CBT for anxiety

Panic, social anxiety, GAD and phobias: the Clark, Wells, Dugas and Borkovec models, what happens in therapy, and what the evidence says

DRAFT this text has not yet been approved by the author and may change.

18 chapters ~54 min read

How solid is each fact

Proven by research **Clinical consensus** **In the author's own words**
Interpretation / disputed **Documented fact** **Not verified**

In short

- **Fear and anxiety are not the same thing.** Fear is a response to a threat that is here now; anxiety is a response to a threat you expect in the future. Both are normal. Anxiety becomes a disorder when it is out of proportion, lasts for months and gets in the way of life.
- **One panic attack is not panic disorder.** About 13 people in 100 have at least one panic attack in their lifetime; fewer than 2 in 100 develop panic disorder.
- **What keeps anxiety going is the protection against it.** In all the main CBT models, fear is maintained not by the threat itself but by avoidance and "safety behaviours", which stop you from finding out that the catastrophe doesn't happen.
- **Panic is about how sensations are read.** In David Clark's model (1986), an attack is driven by the belief that ordinary body sensations mean disaster: "my heart is pounding, so it's a heart attack".
- **"Just relax and breathe" is not a treatment for panic.** In a large component analysis, muscle relaxation was linked to worse outcomes, breathing retraining had no proven benefit, and the best results came from face-to-face therapy that combined rethinking the fear with deliberately bringing on the feared sensations.
- **For social anxiety, individual CBT is the first choice** in the UK's NICE guidelines. In a trial by Clark's group, 84% of people no longer met the diagnosis after cognitive therapy.
- **Generalised anxiety has several models:** intolerance of uncertainty (Dugas), beliefs about worry itself (Wells), and worry as avoidance (Borkovec). All lead to effective treatments, but the evidence hasn't settled which model is best.

- **Health anxiety is kept going by checking and reassurance-seeking.** In the CHAMP trial, after 5–10 sessions of CBT, a normal level of health anxiety at one year was about twice as common as with usual care: 14% against 7%. New symptoms are assessed by a doctor first.
- **CBT works, but it isn't magic.** Against a waitlist the effect is large; against placebo it is moderate. Most key trials were run by the people who created the treatments, and that is worth keeping in mind.

Timeline

1985
Beck, Emery and Greenberg: a book on the cognitive approach to anxiety disorders and phobias
COGNITIVE LINE

1986
David Clark (Oxford): the cognitive model of panic
COGNITIVE LINE

1988
Barlow and Craske: Mastery of Your Anxiety and Panic, the basis of Panic Control Treatment
BEHAVIOURAL LINE

1989
Lars-Göran Öst: one-session treatment for specific phobias
BEHAVIOURAL LINE

1990
Borkovec and Hu: worry dampens the heart's response to a frightening image
EVIDENCE

1991
Paul Salkovskis: the concept of safety behaviours
COGNITIVE LINE

1994
Clark and colleagues' trial: cognitive therapy vs relaxation vs imipramine for panic
EVIDENCE

1995 Clark and Wells: model of social phobia; Wells: metacognitive model of generalised anxiety

COGNITIVE LINE

1998 Dugas and colleagues: the intolerance of uncertainty model

COGNITIVE LINE

2000 Barlow and colleagues' trial: CBT, imipramine and their combination for panic (312 people)

EVIDENCE

2006 Clark and colleagues' trial: cognitive therapy for social phobia, 84% vs 42%

EVIDENCE

2008 Wells's book on metacognitive therapy

THIRD WAVE

2011 NICE CG113: guideline on generalised anxiety and panic

EVIDENCE

2013 NICE CG159: NICE's first guideline on social anxiety

EVIDENCE

2014 Network meta-analysis of 101 trials in social anxiety

EVIDENCE

2017 Barlow's Unified Protocol matches disorder-specific protocols

EVIDENCE

2018 Meta-analysis of placebo-controlled CBT trials; component analysis of panic treatment

EVIDENCE

How to read these notes: evidence labels

Each important claim carries a label in brackets, followed by its source after a semicolon. **Proven by research** means randomised trials (participants are split into groups by chance and the results compared) or meta-analyses (studies that pool many trials). **Clinical consensus** means clinical guidelines (such as those from the UK's NICE), disease classifications and professional bodies. **The author's own account** means a model or claim by the person who created the method, not independently checked. **Interpretation** means a reading of the evidence that can be challenged. **Documented fact** means dates, publications and names. **Not verified** means we could not open the primary source. Where sources disagree, both versions are given.

> Important This is education, not therapy or diagnosis. Techniques are described as they are used in therapy, not as do-it-yourself instructions to replace it. Panic symptoms overlap with heart, lung and other medical conditions, so a doctor needs to rule those out. These notes briefly mention the risk of self-harm; if you need support now, see If you need help now.

Fear and anxiety: what's the difference?

Disease classifications draw the line in time: fear is about "now", anxiety is about "what if, later".

Imagine you're crossing the road and a car shoots round the corner. You jump back before you've had time to think. That's fear. Now imagine a difficult conversation with your boss is a week away, and you're already sleeping badly, rehearsing what they'll say, and feeling your shoulders tighten. That's anxiety.

The World Health Organization's classification, ICD-11, describes fear as a reaction to a perceived imminent threat in the present, and anxiety as more future-oriented, a reaction to a perceived anticipated threat **clinical consensus; ICD-11, WHO, v2026-01, via Find-A-Code**. The American manual DSM-5 adds that fear is more often linked to surges of fight-or-flight arousal and escape, and anxiety to muscle tension, vigilance and avoidance **clinical consensus; DSM-5, via Eppel & Swinson, 2024**. The current edition is DSM-5-TR (2022); we could not check this wording against it word for word **not verified**.

Both reactions are normal and useful: fear gets you out of the car's path, anxiety makes you prepare for the exam. The trouble starts when anxiety is out of proportion to the situation, lasts for months, and starts deciding where you go and who you talk to. That is when clinicians speak of an anxiety disorder.

The main anxiety disorders

ICD-11 has a separate group called "Anxiety or fear-related disorders". The disorders in it differ in *what* the person is afraid of clinical consensus; ICD-11, WHO, v2026-01, via Find-A-Code; Domschke & Zwanzger, 2025.

Disorder	What the person fears	Everyday example
Panic disorder	Repeated unexpected panic attacks and their consequences	Stopping taking the Tube "just in case"
Agoraphobia	Situations that are hard to leave or where help isn't available	Not leaving home without someone
Social anxiety disorder	Being judged negatively, including for visible signs of anxiety	Turning down a promotion to avoid speaking in meetings
Generalised anxiety disorder (GAD)	Many everyday things at once: family, health, money, work	Running through a dozen "what ifs" every evening
Specific phobia	A particular object or situation	Not flying on holiday for years because of a fear of flying

In ICD-11, as in DSM-5, panic disorder and agoraphobia are diagnosed separately and can occur together documented fact; Domschke & Zwanzger, 2025. For generalised anxiety, ICD-11 dropped the strict six-month rule and the fixed symptom count: it requires marked symptoms "for at least several months, for more days than not" documented fact; Domschke & Zwanzger, 2025. OCD and PTSD sit in other ICD-11 groups; they are covered in Episode 9.

How common is it?

Measure	Figure	Source
People with an anxiety disorder worldwide	about 470 million, about 5.8% of the population (2023 estimate)	WHO fact sheet, 15 September 2026
Earlier WHO estimate	about 301 million, about 4% (for 2019)	WHO fact sheet, 2023; Javaid et al., 2023
Women vs men	women 1.66 times more often	Javaid et al., 2023
Receive any treatment	about 1 in 4 of those in need (27.6%)	WHO

The two WHO estimates refer to different years: 301 million for 2019 and 470 million for 2023; the second is the current one **documented fact; WHO, 2023 and 2026**. Both point the same way: anxiety disorders are among the most common mental disorders, and most people who have one get no help.

The common logic of CBT: protection that keeps fear alive

Each anxiety disorder has its own model, but the mechanism they share is the same.

Cognitive behavioural therapy (CBT) for anxiety is not one method but a family of protocols. A protocol is a written-out therapy plan with clear steps. Each disorder has its own cognitive model: what exactly the person sees as dangerous, and what they do to protect themselves. Therapy then targets whatever keeps the anxiety going **documented fact; Barlow et al., 2017**.

The shared idea sounds counter-intuitive: anxiety is maintained not by the threat itself but by what people do to protect themselves from it.

- In panic, someone sits down and holds on to the wall "so I don't collapse".
- In social anxiety, someone stays quiet and hides their hands "so nobody sees them shaking".
- In generalised anxiety, someone keeps worrying "so I'm ready for the worst".

Safety behaviours

In 1991 the British psychologist Paul Salkovskis described these actions as **safety-seeking behaviours**: things a person does because they believe they prevent a catastrophe. Because the person believes these actions are what saves them, "spontaneous disconfirmation" of the threat becomes especially unlikely, which is why safety behaviours may be a key factor in maintaining anxiety disorders **the author's own account; Salkovskis, 1991**.

What it looks like in real life. Someone is afraid of fainting in the supermarket and always holds on to the trolley. They don't faint. The brain's conclusion: "Good thing I held on". They never get to find out whether they would have fainted without the trolley, so the fear stays exactly where it was.

Alongside safety behaviours there is **avoidance**: simply not going where it feels frightening. Avoidance brings instant relief, but the bill comes later: life gradually gets smaller.

How this was tested

In an experiment by Salkovskis, Clark and colleagues (1999), 18 patients with panic and agoraphobia spent 15 minutes in a frightening situation. One group kept their usual safety behaviours; the other deliberately dropped them. On a repeat test, those who had dropped them showed significantly less anxiety and less belief in catastrophe. The authors themselves

note the small sample, and that the effect of dropping safety behaviours can't be fully separated from the effect of the explanation participants were given **proven by research, one small study; Salkovskis et al., 1999**.

Disorder	What the person fears	Typical safety behaviours	What therapy tests
Panic disorder	That sensations mean a heart attack, fainting, going mad	Sitting down, holding on, carrying water and a pill, only travelling with someone	Whether the sensations themselves are dangerous
Social anxiety	That others will notice the anxiety and judge them	Staying quiet, avoiding eye contact, rehearsing sentences, hiding hands	Whether the signs are that visible and others that harsh
GAD	That something bad will happen without worrying; that worry will get out of control	Checking, asking "are you sure it's fine?", planning everything ahead	Whether "preparing" is needed and whether worry really is uncontrollable
Specific phobia	A particular object or situation	Detours, refusing, staying close to a "safe" person	Whether the expected disaster happens

The table is a teaching summary of the models described below (interpretation; based on Clark, 1986; Clark & Wells, 1995; Wells, 1995; Salkovskis, 1991).

How therapy is usually structured

Broadly, the path looks like this: assessment (interview and questionnaires) → ruling out medical causes of the symptoms, especially in panic → a personal map of the problem based on the disorder's model, drawn together with the client using their most recent episode → explaining how anxiety works → rethinking fears and running behavioural experiments → dropping safety behaviours → preparing for setbacks (interpretation; the usual structure of the protocols, based on NICE, 2011, 2013). How the personal map is built is covered in Episode 4, and how thoughts are reconsidered in Episode 5.

Because safety behaviours matter so much, modern protocols usually present exposure (deliberately facing the fear) as a **behavioural experiment**: the person tests a specific prediction, such as "if I let go of the trolley, I'll collapse", and does it without their usual protections **the author's own account; Clark, 1986; Salkovskis, 1991**. Behavioural experiments and exposure as techniques are covered in Episode 6.

Myth vs fact **Myth:** Beck invented CBT for anxiety. **Fact:** Beck laid the groundwork for a cognitive approach to anxiety (his 1985 book with Emery and Greenberg), but the protocols used today came mostly from other groups: Oxford (Clark, Salkovskis, Wells), Boston (Barlow, Craske), Quebec (Dugas, Ladouceur) and Pennsylvania (Borkovec) (interpretation; based on these groups' publications). How CBT itself came about is told in Episode 1.

Panic: how the body frightens itself

A panic attack is a surge of fear; panic disorder is the fear of the next surge.

Panic attack and panic disorder

A **panic attack** is a sudden surge of intense fear or discomfort that peaks within minutes. DSM requires at least four symptoms from a list including a pounding heart, sweating, trembling, shortness of breath, chest pain, nausea, dizziness, a sense of unreality, and fear of going mad or dying **clinical consensus; DSM-5, via Cackovic et al., 2023**. On average an attack lasts about 10 minutes **proven by research, review; Tunnell et al., 2024**.

Panic disorder is when attacks keep coming *unexpectedly*, followed by at least a month of persistent worry about further attacks or their consequences, or changes in behaviour to avoid them **clinical consensus; DSM-5, via Cackovic et al., 2023**. ICD-11 (code 6B01) is similar: recurrent unexpected attacks not tied to particular triggers, plus persistent worry or avoidance that impairs functioning **clinical consensus; ICD-11, WHO, v2026-01, via Find-A-Code**.

Fact **An attack is not a disorder.** In the World Mental Health Surveys (142,949 adults in 25 countries), 13.2% of people had had at least one panic attack in their lifetime, and 1.7% had panic disorder. Among those who had had attacks, only 12.8% met the criteria for the disorder **proven by research; de Jonge et al., 2016**. NICE also stresses that a panic attack does not necessarily mean panic disorder **clinical consensus; NICE, 2011**.

In these surveys the median age of onset of panic disorder was 32, and 80.4% of people with panic disorder also had another mental disorder at some point in their life **proven by research; de Jonge et al., 2016, 2018**. Up to 12% of emergency department patients meet criteria for panic disorder, and 20–35% of those whose complaint is chest pain **proven by research, review; Tunnell et al., 2024**.

Important **See a doctor first.** Panic symptoms overlap with arrhythmias, asthma, vestibular (balance) problems and other conditions. Only a thorough medical assessment

can make sure symptoms are attributed correctly; at the same time, simply being told "you're fine" often doesn't help, and explanation and therapy are needed proven by research, narrative review; Tunnell et al., 2024. An accurate way to put it: a panic attack is very unpleasant, but once a doctor has ruled out other causes, it is not dangerous in itself.

Clark's model: the vicious circle

In 1986 the Oxford psychologist David Clark published "A cognitive approach to panic". His idea: panic attacks come from the **catastrophic misinterpretation** of certain body sensations, mostly those that are part of normal anxiety, such as a pounding heart, breathlessness and dizziness. The main example in the paper is perceiving palpitations as a sign of an impending heart attack the author's own account; Clark, 1986.

The circle goes like this the author's own account; Clark, 1986; the sequence of steps follows the Open University's OpenLearn course:

1. **Trigger**: external (a stuffy train, a queue) or internal (a racing heart after coffee, the thought "what if it happens again").
2. **Perceived threat.**
3. **Apprehension**: anxiety rises.
4. **Body sensations**: heart pounding, short of breath, dizzy, everything feels unreal.
5. **Catastrophic interpretation**: "it's a heart attack", "I'll suffocate", "I'll collapse", "I'm going mad", "I'll lose control".
6. The interpretation increases the sense of threat, the sensations get stronger, and the circle closes within seconds.

Example **One Tube journey (composite example).** Two coffees in the morning, a stuffy carriage. Her heart starts beating faster and she feels hot. The thought: "Something's wrong with my heart. What if it's a heart attack?", believed at 80 out of 100. Anxiety rises, her heart pounds harder, her hands tingle. She gets off at the next station, sits on a bench, breathes slowly. After a few minutes it passes. The brain's conclusion: "Good thing I got off, or it would have been bad". Next time she takes a taxi, and her fear of the Tube grows.

Why the circle doesn't break on its own. First, safety behaviours: sitting down, holding the rail, carrying water and a pill, only going out with someone. Every time an attack ends without catastrophe, the person credits the safety behaviour the author's own account; Salkovskis, 1991. Second, attention: someone afraid for their heart keeps checking it and notices beats others simply wouldn't. Third, avoiding situations and activities that bring on the sensations

(exercise, heat, coffee), which leads to agoraphobia (interpretation; based on the model as described by OpenLearn and Psychology Tools).

The model also explains attacks "out of the blue": a harmless sensation, for example after running for a bus, gets linked to panic. And night-time attacks: a sensation during sleep starts the circle, and the attack wakes the person up **the author's own account; as presented by OpenLearn**. Critics point to night-time attacks with no conscious frightening thought and to biological models of panic; we did not check these lines of criticism against primary sources **not verified**.

The model has also been tested indirectly: cognitive measures at the end of treatment predicted longer-term outcome in the 1994 and 1999 trials, which is consistent with the model **proven by research; Clark et al., 1994; Clark et al., 1999**.

Fact **A label you might meet in post-Soviet countries.** Many people there have been diagnosed with "vegetative-vascular dystonia" (VSD). Neurologists at Sechenov University write that this diagnosis is not in ICD-10, has no accepted criteria, is "not used in world medicine", and that anxiety disorders, including panic disorder, are often found "behind the mask of VSD"; the wrong label leads to ineffective treatment **clinical consensus, peer-reviewed review; Golovacheva & Parfenov, 2017**.

How panic is treated

The most effective part of panic treatment sounds strange: the feared sensations are brought on deliberately.

Cognitive therapy for panic (Oxford)

In outline, the protocol developed by Clark and Salkovskis includes these steps (interpretation; general description of the protocol, the manual itself was not consulted):

1. Map a specific episode with the client using the model: sensations → thought → how strongly believed → what they did.
2. Re-examine the interpretation: what supports "heart attack" and what doesn't, and what else could explain it ("my heart is racing from anxiety and coffee").
3. Behavioural experiments: bring on the sensations in a harmless way (fast breathing, running on the spot) to see where they come from.
4. Drop safety behaviours as an experiment: "what happens if I don't sit down?"
5. Go into avoided situations as a test of a prediction.
6. Prepare for possible setbacks.

A standard course of CBT for panic usually takes 12–15 one-hour sessions (interpretation; review by Rayburn & Otto, 2003). In a 1999 trial (43 people), a brief version, about 6.5 hours of therapist time plus self-study modules, did as well as the full version: both beat the waitlist, and results held at 12 months **proven by research; Clark et al., 1999**.

Panic Control Treatment (Barlow and Craske)

The American psychologists David Barlow and Michelle Craske developed Panic Control Treatment, based on their manual Mastery of Your Anxiety and Panic **documented fact; Barlow & Craske, 1988**. It includes explaining how anxiety and panic work, a panic diary, breathing skills, rethinking fears (especially overestimating the probability of disaster), interoceptive exposure, facing avoided situations, and relapse prevention **the author's own account; Craske & Barlow, via OUPblog, 2007**.

Interoceptive exposure: spinning in a chair with your therapist

Interoceptive exposure means deliberately bringing on feared body sensations. "Interoception" is the sense of signals from inside the body: heartbeat, breathing, balance. The point is for the person to have a new experience: "my heart is pounding and my head is spinning, and nothing terrible happens".

Craske and Barlow described a standard set of exercises **documented fact; Craske & Barlow, 1993, as reproduced in a Macmillan textbook table**:

Exercise	Duration	Sensations it brings on
Shake your head from side to side	30 s	dizziness
Put your head between your knees, then lift it quickly	30 s	light-headedness
Run on the spot	60 s	pounding heart, breathlessness
Hold your breath	30 s or as long as possible	air hunger
Tense all your muscles	60 s or as long as possible	tension, trembling
Spin in a swivel chair	60 s	dizziness, disorientation
Breathe through a thin straw	120 s	feeling of suffocation
Stare at a spot on the wall or at yourself in a mirror	90 s	sense of unreality

The exercises most similar to a panic attack are rapid deep breathing (hyperventilation), spinning and straw breathing **proven by research; Schmidt & Trakowski, 2004; Antony et al., 2006**. In Germany's Panic Net project, with 301 patients, repeating interoceptive exercises reliably reduced both the intensity of the sensations and anxiety, and the more repetitions, the greater the reduction **proven by research; Westphal et al., 2015**.

How it is done in therapy (interpretation; based on Schmidt & Trakowski, 2004):

1. The therapist runs all the exercises in the session; the client rates the intensity of the sensations, their anxiety, and how similar it feels to panic.
2. The exercises are ranked into a ladder, from mildest to most panic-like.
3. Each exercise is done at full strength, then the client stays with the sensations without distraction or safety behaviours. Doing it "half-heartedly" is itself a safety behaviour.
4. Before the exercise the client writes down a prediction ("I'll lose control"); afterwards, what actually happened.
5. Then the skill is carried into daily life: coffee, stairs, sauna, exercise.

Important **This is done with a therapist.** During the assessment exercises in session, 18–36% of patients have a panic attack (the authors' estimate, depending on the threshold),

and the therapist has to be ready for that proven by research, descriptive study; Schmidt & Trakowski, 2004. A piece from the Anxiety and Depression Association of America (ADAA) lists pregnancy, low blood pressure, heart disease, asthma and epilepsy as conditions in which the exercises may not be suitable clinical consensus, professional material; Gupta, ADAA. None of the sources behind these notes gives a peer-reviewed list of contraindications. So a medical history comes first and, where there is illness, a doctor's agreement. These are not exercises to try alone after reading an article.

What works in panic treatment, and what doesn't

In 2018 Pompoli and colleagues broke CBT for panic down into its components: 72 trials, 4,064 participants proven by research; Pompoli et al., 2018. Results as odds ratios for remission (above 1 means better, below 1 means worse):

Component	Result
Interoceptive exposure	1.49: points to benefit, but the interval includes 1
Face-to-face delivery (not just a book or online)	1.27: points to benefit, interval includes 1
Rethinking thoughts (cognitive restructuring)	1.11: uncertain
Breathing retraining	0.84: uncertain; slightly fewer dropouts
Exposure to real-life situations	0.78: uncertain; slightly fewer dropouts
Muscle relaxation	**0.59 (0.40–0.90): significantly worse**

The most effective combination was face-to-face delivery, psychoeducation, support, cognitive restructuring and interoceptive exposure. Compared with the least effective combination, its odds ratio for remission was 7.69; compared with a standard CBT package, 2.33. The authors conclude that effective CBT packages for panic should include face-to-face delivery and interoceptive exposure and leave out muscle relaxation and virtual reality. They list the limitations themselves: small studies, wide intervals, no long-term data, and possible researcher allegiance proven by research; Pompoli et al., 2018.

Myth vs fact **Myth:** in a panic attack the key thing is to breathe properly and relax. **Fact:** in the component analysis, muscle relaxation was the only component significantly

linked to worse outcomes, and breathing retraining had an uncertain effect **proven by research; Pompoli et al., 2018**. Barlow and Craske's own therapist guide says the aim of breathing skills is "not to relax or calm down" but to move towards the fear, and that if a client uses breathing to control symptoms, its use can be reduced **the author's own account; Craske & Barlow, via OUPblog, 2007**. Breathing "so I don't die" becomes one more safety behaviour (interpretation; based on Salkovskis, 1991). That doesn't mean calm breathing is harmful. It means breathing isn't a treatment for panic.

CBT, medication, and what lasts

In Clark and colleagues' 1994 trial (64 people), cognitive therapy was compared with applied relaxation, the antidepressant imipramine, and a waitlist. At 3 months, cognitive therapy beat both alternatives on most measures. At 6 months it was level with imipramine, and both beat relaxation. Between months 6 and 15, some patients on imipramine relapsed, and at 15 months cognitive therapy was again better than both **proven by research; Clark et al., 1994**.

In Barlow and colleagues' large US trial (2000; 312 people, 4 centres, double-blind and placebo-controlled) there were five groups. Over 3 months, 48.7% responded to CBT, 45.8% to imipramine, 60.3% to CBT plus imipramine, and 21.7% to placebo; CBT and imipramine both beat placebo. In the acute phase the combination was not significantly different from the other groups; in the maintenance phase it beat each treatment alone but not CBT plus placebo. Six months after treatment ended, improvement held in 41.0% of the CBT-plus-placebo group, 31.9% after CBT alone, 26.3% after the combination and 19.7% after imipramine alone **proven by research; Barlow et al., 2000**. After treatment stopped, the groups that had CBT without an active drug did best.

NICE recommends CBT for panic totalling 7–14 hours, completed within 4 months, and advises against benzodiazepines because of poorer long-term outcomes **clinical consensus; NICE, 2011**. The American Psychological Association's Society of Clinical Psychology rates CBT for panic as having "strong research support" **clinical consensus; Society of Clinical Psychology**.

Important Decisions about medication, doses and stopping belong to a doctor. Therapy and medication are not enemies; they can be combined if the doctor and patient decide so. A pill carried "just in case" can work as a safety behaviour; this follows from Salkovskis's concept, and the sources behind these notes include no separate study on it (interpretation; based on Salkovskis, 1991). That's something to discuss with your doctor and therapist, not a reason to stop treatment on your own.

Social anxiety: "everyone is looking at me"

In social anxiety, people see themselves not through others' eyes but from inside their own sensations.

Social anxiety disorder (ICD-11 code 6B04; formerly called social phobia) is marked, excessive fear in social situations. The person fears they will act, or *show anxiety symptoms*, in a way that will be judged negatively. The situations are avoided or endured with intense fear, this lasts several months, and it significantly affects life **clinical consensus; ICD-11, WHO, v2026-01, via Find-A-Code**.

In the World Mental Health Surveys (28 surveys, 142,405 people), 4.0% of people have social anxiety disorder at some point in their life and 2.4% in the past year; it is more common in high-income countries and usually starts early **proven by research; Stein et al., 2017**.

Myth vs fact **Myth:** social anxiety is just shyness. **Fact:** it is a diagnosis with criteria and real impairment **clinical consensus; ICD-11**. Evan Mayo-Wilson, lead author of a large 2014 analysis of treatments, said social anxiety is "more than just shyness" **documented fact; Johns Hopkins Bloomberg School of Public Health press release, 2014**. And it is treatable.

The Clark and Wells model (1995)

In 1995 David Clark and Adrian Wells described a cognitive model of social phobia **documented fact; Clark & Wells, 1995**. Its core: in social situations, the person turns their attention inwards and builds an impression of how they look from their own sensations and images, not from what others actually see **the author's own account; Clark & Wells, 1995, as summarised by Brown, 2007, and Psychology Tools**. We could not open the 1995 chapter itself; the components below follow Brown's thesis (2007), Psychology Tools and the treatment targets listed in the NICE guideline.

Example **A colleague's birthday party (composite example).** For three days beforehand he rehearses what he'll say. At the party he holds his glass in both hands so nobody sees his fingers shaking. He barely makes eye contact and says little, because "I'll say something stupid". His face burns and he's sure everyone can see how red he is. He leaves early. At night he goes over every sentence: "They definitely thought I was weird".

The model's components **the author's own account; based on Brown, 2007; Psychology Tools; NICE, 2013**:

1. **Negative beliefs** of three kinds: excessively high standards ("I must sound brilliant"), conditional beliefs ("if I stumble over my words, they'll think I'm weak") and unconditional

beliefs about the self ("I'm boring"). They switch on when the person enters the situation, and the situation is judged as dangerous.

2. **Self-focused attention** and an **observer-perspective self-image**. The impression of oneself is built from the inside: "I feel anxious, so I must look anxious". In a study by Hackmann, Surawy and Clark (1998), 77% of people with social phobia and 10% of controls described negative images of themselves as seen from outside **proven by research, as summarised by Brown, 2007**.
3. **Safety behaviours**: rehearsing sentences, avoiding eye contact, holding a glass with both hands, saying little or, the opposite, talking non-stop. They stop the fear being tested, create an odd impression in their own right (someone who stays quiet and avoids eye contact may come across as cold), and increase self-focus.
4. **Physical symptoms** such as blushing, trembling and a "blank mind", which feel obvious to everyone.
5. **Anticipatory processing**: before the event, running through scenarios of failure and recalling past ones.
6. **Post-event processing**, the "post-mortem": afterwards, going over in detail what went wrong, based on the distorted self-image, so that the event becomes worse in memory than it was.

Not every experiment supports the model: in some studies self-focus did not affect heart rate, and false feedback about heart rate did not strengthen the observer perspective (interpretation; based on the review in Brown, 2007).

Culture shapes what is feared. ICD-11 recognises a Japanese form of social anxiety, taijin kyofusho: the fear is not of being judged but of causing discomfort or offence to others through one's appearance or behaviour **documented fact; Domschke & Zwanzger, 2025**.

How social anxiety is treated

The NICE guideline (CG159) lists what individual CBT based on the Clark and Wells model should include **clinical consensus; NICE, 2013**:

1. Education about social anxiety.
2. Experiments showing the harm of self-focused attention and safety behaviours.
3. Video feedback to correct a distorted negative self-image.
4. Systematic training in externally focused attention.
5. Behavioural experiments in session, with linked homework.
6. Work on traumatic social memories.
7. Examining and changing core beliefs.
8. Working on anticipatory and post-event processing.
9. Relapse prevention.

The dose is up to 14 sessions of 90 minutes over about 4 months clinical consensus; NICE, 2013.

The safety-behaviour experiment. As it's usually done in therapy: the client has a conversation twice, first focusing on themselves and using all their usual safety behaviours, then without them and with attention on the other person, and compares their anxiety and how they think they came across (interpretation; general description of the protocol, the manual was not consulted).

Video feedback. A conversation is recorded. Before watching, the client describes in detail how they think they looked ("red as a tomato, voice shaking, endless pauses"), pictures those signs, and then watches the recording as if seeing a stranger. In an experiment by Harvey, Clark and colleagues (2000), this preparation strengthened the effect: participants who prepared rated their performance more positively than those who didn't proven by research, experiment not in patients; Harvey et al., 2000.

The numbers. In Clark and colleagues' 2006 trial (62 people), cognitive therapy was compared with an established treatment, exposure plus applied relaxation. After treatment, 84% no longer met the diagnosis after cognitive therapy, 42% after exposure with relaxation, and none on the waitlist; the differences held at one year proven by research; Clark et al., 2006.

In Mayo-Wilson and colleagues' network meta-analysis (2014; 101 trials, 13,164 participants), individual CBT had a large effect against a waitlist (SMD −1.19) and beat psychological placebo (−0.56); SSRI and SNRI antidepressants beat pill placebo (−0.44). Only individual CBT and SSRIs/SNRIs outperformed their respective placebos. The authors conclude that individual CBT is the best first choice, with medication for those who prefer it proven by research; Mayo-Wilson et al., 2014.

NICE names individual CBT (based on the Clark and Wells or Heimberg models) as the first-line treatment, advises against routinely offering group CBT instead, and advises against, for example, benzodiazepines for social anxiety, as well as botulinum toxin for sweating and surgery for blushing clinical consensus; NICE, 2013.

Generalised anxiety: why you can't stop worrying

In generalised anxiety, worry feels useful, yet it can't be switched off.

Generalised anxiety disorder (GAD) (ICD-11 code 6B00) means marked anxiety symptoms for at least several months, on more days than not, with general apprehension or excessive worry about many everyday things: family, health, money, study, work clinical consensus; ICD-11, WHO, v2026-01, via Find-A-Code.

Example **One evening (composite example).** Her daughter hasn't replied to a message. Five minutes later: "What if something's happened?" Ten minutes later, in her mind, she is already at the hospital. Then the thought jumps to work ("what if I'm made redundant"), to her mother's health, to money. And it's like that on most days, for months.

In the World Mental Health Surveys (26 countries, 147,261 adults), 3.7% of people have GAD at some point in their life and 1.8% in the past year; in high-income countries the lifetime figure is 5.0%. Severe impairment at work, in study or in relationships was reported by 50.6% of people with GAD, and 49.2% had sought treatment **proven by research; Ruscio et al., 2017**.

CBT has no single model here. A review by Behar and colleagues (2009) compares five models of GAD and finds a common denominator: avoidance of internal experiences, that is, thoughts, beliefs and emotions (interpretation; Behar et al., 2009). Here are the three best known.

Dugas: intolerance of uncertainty

The Canadian psychologist Michel Dugas and colleagues (1998) proposed a model with four elements: intolerance of uncertainty, beliefs about worry, poor problem orientation and cognitive avoidance **the author's own account; Dugas et al., 1998**. In plain words: not knowing feels unbearable even when a bad outcome is unlikely; worry feels like a way to prepare ("if I think through everything that could go wrong, I'll be ready"); the person doubts their ability to solve problems; and they escape frightening images by switching to verbal "going over and over" (interpretation; common description of the model).

In the first test (24 patients with GAD and 20 people without it), all four variables helped tell the groups apart, intolerance of uncertainty was the strongest, and 82% of participants were correctly classified **proven by research, small sample; Dugas et al., 1998**. Group CBT based on this model (14 sessions, 52 adults) beat a waitlist, and improvement continued over 2 years of follow-up **proven by research; Dugas et al., 2003**.

Wells: worrying about worry

The British psychologist Adrian Wells (1995) proposed a metacognitive model. "Metacognitions" are thoughts about thinking. For Wells, the problem lies less in what people worry about than in their beliefs about worrying. On the one hand, worry is seen as useful ("it helps me prepare"); on the other, as dangerous and uncontrollable ("I can't stop it", "it'll drive me mad"). This produces **meta-worry**, worry about worry, and a sense that one's thinking is out of control **the author's own account; Wells, 1995, 1999**.

Metacognitive therapy (MCT; Wells, 2008) works on these beliefs rather than on the content of each "what if". In the protocol used in a 2018 trial, it did not use cognitive restructuring of worry content, exposure or relaxation; its methods were challenging beliefs about the

uncontrollability and danger of worry, behavioural experiments, and postponing further "going over it" documented fact; Nordahl et al., 2018. MCT as part of the "third wave" is covered in Episode 13.

Borkovec: worry as avoidance

The American psychologist Thomas Borkovec proposed the avoidance theory of worry. In an experiment by Borkovec and Hu (1990), people afraid of public speaking imagined a frightening scene after relaxing, thinking neutral thoughts or worrying. After worrying, their heart rate rose least in response to the frightening image, even though they felt more afraid. The authors concluded that worry may suppress emotional processing and so preserve the fear structure proven by research; Borkovec & Hu, 1990.

In plain words: verbal worrying briefly dampens the body's reaction, gives short-term relief, and is reinforced for that reason. And because almost nothing people worry about actually happens, the brain draws a false conclusion: "I worried, and it was fine". This second part is the common interpretation of the theory; we did not find it stated in so many words in the sources we could open (interpretation). The 2004 review chapter by Borkovec and colleagues was not consulted not verified.

Model	What's at the centre	Main target of therapy
Dugas (1998)	Intolerance of uncertainty	Tolerating not knowing, solving real problems, facing feared images
Wells (1995)	Beliefs about worry: "useful" and "dangerous, uncontrollable"	Beliefs about worry rather than its content
Borkovec (1990s)	Worry as a way of avoiding emotion and physical arousal	Early signs of anxiety, applied relaxation, facing the fear

How GAD is treated

Bringing the different protocols together, therapy commonly includes (interpretation; summary based on Dugas et al., 2003; Nordahl et al., 2018; NICE, 2011):

- A worry diary: what about, for how long, what you did.
- Separating a solvable problem ("the bill isn't paid") from a hypothetical "what if" ("what if I get ill"). Solvable problems get solved step by step; with hypothetical ones, the work is learning to tolerate not knowing.
- Postponing worry to a set time, as an experiment against the belief "I can't control it".
- Re-examining beliefs about worry: does it actually help, is it actually dangerous?

- Cutting down on checking and asking "are you sure everything will be fine?" Each reassurance soothes briefly and works as a safety behaviour.

The models have been compared in trials. In Nordahl and colleagues' Norwegian trial (2018; 81 people), metacognitive therapy was compared with Borkovec's CBT. Recovery (on the PSWQ worry questionnaire) was 65% vs 38% after treatment and 57% vs 31% at 2 years **proven by research; Nordahl et al., 2018**. The supervisors were the protocols' own authors, Wells and Borkovec, both of whom receive royalties from related publications; the sample was small and from a single clinic **documented fact; Nordahl et al., 2018**. In a Dutch trial, metacognitive therapy also outperformed intolerance-of-uncertainty therapy **proven by research; van der Heiden et al., 2012, via NICE Evidence Update, 2012**. Earlier, Borkovec and Costello (1993) found applied relaxation and CBT roughly equal for GAD, and both better than non-directive therapy **proven by research; Borkovec & Costello, 1993**.

The APA's Society of Clinical Psychology rates CBT and applied relaxation for GAD as having strong research support, and calls metacognitive therapy "promising" for now **clinical consensus; Society of Clinical Psychology**. NICE recommends stepped care: first information and monitoring, then CBT-based self-help, then, for marked impairment, CBT or applied relaxation (usually 12–15 weekly one-hour sessions) or medication, as the person prefers; for complex GAD or a high risk of self-harm, specialist care **clinical consensus; NICE, 2011**.

Specific phobias: the most "behavioural" case

For phobias the main remedy is exposure, and sometimes one long session is enough.

A **specific phobia** is marked fear of a particular object or situation, such as heights, animals, flying, blood or injections. The fear is out of proportion to the real danger, and the person avoids it **clinical consensus; ICD-11 code 6B03, WHO, v2026-01, via Find-A-Code**.

It is one of the most common anxiety disorders. In the World Mental Health Surveys (25 surveys in 22 countries, 124,902 people), lifetime prevalence of specific phobia was 7.4% and 12-month prevalence 5.5%; it is more common in women (9.8% vs 4.9% lifetime). The median age of onset was 8. Only 23.1% of people with a phobia in the past year had received any treatment **proven by research; Wardenaar et al., 2017**.

The main method is **exposure**: gradually and according to a plan, facing what you fear. In a meta-analysis by Wolitzky-Taylor and colleagues (2008; 33 randomised studies), exposure had a large effect compared with no treatment and outperformed both placebo and other active psychotherapies; real-life exposure beat imaginal and virtual exposure right after treatment, but not at follow-up **proven by research; Wolitzky-Taylor et al., 2008**.

In 1989 the Swedish psychologist Lars-Göran Öst described **one-session treatment**: up to three continuous hours of exposure, therapist modelling, testing feared predictions, and

encouragement. In his first series of 20 patients, 90% were "much improved or completely recovered" **the author's own account; Öst, 1989, via Davis, Ollendick & Öst, 2012**. This was a case series with no control group. A 2008 review calls the method promising but asks for independent replication and comparisons with other active treatments **proven by research, review; Zlomke & Davis, 2008**.

Example **Fear of dogs (composite example).** An exposure ladder might look like this: looking at photos of dogs → videos → standing across the street from a dog on a lead → moving closer → stroking a calm dog held by its owner. At each step the person writes down what they expect ("it'll go for me") and compares it with what happened. The steps and the pace are agreed with the therapist.

How exposure is explained today. Michelle Craske and colleagues (2014) suggest building exposure around an inhibitory learning model rather than aiming only for "getting used to" the fear. Their practical advice includes designing exercises so that the expected catastrophe is clearly disconfirmed, removing safety signals, and varying the contexts and conditions of practice **documented fact; Craske et al., 2014**. The model is usually explained this way: exposure doesn't erase the old fear but creates new learning, "this is safe", that competes with it (interpretation).

Health anxiety: when checking doesn't reassure

Why searching your symptoms online, or one more test "for peace of mind", often makes the anxiety worse.

Health anxiety (once called hypochondriasis) is a persistent fear that you have, or are about to develop, a serious illness, even though tests and doctors don't confirm it. The person isn't pretending: the sensations are real and the fear is distressing.

In 1986 Paul Salkovskis and Hilary Warwick proposed looking at this through a CBT lens. The core of their model is behaviour that works like avoidance: seeking reassurance ("tell me it isn't cancer") and repeatedly checking the body. According to the model, this is what keeps the preoccupation with health going. In two single-case reports, medical reassurance brought only short-lived relief, while a treatment that cut down reassurance-seeking worked quickly (the authors' own account; Salkovskis & Warwick, 1986). These are two cases with no control group, so they are an idea, not proof.

The cycle is usually described like this (interpretation; based on the Salkovskis and Warwick model): the person notices a sensation, say a tingling in the chest → reads it as a sign of illness ("it's my heart") → feels anxious → checks: takes their pulse, reads about symptoms, asks family, requests another test → feels better for a while → but attention to the body grows, they

notice more sensations and start doubting ("what if the test was wrong?") → the circle repeats. The logic is the same as with OCD rituals (Episode 9).

In therapy, client and therapist draw this circle together, test an alternative explanation ("the problem is not an illness but the fear of illness"), use behavioural experiments to see how focusing on the body intensifies sensations, and gradually reduce checking and reassurance-seeking (interpretation; general description of the approach).

The largest trial is **CHAMP**. In six general hospitals in England, 444 adults aged 16–75 with marked health anxiety were randomly allocated either to 5–10 sessions of CBT (about 6 on average) or to usual care. The therapy was delivered by nurses and other staff with no previous CBT expertise, after training and under supervision. At one year, 13.9% of those who had CBT had a normal level of health anxiety, against 7.3% with usual care — roughly twice as many; the improvement held at 2 years **proven by research; Tyrer et al., 2014**. An honest caveat: even after CBT, most participants did not reach a normal level. It is a clear improvement, not a cure for everyone (interpretation).

> Important **See a doctor first.** New, changing or persistent symptoms — unexplained weight loss, bleeding, pain that won't go away — need a doctor's assessment first. A psychologist doesn't decide whether a symptom is dangerous, and CBT doesn't replace a medical examination. The aim of therapy is not "never see a doctor" but to stop checking from running your life; a sensible plan for check-ups is usually agreed with one regular doctor (interpretation).

One protocol for all anxiety?

If anxiety disorders share a mechanism, can one method treat them all?

David Barlow thinks so. His idea is that emotional disorders share a vulnerability: a tendency to react strongly to negative emotions and to avoid them. The **Unified Protocol** (UP) is a **transdiagnostic** approach, meaning one protocol aimed at mechanisms shared by different disorders **the author's own account; Barlow & Gallagher, Society of Clinical Psychology**.

Its modules: the adaptive nature of emotions; motivation; present-moment emotion awareness; cognitive flexibility; identifying and preventing emotional avoidance; tolerating physical sensations; and emotion-focused exposure to situations and sensations **documented fact; Barlow et al., 2017**.

In a 2017 trial (223 patients with panic disorder, GAD, OCD or social anxiety; up to 16 sessions), the Unified Protocol was equivalent to disorder-specific protocols on the severity of the main diagnosis, and more people completed treatment: 87.5% vs 69.2%

proven by research; Barlow et al., 2017. Critics note that the sample was well educated and mostly white, more than half were taking medication, and the trial was run by Barlow's own centre (interpretation; Newby & Norton, 2018, The Mental Elf).

Myth vs fact **Myth:** you should suppress anxiety, "pull yourself together" and not think about it. **Fact:** in Wegner's experiments (1987), students couldn't fully suppress even a neutral thought about a white bear, and after suppressing it they thought about it more than those who had been free to think about it first proven by research; Wegner et al., 1987. The authors themselves note it is unclear whether this carries over to emotional thoughts. Emotional avoidance is a shared target in the Unified Protocol documented fact; Barlow et al., 2017. The aim of therapy is not to stop feeling anxious but to stop fearing anxiety and letting it run your life (interpretation).

How well does CBT for anxiety really work?

The answer depends on what you compare it with.

Compared with a waitlist (people simply waiting for treatment), the effect is large: SMD −1.19 for social anxiety proven by research; Mayo-Wilson et al., 2014. Compared with placebo (for example, conversations without active techniques, or a sugar pill), the effect is moderate.

Carpenter and colleagues' meta-analysis (2018) pooled 41 placebo-controlled trials (2,835 patients) of CBT for anxiety and related disorders proven by research; Carpenter et al., 2018:

Measure	Result
All disorders, target symptoms	g = 0.56: moderate effect
Panic disorder	g = 0.39 (5 studies, 328 people)
Social anxiety	g = 0.41 (12 studies, 753 people)
GAD	g = 1.01, but only 2 studies and 57 people; the authors urge caution
Odds of responding vs placebo	2.97 times higher
Some months after treatment	g = 0.47: the effect holds
Adjusted for publication bias	g = 0.33
Completers only / everyone who started	g = 0.70 / 0.40

How to read this: g is a standardised difference between groups; 0 means no difference, around 0.2 is small, around 0.5 moderate, and 0.8 or more large (interpretation; Cohen's conventional benchmarks). Publication bias is when successful studies are more likely to be published than unsuccessful ones, inflating the average effect. In the non-PTSD studies, participants were on average 82% white **proven by research; Carpenter et al., 2018**.

Other caveats:

- **Evidence quality for panic** was rated low or very low by a Cochrane review **proven by research; Pompoli et al., 2016**.
- **Allegiance.** Key trials (Clark 1994, 1999, 2006; Dugas 2003; Barlow 2017) were run by the protocols' own developers. The component analysis of panic treatment lists the risk of researcher-allegiance bias among its limitations, which is why independent replication matters (interpretation; Pompoli et al., 2018; Newby & Norton, 2018).
- **People over 55.** Against an active control, the effect of CBT for anxiety was small and not significant **proven by research; Gould et al., 2012, via NICE Evidence Update, 2012**.
- **Culture.** We found no studies of CBT for anxiety in Russian-speaking or Azerbaijani samples for these notes.

Fact **Children and teenagers.** A 2020 Cochrane review pooled 87 randomised trials (5,964 participants in the analyses). After CBT, 49.4% of children and adolescents no longer met criteria for their main anxiety diagnosis, against 17.8% on a waitlist; in other

words, for roughly every three young people treated with CBT, one more is free of the diagnosis (NNT = 3). Certainty is moderate. The review could not show that CBT beats usual care or other treatments: those data are sparse and weak. Nor did it find a clear advantage for CBT involving parents over other formats **proven by research; James et al., 2020** . Parents are still often involved: for social anxiety in children and young people, NICE suggests individual or group CBT, 8–12 sessions (45 minutes individually, about 90 in a group), with parents possibly taking part, and medication is not usually offered **clinical consensus; NICE CG159, information for the public** . The SPACE parent programme is covered in Episode 9.

This doesn't mean CBT doesn't work. It means it helps many people, but not everyone, and not by magic. The evidence for and criticism of CBT are covered in Episode 14.

Myths about anxiety: a quick check

Myth	What the evidence says	Label
A panic attack is dangerous: you can die or go mad	It peaks within minutes and lasts about 10 minutes on average; fear of dying or going mad is a symptom, not a forecast. A doctor rules out medical causes	**Clinical consensus; proven by research**
Had an attack, so it's panic disorder	Only 12.8% of people who have had attacks have the disorder	**Proven by research**
The key to panic is breathing and relaxing	Muscle relaxation is linked to worse outcomes; breathing retraining has no proven benefit	**Proven by research**
Anxiety should be suppressed	Thought suppression works poorly; therapy aims at tolerating anxiety, not fighting it	**Proven by research; interpretation**
Avoid your triggers	Avoidance and safety behaviours maintain fear; planned exposure reduces it	**Proven by research; clinical consensus**
Social anxiety is just shyness	It's a diagnosis with criteria, and it's treatable	**Clinical consensus**
Only pills treat anxiety (or: pills are always bad)	Individual CBT is the first choice for social anxiety; for panic, CBT matches imipramine and holds up better after treatment stops; medication is effective and prescribed by a doctor	**Proven by research**
CBT is just "think positive"	The protocols are built on action: experiments, exposure, video feedback, dropping safety behaviours. The aim is to test a specific prediction through experience	**The author's own account**

Try this: translating the language of anxiety

A one-minute exercise. It's a first step in self-observation, not treatment.

Example **Four questions.** Think of the last time your body frightened you: your heart, your breathing, your head.

1. What did I feel in my body?
2. What did I think it meant? How strongly did I believe it, from 0 to 100?
3. What other explanation is there? (coffee, heat, lack of sleep, anxiety)
4. What did I do to "save myself", and could it have ended fine without that?

The point is to notice that between the sensation and the fear there is a thought. It follows the same logic as Clark's model, but it doesn't replace therapy. Interoceptive exercises are not for doing on your own: they are done with a therapist, after a medical check.

When to see a professional

- If attacks keep happening, you've started avoiding places or activities, or anxiety is getting in the way of work, study or relationships: first a doctor, to rule out medical causes, then a psychotherapist who works with CBT.
- A psychiatrist if there is marked depression, thoughts of death or self-harm, dependence on alcohol or sedatives, or a decision about medication to make. If you are having thoughts of self-harm, see If you need help now.
- A psychologist does not rule out physical illness or prescribe medication; that is a doctor's job.

Check yourself

1. **How does fear differ from anxiety?** Fear is a response to a threat now; anxiety, to a threat expected in the future.
2. **What, according to Clark, turns ordinary sensations into a panic attack?** Catastrophic misinterpretation: reading the sensations as a sign of immediate disaster.
3. **Why do safety behaviours keep anxiety going?** The person credits their "rescue" to the safety behaviour and never learns that the catastrophe wouldn't have happened anyway.
4. **According to the component analysis, which two elements should CBT for panic include, and which one not?** Include face-to-face delivery and interoceptive exposure; muscle relaxation is linked to worse outcomes.
5. **How do the Dugas, Wells and Borkovec models of GAD differ?** Intolerance of uncertainty; beliefs about worry itself; worry as avoidance of emotion and physical arousal.
6. **Why doesn't one more test "for peace of mind" help with health anxiety?** Reassurance eases the anxiety only briefly, while it increases attention to the body and doubt, so the

checking circle repeats.

What to remember

- Anxiety is normal; it becomes a disorder when it is out of proportion, lasts and gets in the way of life.
- In all CBT models, anxiety is maintained by avoidance and safety behaviours, which stop the fear from being tested.
- Panic is a circle: sensation → catastrophic thought → more sensations. It is broken by rethinking the fear and deliberately bringing on sensations with a therapist, not by relaxing.
- In social anxiety, people see themselves from inside their own sensations; individual CBT is the first choice.
- In GAD, therapy works on how the person relates to uncertainty and to worry itself, rather than arguing with each "what if".
- For phobias, the main method is planned exposure.
- In health anxiety, CBT reduces checking and reassurance-seeking; new symptoms are assessed by a doctor first.
- Against placebo, the effect of CBT is moderate, and that's an honest benchmark. Medical causes of symptoms and decisions about medication are for a doctor.

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