If you believe in a one-to-one relationship between specific stressors and specific reactions, in personality dispositions that determine the effects of stressors, or in the inevitability of certain events producing stress, then read no further. If, one the other hand, you accept the stress-reducing effects of both successful behavioral experience and informed cognitive processing, then you will find merit in what follows. When considering stress, you will also agree “as I have often said” (the “I” here is Hans Selye), that “it is not what happens to you, but how you take it” (1979, p. 12).

Disproportionate levels of anxiety, tension, worry, apprehension, and general discomfort are often present in patients who are confronted with the potential physical dangers of stressful medical procedures. Some anxiety is legitimate, since the patient is suspected to have a disease (e.g., heart disease). In addition, certain medical assessment procedures are an essential part of proper medical care. Nevertheless, many of the procedures invade the person’s physical and psychological boundaries, often while the person is conscious and, at most, minimally sedated. Patients are typically ill-informed about the procedures to be undergone, unclear about the exact effects that the procedures will have on their health, inexperienced at carrying out tasks required during the actual
procedure, and concerned about both the probability of their death or the likelihood of their subsequent existence in some vegetable state. It is no wonder that the typical patient is not totally calm—the patient can reasonably be considered under stress.

The stressful nature of various medical procedures is further evidenced by the fact that many people who might possibly benefit from certain procedures maintain a pattern of avoidance. Even among those who present themselves for the procedures, many suffer such inordinate anxiety as to interfere with the complete and proper execution of the procedure. Still others suffer from residual distress following the completion of the medical procedures. As clinical psychologists and other behavioral scientists become increasingly involved in the psychology of medicine (e.g., behavioral medicine, medical psychology), the ever-present necessity of assisting these patients under stress becomes increasingly noteworthy.

The general purpose of the present chapter is to describe the cognitive-behavioral intervention strategies relevant for application with stressed medical patients. In so doing, we first examine two stressors that arise in the medical context: the stressful environments and the invasive medical procedures. The results of a survey of patients' self-reported stressors are also detailed. Research and theory bearing on the roles of cognitive and behavioral skills in stress prevention and management are examined. Several cognitive-behavioral intervention programs are described, with research findings demonstrating clinical efficacy. A description of the cognitive-behavioral intervention provides the groundwork for future research and application.

THE STRESSORS

Before considering qualities of the hospital environment and aspects of the medical intervention that are considered stressful, we must first recognize that certain characteristics of the psychologist may "stress" the patient, and that frictions within the hospital environment may in turn stress the psychologist.

Clinical psychologists, when in the environs of a mental health service delivery system, are often viewed by clients as helpers whose sensitivity, skill, and experience provide relief from psychological distress. In non-mental-health settings, such as a medical ward, clinical psychologists can be seen quite differently. Patients scheduled for examinations to assess the presence or severity of heart disease may well wonder to themselves why the hospital has sent a psychologist ("Do I look crazy to them?"). When patients are not yet experiencing psychological distress