CHAPTER 4

Generalized Anxiety Disorder

DESCRIPTION AND DIAGNOSIS

Generalized anxiety disorder (abbreviated GAD in the text of this chapter) has gained increasing attention during the last decade, as several theoretical models have been advanced to address its core cognitive feature—worry. GAD is generally a chronic condition, often preceding the onset of depression by several years. Many people with GAD appear to "normalize" their problem, describing themselves as "worriers" all their lives. They also hold an ambivalent view of their problem: They believe that they need to worry to be prepared, but at the same time they feel that their worry is causing them harm and that they need to stop worrying.

Symptoms

Persons who suffer from GAD exhibit extreme and/or chronic apprehensive worry, as well as related physical symptoms. These persons find it difficult to control their worry and complain of such problems as fatigue, restlessness, irritability, muscular tension, and insomnia. GAD is distinguished from other anxiety disorders in that individuals with GAD are worried about a variety of events, rather than specific stimuli or issues. Persons with panic disorder fear panic attacks; those with social anxiety disorder (social phobia) fear embarrassment in public; those with obsessive–compulsive disorder fear contamination or the consequences of not performing rituals. As in assessment of other anxiety disorders, the clinician assessing for GAD should rule out that the worry is due to a general medical condition or to use of/withdrawal from alcohol or drugs.

For a detailed description of the current diagnostic criteria for GAD, refer to DSM-IV-TR (American Psychiatric Association, 2000, pp. 472–476).

Prevalence and Life Course

Epidemiological studies indicate that lifetime prevalence of GAD varies between 5.8% and 9%, with greater risk for women (the male–female ratio is 2.5:1), young adults, and blacks (Blazer, George, & Winfield, 1991; Breslau & Davis, 1985; Kessler, Walters, & Wittchen, 2004). Patients presenting with GAD often claim that onset has been gradual and that they have been anxious since childhood; some studies indicate that the average duration of this problem prior to treat-

ment is 25 years (Butler, Fennell, Robson, & Gelder, 1991; Rapee, 1991) Because of its chronicity, its self-perpetuating quality, and often its lack of response to treatment, some clinicians and researchers view GAD as a lifelong illness (similar to diabetes or essential hypertension), while others view GAD as representing a personality disorder.

Genetic/Biological Factors

Although some estimates indicate that GAD may have a moderate heritability of 30%, other findings suggest lack of specificity of transmission (Hettema et al., 2001; Kendler et al., 1992; Weissman & Merikangas, 1986). GAD is associated with other specific traits, such as neuroticism, nervousness, depression, low frustration tolerance, and inhibition (Angst & Vollrath, 1991).

Coexisting Conditions

Most patients with GAD present with a variety of other diagnoses, including social anxiety disorder, specific phobia, depression, irritable bowel syndrome, and personality disorders (see Borkovec & Roemer, 1996; Brown & Barlow, 1992; Brown, Moras, Zinbarg, & Barlow, 1993; Hettema, Prescott, & Kendler, 2003; Sanderson & Wetzler, 1991; Tollefson et al., 1991). Up to 8.5% of patients seeing physicians for any medical reason have GAD, and 37% of patients with GAD suffer from irritable bowel syndrome (Roy-Byrne & Wagner, 2004; Tollefson, Tollefson, Pederson, Luxenberg, & Dunsmore, 1991). Ninety percent of individuals who develop GAD during their lifetimes also have another psychiatric condition, with 42% qualifying for a diagnosis of depression (Wittchen, Zhao, Kessler, & Eaton, 1994); there is an increased risk of suicidal behavior in GAD as well (Cougle, Keough, Riccardi, & Sachs-Ericsson, 2009). Agoraphobia, panic disorder, specific phobia, dysthymia, major depression, and mania predict later onset of GAD (Kessler et al., 2002). Close to 50% of patients with GAD have been found to qualify for a diagnosis of some personality disorder (Sanderson, Beck, & McGinn, 1994). The most common personality disorders associated with GAD are avoidant and dependent, although obsessive–compulsive personality disorder proved most common in one study (Nestadt, Romanoski, Samuels, Folstein, & McHugh, 1992). Recent threatening events and recent life stresses are associated with GAD, although its chronicity suggests that the *perception* of stress and threat may partly result from GAD (Blazer, Hughes, & George, 1987; Finlay-Jones & Brown, 1981). With increasing age (after 50), GAD tends to subside and is replaced in many cases by somatization concerns (Rubio & López-Ibor, 2007).

Differential Diagnosis

The nature of GAD is that the individual is worried about a number of things, not simply one or two. Consequently, GAD can be differentiated from specific phobia, in which patients fear a well-defined stimulus (e.g., animals). It is also to be distinguished from social anxiety disorder, in which patients are specifically worried about or avoid situations in which negative evaluation is expected. Furthermore, GAD can be distinguished from obsessive–compulsive disorder, panic disorder, other anxiety disorders, and disorders in other DSM categories. Anxiety may also result from a number of medical conditions (e.g., hyperthyroidism, hypoglycemia, adrenocortical tumor, HIV); when this is the case, the diagnosis should be anxiety disorder due to a general medical

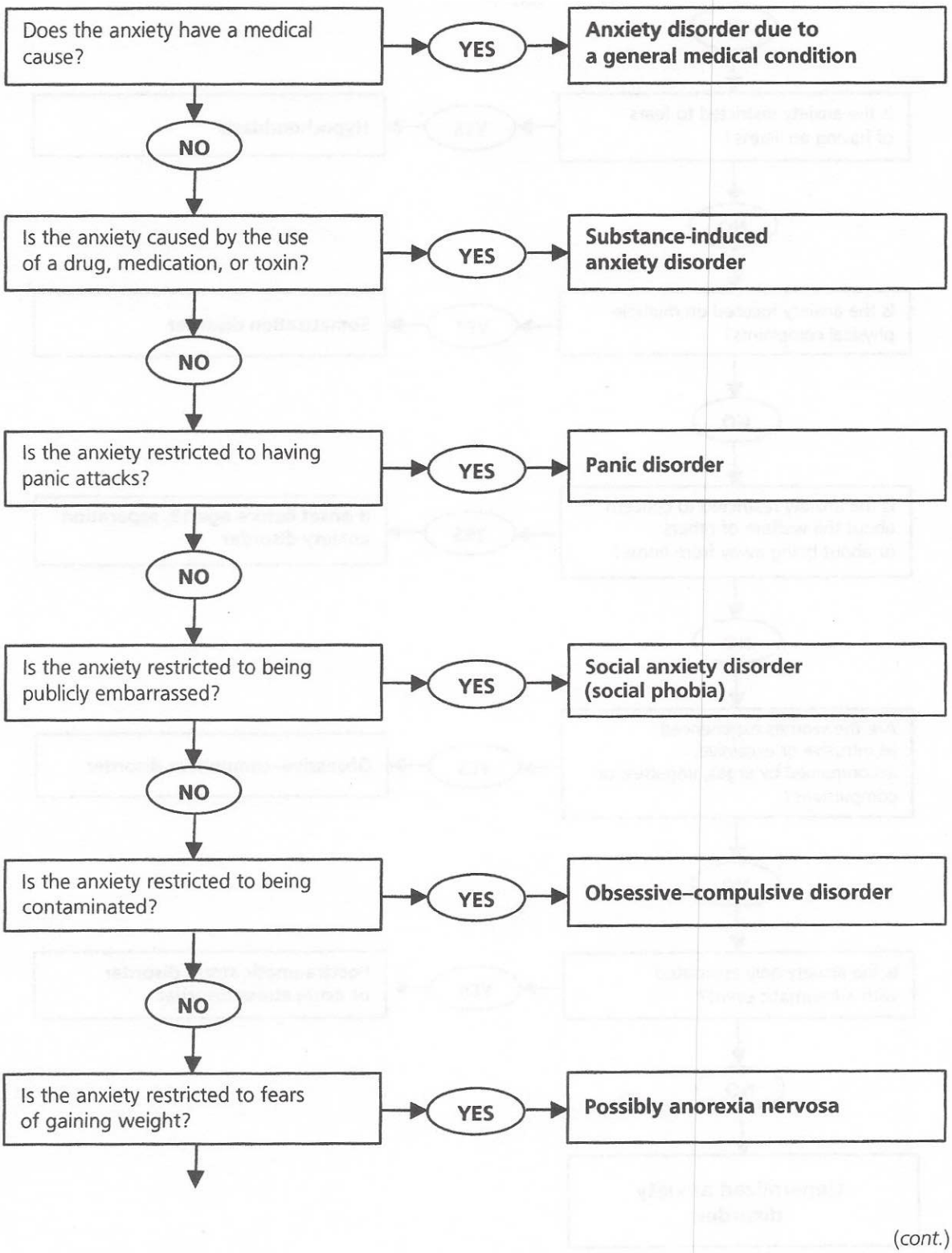

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FIGURE 4.1. Diagnostic flow chart for generalized anxiety disorder.

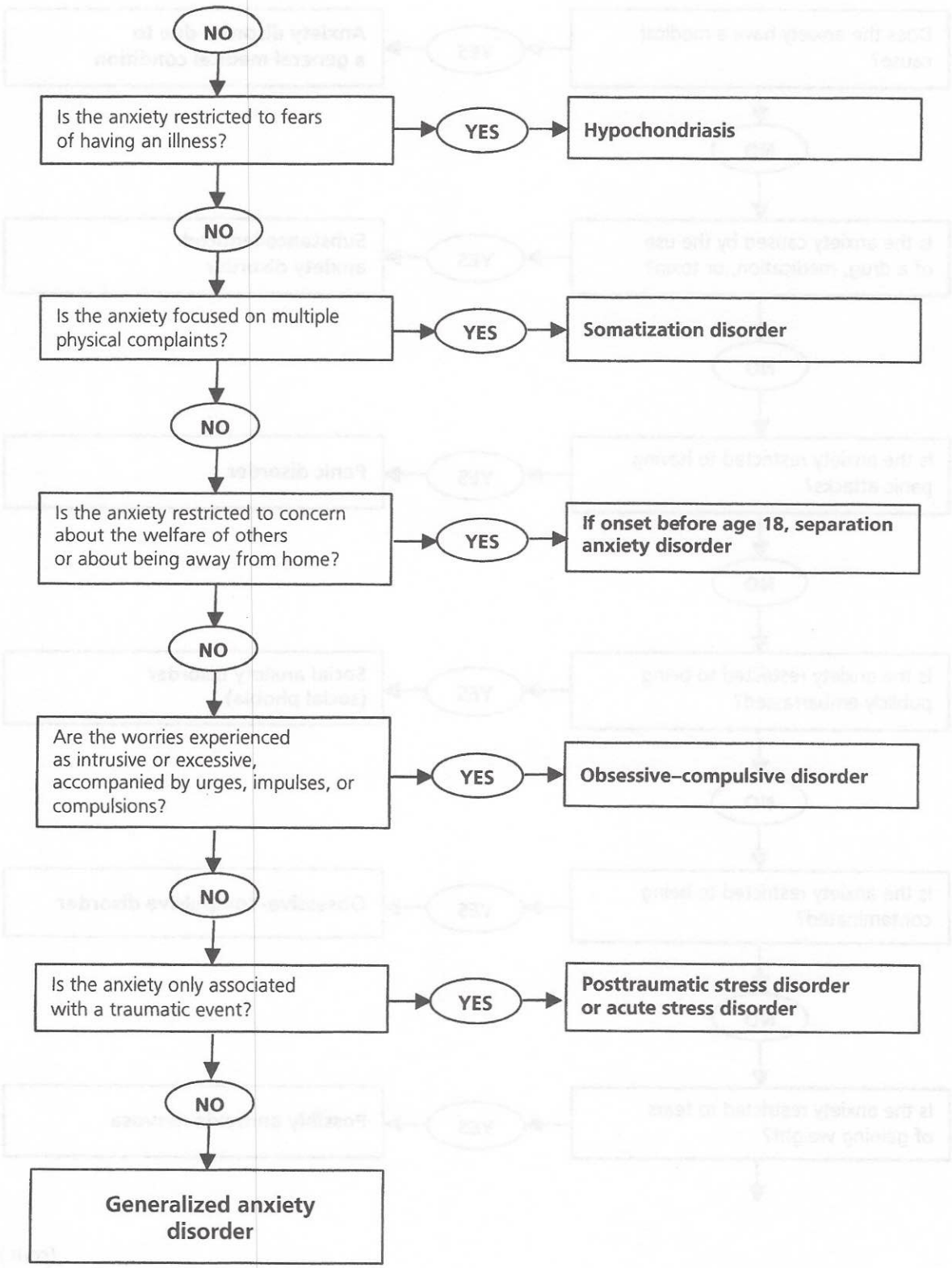

FIGURE 4.1 (*cont.*)

condition, and treatment of the medical condition should be the top priority. Finally, anxiety often results from the use of or withdrawal from certain substances (e.g., anxiolytics, alcohol), and this anxiety is also to be distinguished from GAD. Figure 4.1 is a diagnostic flow chart that provides more details about differential diagnosis of GAD.

UNDERSTANDING GENERALIZED ANXIETY DISORDER IN COGNITIVE-BEHAVIORAL TERMS

Several cognitive-behavioral conceptualizations of GAD are of value to the clinician. In this section, we first discuss behavioral models, emphasizing conditioned anxiety, and cognitive models, emphasizing information processing and appraisal of stress. We then discuss several models that combine cognitive and behavioral elements. Interpersonal models have been incorporated within cognitive-behavioral approaches or used in addition to them.

Behavioral Factors

Wolpe (1990) proposed that a neutral stimulus becomes conditioned to an unconditioned fear-arousing stimulus, leading to the acquisition of fear. His model of reciprocal inhibition proposes that fear may be "unlearned" by pairing the feared stimulus or response with a response that is incompatible with fear, such as relaxation, assertiveness, or sexual arousal. Other models of fear reduction include extinction, habituation, exposure, changes in expectancy, and self-efficacy. As described in Chapter 9 of this volume and the accompanying CD-ROM, a clinician may use various behavioral techniques: construction of fear hierarchies (noting subjective units of distress or SUDs); planned exposure to feared situations, images, or ideas; pairing of relaxation with the feared stimulus; guided imagery paired with relaxation (i.e., self-directed desensitization); modeling; vicarious reinforcement (and punishment); assertiveness training; self-efficacy training; problem-solving training; and a variety of others. Since avoidance is a central feature of GAD, identifying the experiences that are avoided and increasing exposure or direct coping with those experiences will be an essential component of treatment.

Cognitive Factors

According to Aaron T. Beck and his colleagues, anxiety responses had adaptive value in the evolution of the human species. Anxiety responses, such as mobilization, inhibition, and demobilization, reflect active defense, avoidance of risky behavior, and collapse, respectively, which were protective in the face of threat (Beck & Emery with Greenberg, 1985, 2005). Active defense, involving hypervigilance, sensitivity to sound, and increased heart rate, may assist an individual in either flight or fight. Inhibitory responses, such as blocking of thinking, clouding of consciousness, and muscle rigidity, prevent the individual from taking unnecessary risks (as evidenced in fear of heights or in social anxiety disorder). Demobilization is reflected in weakness, fatigue, lowered blood pressure, and heart rate, leading to collapsing or freezing in place, which decrease the likelihood that the individual will be detected by predators (Beck et al., 1985, 2005; Marks, 1987; Nesse & Ellsworth, 2009).

Responses to threat include fight, flight, freezing, fainting (collapse), retraction, dodging, clinging, calling for help, and other reflexes (blinking, gagging, coughing), with corresponding cognitive implications: "I have to get out of here," "I can't move," "What is happening to me?," or "Don't leave me." The cognitive model stresses the importance of various information-processing distortions in anxiety—specifically, hypervigilance, false alarms, loss of objectivity, generalization of danger to other stimuli, catastrophizing, excessive focus on negative outcomes, no tolerance for uncertainty, and "lack of habituation" (Beck et al., 1985, 2005).

Lazarus and his colleagues have proposed a model of appraisal and stress, in which the experience of stress is determined by an interaction between a stressor (event) and the appraisal that one is able to cope with the threat or burden of the event (see, e.g., Lazarus & Folkman, 1984). Cognitive appraisals determine the emotional impact of the event, and appraisals of inability to cope and overwhelming threatening stressors are the focus of cognitive approaches to the treatment of anxiety.

Cognitive models acknowledge that individuals may differ in the extent of their biological predisposition toward the arousal of anxiety symptoms and the perception of threat. However, once the anxiety is aroused, it is increased or maintained by specific cognitive distortions. Some examples of the three types of cognitive distortions in GAD are provided in Table 4.1.

TABLE 4.1. Examples of the Three Types of Cognitive Distortions in Generalized Anxiety Disorder

Distorted automatic thoughts
Catastrophizing: "Something terrible is going to happen," "I am going to fail."
Labeling: "I'm a failure," "My boss is a tyrant."
Dichotomous thinking: "I am always anxious," "I'm never good enough."
Overgeneralizing: "I can't handle my anxiety. I can't handle anything."
Maladaptive assumptions
"I must get rid of all anxiety—immediately and forever."
"Anxiety and worry are unhealthy."
"If people knew that I was anxious, they would reject me."
"Anxiety is a sign of weakness. I should never be weak."
"I shouldn't be anxious."
"I have to watch out for my anxiety so it doesn't catch me by surprise."
Dysfunctional schemas
Biological threat: "Anxiety means I'm sick."
Humiliation: "People will laugh at me."
Control: "I am either in complete control or I have no control."
Autonomy: "Anxiety means I'm weak and dependent. I can't survive on my own."
Abandonment: "I will be abandoned."

Note. Adapted from Leahy (1996). Copyright 1996 by Jason Aronson, Inc. Adapted by permission.

Other Cognitive-Behavioral Models

Barlow's Model

Barlow has proposed models for several anxiety disorders that integrate various modalities of experience and learning. GAD, with its focus on arousal, hypervigilance, and worry, is explained by reference to five factors operating in interaction with one another (Barlow, 1988): negative life events, biological vulnerability, diffuse stress response, psychological vulnerability (with accompanying sense of lack of control and predictability), and presence or lack of coping skills or support that might mitigate lack of controllability. During the "anxious apprehension cycle," there may be accompanying "false alarms" that serve to exacerbate the sense of uncontrollability and vulnerability. With the focus on (sometimes) minor life events and the accompanying sense of loss of control over worry, the anxiety may generalize to a variety of innocuous situations and increase. Barlow (2000) has extended his model into "emotion theory," proposing that anxiety arises from an interaction of a "generalized biological (heritable) vulnerability, a generalized psychological vulnerability based on early experiences in developing a sense of control over events, and a more specific psychological vulnerability in which one learns to focus anxiety on specific objects or situations." Recognizing the genetic component of anxiety and of psychological problems in general, Barlow has proposed that these biologically determined traits are also related to anxiety sensitivity and general neuroticism. False alarms are learned through associations with internal and external stimuli, which then lead to maladaptive coping through hypervigilance and avoidance. The recommended treatment involves reducing autonomic arousal via relaxation techniques, improving coping skills, and cognitive restructuring. More recently, acceptance and mindfulness have been included as part of a treatment package (Orsillo, Roemer, & Barlow, 2003).

Borkovec's Model

Borkovec's model of worry and GAD has evolved over the years, beginning with his description of the role of attempts at suppression of negative images as a manifestation of avoidance. Anxiety is maintained through the negative reinforcement of escape and/or avoidance, which perpetuates the belief that these are the only ways to cope. The anxious individual, beset by concerns about negative and catastrophic outcomes, attempts to prevent these outcomes by anticipating escape or avoidance (which presumably will suppress the occurrence of the negative outcome images). For example, an individual who begins to worry about going bankrupt then examines all the evidence that he or she will not be able to pay the bills, attempting to figure out how these problems could occur and be avoided or solved. Borkovec's model has stressed the fact that worry serves the function of temporary "emotional avoidance" of anxious arousal (Borkovec, Alcaine, & Behar, 2004). More recently, Borkovec and colleagues have integrated interpersonal and emotional coping factors in a more comprehensive approach to GAD (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008).

Wells's Model

Wells and colleagues have advanced a sophisticated model of GAD (and other disorders), which proposes that worry is maintained by a set of beliefs about the function and danger of worry

(Wells, 1997, 2004, 2008). "Metacognition" refers to one's beliefs about the nature and function of thinking. Wells has identified five general factors reflecting metacognition about worry—for example, Positive Worry Beliefs ("Worry helps me to solve problems") and Cognitive Self-Consciousness ("I am constantly aware of my thinking"). A questionnaire developed by Wells (2009), included in this chapter as Form 4.4, assesses these five metacognitive factors.

Wells and Butler (1997) indicate that patients with GAD overestimate the likelihood of negative events, rate the cost of threatening events as very high, and interpret ambiguous events as more threatening. Wells and Butler distinguish between Type 1 and Type 2 worry. Type 1 worry refers to concern or vigilance about external or internal (e.g., health) threats. Type 2 worry, or "metaworry," refers to negative appraisals of one's own cognitive processes—for example, "Worrying will make me crazy." According to this model, the anxious individual is locked in a conflict between the fear that worry is uncontrollable and the belief that worry protects him or her.

The therapeutic model derived from this theory involves identification of the patient's beliefs about the costs and benefits of worrying, experiments in "letting go" of worry or postponing worry, challenging avoidance of activities or thoughts about which the patient worries, and constructing positive outcomes in imagery (Wells, 2004, 2008; Wells & Butler, 1997). Other aspects of the metacognitive approach include (1) testing the patient's belief that worry will lead to insanity by instructing the patient to "attempt to go crazy"; and (2) using mindfulness exercises to illustrate that the patient can observe worry without controlling it, and can engage in an observing stance toward personal thought processes without judging or directing them.

Intolerance of Uncertainty

Dugas, Ladacoeur, Freeston, and their colleagues have identified "intolerance of uncertainty" as a significant predisposing process underlying worry and GAD (Dugas, Buhr, & Ladouceur, 2004; Ladouceur et al., 2000). This is defined as the underlying belief that uncertainty is associated with negative outcomes, lack of responsibility, and other problems. Increasing tolerance of uncertainty reduces worry and can lead to remission of GAD symptoms. The approach advocated by Dugas and colleagues helps patients identify their intolerance of uncertainty, their beliefs about the negative implications of uncertainty, and their endless search for perfect solutions that will reduce uncertainty. Individuals who are intolerant of uncertainty attempt to reduce uncertainty by generating possible problems, examining possible solutions, measuring these solutions against the criteria of certainty and perfect outcomes, rejecting these solutions, and then utilizing worry as a way to achieve certainty. The search for certainty also accounts for the "reassurance seeking" that is so characteristic of worried patients. Because the search for certainty is the underlying process in worry, there is an endless self-perpetuation of worry about a variety of topics. Dugas and colleagues have developed a cognitive model for treating GAD that incorporates training in tolerance for uncertainty with practical problem solving.

Additional Models

Interpersonal and Emotional Processes

Several lines of research converge on the view that GAD is related to emotional avoidance and difficulties in interpersonal relations. Worriers focus on abstract linguistic content rather than

emotionally laden visual imagery; worry distracts from emotional issues; worriers have negative views of emotion and more difficulty in labeling emotion; and worry may temporarily suppress arousal (Borkovec et al., 2004; Borkovec & Hu, 1990; Mennin, Turk, Heimberg, & Carmin, 2004; Newman et al., 2008). An integrative interpersonal–emotional processing approach stresses examination and expression of interpersonal conflicts and meanings, as well as evocation and acceptance of difficult emotions (Safran & Segal, 1990). The interpersonal–emotional approach can be added to more traditional cognitive-behavioral approaches (Newman et al., 2008).

Developmental History

Chronic worriers report a history of overprotection from parents, role reversal and reverse parenting, less parental love, divorce or separation of parents, and more difficulty recalling childhood experiences (Cassidy, Lichtenstein-Phelps, Sibrava, Thomas, & Borkovec, 2009). Lack of perceived control in the context of demanding greater control appears implicated in the developmental histories of chronic worriers (Chorpita & Barlow, 1998). However, no single parenting style or developmental history appears strongly associated with the emergence of GAD.

Form 4.1 is a general schematic depiction of the various antecedents and processes underlying GAD, which can be given as a handout to patients.

OUTCOME STUDIES OF TREATMENTS FOR GENERALIZED ANXIETY DISORDER

Given the apparent chronicity and poor spontaneous remission rates of GAD, it is promising that there are now treatments with some demonstrated efficacy. As indicated above, there are various cognitive-behavioral approaches to treating GAD, and studies differ in the evaluation of their outcome and efficacy. Each of the clinical cognitive-behavioral models described here has been found to be effective in reducing worry and other symptoms of GAD (Covin, Ouimet, Seeds, & Dozois, 2008; Norton & Price, 2007). In addition, cognitive-behavioral treatment was found to be effective in reducing worry for older adults (mean age 66.9) in one study (Stanley et al., 2009). However, although significant improvement has been obtained with these treatments, many patients after completion of therapy are still somewhat symptomatic.

Borkovec and Whisman (1996) indicate that psychosocial treatments (especially cognitive-behavioral treatment) have proven to be more effective than nondirective treatment, a placebo, or a benzodiazepine; that gains are maintained by cognitive-behavioral therapy or behavior therapy; that cognitive-behavioral therapy leads to a reduction in the use of benzodiazepines; that these gains are clinically significant; and that for some patients, gains actually improve even after therapy is discontinued. (For more recent research confirming these findings, see Butler et al., 2006; Covin et al., 2008; Hofmann & Smits, 2008.) Butler et al. (1991) found that cognitive-behavioral therapy was superior to behavior therapy in producing "good outcome" for patients 6 months after treatment ended (42% vs. 5%, respectively), although another study found statistically similar outcomes for cognitive-behavioral therapy and behavior therapy (58% and 38%, respectively) (Durham et al., 1994). Ladouceur et al. (2000) found that 77% of patients no longer met criteria for GAD after treatment with their cognitive-behavioral therapy inter-

ventions focused on increasing tolerance for uncertainty and increasing active, problem-solving coping. Open trials have indicated efficacy for metacognitive approaches and emotion regulation therapy (Mennin, 2004; Wells, 2009). When compared with psychoanalytic treatment, cognitive-behavioral therapy was far superior—a "good outcome" rate of 72% vs. 31%, respectively (Durham, 1995).

ASSESSMENT AND TREATMENT RECOMMENDATIONS

Rationale and Plan for Treatment

A patient presenting with GAD has symptoms that include physiological arousal (restlessness, muscle tension, sleep disturbance), as well as cognitive symptoms (worry, difficulty controlling worry, and inability to concentrate). The goals of treatment are to reduce the overall level of autonomic arousal, to decrease the concern about worry, and to assist the patient in reducing worry to a reasonable level. In addition, therapeutic goals can include improvement in quality of life; improved interpersonal relations; reduction of avoidance; decreased reassurance seeking; and greater comfort with, and more effective processing of, emotions. Since the patient is worried about a variety of situations and themes, more "general" interventions are employed. That is, the therapist will use interventions such as relaxation, biofeedback, breathing exercises, and behavioral treatment of insomnia in order to reduce overall levels of anxious arousal, and will employ a variety of cognitive interventions to address the worry. These cognitive interventions include assisting the patient in distinguishing between productive and unproductive worry; addressing the patient's concern that worrying too much may be harmful; assessing the patient's tendency to jump to conclusions and catastrophize possible outcomes; and helping him or her learn to distinguish between anxiety and actual facts. We have developed an extensive self-help form called Questions to Ask Yourself If You Are Worrying (see Form 4.9, below), which may be tailored to the individual patient. In addition, since a patient with GAD is worrying throughout the day, the clinician will assist the patient in limiting worry to "worry time" and will help the patient monitor the different themes of worry. Finally, the treatment approach will help the patient recognize that he or she may be quite able to cope with a variety of problems, should they arise.

The integrative approach described here also recognizes the value of increasing tolerance of uncertainty, modifying dysfunctional emotional schemas and strategies for coping with emotion, and assisting in enhancing interpersonal functioning. In regard to the patient's problematic evaluation of the intrusive thoughts underlying worry, we include in this treatment plan metacognitive and acceptance/mindfulness approaches. The clinician may need to use his or her judgment to determine which of these various strategies needs more emphasis for a particular patient.

The treatment of a patient with GAD often involves addressing more than one disorder, since 82–90% of these patients present with more than one diagnosis (such as social anxiety disorder, specific phobia, dysthymia, or depression). The treatment package for GAD is outlined in Table 4.2. In practice, the sequence of the elements listed in this table is variable, with the therapist often using several techniques simultaneously. Moreover, since GAD is frequently comorbid with depression and other anxiety disorders, the clinician will need to refer to more than one treatment package although the remission of GAD, especially worry, may lead to improvement across different disorders.

TABLE 4.2. General Plan of Treatment for Generalized Anxiety Disorder

- Assessment
  - Tests and clinical interviewing
  - Consideration of medication
- Socialization to treatment
- Relaxation training
- Mindfulness training
- Assessing and confronting avoidance: Exposure and other techniques
- Monitoring worries and assigning "worry time"
- Cognitive evaluation and treatment of worrying
  - Step 1: Distinguishing between productive and unproductive worry
  - Step 2: Acceptance and commitment
  - Step 3: Challenging worried automatic thoughts and maladaptive assumptions
  - Step 4: Examining core beliefs about self and others
  - Step 5: Examining fear of failure
  - Step 6: Using emotions rather than worrying about them
  - Step 7: Putting time on the patient's side
- Interpersonal interventions
- Problem-solving training
- Phasing out treatment

Assessment

Tests and Clinical Interviewing

Evaluation of anxiety during the intake and after may involve a number of self-report and interview instruments. The BAI, mentioned in Chapters 2–3 is similar in structure to the BDI-II; there are 21 questions scored from 0 to 3, yielding a score ranging from 0 to 63, with higher scores indicative of greater anxiety. Brown et al.'s (2005) ADIS-IV allows the clinician to evaluate anxiety, depression, substance abuse, and other disorders. These forms are not sufficient by themselves for a diagnosis (and certainly not for differential diagnosis), but they do provide the clinician with baseline measures for evaluating therapeutic efficacy, and they do assess a variety of symptoms to allow for direction in reaching a diagnosis. Other evaluations include the State–Trait Anxiety Inventory (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). We provide the Leahy Anxiety Checklist for Patients as a measure of anxiety (see Form 4.2).

Since worry is the central feature of GAD, the clinician will particularly want to assess the level of worry and the processes underlying worry. Three self-report questionnaires are useful. First, the Penn State Worry Questionnaire (PSWQ; see Form 4.3) assesses overall levels of worry (Meyer, Miller, Metzger, & Borkovec, 1990). In fact, the PSWQ really consists of one general factor—worry (Ladouceur et al., 1992). However, scores on the PSWQ are related not

only to overall anxiety level, but also to problematic coping styles—such as self-blame, dread, wishful thinking, and avoiding problems (Molina & Borkovec, 1994). Second, the Metacognitions Questionnaire 30 (MCQ-30; see Form 4.4) assesses five general factors of the structure and processes underlying worry (Wells, 2009). Third, the Intolerance of Uncertainty Scale (IUS; see Form 4.5) assesses the individual's ability to tolerate uncertainty or incomplete information.

Form 4.6 provides space for recording scores on these instruments. It also enables the clinician to record the patient's medication and alcohol/other substance use, to record the history of previous episodes of anxiety, to note treatment progress, and to indicate treatment recommendations. Finally, Form 2.1 in Chapter 2 should be used as a general intake form.

Consideration of Medication

Treatment with medication may involve both acute and chronic (or maintenance) treatment. Benzodiazepines and selective serotonin reuptake inhibitors (SSRIS) are the most commonly used and effective pharmacological treatments for GAD and can be combined with cognitive-behavioral treatment.

Socialization to Treatment

We recommend that patients with GAD read *The Worry Cure: Seven Steps to Stop Worry from Stopping You* (Leahy, 2005) and *Anxiety Free: Unravel Your Fears before They Unravel You* (Leahy, 2009). *The Worry Cure* is a detailed account of how to use seven different sets of strategies to address worry and outlines specific plans for specific worries (e.g., relationship, health, financial, work, and other worries). This book incorporates approaches from traditional cognitive and behavioral approaches, as well as metacognitive, acceptance/mindfulness, and other models.

The patient should be told that he or she has an anxiety disorder known as "generalized anxiety disorder" or "GAD." This means that the patient worries about a variety of things and may experience muscle tension, insomnia, physiological arousal, fatigue, and other symptoms. We find it helpful to explain that everyone has worries some of the time, and that some worrying is productive (useful) while other worries are unproductive and cause unneeded anxiety. We indicate that medication may be included in the treatment plan, which will emphasize teaching the patient how to relax, improving his or her ability to handle stress, enhancing his or her ability to cope with interpersonal issues, evaluating how the patient is thinking about his or her worrying and other problems, and providing the patient with useful self-help techniques. Form 4.7 is an information handout about GAD that can be given to patients. Our handout about cognitive-behavioral therapy in general (Form 10.1 in Chapter 10) can also be used.

Relaxation Training

The therapist may indicate to the patient that anxious thoughts and feelings are more likely to occur when the patient is physiologically aroused. Consequently, the patient can learn any number of relaxation techniques (e.g., progressive muscle relaxation, breathing relaxation; see Chapter 9 and the CD-ROM), and can be encouraged to practice more than one technique.

Patients may also be assisted in guided imaginal exposure to feared situations or to their internal physiological symptoms. In addition, the use of stimulants (such as caffeinated beverages) should be discouraged, as should the excessive use of alcohol. Patients complaining about insomnia should be given the information handout on insomnia (see Chapter 2, Form 2.11); the use of the bed only for sleep and sex should be emphasized. Finally, overall relaxation is increased if the patient can regularly engage in aerobic exercise.

Mindfulness Training

As in the treatment of other anxiety disorders, mindfulness training can be utilized as a component of treatment for GAD. Specific goals of such training for patients with GAD are to practice awareness or observation of thoughts and feelings without attempting to control or judge them. Thus patients who have been plagued by intrusive worries can practice observing a worry, recognizing it as "just a thought," and bringing the mind's awareness back to the breath in mindful breathing. This allows for both acceptance and metacognitive awareness of intrusive and bothersome thoughts (Hayes et al., 1999; Wells, 2008).

Assessing and Confronting Avoidance: Exposure and Other Techniques

A patient with GAD may actually present with few anxious symptoms. On closer inquiry, however, the clinician may find that numerous situations are avoided and that the patient is underperforming at work or in personal relations because he or she fears an increase in anxiety. When this is the case, the therapist and patient may construct a hierarchy of avoided situations, rate the SUDs for each situation, and identify the negative thoughts associated with these situations. (The appropriate forms in Chapter 3 can be used for this purpose.) The therapist may use behavioral rehearsal, cognitive rehearsal, and/or modeling of confronting avoidance. Or the therapist may guide the patient through imaginal exposure to the feared situations. Homework assignments may involve planned *in vivo* exposure to avoided situations. (See Chapter 9 for a fuller discussion of exposure.)

Desensitization: Pairing (or Not Pairing) Exposure with Relaxation

The foregoing intervention (exposure, etc.) may be viewed as a form of desensitization. The patient may also be trained in pairing his or her relaxation response with imaginal exposure to the feared stimulus, with the patient moving up the hierarchy from less to more feared thoughts or images. In addition, the patient may practice pairing relaxation with exposure in the actual situations. Alternatively, the patient may be instructed *not* to pair exposure to the stimulus with relaxation; instead, the patient may simply practice experiencing the anxious arousal in the presence of the feared images and situations, and note how the anxious arousal decreases on its own with increased length of exposure. Our current preference is to forgo the older approach of pairing relaxation with aversive stimuli, since this may reinforce the belief that anxiety cannot abate without relaxation interventions. One can view this as the difference between the "reciprocal inhibition" model advocated by Wolpe on the one hand, and the "cognitive disconfirmation"

model advocated by Beck, Wells, and their associates or the "acceptance" model advocated by Hayes and colleagues on the other hand. However, relaxation therapy has proven to be effective in reducing GAD (Siev & Chambless, 2007).

Evaluating Worry

After the patient has completed the forms for evaluating worry, the clinician can review the level of worry (PSWQ), the metacognitive factors (MCQ-30), and intolerance of uncertainty (IUS). The initial level of worry may be used as a baseline measure for treatment, and repeated evaluations can be made during the course of treatment. The MCQ-30 can help the clinician identify with the patient the specific problematic factors underlying worry. Finally, targeting intolerance of uncertainty can help the patient recognize that the problem is less the content of the worry and more the underlying endless and futile search for certainty. Throughout treatment, repeated measures of worry and anxiety (these three forms, the BAI, or other self-report forms) can be administered.

In evaluating the process of worry, the therapist can ask the patient to identify its advantages and disadvantages. For example, the patient may believe that an advantage of worry is that he or she will avoid surprise and will be prepared. The disadvantages may be that the patient is anxious, worried, and pessimistic; is constantly seeking reassurance; and cannot enjoy the present moment. Closer inquiry may help the patient examine the evidence whether worry has actually been helpful in preparing him or her, or whether it has been largely useless and demoralizing. Learning to abandon the fruitless search for certainty by using worry as a "tool" or "strategy" can provide the motivation to utilize other techniques in this treatment package.

Monitoring Worries and Assigning "Worry Time"

Two distinguishing elements for many patients with GAD are that their worries focus on more than one theme and that their worries seem to pervade their day. The clinician and patient should assess various characteristics of worries: their content areas and situational elicitors, the specific predictions they entail, the level of anxiety these predictions generate, and the strength of the patient's confidence in these predictions. The Patient's Worry Log (Form 4.8) is useful in evaluating these specific features of worries and in helping the patient recognize his or her tendency to make "false predictions." As Borkovec and Wells suggest, worries are reinforced by the nonoccurrence of negative events and by the magical belief that worries are protective and preparatory.

In addition, "worry time" should be assigned to the patient. That is, the patient should be *required* to worry for a specific period of time (e.g., 20 minutes) at an assigned time and place. Other worries that occur during the day are to be delayed until worry time. The patient can write down worries at times other than worry time and save this list for the assigned time. This allows stimulus control of worries; it also helps the patient recognize that worries are about finite themes. Moreover, worry time helps the patient realize that worries that are postponed often seem irrelevant by worry time, and this realization may decrease the patient's sense of urgency about "responding" to a worry.

Cognitive Evaluation and Treatment of Worrying

We utilize a seven-step program to deal cognitively with worries, based on a variety of theoretical orientations (e.g., metacognitive therapy, evaluation of productive worry, acceptance/commitment, emotional processing, standard cognitive therapy, intolerance-of-uncertainty training, and other approaches). The patient can follow this program with the self-help book *The Worry Cure* (Leahy, 2005).

Step 1: Distinguishing between Productive and Unproductive Worry

Many worriers believe that their worry will prepare them, prevent surprise, and help them solve problems before they get out of hand. Indeed, some worry can be useful. For example, if I need to get from New York City to San Diego, California, it would be useful for me to "worry" about having plane and hotel reservations and ground transportation in California. The question is how long this worry needs to be sustained. Productive worry is a set of questions leading to solutions to a problem that can be addressed *today* (Leahy, 2005). For instance, I can get reservations for a flight, hotel, and rental car today. Unproductive worry involves a series of "what-if" questions about problems over which I have no control and that I cannot really solve today. In the present example, these might include "What if my car breaks down in California?" or "What if my talk goes badly?" The therapist and patient categorize the patient's worries as productive or unproductive, using the following list as a guide:

Signs of unproductive worry:

- You worry about unanswerable questions.
- You worry about a chain reaction of events.
- You reject a solution because it is not a perfect solution.
- You think you should worry until you feel less anxious.
- You think you should worry until you control everything.

Signs of productive worry:

- There is a question that has an answer.
- You are focused on a single event, not a chain reaction.
- You are willing to accept imperfect solutions.
- You do not use your anxiety as a guide.
- You recognize what you can control and what you cannot control.

Step 2: Acceptance and Commitment

The second step involves acceptance of limitations, such as uncertainty, imperfection, and lack of complete control. The patient can be asked to indicate the advantages and disadvantages of accepting these limitations; to give examples of current acceptance of limitations; and to decide whether acceptance of limitations implies lack of responsibility or bad outcomes. Intolerance of uncertainty can be addressed with the patient in the following ways:

1. Ask yourself, "What are the advantages and disadvantages of accepting uncertainty?"
2. In what areas of your life do you currently accept uncertainty?
3. Are you equating uncertainty with a negative outcome?
4. If you had to make a bet, how would you bet? For instance, if you think, "It's possible that this blemish is cancer," how much would you bet that it is?
5. What would be the advantage of saying, "It's good enough for me to act on?"
6. Practice repeating to yourself, "It's possible that something bad will happen." Repeat this slowly, over and over, for 20 minutes each day. Repeat your specific worries in this way as well.
7. Ask yourself, "Do I actually have a need for some uncertainty?" Life would be boring otherwise. Would you watch the same television program if it were entirely predictable—or watch a sporting event if you always knew the final score before the game occurred—and you knew before the game exactly what would happen?

In addition, a worried thought can be treated as an intrusive thought that the patient negatively evaluates. For example, the patient may believe that an intrusive thought about a possible bad outcome needs to be addressed immediately, predicts the future, is personally relevant, and needs to be suppressed or feared (D. A. Clark, 2005; Purdon, Rowa, & Antony, 2005; Wells, 2003). A number of interventions may be useful. One is to have the patient flood him- or herself for 30 minutes with the negative thought until it becomes boring; another is to practice mindful awareness and nonjudgmental, noncontrolling observation of the thought (e.g., to observe "This is just a thought," or "I can see that there is a mental event"). A worried thought can be imagined as a small figure marching out of one's head, or some other diminishing/externalizing acceptance technique can be used.

Commitment to change involves two processes: (1) "successful imperfection," in which the individual is willing to accept less than 100% in order to make progress; and (2) "constructive discomfort," in which the individual tolerates unpleasant emotions and sensations in order to get things done (Leahy, 2005). Worry is a form of emotional or experiential avoidance, and these guidelines can be helpful in breaking free from maladaptive beliefs such as "I can't do anything until I am ready," or "I can't do it because I am anxious."

Step 3: Challenging Worried Automatic Thoughts and Maladaptive Assumptions

Many of the thoughts characterizing worry are negative automatic thoughts or maladaptive assumptions (see Table 4.1 for some GAD-specific examples of these types of cognitive distortions). The therapist and patient can utilize Form 4.9, Questions to Ask Yourself If You Are Worrying, to evaluate specific predictions; the tendency to jump to conclusions; the difference between possibility and probability; the safety or protection factors available; the tendency to catastrophize outcomes; and other responses that may indicate a sense of negativity, imminence, and exaggerated outcome. (This form may be simplified, expanded, or modified by the therapist to fit the needs of the individual patient.) In addition, the patient may be assigned to write a story where positive instead of negative outcomes occur, and to outline the actual steps, he or she might need to take to make this happen. The therapist can also address the specific categories

of negative automatic thoughts underlying worrying, such as labeling ("I'm incapable of handling stress"), catastrophizing ("I'm going to lose everything"), fortunetelling ("I'll get rejected"), dichotomous thinking ("Nothing is working out"), and discounting the positives ("I don't have anything going for me"). The therapist can focus as well on the patient's particular maladaptive assumptions (needs for approval, perfection, and certainty; assumptions of essentialness and emergency; etc.). Finally, the patient's rhetorical questions that reflect worrying, such as "What if it doesn't work out?" or "What's wrong with me?", can be examined and rephrased as propositional statements that can be tested, such as "Nothing will work out," or "Everything is wrong with me." Specific techniques to examine and challenge these worries are described in Chapter 10, as well as in Leahy's (2003) *Cognitive Therapy Techniques: A Practitioner's Guide* and J. S. Beck's (2011) *Cognitive Behavior Therapy: Basics and Beyond.*

Step 4: Examining Core Beliefs about Self and Others

Core beliefs or personal schemas are often the fundamental sources of worries. For example, patients who view themselves as helpless and unable to take care of themselves may worry about being abandoned. Overly conscientious individuals may worry that they won't get all their work done. Narcissistic patients with excessive standards for admiration and needs to be special may worry about defeat, humiliation, or mediocrity. Table 4.3 provides several examples of the relationships between core beliefs and worries, and of how these may be examined with patients.

Core beliefs about defectiveness, abandonment, excessive responsibility, and so forth may be examined via standard cognitive therapy techniques. For example, the therapist can ask the patient to examine these beliefs in the following ways:

1. Identify your core beliefs about yourself and other people.
2. Examine the costs and benefits of these beliefs.
3. How has your belief affected you in the past?
4. Are you viewing yourself in all-or-nothing terms?
5. What is the evidence for and against your belief?
6. Would you be as critical of other people?
7. Is there some truth in your belief?
8. Can you act against your belief?
9. Can you develop a more positive belief?

After this discussion, Form 4.10 may be used for homework.

Step 5: Examining Fear of Failure

Worry is often an attempt to avoid failure at all costs, since failure may be viewed as catastrophic, humiliating, permanent, overgeneralized, and unique to the self. The therapist can help the patient to "deconstruct" the meaning of failure and to challenge the idea that failure is intolerable. Once failure is feared less, then worry becomes less compelling as a strategy to avoid failure. The examples of challenging fear of failure in Table 4.4 can be helpful.

TABLE 4.3. Examining Relationships between Core Beliefs and Worries with Patients

Personal beliefs	Example	Worries	How you adapt to your belief
Defectiveness	You think that you are incompetent and inferior.	"If they get to know me, they'll reject me. No one wants defective people."	You avoid letting people really get to know you. You avoid taking on challenging tasks or relationships. You try to please other people so that they won't see that you are really "inferior."
Abandonment	You believe that people will leave you and that you will end up alone and miserable.	"My partner is no longer interested in me. Other people are more appealing. If I am on my own, I can't be happy."	You continually seek reassurance that you are loved and accepted. You check on your partner to see whether your jealousy is valid. You don't express your true opinions because you are afraid people will leave you.
Helplessness	You think that you can't take care of yourself.	"If _____ leaves me, I won't be able to make myself happy or take care of myself. I won't be able to survive."	You stay in unrewarding relationships or jobs because you are afraid of making a change that will result in being alone and helpless.
Specialness	You think you are superior and deserve a lot of attention and praise.	"If I don't excel, then I am just inferior and worthless. "If people don't respect my outstanding qualities, then I can't stand it. "Maybe I'll just end up ordinary. I might be humiliated."	You surround yourself with people who need you so that they will tell you how great you are. You break the rules so that you can get your way. You demand that others give in to your needs.
Responsibility	You take pride in being rational and diligent and in getting things right.	"If I make a mistake, it means that I'm careless. I might forget something. Things might get out of control."	You exhaust yourself with work so that you can feel you are doing the right thing. You review what you do to make sure you didn't make mistakes.
Glamour	You focus on being attractive and impressive to other people.	"If I have any imperfections in my appearance, then I won't be loved and admired."	You spend considerable effort trying to be physically attractive or fascinating. You flirt and seduce people. You check the mirror.
Autonomy	You value your freedom to do things your way.	"If someone intrudes on my time and space, then I will have no freedom at all."	You put up barriers to letting people have authority over you. You refuse to comply with others' requests. You insist on doing things your way.
Caretaking	You think you are responsible for making everyone feel comfortable and happy.	"Did I say something that hurt others' feelings? Have I disappointed them? Could I do something to take care of them?"	You constantly sacrifice yourself for the needs of other people. You apologize and play the part of someone who is always pleasing and cooperative.

TABLE 4.4. Suggestions for Helping Patients Overcome Fear of Failure

1. You didn't fail; your behavior failed.
2. You can learn from your failure.
3. You can be challenged by your failure.
4. You can try harder.
5. Maybe it wasn't a failure.
6. You can focus on other behaviors that will succeed.
7. You can focus on what you can control.
8. It wasn't essential to succeed at that.
9. There were some behaviors that did pay off.
10. Everyone fails at something.
11. Maybe no one noticed.
12. Did you have the right goal?
13. Failure is not fatal.
14. Were your standards too high?
15. Did you do better than before?
16. You can still do everything you always did, even though this failed.
17. Failing at something means you tried; not trying is worse.
18. You've just begun.
19. Tomorrow is another success.
20. Tomorrow is today.

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Step 6: Using Emotions Rather Than Worrying about Them

Borkovec's emotional avoidance theory of worry stresses the fact that worry temporarily blocks emotional arousal. Research on emotional schemas illustrates that worry is associated with negative views of emotions. Leahy (2002b, 2007a) has proposed that individuals have specific interpretations, intolerance, and strategies for their emotional experiences. Applying this emotional schema model to worry, worriers often believe that their emotions will last indefinitely, that emotions will overwhelm them, that their emotions don't make sense, and that mixed feelings are intolerable. In this sixth step for handling worry and GAD, the therapist can assist the patient in validating his or her right to have feelings; can use emotion-focused techniques to help identify, label, and differentiate emotions; can link emotions to needs and higher values; can help the patient recognize the temporary or transient nature of emotion; and can encourage him or her to practice acting against the emotion in order to obtain valued goals or needs.

Step 7: Putting Time on the Patient's Side

Worriers often report a sense of time urgency about their worrying. That is, they feel that they need answers or solutions to their problems immediately. A worrier's intolerance of uncertainty, along with the sense that danger is looming, can propel him or her into a cascade of catastrophic predictions for which immediate answers are required (Riskind, 1997). This process may also drive reassurance seeking, which in itself may alienate supportive people in the patient's life. Several techniques may be employed to address this: encouraging the patient (1) to turn the urgency

off by recognizing that answers are not required and can be delayed; (2) to accept impermanence of thoughts and feelings since these will change during the course of the day; (3) to stay in and appreciate the moment; (4) to improve the moment; (5) to stretch time to realize that whatever is bothering the patient now will pass; and (6) to plan time so that the patient is not overwhelmed with too many tasks (Leahy, 2005).

Interpersonal Interventions

Anxious patients often have interpersonal problems that contribute to their worries and general discomfort. Indeed, worry about relationships and what people think are among the most common themes for patients with chronic GAD. A clinician can assist a patient in learning more effective alternatives to complaining and other negative strategies—appropriate assertiveness, social skills (e.g., rewarding and attending to others), mutual problem solving, active listening and other communication skills, acceptance of others, negotiation skills, and conflict resolution skills. Specific cognitive interventions may focus on the tendency to engage in cognitive distortions (at all three levels) in regard to other people. The clinician may assist the patient in learning appropriate behavior through modeling and behavioral rehearsal, as well as in constructing specific interpersonal goals (e.g., complimenting five people every day or calling up three people each week to pursue rewarding behaviors).

Finally, many patients with GAD experience marital/couple conflict, partly because of their tendency to view neutral events as potentially negative or even dangerous. Continual worry in an intimate relationship results in overfocus on the most negative interpretation of potentially neutral events (e.g., "She's reading the paper because she finds me boring"), excessive reassurance seeking, and passive and withdrawn behavior (e.g., pouting). If necessary, the patient's spouse or partner may be included in the treatment, with an emphasis on increasing positive reinforcement, positive tracking for both members of the couple, modification of problematic thinking styles, and encouraging the patient to avoid enunciating too many worrisome thoughts.

Problem-Solving Training

Worriers often rely on anticipation of problems by trying to eliminate uncertainty rather than solving specific real problems. As described above, two cognitive components of the present treatment package are (1) distinguishing between productive and unproductive worry and (2) practicing acceptance of uncertainty and limitations. However, the evaluation of productive worry may identify real problems that can be solved, but that may be avoided because of fear of negative affect, fear of outcome, or reliance on the experiential avoidance of worry (Dugas & Robichaud, 2007). A cognitive-behavioral approach to problem solving may be employed as part of treatment (Dugas, Freeston, & Ladouceur, 1997; Nezu, Nezu, & D'Zurilla, 2007). This involves defining the problem, clarifying how a solution would be defined, reviewing resources, brainstorming possibilities, rank-ordering options, setting up a plan of action, stipulating behaviors, and carrying out the plan to see what happens. In addition, time management (with an emphasis on being careful not to plan too many things), introduction of stress breaks, self-contingency contracting (e.g., establishing positive rewards and other reinforcements), anger control, and other techniques are useful (Leahy, 2004; Novaco & Taylor, 2006).

A Summary of Interventions

A summary of possible interventions is provided in Form 4.11 as a guide to self-help. Some or all of them may be used. Detailed descriptions and guidelines for patients can be found in Leahy (2005, 2009).

Phasing Out Treatment

As in the case of panic disorder and agoraphobia, we caution against premature termination of treatment for GAD—especially since GAD in many cases has been chronic for years and is resistant to treatment. Accordingly, the treatment package described in this chapter calls for 20 sessions, although it may sometimes be possible to provide adequate treatment in fewer sessions. Phasing back to biweekly or monthly sessions after the patient shows some improvement helps the patient to begin functioning independently of therapy. During phase-out, as noted in connection with other disorders in other chapters, the patient is encouraged to self-assign homework; this can focus on various aspects of treatment that have been particularly challenging for the patient.

TROUBLESHOOTING PROBLEMS IN THERAPY

Patients presenting with GAD have experienced significant anxiety for most of their lives (the average length of time between onset of the disorder and first treatment is 10 years or more). Consequently, they may be impatient, demanding, skeptical, hopeless, or minimally compliant with treatment. In addition, if a patient self-medicates with alcohol or other substances, the therapy may be compromised. The following problems are often confronted in treatment.

Beliefs That Worries Are Realistic

Some patients may claim that their worries are "realistic" because "they could happen." This claim may be addressed by having such patients assign subjective probabilities to feared events and evaluate whether these are related to actual facts. For example, having heard of an airplane crash on the news, one patient estimated her significant chances of being in a similar crash at 10%. She was surprised to learn that the facts indicate that one can take a round trip on a commercial airliner every day for 45,000 years and expect one fatal accident. Confusing subjective feelings of anxiety with probabilities often contributes to extreme estimates of danger. Furthermore, a patient may be asked to estimate the sequence of probabilities of feared events. Almost always, this estimation will result in an extremely low probability of the ultimate outcome, since all prior events (the probabilities of which are usually very low themselves) have to occur.

Beliefs That Worry Protects

As indicated throughout this chapter, many worriers believe that worry is a self-protective strategy. Such beliefs can be addressed through a number of interventions. For example, practicing

"worry time" by delaying worry can test out whether terrible things happen during the period when the patient is delaying the worry. Or the therapist can ask this question: "If worry is associated with anxiety and depression, should you conclude that the best way to handle real problems is to make yourself anxious and depressed?" Another inquiry can focus on the illusory correlation—that since bad things are seldom happening, the patient is attributing a *safe reality* to worry, rather than to the real and external world. Again, the distinction between productive and unproductive worry may be helpful.

Difficulty in Identifying Automatic Thoughts

Because of the intensity of patients' feelings or because of their exclusive focus on their discomfort, many anxious patients claim that they cannot identify their thoughts. The therapist may ask such a patient to slow down the process through the use of guided imagery in the session, in which anxiety-provoking situations are described and the patient slowly goes through his or her feelings, images, and thoughts. If the patient describes visual images, these can then be used as primes for automatic thoughts, as in this example:

THERAPIST: You said that you had the image of your head exploding. Complete this sentence: "When I think of my head exploding, it makes me anxious because I think that what is happening is . . ."

PATIENT: I'm losing control. I'm going crazy.

Another technique that can be useful is to suggest automatic thoughts that the patient may or may not have had and ask, "Could this be what you were thinking?" (See J. S. Beck, 2011, for a description of these techniques.)

Demand for Immediate Results

Anxious patients often demand immediate, total relief from their negative feelings, hoping for a "magic bullet." This demand can be addressed in the following ways: clarifying that anxiety has been a lifelong problem, and thus requires an investment of time and effort to treat; stressing that old habits of thinking, feeling, and behaving do not change overnight; examining the costs and benefits of demanding immediate results; examining what will happen if immediate results are not obtained and what will happen if results are obtained gradually; evaluating how the demand for immediate results (low frustration tolerance) actually results in greater vulnerability to anxiety; and indicating how these demands contribute to feelings of hopelessness. Indeed, the sense of time urgency may underlie worry ("I need the answer right now"), and the lack of a definitive answer may be equated with danger and uncontrollability.

Perfectionistic Beliefs in Anxiety Reduction

Similar to the demand for immediate results is this dichotomous belief about anxiety: "Either I am totally anxious, or I should have no anxiety." We tell patients that eliminating all anxiety is

impossible, except for dead people! Reducing, moderating, coping with, and not catastrophizing anxiety are suggested as alternative appropriate goals. Furthermore, a patient can examine how small amounts of anxiety can be useful to motivate the self or to indicate that something may be problematic. In addition, the patient can recognize that he or she can still engage in productive activities even while feeling anxious or uncomfortable.

Demands for Certainty

Patients who ask rhetorical "What if ... ?" questions may demand certainty about feared events or about the outcome of therapy. These demands for certainty in an uncertain world are modified in therapy to statements about probability: "What is the probability that you will fail? Be rejected? Have cancer?" Patients who dwell on "What if ... ?" are asked to examine the costs and benefits of demanding certainty about every possible imagined event. The therapist may indicate many situations—for example, driving a car, eating chicken in restaurants, or walking across the street—that are possibly dangerous, but that are generally tolerated as acceptable risks. Magical, absolutistic beliefs about negligence and responsibility, which contribute to the demand for certainty, are evaluated; the therapist indicates to the patient that responsibilities are not about all possible events, but about reasonable precautions taken by reasonable people.

Difficulty in Relaxing

Some patients describe difficulty in relaxing, even when given relaxation training. The therapist may increase a patient's ability by including relaxation training in every session for several weeks to evaluate whether the patient is rushing through the exercise or not doing it properly. In addition, it is wise to train a patient in more than one exercise, to assure that the patient does not have time pressures following the exercises, and to check whether he or she is practicing relaxation with distracting stimuli (such as music or TV). Some anxious patients fear that their relaxation will leave them vulnerable and unaware of danger, and these thoughts, when elicited, may be evaluated via the cognitive therapy techniques described earlier. In patients with concomitant panic disorder, the decrease in tension may actually evoke a panic attack (see Chapter 3). The patients should be informed that this may happen in some cases, but that relaxation-induced panic usually subsides with continued practice of the exercises.

Refusal to Engage in Exposure

Some patients fear exposure so greatly that they refuse to confront feared situations. Interventions that may be helpful include using guided imagery in session before actual exposure is employed; extending the fear hierarchy to include even less anxiety-provoking events; modeling exposure; accompanying the patient in the feared situation; cognitive rehearsal of coping statements in the session; eliciting and challenging (through role plays and role reversals) the feared exposure; and using time projection ("How will you feel 30 minutes, 1 hour, 2 days after you have completed this task?"). Many anxious patients have negative emotional schemas about anxiety—that once anxiety arises it will ruin their day, take over, and make them miserable. Behavioral experiments

may be set up to evaluate whether exposure leads to a worsening of the entire day or whether exposure leads to a brief increase in anxious arousal, followed by a decrease (Leahy, 2007a; Sookman & Leahy, 2009).

DETAILED TREATMENT PLAN FOR GENERALIZED ANXIETY DISORDER

Treatment Reports

Tables 4.5 and 4.6 are designed to help in writing managed care treatment reports for patients with GAD. Table 4.5 shows sample symptoms; select the symptoms that are appropriate for your patient. Be sure also to specify the nature of the patient's impairments, including any dysfunction in academic, work, family, or social functioning. Table 4.6 lists sample goals and matching interventions. Again, select those that are appropriate for the patient.

Sequence of Interventions

Given the long-standing, chronic, and often treatment-resistant nature of GAD, we advocate that the treatment plan include *at least* 20 sessions of individual cognitive-behavioral treatment, with the opportunity for periodic follow-ups once regular treatment has been completed. Table 4.7 shows the sequence of interventions for a 20 session treatment plan for patients with GAD. (As noted earlier, the sequence of interventions presented here may vary, depending on individual patients' needs.)

CASE EXAMPLE

Sessions 1–2

Assessment

The patient, Jacob, was a 34-year-old single man who described himself as someone who had worried all his life. On intake, he had elevated scores on the BAI (23), the BDI-II (18), the MCQ-30 (on Positive Worry Beliefs, Cognitive Self-Consciousness, and Need for Control), and the PSWQ. He also had a slightly elevated score on the MCMI-III for dependent personality. His worries focused on concerns about how his father viewed him, whether he would be able to make a living, how his other relatives and his girlfriend felt about him, and whether he would ever improve. The patient's adolescence had been characterized by indifference to school, alcohol and marijuana abuse, mild depression, and chronic worry. He described himself as someone who was always trying to please his family members, which led to a great deal of resentment toward them, since he believed that they took advantage of him.

Bibliotherapy

The therapist provided Jacob with Leahy's (2005) *The Worry Cure: Seven Steps to Stop Worry from Stopping You.* The intake forms revealed

Cognitive/ metacognitive conceptualization:

Jacob's beliefs that worry protected and prepared him, but that his worry was out of control; his elevated cognitive self-consciousness; and his belief in his low cognitive competence. These metacognitive factors suggested

TABLE 4.5. Sample Symptoms for Generalized Anxiety Disorder

Anxious mood
Excessive worry
Irritable mood
Restlessness
Feeling on edge
Fatigue
Impaired concentration
Digestive problems
Muscle tension
Insomnia
Specify length of time symptoms have been present

TABLE 4.6. Sample Treatment Goals and Interventions for Generalized Anxiety Disorder

Treatment goals	Interventions
Reducing physical symptoms of anxiety	Relaxation or breathing exercises
Reducing agitation about thinking and feeling	Mindfulness training, meditation
Reducing time spent worrying (to under 30 minutes/day)	Distraction, worry time, activity scheduling
Reducing negative automatic thoughts	Cognitive restructuring
Enhancing acceptance	Cognitive restructuring, mindfulness training, metacognitive techniques
Eliminating avoidance (specify)	Exposure, behavioral activation
Eliminating assumptions about danger of anxiety	Cognitive restructuring, behavioral experiments
Eliminating assumptions about positive value of worry (or other assumptions—specify)	Cognitive restructuring, metacognitive techniques
Modifying need for certainty	Uncertainty training (costs–benefits of tolerating uncertainty, flooding oneself with uncertainty, practicing the negative emotional image, problem-solving training)
Modifying schemas of threat/vulnerability/need for control (or other schemas—specify)	Cognitive restructuring, developmental analysis, other schema work
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

TABLE 4.7. Detailed Treatment Plan for Generalized Anxiety Disorder

Sessions 1–2

Assessment

Evaluate presenting problems
Evaluate specific anxiety problems with the Leahy Anxiety Checklist for Patients (Form 4.2), plus other anxiety instruments as appropriate
Administer worry evaluations (PSWQ, MCQ-30, IUS; see Forms 4.3–4.5)
Administer standard intake battery (see Form 4.6)
Identify specific content of worries, as well as metacognitive factors
Determine differential diagnosis and evaluate for any comorbid diagnoses
Evaluate for substance abuse, use of caffeine or tobacco, sleep disorders

Socialization to Treatment

Provide patient with information handouts on GAD (Form 4.7) and on cognitive-behavioral therapy in general (Form 10.1 in Chapter 10)
Bibliotherapy: Assign *The Worry Cure: Seven Steps to Stop Worry from Stopping You* (Leahy, 2005) or *Anxiety Free: Unravel Your Fears before They Unravel You* (Leahy, 2009)
Indicate how GAD involves motor tension and arousal
Indicate that worries are a central part of GAD, and that worries are reinforced by their nonoccurrence
Develop short-term and long-term goals

Behavioral Interventions

Identify triggers for anxiety and avoidance
Evaluate and decrease use of anxiety-producing substances (e.g., caffeine, amphetamine) and abuse of self-medicating substances (e.g., alcohol, benzodiazepines)

Cognitive Interventions

Normalize worrying—review productive versus nonproductive worrying
Determine whether patient "worries about worrying" (e.g., "Worrying means I'm going crazy or I have no control over my thoughts and feelings")
Introduce Patient's Worry Log (Form 4.8)

Medications

Consider use of SSRIs or benzodiazepines

Homework

Have patient begin reading Leahy (2005) or Leahy (2009)
Assign use of Patient's Worry Log to monitor worries

Sessions 3–5

Assessment

Evaluate anxiety (BIA) and depression (BDI-II)
Continue to identify themes of patient's worries
Review Patient's Worry Log—frequency, duration, situations (triggers), precursors, and consequences of worries

Behavioral Interventions

Train patient in progressive muscle relaxation and/or relaxing breathing, and/or use mindfulness exercises
Use reward planning/activity scheduling to monitor pleasure, mastery, and anxiety
Describe and encourage "worry time"
Evaluate need for exposure to avoided situations; discuss exposure with patient

TABLE 4.7 (*cont.*)

Evaluate need for assertion training, communication training, conflict resolution, couple therapy
Encourage exercise
Treat insomnia, if necessary

Cognitive Interventions

Introduce Questions to Ask Yourself If You Are Worrying (Form 4.9)
Begin to identify and categorize automatic thoughts (with specific emphasis on fortunetelling, catastrophizing, discounting positives, personalizing, etc.)
Begin challenging thoughts by evaluating costs and benefits of worrying, using other cognitive techniques (see Chapter 10 and Appendix B)
Utilize acceptance strategies (advantages and disadvantages of accepting limitations and uncertainty, current examples of acceptance, etc.)
Utilize metacognitive strategies (identify patient's theories about worry, increase recognition that worry is a mental event, modify beliefs that worry needs to be controlled)

Medication

Evaluate side effects of medication
Evaluate need to increase dosage
If no improvement, either increase dosage, add another medication, or change class of medication (consider need to taper or discontinue one class when adding another class)

Homework

Assign breathing relaxation, progressive muscle relaxation, mindfulness exercises
Have patient follow self-help tips for insomnia (Form 2.11 in Chapter 2)
Assign worry time
Have patient increase exercise
Have patient engage in reward planning/activity scheduling
Have patient continue to monitor worries, test predictions, track negative thoughts, and categorize those thoughts
Assign continued reading

Sessions 6–8

Assessment

As in Sessions 3–5
Review homework

Behavioral Interventions

Train patient in generalizing relaxation and/or mindfulness to new situations
Encourage patient to decrease rumination time—develop an antirumination script
Examine situational/life sources of stress (e.g., financial, interpersonal, work, family, etc.)
Introduce problem-solving skills and apply to situational sources of stress
Guide patient in confronting avoided situations

Cognitive Interventions

Identify patient's underlying maladaptive assumptions
Challenge assumptions via cost–benefit analysis, other cognitive techniques (see Chapter 10 and Appendix B)
Continue challenging automatic thoughts
Introduce Patient's Daily Record of Dysfunctional Automatic Thoughts (Form 2.10 in Chapter 2)

(*cont.*)

TABLE 4.7 *(cont.)*

Use vertical descent on worries
What is the ultimate outcome or fear that the patient anticipates?
Distinguish between possible and probable outcomes
Examine worries for probability, plausibility

Medication
As in Sessions 3–5

Homework
As in Sessions 3–5
Have patient begin use of Form 2.10
Encourage patient to schedule stress breaks, self-reward for behavior
Assign use of problem solving
Encourage patient to decrease rumination through distraction, activity scheduling, rational responding

Sessions 9–15

Assessment
As in Sessions 6–8

Behavioral Interventions
Continue with assertion training and introduce anger control training (if needed)
Continue with problem-solving training
Begin self-efficacy training: Have patient list personal positives, take credit for positives, continue with self-reward

Cognitive Interventions
Continue evaluating and challenging automatic thoughts
Identify, evaluate, and modify dysfunctional personal schemas (see Chapter 10 and Appendix B)
Examine how worries are related to schemas (about defectiveness, failure, biological vulnerability, abandonment, responsibility, etc.)
Continue to evaluate and modify maladaptive assumptions (about control, excessive responsibility, time pressure, what is "essential," and imminence of "disasters")
Identify beliefs about failure, and introduce rational responding to fear of failure
Identify and modify emotional schemas (beliefs about emotions as dangerous, out of control, incomprehensible, shameful, etc.)
Encourage patient to practice self-validation for emotional distress
Focus on putting time in perspective—living in the moment, mindfulness, stretching time, looming-vulnerability interventions (slowing down image of impending threat and identifying intervening or contingent events)

Medication
As in Sessions 3–5

Homework
As in Sessions 3–5 and 6–8
Have patient increase exposure to feared situations as appropriate
Assign assertion and anger control practice
Have patient increase self-reward
Have patient identify and challenge maladaptive assumptions and dysfunctional schemas (including beliefs about control, responsibility, and imminence)

TABLE 4.7 (*cont.*)

Sessions 16–20

Assessment
As in Sessions 6–8

Behavioral Interventions
Plan phase-out of treatment
Have patient identify short-term and long-term goals for self-help
Identify how behavioral techniques can be used in future

Cognitive Interventions
Review what has been learned about automatic thoughts, assumptions, and schemas
Use rational responding to play "devil's advocate" for patient
Help patient develop new, more pragmatic assumptions and schemas

Homework
Have patient self-assign homework focused on troubleshooting future problems

Identifying automatic thoughts, assumptions, and core beliefs

that he was conflicted by the beliefs that worry served positive functions but was something that needed to be controlled or eliminated. His core beliefs about himself were that he was inadequate and undeserving, and that people would reject him if he asserted his needs. He revealed that he had used alcohol and marijuana as strategies to handle his worry.

Sessions 3–5

Mindful breathing

Jacob was guided through the exercise of mindful breathing; he was asked to focus on noticing and letting go of the breath, while also being aware of how the mind drifted away from the breath. A tape was made of this exercise, and he was instructed to practice mindful breathing for 20 minutes every day. Mindfulness exercises throughout therapy helped him recognize how active and distracting his thinking was, and realize that he might be able simply to notice a thought without having to respond to it or suppress it.

Worry time

In addition, Jacob was asked to write down worries as they occurred during the day or evening, and to set aside "worry time" for 4:30 in the afternoon. Initially, he thought that it would be impossible to set aside the worries, "since they just come to me"; with practice, however, he realized that they could be postponed and that by worry time they seemed largely irrelevant. Worry time also helped him challenge the sense of urgency about finding answers, since worries delayed became worries denied.

Examining beliefs about worrying; evaluating costs and benefits of worrying

The therapist and Jacob examined the advantages and disadvantages of worrying. The advantages, as Jacob saw them, were that worry prepared him and avoided surprise; the disadvantages were anxiety, depression, irritability, and generally feeling out of control. He also indicated his belief that if he didn't stop worrying, he would "probably eventually go crazy."

This was linked to his belief that telling himself to stop worrying would help him, although it generally led to more frustration.

Distinguishing productive from unproductive worry

The therapist suggested that Jacob distinguish between productive and unproductive worry, in that productive worry could lead to a "to-do list today." He realized that almost none of the things that he worried about could lead to a to-do list, and so they were categorized as unproductive.

Uncertainty training

Jacob and the therapist then examined the advantages and disadvantages to accepting some uncertainty and some lack of control. He acknowledged that he already accepted some uncertainty in the work he was doing and in driving on the highway. He also recognized that accepting some uncertainty might free him from the task of worrying and that he might enjoy his present life more. The therapist and Jacob examined how he equated uncertainty with a bad outcome, rather than viewing uncertainty as neutral. In order to "practice accepting uncertainty," he was asked to repeat for 10 minutes, "It's possible I could lose my job." His anxiety initially increased to a SUDs level of 8, but gradually subsided to 2. He was instructed to repeat the feared thought "like a zombie" for 20 minutes each day. The therapist also engaged him in an exercise called "On My Mind," in which an intrusive thought is depicted as a character who comes to visit a therapist. Jacob was asked to pay attention to the fact that the thought could be accepted, much as a therapist would accept a patient, or a person would accept a relative at a dinner party.

Flooding of feared thoughts

Examining beliefs about control

Next, the therapist and Jacob examined his beliefs about control. First, they targeted his belief that he had to "control" or "eliminate" his worry thoughts. This was addressed first by evaluating the costs and benefits of this belief, weighing the evidence whether it was possible, examining the rationale of "don't think of white bears," and nothing the futility of trying to control your inner thoughts and sensations. Second, he practiced "thought flooding" as described above. Third, he and the therapist examined his belief that when he was with his family, "he had to get them to calm down." He was instructed to view his family as if he were a journalist who was collecting information for an interesting story. The goal of this new approach was to observe, rather than to judge and control. He reported after a family holiday dinner that it was the best time he had had in years, since "I didn't have to get involved in their craziness."

Practicing acceptance and mindful observing

Patient's Worry Log

Jacob then began making regular use of the Patient's Worry Log (Form 4.8) to track his worries. Initially, the goal was simply to write down the situation and the actual worries. As therapy progressed, the Patient's Worry Log was used to challenge his worried thinking.

Categorizing automatic thoughts

In reviewing his worries and in using the checklist of distorted automatic thoughts (see Chapter 10, Form 10.2), he was able to realize that he repeatedly engaged in the same categories of thoughts: mind reading, personalizing, fortunetelling, catastrophizing, all-or-nothing thinking, and labeling himself. His worries seemed to follow a pattern, which gave him some comfort, since he was able to realize that they were finite and therefore possibly open to modification.

Sessions 6–8

Specific challenges to worries, using the form Questions to Ask Yourself If You Are Worrying

Jacob continued to track his worries with the Patient's Worry Log. The log indicated that he worried about things that were beyond his control, about losing his job, about what family members thought of him, about his finances, and even about his worrying too much. The therapist introduced a number of challenges and questions to ask when he noticed a worry. Using the form Questions to Ask Yourself If You Are Worrying (Form 4.9), Jacob went through each of the points and provided responses. Examples of these responses are given below. (The questions from the form are presented in italics; Jacob's responses are in roman with quotation marks.)

Specifically, what are you predicting will happen? "My aunt will be angry with me because I'm not working with them any more."

How likely (0–100%) is it that this will actually happen? "Likelihood: 80%."

How negative an outcome are you predicting (from 0% to 100%)? "How negative: 80%."

What is the worst outcome? "Worst: She will be so angry at me that she will never talk to me again."

The most likely outcome? "Most likely: She'll be angry for a while and get over it."

The best outcome? "Best: She will find someone to replace me and be happier with that person."

Are you predicting catastrophes (awful things) that don't come true? "Yes—I think that if someone is angry at me it's terrible, and that it will be the end of the relationship."

What are some examples of the catastrophes that you are anticipating? "I'm predicting that my entire family will be so angry at me that it will be impossible for me to see them. That I will get fired, not have any money, and end up alone."

What is the evidence (for and against) your worry that something really bad is going to happen? "Evidence for: There are continual conflicts in my family. We all need therapy. Evidence against: My family has always had a lot of conflict, but we still manage to get along. We are a bunch of yellers and screamers. I'm doing a good job—bringing in money. It would be hard to replace me."

If you had to divide 100 points between the evidence for and against, how would you divide these points? For example, would it be 50–50? 60–40? "Points: Evidence for = 10. Evidence against = 90."

Are you using your emotions (your anxiety) to guide you? Are you saying to yourself, "I feel anxious, so something really bad is going to happen"? Is this a reasonable way to make predictions? Why/why not? "I am doing a lot of emotional

reasoning, which I seem to do most of the time. My emotions seem to be a bad way to predict—for one thing, people are not making their decisions based on my emotions. They have their own problems to deal with."

How many times have you been wrong in the past about your worries? What actually happened? "I'm continually wrong in my predictions. I've been worried I would get fired, my family would disown me, and that I would end up with no money. The fact is that I am probably one of the most liked people in my family. They all turn to me with their problems. Which is a problem!"

What are the costs and benefits to you of worrying about this? "Costs: Anxious, angry, helpless, frustrated, and confused. Benefits: I think I might be able to prevent things unraveling. I keep thinking I can keep people from being angry with me."

What evidence do you have from the past that worrying has been helpful to you and hurtful to you? "Sometimes I think that people like me because I've been able to figure out how to avoid getting them angry. But the reality is that some of my family members get angry and frustrated because they are unrealistic. And then they get over it."

Jacob completed the rest of this form in the same way. He found these challenges to his negative thoughts quite useful.

Sessions 9–11

Identifying maladaptive assumptions

A considerable amount of Jacob's worry was related to his concern about how others felt about him. He and the therapist now focused on identifying his maladaptive assumptions—his "if–then" rules and his "shoulds." These included "I should always make other people like me," "If people don't like me, then I've done something wrong," "It's intolerable to be disliked," and "I need to know why someone is upset." This sensitivity to rejection, and his tendencies to personalize it and to catastrophize not getting approval were at the heart of his worries.

Modifying maladaptive assumptions

The therapist and Jacob then worked on modifying his maladaptive assumptions by examining the costs and benefits of these rules, asking whether he would apply these rules to other people (the double-standard technique), noting the impossibility of attaining approval from other people, and using the empty-chair technique (talking back to the negative voice). He realized that his assumptions about getting approval had contributed to his frustration, his anger, his anxiety, and even his use of alcohol and marijuana over the years, and that modifying this need for approval would free him up considerably.

Jacob indicated that he would not apply these rules to other people: "It's not fair to expect someone to get approval from everyone. It's impossible, anyway. Sometimes you have to assert yourself." We also looked at his assumption that if he disagreed with someone or asserted himself, then he would be marginalized and rejected completely. He set up a behavioral experiment in which he diplomatically but firmly asserted himself with his father. The

outcome was that his father initially disagreed with him, but eventually reached a compromise.

Examining core beliefs

The therapist and Jacob next turned to his core beliefs or personal schemas. These included his belief that he wasn't "good enough": "Because I never went to college, I went into the family business." Another core belief was that he had to sacrifice his own needs to be accepted, because his needs were not important. These core beliefs about being defective and unworthy were linked to his excessive need to please and to his worries. Jacob and the therapist went on to examine the developmental origins of his beliefs: "My older brother always had problems with drugs. He had gotten arrested a few times, and my parents were always bailing him out of trouble. Everything was about him. I had to be the 'good kid'." I had to make things easier for Mom and Dad, because they already had enough problems with my brother." This situation contributed to his belief that his needs were not important, that he had to "earn love," and that everything could be taken away by the family (or other people) because he wasn't important enough.

Developmental origin of core beliefs

Schema therapy for core beliefs

The therapist and Jacob then focused on using schema therapy techniques to modify his core beliefs. The therapist asked questions such as these: "What are the costs and benefits of these beliefs about yourself—especially your needs?", "What is the rationale that your needs are just as important as someone else's needs?", "If you assert yourself, does it always happen that you are rejected?", and "Are you teaching other people that you don't matter? If you asserted yourself, could you teach them—and yourself—that you do matter?" The therapist also had him do a role play, with the therapist as his "judgmental father" and the patient as himself: Jacob was able to say assertively, "You have always taken me for granted. You always thought I should do whatever you wanted, because my brother was such a screw-up. But my needs are just as important. I will not always do what you want. I will do what I want to do."

Modifying beliefs about failure

Jacob's sense of "failure" was that he had failed if someone was dissatisfied. This helped him recognize that other people could have unrealistic expectations of him, but that this did not mean he had failed. In fact, by asserting himself (which now was categorized as successful behavior), he could recognize that this led other people to be unhappy with him on occasion. In other words, their problem might be the result of his personal growth. "I failed to satisfy unreasonable people" became a new way for him to reframe what was going on.

Examining beliefs about emotions

In addition, Jacob and the therapist examined his beliefs about his anxiety and discomfort. These included his thoughts that his feelings didn't make sense, that others would not understand his anxiety, and that he had to get rid of the discomfort immediately. Mindful breathing became the analogue for understanding that sensations and thoughts come and go—and that their impermanence is why they do not need to be avoided or controlled. In addition, the cognitive evaluation (automatic thoughts, assumptions, and core beliefs) helped him understand how his emotions (anger, anxiety, frustration, helplessness) all made sense, given the way he was thinking about things. Of course, his thinking was changing.

Sessions 12–16

Assertiveness training

As Jacob continued to examine his assumptions and core beliefs, he realized that he had felt oppressed, even humiliated, by his father and controlled by other family members. But he also realized that he was an essential part of the family business—and, in fact, that they needed him more than he needed them. He and the therapist then decided to focus on his interpersonal relationships. This included becoming more assertive with his father and expanding his social network, including dating (he had just broken up with his girlfriend). The more he was able to recognize that he could find rewards, appreciation, and respect outside the family, the freer he became from their evaluations. In addition, the therapist and Jacob examined alternatives to working with family members, including possibly starting up his own business outside the city. As he constructed his own alternatives, he began to feel less trapped and less angry. He worried less, because pleasing others was now only one alternative; he could also please himself.

Examining previous history of nonassertion

As Jacob reviewed his history of intimate relationships, he realized that his past relationship with a woman had been one-sided. That is, he had deferred to her needs, had not asserted himself, and had felt guilty about disappointing her. As a result, he had stayed for several years in a relationship that he did not find rewarding. He and the therapist then examined his fear of getting involved at the present moment because of his fear of being "trapped" by his lack of assertiveness. His goal now was to be free to be assertive, rather than worry that he was responsible for making other people happy all the time. He was able to be assertive by setting limits with a "new" woman he was beginning to date; that is, he was able to indicate that he was under no obligation to be available to her if he wasn't interested. Initially he felt guilty and worried about this, but he then realized that he had the right to say "no" and to pursue what he felt was his interest, not hers.

Developing a "bill of rights"

In order to continue his assertive approach, Jacob was asked to develop a "bill of rights": "What are your rights with other people and your rights in living your own life?" He realized that he had the right to an individual life, the right to say "no," and the right to disappoint other people.

Sessions 17–20

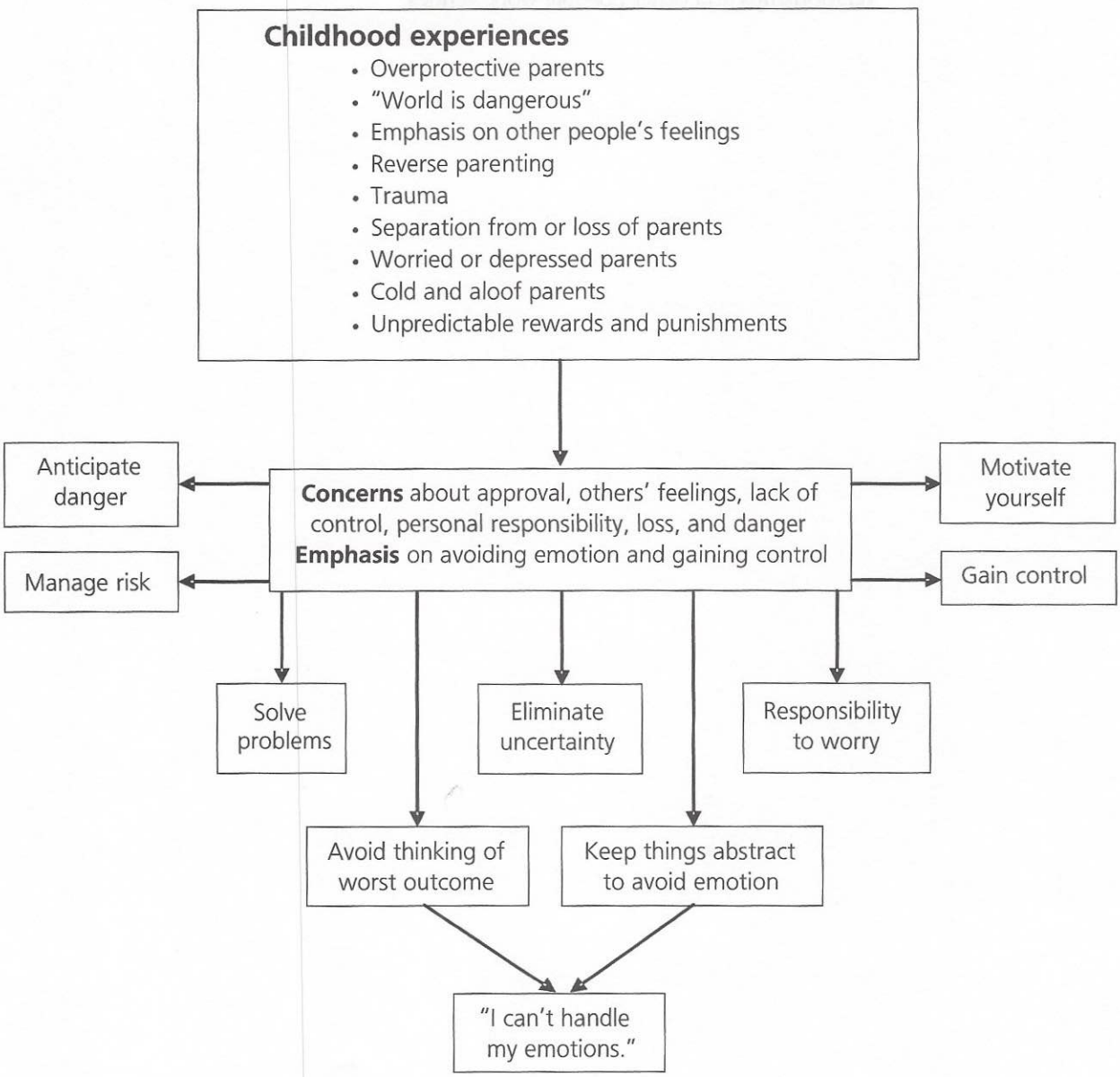
Phasing out treatment

Jacob continued to make progress in accepting limitations about getting approval all the time. He came to value the idea of being an "observer"—or, as he labeled it, a "Zen warrior." The idea of being a Zen warrior was to observe and empathize with others rather than try to control them, struggle against them, or feel defeated. In other words, he was "there" without being "against." He could also accept others' being disappointed without having to do anything.

The phase-out of therapy began with sessions once every 2 weeks, then sessions once per month, and finally a booster session after 3 months. The phasing-out process began with summarizing what was learned in therapy

about productive versus unproductive worry, accepting limitations and uncertainty, examining his negative automatic thoughts, setting aside worry time, recognizing that he didn't have to get rid of worries as much as make space for them, examining and modifying his assumptions and core beliefs, practicing assertion, knowing his rights, and creating alternatives to the family with other relationships and other possible work venues.

FORM 4.1. Generalized Anxiety Disorder: Antecedents and Underlying Processes



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FORM 4.2. Leahy Anxiety Checklist for Patients

Patient's name: _____ Today's date: _____

Place a number next to the answer that best describes how you have been feeling generally during the past month. Use the scale below:

1 = Not at all 2 = Slightly true 3 = Somewhat true 4 = Very true

1. Feeling shaky _____
2. Unable to relax _____
3. Feeling restless _____
4. Get tired easily _____
5. Headaches _____
6. Shortness of breath _____
7. Dizzy or light-headed _____
8. Need to urinate frequently _____
9. Sweating (unrelated to heat) _____
10. Heart pounding _____
11. Heartburn or upset stomach _____
12. Easily irritated _____
13. Startled easily _____
14. Difficulty sleeping _____
15. Worried a lot _____
16. Hard to control worries _____
17. Difficulty concentrating _____

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FORM 4.3. Penn State Worry Questionnaire (PSWQ)

Patient's name: _____ Today's date: _____

Enter the number that best describes how typical or characteristic each item is of you, putting the number next to the item.

1	2	3	4	5
Not at all typical		Somewhat typical		Very typical

_____ 1. If I don't have enough time to do everything, I don't worry about it. (R)

_____ 2. My worries overwhelm me.

_____ 3. I do not tend to worry about things. (R)

_____ 4. Many situations make me worry.

_____ 5. I know I shouldn't worry about things, but I just cannot help it.

_____ 6. When I am under pressure I worry a lot.

_____ 7. I am always worrying about something.

_____ 8. I find it easy to dismiss worrisome thoughts. (R)

_____ 9. As soon as I finish one task, I start to worry about everything else I have to do.

_____ 10. I never worry about anything. (R)

_____ 11. When there is nothing more I can do about a concern, I don't worry about it anymore. (R)

_____ 12. I've been a worrier all my life.

_____ 13. I notice that I have been worrying about things.

_____ 14. Once I start worrying, I can't stop.

_____ 15. I worry all the time.

_____ 16. I worry about projects until they are done.

Your total score: _____

Note that (R) after a question indicates a reverse score. Thus, to reverse-score your question, if you give an answer of 1 (Not at all typical), score it as a 5.

Add up your scores on the test—and be sure to note which items are reversed-scored (see above for how to reverse score your responses). On the average, people with some problems with worry score above 52, and really chronic worriers score above 65. "Nonanxious" people have average scores around 30. It is also quite possible to score below the clinical range (somewhere between 30 and 52) but still feel that your worries are bothering you.

The PSWQ itself (not the scoring instructions) is from Meyer, Miller, Metzger, and Borkovec (1990). Copyright 1990 by Pergamon Press. Reprinted by permission of Elsevier B. V.

Score ranges are based on Table 11-2 from Molina and Borkovec (1994).

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FORM 4.4. Metacognitions Questionnaire 30 (MCQ-30)

Patient's name: _____ Today's date: _____

This questionnaire is concerned with beliefs people have about their thinking. Listed below are a number of beliefs that people have expressed. Please read each item and say how much you *generally* agree with it by *circling* the appropriate number. Please respond to all the items; there are no right or wrong answers.

Metacognitions	Do not agree	Agree slightly	Agree moderately	Agree very much
1. Worrying helps me to avoid problems in the future	1	2	3	4
2. My worrying is dangerous for me	1	2	3	4
3. I think a lot about my thoughts	1	2	3	4
4. I could make myself sick with worrying	1	2	3	4
5. I am aware of the way my mind works when I am thinking through a problem	1	2	3	4
6. If I did not control a worrying thought, and then it happened, it would be my fault	1	2	3	4
7. I need to worry in order to remain organized	1	2	3	4
8. I have little confidence in my memory for words and names	1	2	3	4
9. My worrying thoughts persist, no matter how I try to stop them	1	2	3	4
10. Worrying helps me to get things sorted out in my mind	1	2	3	4
11. I cannot ignore my worrying thoughts	1	2	3	4
12. I monitor my thoughts	1	2	3	4
13. I should be in control of my thoughts all of the time	1	2	3	4
14. My memory can mislead me at times	1	2	3	4
15. My worrying could make me go mad	1	2	3	4
16. I am constantly aware of my thinking	1	2	3	4
17. I have a poor memory	1	2	3	4
18. I pay close attention to the way my mind works	1	2	3	4
19. Worrying helps me cope	1	2	3	4

(*cont.*)

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FORM 4.4. Metacognitions Questionnaire 30 (p. 2 of 2)

20. Not being able to control my thoughts is a sign of weakness	1	2	3	4
21. When I start worrying, I cannot stop	1	2	3	4
22. I will be punished for not controlling certain thoughts	1	2	3	4
23. Worrying helps me to solve problems	1	2	3	4
24. I have little confidence in my memory for places	1	2	3	4
25. It is bad to think certain thoughts	1	2	3	4
26. I do not trust my memory	1	2	3	4
27. If I could not control my thoughts, I would not be able to function	1	2	3	4
28. I need to worry, in order to work well	1	2	3	4
29. I have little confidence in my memory for actions	1	2	3	4
30. I constantly examine my thoughts	1	2	3	4

This questionnaire pinpoints the five most common types of beliefs about worry. These include Positive Worry Beliefs (e.g., "Worrying helps me to avoid problems in the future"); Uncontrollability and Danger: Negative Beliefs (e.g., "My worrying is dangerous for me"); Cognitive Confidence (or lack of it—e.g., "I have little confidence in my memory for words and names"); Need for Control (e.g., "If I did not control a worrying thought, and then it happened, it would be my fault"); and Cognitive Self-Consciousness (e.g., "I think a lot about my thoughts").

These factors reflect conflicting functions that you believe worry serves. For example, you may feel conflicted between having positive views of worry and, at the same time, believing that worry is uncontrollable and dangerous. You may also distrust your own memory, believing that there is something that you may overlook. This distrust in your memory may make you worry that you will neglect something. You may be scanning your mind to monitor your own thoughts, continually focusing on what you are thinking, perhaps because you believe your worry thoughts may signal impending danger.

In order to determine your score for each of these five factors on the MCQ-30, use the table below. For example, to find your score for Positive Worry Beliefs, add up your scores for each of this factor's six questions (1, 7, 10, 19, 23, 28) to get your score. Go through each of the factors this way. Then, at the end, add up your scores for each of the factors. Although there are no established norms yet for this scale, you will be able to see whether you have relatively more elevated scores on certain factors than on others.

Factor—"Your theory about your worry"	**Your total score on each factor**
Positive Worry Beliefs—questions 1, 7, 10, 19, 23, 28	_____
Uncontrollability and Danger: Negative Beliefs—questions 2, 4, 9, 11, 15, 21	_____
Cognitive Confidence—questions 8, 14, 17, 24, 26, 29	_____
Need for Control—questions 6, 13, 20, 22, 25, 27	_____
Cognitive Self-Consciousness—questions 3, 5, 12, 16, 18, 30	_____

FORM 4.5. Intolerance of Uncertainty Scale (IUS)

Patient's name: _____ Today's date: _____

You will find below a series of statements that describe how people may react to the uncertainties of life. Please use the scale below to describe to what extent each item is characteristic of you (please write the number that describes you best in the space before each item).

1	2	3	4	5
Not at all characteristic of me	A little characteristic of me	Somewhat characteristic of me	Very characteristic of me	Entirely characteristic of me

_____ 1. Uncertainty stops me from having a firm opinion.

_____ 2. Being uncertain means that a person is disorganized.

_____ 3. Uncertainty makes life intolerable.

_____ 4. It's not fair that there are no guarantees in life.

_____ 5. My mind can't be relaxed if I don't know what will happen tomorrow.

_____ 6. Uncertainty makes me uneasy, anxious, or stressed.

_____ 7. Unforeseen events upset me greatly.

_____ 8. It frustrates me not having all the information I need.

_____ 9. Being uncertain allows me to foresee the consequences beforehand and to prepare for them.

_____ 10. One should always look ahead so as to avoid surprises.

_____ 11. A small unforeseen event can spoil everything, even with the best of planning.

_____ 12. When it's time to act uncertainty paralyzes me.

_____ 13. Being uncertain means that I am not first-rate.

_____ 14. When I am uncertain I can't go forward.

_____ 15. When I am uncertain I can't function very well.

(cont.)

The IUS itself (not the scoring instructions) is from Freeston, Rhéaume, Letarte, Dugas, and Ladouceur (1994). Copyright by Elsevier Limited. Reprinted by permission.

Scores ranges are based on Dugas et al. (2004) and Ladouceur et al. (2000).

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FORM 4.5. Intolerance of Uncertainty Scale (p. 2 of 2)

_____ 16. Unlike me, others always seem to know where they are going with their lives.

_____ 17. Uncertainty makes me vulnerable, unhappy, or sad.

_____ 18. I always want to know what the future has in store for me.

_____ 19. I hate being taken by surprise.

_____ 20. The smallest doubt stops me from acting.

_____ 21. I should be able to organize everything in advance.

_____ 22. Being uncertain means that I lack confidence.

_____ 23. I think it's unfair that other people seem sure about their future.

_____ 24. Uncertainty stops me from sleeping well.

_____ 25. I must get away from uncertain situations.

_____ 26. The ambiguities in life stress me.

_____ 27. I can't stand being undecided about my future.

Total score (Sum your scores above) _____

There are five different factors on the IUS. These reflect the following beliefs:

1. Uncertainty Is Unacceptable and Should Be Avoided
2. Uncertainty Reflects Badly on a Person
3. Frustration with Uncertainty
4. Uncertainty Causes Stress
5. Uncertainty Prevents Action

In order to obtain your total score, simply add up your responses for each question. Overall, scores below 40 reflect tolerance of some uncertainty; scores above 50 reflect problems with uncertainty; and scores above 70 suggest real problems in handling uncertainty. People with GAD have an average score of 87 on the IUS. However, even if your score is below 87, your intolerance of uncertainty can be a vulnerability factor for your worry and anxiety.

FORM 4.6. Evaluation of Generalized Anxiety Disorder: Test Scores, Substance Use, History, Treatment Progress, and Recommendations

Patient's name: _____ Today's date: _____

Therapist's name: _____ Sessions completed: _____

Test data/scores

Beck Depression Inventory–II (BDI-II) _____ Beck Anxiety Inventory (BAI) _____

Global Assessment of Functioning (GAF) _____ Leahy Anxiety Checklist _____

Penn State Worry Questionnaire (PSWQ) _____ Metacognitions Questionnaire 30 (MCQ-30) _____

Intolerance of Uncertainty Scale (IUS) _____

Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) _____

Other questionnaires (specify) _____

Use of pharmacological agents

Current medications (include dosage): _____

_____

Past medications (include dosage): _____

_____

Current use of alcohol or other substances (note kind and amount): _____

_____

Past use of alcohol or other substances (note kind and amount): _____

_____

History (intake only)

Previous episodes of anxiety (specify nature):

Onset	Duration	Precipitating events	Treatment

(*cont.*)

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Treatment progress (later evaluations only)

Situations still avoided: _____

_____

Situations approached that were previously avoided: _____

_____

Recommendations

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

FORM 4.7. Information for Patients about Generalized Anxiety Disorder

WHAT IS GENERALIZED ANXIETY DISORDER?

People with generalized anxiety disorder (GAD) have persistent and disturbing worries on a daily basis. They also experience physical symptoms, such as restlessness, shortness of breath, palpitations, muscle aches, sweating, and insomnia. Often people with GAD will have another anxiety disorder; for example, many people with GAD also have social anxiety and worry about other people seeing them as anxious. If untreated, GAD often leads to depression.

WHAT CAUSES GENERALIZED ANXIETY DISORDERS?

There are many factors that may account for GAD. Between 30% and 50% of the cause may be genetic, but early childhood experiences (such as loss of a parent, feeling the need to comfort and protect a parent, parental separation/divorce of parents, parental overprotection, or parental statements that the world is a dangerous place), recent stresses in life, unrealistic expectations about yourself and others, relationship conflicts, alcohol or caffeine use, poor coping skills, and other factors all contribute to the experience of anxiety. Studies indicate that the level of anxiety in the general population has been increasing over the last 50 years—perhaps due to a decrease in social connectedness and community, unrealistic expectations about what life should be, an overfocus on bad news in the media, and other social and cultural factors.

HOW DOES THINKING AFFECT GENERALIZED ANXIETY DISORDER?

Anxious persons are plagued with a stream of irrational thoughts that further increase their anxiety: "People can see I'm anxious. They think less of me. I'm the only one with this problem. I can't stand to be disapproved of. It's awful that this could happen." Many people with GAD have an endless stream of worries that begin with "What if?" Typical thoughts of this type are "What if I'm losing control/going crazy/making a fool out of myself?" They may also worry about their worrying—for example, "I need to get rid of this anxiety [obsession, behavior, etc.] immediately. I am going to fail. My worrying is out of control and I'll go crazy. I should never worry." Chronic worriers often have mixed feelings and beliefs about their worry. On the one hand, they believe that their worry prepares and protects them. But, on the other hand, they believe that their worry will make them sick and that they need to stop worrying completely. Worriers are also often highly intolerant of uncertainty, often believing that if they don't know something for sure, then it will turn out badly. People who are anxious tend to predict the worst, expect that they will not be able to handle stress, and demand certainty in an uncertain world. If you are a worrier, you may have difficulty living in the present moment and enjoying your life. You are constantly seeking answers that you may never get.

HOW DOES PERSONALITY AFFECT GENERALIZED ANXIETY DISORDER?

People with GAD are anxious about things that are personally relevant to their concerns. Depending on your personality, you may worry about being rejected, making mistakes, not achieving success, getting sick, or being abandoned. Furthermore, you may avoid or leave situations that make you anxious, or you may try to compensate for your anxiety by trying to be overly controlling, by being overly concerned about approval, or by

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trying to be perfect. Your individual concerns and your style of coping with anxiety may thus actually make you more vulnerable to anxiety.

HOW CAN TREATMENT BE HELPFUL?

Cognitive-behavioral therapy and/or medication are especially useful in treating GAD. Both during therapy sessions and as part of the your self-help homework, you may be instructed in a number of techniques to decrease anxiety. Let's take a look at some of these techniques.

- **Decrease your arousal.** You are more likely to feel anxious when you are physically aroused. You should examine how much caffeine (coffee, teas, sodas) and alcohol you use. Your therapist may teach you breathing and relaxation exercises that can help you moderate your general arousal. Meditation and yoga are often very helpful to calm your body and mind. In addition, regular exercise may be helpful. Medications can also help reduce your arousal.
- **Identify and confront your fears.** Your therapist will assist you in recognizing the specific situations, sensations, or thoughts that are disturbing to you. You may be asked to rank these fears from least to most feared and to identify exactly what you are afraid will happen. Through gradual and guided exposure to these fears, with the help of your therapist, you may begin to modify the way you experience these situations.
- **Modify your thinking.** Your therapist may help you to identify and modify your negative thinking. You may be taking things too personally, engaging in fortunetelling about events that never happen, or predicting catastrophes that turn out to be mere inconveniences. Many worriers have a set of rules about life, such as "If I'm not perfect, I'm a failure" or "If someone doesn't like me, it's a disaster." Other rules might be "I need to know for sure" or "I should never feel anxious." You can learn to use cognitive therapy techniques to identify and modify your thinking in ways that are more realistic and fairer to yourself.
- **Learn how to deal with worry.** Like many worriers, you may believe that your worry prepares and protects you. You can learn how to distinguish between productive and unproductive worry, how to accept limitations and live with reasonable uncertainty, how to enjoy the present moment in a nonjudgmental way, and how to view your worries as "background noise" that does not need to control you. You can learn how to turn off the sense of urgency that makes you feel constantly under pressure.
- **Develop "emotional intelligence."** Many worriers have a hard time coping with their emotions. They often believe that their emotions will overwhelm them, will last indefinitely, or don't make sense. Life is not about eliminating emotions; it entails learning to live meaningfully with your emotions. Cognitive-behavioral therapy can help you come to terms with the emotions that give richness and meaning to your life.
- **Improve your relationships.** Your anxiety may often be related to conflicts and misunderstandings in your relationships. Therapy can assist you in identifying these problematic issues, developing more effective ways of thinking about your relationships, and actively coping to make things better. Communication, listening, assertion, mutual problem solving, and increasing positive experiences can be important parts of your therapy.
- **Become a problem solver.** Worriers often generate a lot of problems that don't exist, but often avoid solving problems that they can address. This is because a lot of their anxiety is based on avoiding

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experiences that make them anxious. Your therapist can help you become a practical and productive problem solver, which will make you more confident about "potential" problems.

MEDICATION

Depending on how severe your GAD is, and on whether depression is also part of the problem, your doctor may prescribe any number of medications that have proven effective for these disorders. Cognitive-behavioral therapy may be augmented with medication for anxiety disorders. Benzodiazepines and some antidepressants have been found useful for GAD. Your doctor can assist you with medication. You should never self-medicate.

HOW EFFECTIVE IS TREATMENT?

Until about 10 years ago, treatments for GAD had limited success. However, today the outcome is very promising for GAD and most other anxiety disorders. The newer forms of cognitive-behavioral therapy have proven quite effective for chronic worriers.

WHAT IS EXPECTED OF YOU AS A PATIENT?

The treatment of GAD requires your regular attendance in therapy and your willingness to carry out self-help homework assignments that can be very effective in helping you cope with your anxiety. Many patients also benefit from medication, which should only be taken as prescribed by your doctor.

FORM 4.8. Patient's Worry Log

Patient's name: _____

Content area for each worry	Factors in situation that bring out the worry	Prediction (Specify exactly what you think will happen and when it will happen)	Anxiety rating for each prediction (0–10)	Rating of confidence in accuracy of prediction (0–10)	Actual outcome (Exactly what happened?)	Anxiety rating at outcome (0–10)

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FORM 4.9. Questions to Ask Yourself If You Are Worrying: A Self-Help Form for Patients

Specific worry: _____

Questions to ask yourself:	Your response:
Specifically, what are you predicting will happen?	
How likely (0–100%) is it that this will actually happen? How negative an outcome are you predicting (from 0% to 100%)?	Likelihood: How negative:
What is the worst outcome? The most likely outcome? The best outcome?	Worst: Most likely: Best:
Are you predicting catastrophes (awful things) that don't come true? What are some examples of the catastrophes that you are anticipating?	
What is the evidence (for and against) your worry that something really bad is going to happen? If you had to divide 100 points between the evidence for and against, how would you divide these points? (For example, would it be 50–50? 60–40?)	Evidence for: Evidence against: Points: Evidence for = _____ Evidence against = _____
Are you using your emotions (your anxiety) to guide you? Are you saying to yourself, "I feel anxious, so something really bad is going to happen"?	
Is this a reasonable or logical way to make predictions? Why/why not?	
How many times have you been wrong in the past about your worries? What actually happened?	

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FORM 4.9. Questions to Ask Yourself If You Are Worrying (p. 2 of 2)

Questions to ask yourself:	Your response:
What are the costs and benefits to you of worrying about this? If you had to divide 100 points between the costs and benefits, how would you divide these points? For example, would it be 50–50? 60–40?)	Costs: Benefits: Points: –_____ (costs) _____ (benefits) Subtract costs from benefits: _____ – _____ = _____
What evidence do you have from the past that worrying has been helpful to you and hurtful to you?	
Are you able to give up any control in order to be worried less?	
Is there any way that worrying really gives you any control, or do you feel more out of control because you are worrying so much?	
If what you predict happens, what would that mean to you? What would happen next?	
How could you handle the kinds of problems that you are worrying about? What could you do?	
Has anything bad happened to you that you were not worried about? How were you able to handle that?	
Are you usually underestimating your ability to handle problems?	
Consider the thing you are worried about. How do you think you'll feel about this 2 days, 2 weeks, 2 months, and 2 years from now? Why would you feel differently?	
If someone else were facing the events that you are facing, would you encourage that person to worry as much as you? What advice would you give him or her?	

FORM 4.10. Challenging Your Core Beliefs

1. Identify your core beliefs about yourself and other people.

2. Examine the costs and benefits of these beliefs.

3. How has this belief affected you in the past?

4. Are you viewing yourself in all-or-nothing terms?

5. What is the evidence for and against your belief?

6. Would you be as critical of other people?

7. Is there some truth in your belief?

8. Can you act against your belief?

9. Can you develop a more positive belief?

Conclusions:

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FORM 4.11. Possible Interventions for Worrying: A Self-Help Guide for Patients

1. **Relax your mind and relax your body.** Practice muscle relaxation and mindful breathing. Learn how to stay in the moment and let go of your thoughts and tension.

2. **Examine the advantages of letting go of worry.** Be honest with yourself about your mixed motives about worrying. Part of you wants to decrease worry; the other part feels a need to worry to be prepared. The key here is knowing whether your worry will lead to productive action. If not, then it's useless mental energy.

3. **Keep in mind that a thought is a thought—it's not reality.** Keep your thoughts *in mind*, and recognize that reality is not the same thing as your thoughts. As you become a mindful observer of your breathing, you can practice simply *observing* your thoughts. You can stand back and say, "That's just another thought." And then you can practice saying, "Let it go."

4. **Ask yourself whether your worries are really rational.** Practice the cognitive therapy techniques you have learned. Examine the evidence for and against it; ask yourself what advice you would give a friend; review how many times you have been wrong in the past; and so on.

5. **Set aside "worry time," write out your predictions, and keep a worry log to test out what actually happened.** You will find that your worries are almost always false predictions, and you can set them aside for your worry time—which, let's hope, will eventually bore you!

6. **Validate your emotions.** Keep a daily journal of your emotions, both positive and negative. Identify why your emotions make sense, why they are not dangerous, and why other people would have many of the same feelings. Validate yourself.

7. **Accept uncertainty, and accept your limitations.** You can't control or know everything. It's not all up to you. The more you accept what you cannot do, the greater your sense of being empowered in the real world will become.

8. **Realize that it's not urgent.** You don't need to know right now. Nothing will happen if you don't know. But you can focus on enjoying the present moment—and making the best of the moment in front of you.

9. **Practice losing control.** Rather than trying to stop or control your worry, flood yourself with it. Surrender to the worry, repeat the worry, and bore yourself with constant repetitions of exactly the same worried thought. You will get bored and less worried.

10. **Similarly, try to go crazy.** You can't go crazy from your worry. But you can learn that letting go of control allows you to overcome your fear of losing control.

11. **Practice your worst fears.** Imagine the worst outcome, and repeat imagining it. You will find that with time, your images and thoughts will become boring. Think about it: The "cure" is boredom?

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