is on the train home; the train is delayed. By seven she is making dinner. By half past nine, having helped her son with homework and answered a work email she had been carrying since lunchtime, she sits down for

the first time. She is asleep on the sofa within twenty minutes.

The pattern repeats Tuesday, Wednesday, and Thursday. Friday brings a small victory at work that is real but does not produce the felt sense of accomplishment a similar victory would have produced eighteen months earlier. The weekend is taken up by a family commitment on Saturday and her son's appointment with the educational psychologist on the Sunday. By Monday morning she is starting the next week from approximately the same physiological state she ended the previous one in. The cycle has not completed at any point across seven days.

Her doctor measures her resting heart rate at sixty-eight in autumn; eighteen months earlier it had been fifty-eight. Her morning cortisol is elevated. She has not slept through the night for some months. She would not, if asked, describe herself as being in any acute crisis. What she has, by any clinical measure, is high allostatic load, which is the predictable consequence of running the stress system continuously for a substantial period without recovery. The skills the rest of this programme covers are about restoring the recovery, not about eliminating the demand; the demand is mostly real, and most of it cannot be wished away.

**A NOTE**

*Stress is not a personal failing. It is the body's adaptive response to demand. The problem is not that you have a stress response; the problem is that, in a modern life, the response often does not get to complete. The skills in this programme are about helping the cycle complete more often, so the system can return to baseline and the body can recover.*

CHAPTER 3

# Eustress, distress, and burnout

Not all stress is harmful, and one of the more useful distinctions in the stress literature is between eustress and distress.

Eustress is the kind of pressure that mobilises you, focuses your attention, and produces effort that ends in completion and a felt sense of accomplishment. Preparing for an exam you are likely to pass. Standing up to give a presentation you have rehearsed. Pushing through the last mile of a run that ends with a shower and a meal. The body's stress response is fully engaged, but the demand is finite, the resources are sufficient, and the cycle completes.

Distress is the kind of pressure where the demand exceeds the resources, where there is no clear finish line, or where the cycle keeps re-opening before the previous one has closed. Carrying a workload that has been impossible for months and looks impossible for the next several. Caring for an unwell relative whose needs change unpredictably. Working in an environment where the threat of redundancy never fully goes away. The body's stress response is engaged, but the demand outlasts the system's tolerance for being engaged, and the cycle never properly completes.

The same physiological response sits underneath both, but the long-term consequences are different. People who experience eustress regularly tend to thrive on it; the demand-completion-recovery cycle is itself stimulating and develops capacity. People who experience distress for months at a time accumulate allostatic load, lose sleep quality, lose the felt sense of competence, and slide gradually towards burnout.

Two architects work at the same practice, on the same floor, on the same kind of project. Both are running an active scheme that will take eighteen months to complete; both have full diaries; both work hours that are at the upper end of what is reasonable.

The first is in eustress. The scheme is one she pitched for and was given. The team is well-resourced, the client is engaged, the design questions are difficult in the way she finds energising. She works hard. The week ends and she goes for a long Saturday walk that she can feel undoing the tension she has accumulated. By Monday morning the system has reset. Three months in, she is sleeping well, has more energy for her partner in the evenings, and has the felt sense that the project is moving the way it should be moving. Her stress system is busy; it is also completing its cycles.

The second is in distress. The scheme was assigned to him because two more senior colleagues were unavailable. He has reservations about the design direction that he has not been able to get heard. The client is exacting in ways that require constant managing. The team has been quietly understaffed since a colleague went on extended leave in spring. He works hard. The week ends and he carries a felt sense of the project into the weekend; Saturdays are spent thinking about it; the Sunday-evening dread starts at four in the afternoon. By Monday morning the system has not reset; it has merely been ignored for a day and a half. Three months in, he is sleeping less well, is shorter with his partner in the evenings, and has the felt sense that the project is moving the way it

should not be moving. His stress system is busy; it is not completing its cycles.

The objective workload is similar. The physiological response is the same. The trajectory across eighteen months will diverge substantially, and the difference traces to whether the cycle is closing or not closing, not to any difference in resilience or character between the two people.

### Burnout, in clinical terms

Burnout is the end stage of unrelenting distress, particularly distress associated with work or caring roles. The World Health Organization recognises it as an occupational phenomenon characterised by three components: emotional exhaustion (feeling depleted, drained, unable to summon energy for ordinary demands), depersonalisation or cynicism (feeling detached from the work, the people you work with, or the people you care for, often in a way that feels uncharacteristic), and reduced sense of personal accomplishment (a creeping sense that your work no longer matters or that you are no longer effective at it).

Burnout is not the same as depression, although the two often overlap. Burnout is specifically tied to a domain (usually work or caring); depression is more pervasive and affects most areas of life. Burnout typically lifts when the underlying demand reduces or is restructured; depression typically does not. The distinction matters because the response to each is different. Burnout responds to changes in workload, role, recovery, and boundaries. Depression typically needs more substantial intervention, often including individual therapy and sometimes medication.

A consultant nurse in her early fifties has been in a senior role at a busy hospital trust for the past nine years. She is good at her work and is widely respected. Across the previous winter, two consecutive periods of severe staff shortage and a particularly difficult succession of cases have pushed her past a threshold she had not known was there. By spring, the three components of burnout are clearly present in her.

The first is emotional exhaustion. She wakes tired regardless of how long she has slept. She finds it harder to summon energy for ordinary requests than she used to. Coming home from a normal shift she cannot tolerate any further demand from family or household; she retreats to her bedroom and reads on her phone for an hour, not because she particularly wants to but because she has nothing left.

The second is depersonalisation, in the specific clinical sense: she has become detached from the patients and from the team in a way that is uncharacteristic. The compassion that has been the centre of her professional identity is still there but feels distant, as if she is watching herself care for the patients rather than caring for them. She is sharper with junior colleagues than she used to be. She catches herself wishing certain patients would be discharged faster so she does not have to spend more time with them, and this catches her with a felt sense of horror, because the wish does not match who she understands herself to be.

The third is reduced sense of personal accomplishment. The work that she has known to be meaningful for nine years has started to feel pointless. The same actions that previously felt like genuine clinical contribution now feel like tasks completed on a list. She cannot summon the sense that what she does matters, even when, by every external measure, it continues to matter.

She is not depressed. Her relationships outside work are still warm, although stretched. Her

interests outside work are still there, although she has less energy for them. The picture is specifically tied to the work, and the trajectory across the spring (worsening as the work continues, briefly lifting after a week's leave at Easter, returning shortly after she comes back) is recognisable as occupational burnout rather than as something more pervasive. The response her own GP and her supervisor agree on is targeted: reduced clinical sessions for three months, a shift in her on-call rota, a formal piece of caseload review, and a return to the supervision she had let slip the previous year. The skills the rest of this self-help programme cover sit alongside that targeted response.

This programme is designed for stress and the early stages of burnout. If you are already at the depleted end of the spectrum, the skills here will still help, but they may need to be combined with other support. Module eight covers how to assess where you are and what to do next.

**A NOTE**

*A useful question for the start. Are you under pressure that you can foresee an end to (eustress, with completion in sight), or are you under pressure that has no clear horizon (distress, with the cycle not completing)? The honest answer to that question changes the kind of work the rest of this programme has to do for you.*

**WORKSHEET**

## Sort each situation into the stress category it represents

Before setting your personal goals, sort twelve work-and-life situations by which of the three categories on the eustress-distress-burnout continuum each one represents. The exercise sharpens the distinction so that you can read more accurately where you yourself are sitting, which is the foundation for the goals you will set in the next exercise.

Eustress is finite pressure with completion in sight; the demand is real, the resources are sufficient, the cycle closes with recovery. Distress is pressure that has no clear horizon or that runs while the cycle never properly completes; the demand outlasts the system's tolerance for being engaged. Burnout is the end-stage of unrelenting distress and shows up as three components: emotional exhaustion, depersonalisation or cynicism, and reduced sense of personal accomplishment.

**The groups: A Eustress (mobilising, finite, completes) B Distress (cycle does not complete) C Burnout (end-stage depletion)**

Write the letter of the group each item belongs to in its box.

☐ 1. Preparing for an exam I have studied properly for, putting in three intensive evenings of revision, sitting it on Friday, and being out for a long Saturday walk by lunchtime

☐ 2. Carrying a workload that has been impossible for four months, with no visible plan for resolution and no recovery space between the end of one demand and the start of the next

☐ 3. Waking tired regardless of how long I have slept, finding that ordinary household requests after work feel like more than I can manage, retreating to my room each evening because I have nothing left

- [ ] 4. Pushing through the final mile of a half-marathon I have trained for, finishing in the time I had hoped for, eating well that evening, and being recovered by the following morning
- [ ] 5. Caring for an unwell relative whose needs change unpredictably, with no end point in sight, and with the felt sense that the cycle of demand has not closed in months
- [ ] 6. The compassion that has been the centre of my professional identity is still there but feels distant, as if I am watching myself care for the patients rather than caring for them
- [ ] 7. Standing up to give the presentation I have rehearsed, feeling the activation before it begins, delivering it well, and going for a coffee with the team afterwards in a noticeably different state
- [ ] 8. Working in an environment where the threat of redundancy never fully goes away, with the consequence that the body never settles fully into recovery even on weekends
- [ ] 9. The work that has been meaningful to me for nine years feels pointless; the same actions that previously felt like genuine contribution now feel like tasks completed on a list
- [ ] 10. Running an active eighteen-month project that I pitched for and was given, with a well-resourced team, an engaged client, and Sunday evenings that feel calm by the time the walk has finished
- [ ] 11. Running an eighteen-month project that I was assigned because more senior colleagues were unavailable, with weekends spent thinking about it and Sunday-evening dread starting at four in the afternoon
- [ ] 12. Catching myself wishing certain patients would be discharged faster so I do not have to spend more time with them, and feeling a quiet horror at the wish because it does not match who I understand myself to be

The answers are at the back of the book.

**WORKSHEET**

## Set three goals for the programme

Before going further, take fifteen minutes to set three concrete goals for what you want this programme to change. The goals should be specific enough that you would know whether you had achieved them. Vague goals like ‘feel less stressed’ are hard to measure and tend to drift. Specific goals like ‘sleep through the night four times a week’ or ‘leave the office by 6 pm three days out of five’ are workable.

Set three goals. The good ones are specific, observable, time-bounded, and within your influence. They do not have to be ambitious; small concrete goals that you actually achieve build momentum better than large abstract ones that drift.

**Goal 1**

**How I will know I am making progress on Goal 1**

**Goal 2**

**How I will know I am making progress on Goal 2**

**Goal 3**

**How I will know I am making progress on Goal 3**

CHAPTER 4

# Closing Module 1

You have a working understanding of what stress is, why it evolved, and what happens when the system is asked to run continuously rather than in completable bursts. You have three concrete goals for what this programme should change.

## Looking ahead

Module 2 maps the specific stressors in your own life. The map is the foundation for everything later modules will do; you cannot reduce stressors you have not first identified clearly. The exercise in Module 2 is an honest stock-take rather than a problem-solving session, and is most useful if you give yourself permission to be specific about what is actually pressing on you, rather than what you feel you should be coping with already.

## Practice for the week ahead

Notice, across the next several days, the moments where you feel the stress response activating. The point is not to do anything about them yet; the point is to start building the awareness that the rest of the programme will work with. The body is a more reliable reporter of stress than the mind in most people; the physical signs (jaw tension, shallow breathing, restless sleep, the felt sense of being braced) often arrive before the verbal recognition that something is wrong.

CHECK-IN

## Mood check-in (PHQ-9)

Before you begin, take a few minutes to complete this short questionnaire. It is the same one used in NHS Talking Therapies and gives us a baseline against which to measure your progress over the programme.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

| | Not at all (0) | Several days (1) | More than half the days (2) | Nearly every day (3) |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |

| | | | | |
|---|---|---|---|---|
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**Total: _____ Date: _____**

*Add up the numbers you have circled. A total of 0 to 4 suggests minimal symptoms of depression, 5 to 9 mild, 10 to 14 moderate, 15 to 19 moderately severe and 20 to 27 severe. Note your total and the date, so you can compare the next check-in with this one.*

*If you circled anything other than 0 for the last question, please talk to your GP or call NHS 111 today. If you are in danger now, call 999.*

*The PHQ-9 and GAD-7 were developed by Drs Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission is required to reproduce, translate, display or distribute them.*

CHECK-IN

## Everyday life check-in (WSAS)

And one more short questionnaire about how things are affecting everyday life: work, home, social life, relationships and leisure. Functioning often recovers on a different timetable to symptoms, and it matters just as much.

*This check-in uses the WSAS (Work and Social Adjustment Scale). If you are using the online programme, complete it there, where your scores are kept and compared for you. If you are working from this book alone, your GP or therapist can give you a copy.*

WORKSHEET

## Taking this forward

Before you move on, take two minutes to make this module harder to lose. Skills fade fastest in exactly the moments they are needed most, so the work here is to decide now, while things are steady, what you will reach for when they are not.

If things ever feel much worse rather than better, that is a signal to reach out rather than push on alone: use the messaging button to contact the practice, speak to your GP, or if you feel unsafe right now contact 999 or the Samaritans on 116 123.

**Three short answers, in your own words. First: what single idea or skill from this module do you most want to keep? Second: when, realistically, will it be hardest to use, name the actual situation. Third: what exactly will you do in that moment? Write it as a sentence you could follow when stressed.**

PART 2

# Identifying Your Stressors

*Mapping the specific pressures in your life and sorting them by what you can change*

CHAPTER 5

## You cannot reduce what you have not named

The most common pattern in chronic stress is that the person experiencing it can describe the felt sense of being overwhelmed but cannot easily list the specific pressures producing the feeling. The stress is generalised, ambient, and seems to come from everywhere at once. The mind reaches for a single explanation (work is too much, the family is exhausting, life is unfair) which is true at a level of abstraction but not actionable at the level of any specific change.

This module is the antidote to that pattern. The work is to take the diffuse felt sense of stress and break it down into the specific, namable pressures that are producing it. Some of these will be obvious. Some of them will turn out to be smaller than they felt when they were nameless. Some of them will turn out to be larger. The point is to get them on a list, in your own words, where they can be looked at one at a time.

The exercise is uncomfortable for some people because seeing the list written down can briefly intensify the felt sense of how much you are carrying. That intensification is normal and usually subsides within a day or two as the items become workable rather than amorphous. If the list at the end of this module looks longer than you expected, that is information; it is not evidence of weakness, it is evidence that your stress system has been doing more work than you have been giving it credit for.

CHAPTER 6

# A taxonomy of stressors

Stressors come in different kinds and the kind matters because the response to each is different. The taxonomy below is not academic; it is the working framework used by stress researchers and CBT clinicians, and the distinctions translate into very different practical responses.

## External versus internal

External stressors are pressures coming from outside you. Workload, deadlines, financial demands, family responsibilities, illness in someone you care for, traffic, noise, an unstable housing situation, a difficult relationship.

Internal stressors are pressures coming from how you are running yourself. Perfectionism, the inner critic, an inability to delegate, a tendency to over-commit, unrealistic standards, the felt obligation to keep everyone else comfortable, the rule that you should be able to handle this without help.

Most people in chronic stress are running both. The external pressures are real, and reducing them is part of the work. But internal pressures often amplify the external ones substantially. Two people facing the same workload can experience radically different stress levels depending on whether they hold themselves to a standard of good enough or to a standard of every possible deliverable must be excellent. Module four works specifically on internal pressures; this module aims to identify them clearly enough that you can tell them apart from the external ones.

A senior solicitor in his late forties is carrying an objectively heavy caseload: twelve active matters, three of which are complex and at difficult stages. The external pressure is real. He also operates by several internal rules that significantly amplify the felt experience of the workload.

The first rule is I must respond to every email within two hours. The rule has been in place for fifteen years. Across a normal working week he handles around four hundred emails. The rule adds, on a typical day, around ninety minutes of low-grade vigilance that has nothing to do with the actual work of the twelve matters and everything to do with the monitoring of an inbox.

The second rule is I must catch every error in any document I am responsible for before it leaves my hands. The rule produces multiple rereads of every draft. On a piece of work that would take three hours to do well, the rule typically adds another two hours of progressively diminishing-returns review.

The third rule is I must never appear under pressure to clients or junior colleagues. The rule means he never asks for an extension on a deadline even when an extension would be reasonable. It means he never asks a junior colleague to take a piece of work back when they have given it to him at a difficult moment. It means he never declines a new instruction even when his existing capacity is at its limit.

The external workload is one thing. The combination of the external workload with these three rules is something different and substantially harder. If he could carry the same twelve matters

under the rules I will respond to emails within twenty-four hours, I will review documents twice, and I will be straightforward about my capacity, the same twelve matters would produce a noticeably lower felt experience of stress. The work of stress management has to address both layers; reducing the caseload would help, and so would loosening the rules that have made every case substantially more taxing than it needs to be.

### Controllable versus uncontrollable

Controllable stressors are pressures you can directly influence. Whether you take on the extra project. Whether you have the difficult conversation with your manager. Whether you renegotiate the family's evening routine. Whether you stop saying yes to invitations you would rather decline.

Uncontrollable stressors are pressures you cannot directly influence. The economic situation. The fact that a loved one is unwell. The way your manager runs the team. The behaviour of someone you cannot change. Decisions made by other people that affect your life.

The mistake in stress management is to treat all stressors the same. Controllable stressors respond to problem-solving; you identify the pressure, work out an action that would reduce it, and take the action. Uncontrollable stressors do not respond to problem-solving; they require a different set of skills (acceptance, recovery, emotional support, sometimes professional help) which the later modules cover. People who try to problem-solve uncontrollable stressors generally fail at it and conclude that they themselves are inadequate, when in fact they were using the wrong tool. People who try to accept controllable stressors often end up tolerating things that could have been changed, which is its own kind of damage.

A woman in her thirties spends substantial time and energy across a year trying to problem-solve her father's deteriorating health. She researches treatment options. She reads on the conditions involved. She makes lists of practitioners to consult. She writes detailed messages to her siblings about coordinating care. She produces an action plan and updates it weekly. She is doing what she does best, which is to break a difficult situation down into addressable components and act on them.

The strategy mostly does not work, because the underlying situation is the gradual age-related decline of a man in his late eighties, and no amount of planning can change the direction of travel. By the end of the year she is exhausted in a particular way she has not previously experienced: not because she has done too little, but because she has been pouring effort into a problem that does not respond to effort.

Her own GP, in a routine appointment, names what is happening. The work she has been doing is the work that would solve a controllable problem; her father's decline is not a controllable problem. The skills the situation actually calls for are different: presence with him in the time that remains, acceptance of what cannot be changed, attention to her own grief as it is forming, support from others who can hold the weight with her. Reframing the situation as one calling for acceptance rather than for problem-solving does not lift the underlying difficulty. It does free her from the additional layer of strain she had been adding by trying to use the wrong tool, and it allows the energy she has been spending on the action plan to be redirected to the things that matter most across the remaining time.

### Acute versus chronic

Acute stressors are time-limited. The presentation next Tuesday. The medical procedure scheduled for next month. The house move planned for autumn. They have a beginning, a middle, and an end. They activate the stress response, but in a way the response was designed to handle.

Chronic stressors run for months or years. The job that is unsustainable. The caring responsibility that does not have an end point. The financial situation that does not improve. The relationship that has been deteriorating for two years. They activate the stress response continuously, and they are the main driver of allostatic load.

Many people in chronic stress have a long list of acute stressors stacked end-to-end with no recovery space between them. The objective experience is of one demand after another, but the underlying problem is not any single demand; it is the absence of recovery. Identifying chronic stressors as chronic, rather than as a long list of acute ones, often clarifies what the work actually has to be.

WORKSHEET

## Sort each stressor into the type it represents

Before doing your own stress audit, sort twelve stressors by which type each one represents. The three categories distinguish between stressors that respond to problem-solving (external and controllable), stressors that respond to acceptance and emotion-focused coping (external and uncontrollable), and stressors that respond to cognitive work on your own rules and standards (internal). Recognising which kind of stressor you are dealing with is what determines which response strategy will actually work.

External and controllable stressors come from outside you and you can directly influence them through action; they call for problem-solving. External and uncontrollable stressors come from outside you and you cannot directly influence them; they call for acceptance and emotion-focused coping. Internal stressors come from how you are running yourself (perfectionism, inner critic, over-commitment, unrealistic standards, the rule that you should be able to handle everything alone); they call for cognitive work to loosen the rules amplifying the external pressure.

**The groups: A External and controllable B External and uncontrollable C Internal (how I run myself)**

Write the letter of the group each item belongs to in its box.

- [ ] 1. Whether I take on the additional project that has just been offered to me, when my existing capacity is already at its upper limit
- [ ] 2. My father's gradual age-related decline, which no amount of planning, research, or appointment-making can change the direction of
- [ ] 3. My rule that I must respond to every email within two hours, which adds ninety minutes of low-grade vigilance to every working day
- [ ] 4. Whether I have the difficult conversation with my manager about the unworkable structure of the role I have been promoted into

- [ ] 5. The economic situation that has affected my employer's revenue and that is shaping the wider redundancy environment in my sector
- [ ] 6. My standard that every document I am responsible for must be reread four times before it leaves my hands, which adds two hours of diminishing-returns review to every drafting day
- [ ] 7. Whether I renegotiate the household evening routine that has been generating tension at predictable points every weekday for the past six months
- [ ] 8. The chronic illness of a close family member, the course of which is what it is regardless of how thoroughly I have researched the literature
- [ ] 9. My rule that I must never appear under pressure to clients or junior colleagues, which means I never ask for an extension or decline a new instruction even when both would be reasonable
- [ ] 10. Whether I stop accepting the social invitations I do not actually want to attend, which have accumulated to several per fortnight
- [ ] 11. The way my line manager runs the team, which I have no authority to change and which is not going to alter while she remains in the role
- [ ] 12. My felt obligation to keep everyone else comfortable in any room I am in, which adds a constant low-grade vigilance that has nothing to do with the actual work being done

The answers are at the back of the book.

WORKSHEET

## Stress audit

Take twenty to thirty minutes for this. The point is honesty rather than comprehensiveness; if a stressor is real for you, it counts, even if you feel you should be over it by now or that other people would not consider it stressful.

**## EXTERNAL STRESSORS List the pressures coming from outside you that are currently active. Work, family, financial, health, relational, environmental, anything that is putting demand on you that originates outside yourself. Work and professional life: Family and household: Finances: Health (yours or someone you care for): Relationships and social: Environmental (housing, commute, noise, location): Anything else external: —- ## INTERNAL STRESSORS List the pressures coming from how you run yourself. Standards, expectations, rules, habits. Standards I hold myself to that may be higher than necessary: Things I find hard to say no to: Tasks I struggle to delegate or share: Inner-critic patterns I notice (self-talk that adds pressure): Anything else internal: —- ## SORTING Look back at the list above and mark each item. Stressors I can directly influence (controllable): Stressors I cannot directly influence (uncontrollable): Stressors that have a clear endpoint (acute): Stressors that have been running for months or years (chronic): —- ## PRIORITY The two or three stressors that, if reduced, would make the biggest difference to my felt experience of life right now: Of those, which are controllable and which are not? One thing I notice from doing this audit that I had not seen clearly before:**

## The end of the sample

This is a free sample of “Stress Management for Everyday Life”, and it ends here.

Everything you have read here is from the opening of the book, set exactly as it is printed in it. The rest follows in the same way, chapter by chapter, with its worksheets, its examples and its reference list.

The full book is on sale in the Talking Therapies UK shop. A copy is yours to keep, as a PDF and an ebook, licensed to you by name: a short line saying so is printed at the foot of each page of the PDF and on the title page of the ebook.