

4th Edition

**THE SAGE HANDBOOK OF**  
**COUNSELLING AND**  
**PSYCHOTHERAPY**

Edited by  
Colin Feltham | Terry Hanley | Laura Anne Winter



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Editorial assistant: Talulah Hall

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Marketing manager: Michael Ainsley

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- Miller, W. and Wilbourne, P. (2002) Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. *Addiction*, 97(3): 265–277.
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- Velleman, R. (2011) *Counselling for Alcohol Problems* (3rd ed.). London: Sage.

## RECOMMENDED READING

- Galvani, S. (2011) *Supporting People with Alcohol and Drug Problems: Making a Difference* (Social Work in Practice). London: Policy Press.

A book focusing on a social work practice approach to helping problem drinkers, anchored in relevant research.

- Miller, W. and Rollnick, S. (1991) *Motivational Interviewing: Preparing People for Change* (3rd ed., 2012). New York and London: Guilford Press.

Motivational interviewing is the leading method of engaging with and helping those with alcohol problems, and this is the best introduction, by its originators.

- Velleman, R. (2011) *Counselling for Alcohol Problems* (3rd ed.). London: Sage.

A highly practical guide to the steps that counsellors can take on a day-to-day basis to help those who have problems with their use of alcohol. The key book recommended by most alcohol counselling courses in the UK and a number of other countries, including the Scottish National Alcohol Counsellors Training Scheme.

# 6.3

## ANXIETY AND PANIC

GILL DONOHOE AND TOM RICKETTS

### OVERVIEW AND KEY POINTS

Problematic anxiety is a common and pervasive difficulty which manifests in many ways. Along with social anxiety disorder and post-traumatic stress disorder, generalised

anxiety disorder (GAD) and panic are the most common anxiety disorders encountered in primary care services and are the focus of this chapter. Given the increasing effectiveness of cognitive-behavioural approaches to these disorders, this is the perspective which will be taken throughout.

This chapter will first outline the defining features of panic disorder and generalised anxiety disorder and guidance on assessment. Key models for understanding these difficulties will be introduced, along with case examples, to demonstrate clinical formulation and interventions based on the model. Finally, research and updates on the findings in relation to delivery options and core reading will be recommended.

## DEFINING PANIC AND GENERALISED ANXIETY DISORDER

In the first, panic disorder, the main problem is recurrent panic attacks which occur unexpectedly at times when the individual does not anticipate anxiety. A panic attack is a discrete period of intense fear or discomfort that is accompanied by a range of somatic or cognitive symptoms (see Table 6.3.1). Panic attacks are often accompanied by a sense of imminent danger or impending doom and an urge to escape. They may be cued, that is triggered by specific situations, such as in phobic conditions or following trauma, or may be spontaneous. Unexpected or spontaneous panic attacks are important in the *diagnosis* of panic disorder, where more than one attack needs to have occurred unexpectedly and with at least four of the symptoms outlined in Table 6.3.1. Panic disorder and agoraphobia commonly occur together, with the fear and avoidance of a wide range of situations common in agoraphobia often being linked to a fear of the recurrence of panic attacks. In the most recent *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association, 2013), panic disorder and agoraphobia have been separated to recognise that panic may not be present in all cases of agoraphobia, and describing attacks as ‘expected’ or ‘unexpected’ rather than ‘situationally bound’ highlights that people often experience both types. Other features of panic disorder are that sufferers experience persistent concern about having additional attacks, worry about the implications of the attack or its consequences or a significant change in behaviour related to having had a panic attack.

Individuals may also experience panic attacks as a result of substance use, or as part of a medical condition such as hyperthyroidism. These possible explanations for symptoms should be explored in assessment.

In the second type of anxiety disorder, generalised anxiety disorder (GAD), the main defining feature is excessive anxiety and worry. To meet diagnostic criteria these feelings must be experienced more days than not for at least six months, must be about a range of different events or

**Table 6.3.1** Criteria for a panic attack

A discrete period of intense fear or discomfort, in which four or more (at least once for full-symptom panic) of the following symptoms developed abruptly and reached a peak within minutes:

- 1 palpitations, pounding heart or accelerated heart rate
- 2 sweating
- 3 trembling or shaking
- 4 sensations of shortness of breath or smothering
- 5 feeling of choking
- 6 chest pain or discomfort
- 7 nausea or abdominal distress
- 8 feeling dizzy, unsteady, light-headed, or faint
- 9 derealisation or depersonalisation
- 10 fear of losing control or going crazy
- 11 fear of dying
- 12 paresthesias (pins and needles in extremities)
- 13 chills or hot flushes

**Table 6.3.2** Diagnostic features of generalised anxiety disorder

Excessive anxiety and worry, occurring more days than not for at least six months, about a number of events or activities (such as work or school performance). At least three out of the following symptoms:

- 1 restlessness or feeling keyed up or on edge
- 2 being easily fatigued
- 3 difficulty concentrating or mind going blank
- 4 irritability
- 5 muscle tension
- 6 sleep disturbance

The anxiety, worry or physical symptoms must lead to significant distress or impairment in important areas of functioning

The focus of the anxiety or worry is not exclusively related to another psychiatric disorder

activities and must cause significant interference with the individual’s functioning. Table 6.3.2 shows other diagnostic features for generalised anxiety disorder.

Overall, the symptoms experienced in generalised anxiety disorder are less intense than in panic disorder, onset is more gradual and the central feature is the repeated experience of excessive worry. Although less intense, GAD can be very difficult to control (which is in itself one of the defining features) and the condition tends to be under-recognised, although prevalence rates, difficulties in diagnosis and the chronic course of the untreated disorder have been recognised (McManus et al., 2009).

## **AETIOLOGY OF PANIC DISORDER AND GENERALISED ANXIETY DISORDER**

It is useful when considering the causes of anxiety, to consider the range of both general and problem-specific factors. These can be broadly considered as an interacting set of vulnerabilities, including biological, psychological and more specific learning experiences which may influence the development of specific disorders (Barlow, 2002). Biological factors can include genetic contributions towards certain common traits, such as a neurotic or anxious predisposition. Environmental and learning experiences in each individual's history can then contribute to psychological vulnerabilities. An example of a key psychological factor relevant in the case of anxiety is a persistent sense of anticipated threat and lack of control. In the case of specific disorders, for example, panic, there may be a clear learning history which places particular emphasis on the dangerousness of somatic symptoms. In the case example described below, Jo's mother had herself experienced anxiety and panic as a parent, and had reacted to any unusual or sudden physical symptoms in herself or her children with alarm. She had regularly sought advice and reassurance from medical agencies. This could be considered as a form of vicarious learning and the development of cognitions regarding threat related to somatic experiences.

## **ASSESSMENT OF ANXIETY AND PANIC**

Interventions for anxiety or panic should be based on a detailed assessment and analysis of the presenting difficulty along with any other associated problems. This will include taking a history of the development of the problem, identifying goals for therapy and the use of measurement tools to assist in the process and review outcomes. The assessment information is then discussed with the client within a cognitive-behavioural framework.

## **FORMULATION**

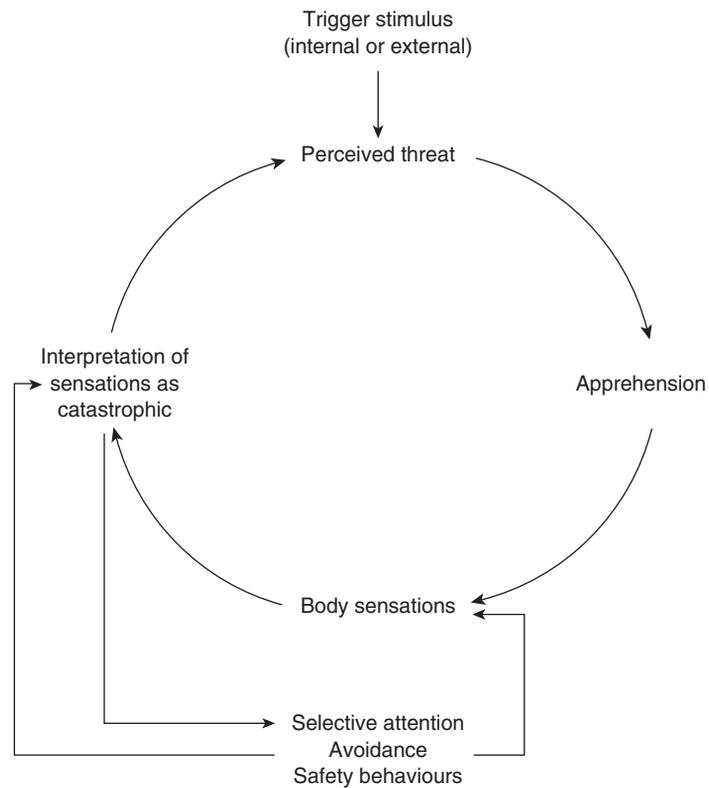
### **PANIC DISORDER**

In the cognitive model of panic disorder, it is proposed that panic attacks result from the misinterpretation of certain bodily sensations, with the sensations being perceived as much more dangerous than they actually are. Examples would be an individual perceiving palpitations as evidence of an impending heart attack, or perceiving a shaky feeling as evidence of loss of control and insanity.

Figure 6.3.1 illustrates the model. Triggers can be either external (e.g., a department store for a client suffering from agoraphobia, as in the case below), or internal (e.g., bodily sensations, thoughts or images), or both. If the trigger is experienced as threatening, a mild state of apprehension occurs. This is accompanied by a range of bodily sensations, which are then interpreted as catastrophic. This interpretation becomes the next perceived threat, and the vicious circle continues, culminating in a panic attack.

Once panic attacks have become established, the individual develops further responses to panic which serve to maintain the problem, namely selective attention, safety behaviours and avoidances. Selective attention relates to the way in which clients are watching out for physical symptoms constantly, and therefore notice them more, activating the panic cycle. Safety behaviours develop to prevent the feared catastrophic consequence from occurring, and include such things as holding on to walls or sitting down to prevent collapse. These behaviours give the individual an alternative explanation for why the feared event did not occur, and prevent changes in thinking during panic attacks. An example would be the individual thinking that they did not collapse because they sat down. Avoidances develop which restrict the individual's contact with anxiety-inducing situations, thereby reducing opportunities for discovering that the feared consequences do not occur.

The cognitive model proposes that panic disorder develops as a result of the triggering of pre-existing learnt assumptions about physical symptoms such as 'bodily symptoms are always an indication of something being wrong'. These assumptions are viewed as being developed through a range of routes, such as parental response to illness, perceived medical mismanagement and sudden deaths of significant others. Such assumptions are argued to be relatively stable (Beck, 1976), but to become more pertinent when triggered by events such as the individual experiencing illness themselves, or a first panic attack.



**Figure 6.3.1** Cognitive model of panic disorder

Source: adapted from Clark (1986), Wells (1997)

### PANIC CASE EXAMPLE

Four months previously, Jo gave birth to her first daughter and six weeks ago experienced her first panic attack. The birth of her daughter was complicated, leading to an emergency C-section, but this was well managed and despite the baby requiring initial intensive care, all was well and she returned home within a week. On the day she experienced her first panic attack Jo was feeling tired and stressed as usual, but needed to go to the local supermarket to pick up items for the baby. She started to feel unwell in the shopping aisle. She continued with her shopping but at the queue started to have difficulty with her breathing, pounding heart and experienced a strong sense of dread. This rapidly intensified to the point that she felt that she couldn't breathe and that her heart was going to explode. She felt hot and shaky and didn't know what was happening to her, but believed she was about to die. She managed somehow to pay for her items and quickly get out to the car. Once there she felt a little better and although still feeling very shaky and light-headed, managed to get home where, after a short time, she felt recovered. Jo, however, continued to experience attacks, usually when out in public places and sought advice from her General Practitioner (GP) as she was concerned about both her health and her ability to care for her family.

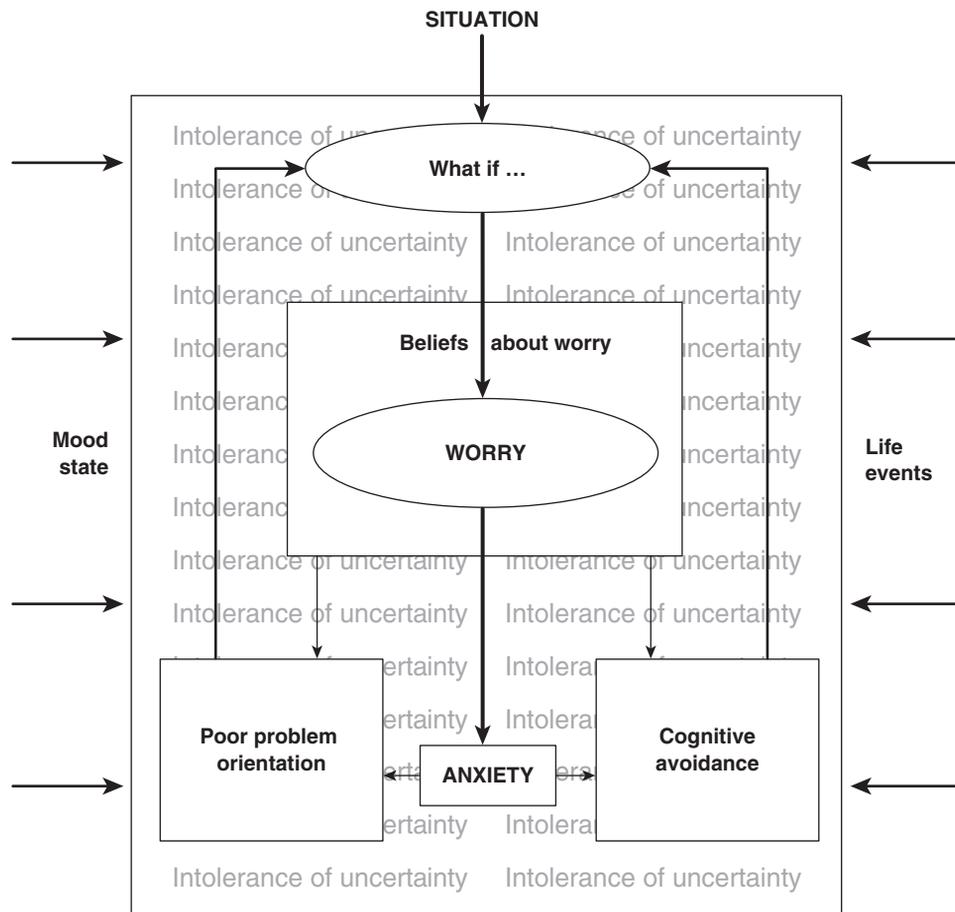
In the next section, reference will be made to Jo in terms of how interventions were used to help her to manage her symptoms of panic and reduce the impact on her life.

### GENERALISED ANXIETY DISORDER

Models of generalised anxiety disorder (Dugas et al., 1998; Zinbarg et al., 2006) all share a focus on the central element of worry. This is consistent with developments in the understanding of the nature of the disorder, and changes from the initial diagnostic manual (*DSM*) (American Psychiatric Association, 1987). Further revisions supported the need to categorise GAD as a chronic and disabling disorder, identifiable even if coexisting

with another anxiety disorder and present for at least six months (instead of just one month).

A model outlined by Dugas and colleagues (1998) represents the considerable advancement in the understanding of GAD over the last 15–20 years, and forms the basis of a step-by-step treatment approach now recommended by the Department of Health in the United Kingdom (UK) (IAPT, 2007). Figure 6.3.2 outlines this model. Central to the Dugas model is the tendency of the individual to have a set of negative beliefs around uncertainty and its implications. An example is the belief that uncertainty is unfair or upsetting and should be avoided at all costs. This enduring tendency is described as an ‘intolerance of uncertainty’



**Figure 6.3.2** Cognitive model of generalised anxiety disorder

Source: Dugas et al. (1998), reprinted with permission from Elsevier

and is usually overtly manifested in the ‘what if?’ style of thinking which feeds the worry, and a range of possible approach or avoidance behaviours. These can include, among others, repeated checking, reassurance seeking, not being able to delegate, procrastination or avoidance of commitment. Consistent with previous models, the beliefs the individual holds about the worry itself have an important part to play in the development and maintenance of the problem. These can be either negative or positive. An example of a negative belief would be that the ‘worrying will send me crazy’, whereas a positive belief may be that ‘worrying can prevent bad things from happening’ or ‘I need to worry to help me solve my problems’. Although both negative and positive beliefs may require targeting in therapy, Dugas and colleagues (1998) have helped to focus attention on the key role that positive beliefs may have in that if the act of worrying leads to a desired

outcome (even if this may be coincidental), then the beliefs, and in turn the worry, will be reinforced. An example of negatively reinforced worry would be where a negative outcome is avoided.

The two other key aspects of the Dugas model are negative problem orientation and cognitive avoidance. Cognitive avoidance incorporates both emotional and cognitive features. The role of cognitive avoidance has had important implications for the treatment of GAD as it has led to the incorporation of exposure approaches where appropriate – methods traditionally associated primarily with phobic anxiety. Negative or poor problem orientation seems to be closely linked to the intolerance of uncertainty and relates to the way an individual approaches problems, for example, viewing them as threatening, with associated doubts regarding their confidence to solve them or to have a positive outcome.

## GAD CASE EXAMPLE

John has always been a worrier. He cared for his younger brother from an early age as he had problems with learning difficulties and his parents separated when he was in his early teens. He managed well at school and became a teacher. His problems with worry and anxiety became more problematic when he got married and had a daughter. Along with work stress and a range of concerns regarding the health of his wife and his daughter’s progress at school, he found he was struggling to sleep, to sustain work tasks and found the worry and associated symptoms to be increasingly difficult to control.

These explanations of panic disorder and generalised anxiety disorder have led to the development of specific interventions, which will be outlined below.

## INTERVENTIONS

A considerable proportion of individuals with anxiety may be managed within primary care, adopting a self-help approach with more limited therapist involvement but still within the framework described in this section. The National Institute for Health and Care Excellence guidance on anxiety (NICE, 2011a) reinforces the role of a stepped-care framework to assist in the management of GAD. Low-intensity interventions following assessment and identification of anxiety can enable individuals to access help more quickly, and in less severe cases yield considerable benefits. Self-help may be non-facilitated with minimal therapist contact over approximately six weeks or guided with regular face-to-face or telephone sessions by an experienced practitioner. Psycho-education

groups are further low-intensity (Step 2) options delivered over at least six weeks. Stress Control courses are a recognised and well-evaluated format delivered widely (Delgadillo et al., 2016; White, 1998).

Stepped-care interventions delivered within primary care have enabled sufferers to access help more rapidly. NICE guidance recommend that the range of options described above are all clearly available but that if these are not effective or the presentations are more severe, then intensive (Step 3) approaches are required and with a choice of psychological or pharmacological interventions.

For both anxiety and panic, cognitive-behavioural approaches have been shown to be effective, along with earlier methods based upon conditioning and learning theories (see Craske and Barlow, 2007). The first stage of therapy for any anxiety problem is to educate the client on the principles of the approach and the rationale for the treatment plan based upon their difficulties. It is therefore important to start this process from the very onset, ideally developing a formulation with the client at session one,

particularly in the case of panic disorder. In cases of GAD, the formulation may be progressively developed in stages over the course of therapy in line with the interventions and model described in this chapter. In all cases, it is important to make use of recommended outcome measures designed to monitor progress on a session-by-session basis.

## INTERVENTIONS FOR PANIC DISORDER

- *Education about anxiety.* Given the importance of catastrophic misinterpretations of bodily symptoms in panic disorder, education regarding the features of normal anxiety is a first stage in treatment. In the case example described, Jo was reassured by being provided with clear verbal and written details on anxiety and panic, along with the formulation to make sense of why it was understandable and natural to experience the body's normal response to perceived threat and how this would be an adaptive response to actual current danger. Experiments can also be utilised to enhance socialisation to the model, for example, the 'paired associates task' (Clark et al., 1988), where Jo was instructed to read aloud and focus on symptoms, such as (dizziness), paired with typical misinterpretations (fainting), to test whether attention alone has an impact on symptoms.
- *Dealing with misinterpretations of physical symptoms.* This part of the treatment focuses on enabling the client to identify thoughts associated with concerns about physical symptoms, and then to begin to develop alternative perspectives on those same symptoms. The previous educational and socialisation interventions regarding the nature of anxiety and panic provides the client with a starting point for identifying an alternative perspective. Once an alternative perspective has been developed, current evidence for each of the two perspectives should be considered in detail, and a behavioural experiment agreed. Within this process the therapist is directive in engaging the client in consideration of their thoughts regarding symptoms, but the alternative views need to be elicited from the client, rather than presented by the therapist. When experiencing palpitations Jo continued to automatically see herself at risk of an imminent heart attack rather than as being the result of the release of adrenalin into her bloodstream. An example of a behavioural experiment for Jo involved running up and down stairs vigorously, at first in the treatment setting in order to test her belief regarding the dangerousness of her heart racing.
- *Dealing with avoidance.* Following a reduction in the degree of belief in the dangerousness of physical

symptoms, the client should gradually resume all avoided behaviours, utilising a graded exposure approach as described within the chapter on phobias in this volume (Ricketts and Donohoe – Chapter 6.14, this volume). These can be framed as experiments to continue to challenge beliefs, for example, 'if I get hot and it is busy in the shop, then I will faint and make a fool of myself'.

- *Reduction of safety behaviours.* The use of safety behaviours by panic sufferers helps to explain how, despite the repeated failure of the feared consequence to occur during panic attacks, they continue to believe that it may occur next time. Safety behaviours will therefore prevent the cognitive approach outlined earlier from being effective. As for avoidances, safety behaviours (such as having to hold on to the trolley) should be gradually reduced as the client becomes more confident in the alternative explanations for their symptoms.
- *Relapse prevention.* Consideration of the patterns of unhelpful behaviours which the client had engaged in, together with discussion and reconsideration of any long-standing assumptions regarding the dangerousness of physical symptoms, should occur towards the end of treatment, with a view to maintenance of change.

## INTERVENTIONS FOR GENERALISED ANXIETY DISORDER (GAD)

- *Education.* As with panic disorder, educating the client about the normal features of anxiety is a first component of treatment. This should include an explanation of the model, for example, as outlined above, and the central role of worry. Anxiety and worry in GAD should be explained as the extreme end of a normal and universal mental phenomenon. Dugas and colleagues (1998) suggest that the treatment model and approach should be presented to the client in a step-by-step fashion. Following and alongside psycho-education, the client is instructed to keep a 'worry diary'. This helps the client to recognise the triggers for worry and the types of worry they experience. Worries are then classified into two main types: worries about current problems and worries about future hypothetical situations. In the case example outlined above, John found it helpful to identify that although some of the worries regarding his work were current and practical, the majority of his concerns were possible future scenarios that may not arise.
- *Modifying beliefs about worry.* As with panic disorder, a process of identifying and then reconsidering beliefs about the nature of symptoms, in this case worry, is

central to treatment of generalised anxiety disorder. Other strategies seek to disconfirm beliefs, both positive and negative, about worry, specifically through behaviour change. Behavioural experiments can be used to increase tolerance of uncertainty by targeting avoidance or reducing other behaviours, such as checking or reassurance seeking. To engage the client in experiments they are first helped to identify the range of behaviours which they have been adopting in an attempt to be more certain but which in effect fuel the worry. Tolerating uncertainty experiments are planned and recorded. For example, a homework experiment may be to go to an unknown restaurant without first checking or to invite a colleague or friend out for the evening. John agreed to stop checking his work emails every evening for a one-week period in order to test whether this would increase or reduce his work problems and worry. Other more internal behaviours, such as thought control, can also be abandoned in a controlled therapeutic experiment. Challenging thoughts about the usefulness of worry (targeting positive beliefs about worry) may follow. For example, 'worry helps me to prepare and perform better at work'. Beliefs should be identified and sensitively challenged through non-judgemental questioning and discussion. See Dugas and Robichaud (2007) for a list of possible approaches. Negative beliefs can also be targeted. An example of a strategy which may be incorporated here includes the use of controlled worry periods, in which a 15-minute period each day is set aside to actively worry about issues. Throughout the rest of the day, when worry is identified, it is deferred until the planned worry period. This can be utilised to challenge perceptions of the uncontrollability of worry. Another example could be where the client is encouraged to 'lose control' of worry, or actively exaggerate their worries, so that the possible feared consequence of mental illness or complete loss of control is disconfirmed.

- *Problem-solving training.* In line with recent developments in the understanding of worry and GAD (Dugas and Robichaud, 2007), two aspects to problem-solving approaches should be considered – problem-solving orientation and problem-solving skills. Strategies to improve problem-solving orientation incorporate a number of cognitive and behavioural approaches, such as assisting the individual to view problems as opportunities rather than threats and identifying and approaching problems earlier (rather than putting off or avoiding). Actual problem-solving skills can then follow with a step-by-step method for identifying and dealing with problems and decision-making.

- *Imaginal/cognitive exposure.* The roles of avoidance, thought suppression and neutralisation are explained to clients along the lines of that which would be considered in the treatment of a phobia. The individual is then helped to identify core fears associated with worry. A scenario is then developed with the client, which can be drafted and eventually audio-recorded. This forms the material for exposure sessions and is repeatedly presented until anxiety levels reduce. It is important that the exposure scenario does not include neutralisation, for example, self-reassuring statements, and that core fears are addressed but without them being taken to a ridiculous extreme. Sessions are initially conducted in clinic but can be repeated for homework.
- *Relaxation training.* Given the tension and restlessness evident in GAD, there is a place for the teaching of progressive and applied relaxation for clients. It is important to recognise applied relaxation as a stand-alone approach which, if utilised, should adhere to a standard protocol and, like cognitive-behavioural therapy (CBT), be delivered over approximately 12–15 sessions (see NICE, 2011a; Ost, 1987). This does not mean, however, that relaxation skills may not be utilised with other approaches. Caution should be exercised that doing the relaxation 'right' does not become another source of worry for the client.

## EVALUATION

Treatment outcome studies into the cognitive treatment of panic disorder have shown generally good results, despite some studies having relatively small sample sizes. Cognitive therapy has been shown to be more effective than supportive therapy (Beck et al., 1992), applied relaxation (Clark et al., 1994) and imipramine (Clark et al., 1994). Cognitive therapy targeting catastrophic misinterpretations of physical symptoms, and excluding all exposure elements, has been found to be successful in reducing panic frequency. The addition of exposure-based approaches does appear to strengthen treatment effects, however. Where research has focused on panic disorder with agoraphobia, the superiority of cognitive therapy over exposure therapy alone is less clear-cut, with Bouchard et al. (1996) finding no significant difference.

Research into the treatment of generalised anxiety disorder by cognitive therapy is more recent, but results are promising. Cognitive-behavioural therapy has been found to be more effective than behaviour therapy alone (Butler et al., 1991), having good effects on thoughts, expectations and beliefs about worry in something less than half the clients. Hunot et al. (2007) conducted a

Cochrane review into the effectiveness of psychological therapies for GAD and found that CBT was effective for short-term treatment of anxiety. For both panic disorder and generalised anxiety disorder, if medication is to be offered, an antidepressant from the selective serotonin reuptake inhibitor (SSRI) group has generally been shown to be most effective, with sertraline most highly recommended in the case of GAD. The National Institute for Health and Care Excellence (NICE, 2011b) recommends that psychological therapy (cognitive-behavioural therapy, applied relaxation) or drug treatment should be offered if a less intensive approach, for example self-help or psycho-educational group, is not effective, and this should be before a referral is made to specialist mental health services.

The expansion of the Improving Access to Psychological Therapies (IAPT) programme and increased access to clinical data (session-by-session symptom measurement) has informed recent evaluation and the importance of the variables which may influence the

recovery of individuals with anxiety across the range of treatment intensities at different steps. The development of the NICE Guidance *Common Mental Health Problems: Identification and Pathways to Care* (2011b) builds on the recommendations (Kaltenhaler et al., 2004) for further research on the effectiveness of formats and types of intervention in low-intensity approaches, including computerised cognitive-behavioural therapy and other guided and non-facilitated self-help methods. For example, in the NICE Evidence Update for generalised anxiety disorder (NICE, 2012), all evidence reviewed supported the pathways and interventions for anxiety and panic but with further recommendations on comparing the methods of delivery of guided self-help. For the proportion with complex problems and increased risk of self-harm, which require a combined approach, then a collaborative care intervention including psychological and pharmacological methods should be utilised and further work is required in this endeavour.

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## RECOMMENDED READING

1. Barlow, D.H. (2002) *Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic* (2nd ed.). New York: Guildford Press.

This is a thorough and extensive book covering the full range of theories relevant to the understanding and management of all of the anxiety disorders and the nature of the emotion.

2. Wells, A. (1997) *Cognitive Therapy of Anxiety Disorder: A Practice and Conceptual Guide*. Chichester: Wiley.

This book is an excellent manual for the range of anxiety disorders, with clear models, case formulations and treatment interventions, delivered in a way which clearly connects with cognitive theory and the skills required to deliver therapy.

3. Dugas, M.J. and Robichaud, M. (2007) *Cognitive-Behavioural Treatment for Generalized Anxiety Disorder: From Science to Practice*. London: Routledge.

This book provides the step-by-step treatment manual and formulation for the treatment of generalised anxiety which emphasises the critical role of dealing with uncertainty. Research and examples are clearly provided to guide the clinician.