Worry Management for Generalised Anxiety

THE TALKING THERAPIES UK SELF-HELP SERIES



Worry Management for Generalised Anxiety

An eight-module CBT programme for chronic worry and Generalised Anxiety Disorder, working with the cycles that keep worry going and the intolerance of uncertainty that fuels it

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

TALKING THERAPIES UK

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First edition, 2026.

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

Revision 7. This printing was set on 15 November 2026 from the programme as it stood that day.

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

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

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How to use this workbook

Chronic worry is exhausting, and the conventional advice (try not to worry, think positive, distract yourself) tends not to help, because the underlying mechanisms of worry are not the ones the advice assumes. Worry is a form of attempted problem-solving that has become disconnected from any actual problem-solving function: the mind cycles through possible future negatives because at some level it believes this preparation is keeping you safe, even though the actual effect is the opposite. This eight-module programme works with the actual mechanisms identified by the contemporary research literature on Generalised Anxiety Disorder (GAD), the clinical name for the pattern most people simply call 'I am a worrier'. The approach combines classical CBT for worry, Michel Dugas's intolerance-of-uncertainty model, and elements of Adrian Wells's metacognitive therapy, all of which have NICE-recognised evidence bases for GAD and which between them account for the substantive body of clinical research on chronic worry over the last three decades. Understanding worry. The first conceptual move is recognising that worry is not the same as ordinary thinking about a problem. Worry has a specific signature: it is verbal rather than imaginal (you tend to think in language rather than images), it focuses on possible negative future outcomes, it loops without resolution, and it produces a low-grade physical activation that the system does not switch off. Ordinary problem-solving is brief, leads to a decision or an action, and ends; worry continues indefinitely. Once you see worry as a distinct cognitive process rather than as serious thinking, the work changes shape: it becomes about disrupting the process rather than about resolving every possible negative future. The worry cycle and the beliefs that maintain it. Worry is maintained by positive beliefs about worry that you may not have explicitly noticed: 'worrying helps me prepare', 'if I worry I will not be caught off guard', 'worrying shows I care', 'if I stop worrying something bad will happen'. These beliefs feel intuitively true and they keep the worry process going long after it has stopped serving any useful function. The cognitive modules identify and test these beliefs explicitly, since direct attempts to stop worrying without addressing the underlying belief system produce only temporary improvement. The practical skill of worry postponement. One of the most evidence-supported behavioural interventions for chronic worry is the structured postponement of worry to a specific scheduled time in the day, typically fifteen to thirty minutes at the same time each day, in the same place, with the same notepad. The point is not to suppress worry but to displace it from the times when it interferes with life, and to discover, as most people do, that by the time the scheduled worry slot arrives most of what seemed urgent earlier has lost its grip. Productive versus hypothetical worry. Some worry is genuinely productive: it is about a real, current, actionable problem and it leads to a decision. Most worry is hypothetical: it is about something that has not happened, may not happen, and cannot be acted on right now. The programme teaches the practical distinction between these two and what to do with each: productive worry gets converted into structured problem-solving, hypothetical worry gets handled through the worry-postponement and acceptance approaches. Intolerance of uncertainty. The deeper driver of chronic worry, identified across multiple research programmes, is intolerance of uncertainty: the difficulty staying in the not-yet-knowing space without immediately filling it with worried prediction. The work on intolerance of uncertainty is about deliberately allowing some uncertainty rather than always trying to resolve it through more thinking, and discovering that the system can tolerate the open question better than the worry-driven need for closure assumed. The

metacognitive perspective. Adrian Wells's metacognitive therapy adds a further layer: it shifts attention from the content of worry (what specifically is being worried about) to the relationship with worry (how you engage with the worried thoughts). Detached mindfulness, the metacognitive skill of noticing thoughts without engaging with them, gives you a way of relating to worried thinking that does not require resolving every individual worry. Imagery work. Some worry patterns include imagery (vivid mental pictures of feared outcomes) alongside the verbal worry process. The programme includes the specific imagery-based techniques developed for this presentation, including imaginal rescripting where appropriate. The maintenance plan. The final module is a personalised maintenance plan for living well with a worry-prone mind: the early warning signs that worry is creeping back to interfering levels, the specific strategies that work for you at each level of intensity, and the conditions under which stepping up to therapist-led care is the right move. Who this is for and what it is not. The programme is suitable for adults experiencing chronic worry at NHS Talking Therapies Step 2 equivalent: persistent worry across a range of life areas, difficulty controlling worry, and the physical and emotional consequences that go with it. If your worry is severe and incapacitating, if it is accompanied by panic disorder requiring its own treatment, if there is a substantial trauma history that the worry is part of, or if you are in crisis, individual therapy is more appropriate; the worry-management techniques in this programme are typically integrated into broader therapeutic work in those situations. If you are in crisis, please contact Samaritans on 116 123, text SHOUT to 85258, or NHS 111 option 2.

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

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

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

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

When self-help is not enough

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

What this workbook will help you to do

- By the end of this module you will:
- Understand worry as a specific cognitive process rather than as a personality flaw or a moral failing
- Know the difference between everyday concern and the chronic worry that meets the criteria for GAD
- Recognise the cognitive, behavioural, and physiological features of GAD
- Have set three goals for what this programme should change
- Understand the cycle through which worry maintains itself once it starts
- Recognise the positive and negative beliefs about worry that keep the cycle going
- Identify your own safety behaviours, reassurance seeking, and avoidance patterns
- Have begun mapping your own version of the worry cycle
- Understand why worry postponement works and what it is not

PART 1

Understanding Worry and Generalised Anxiety

What worry actually is, how it differs from ordinary concern, and what makes the chronic version a clinical condition

CHAPTER 1

Welcome to the programme

This is an eight-module programme for people whose lives are dominated by worry. Worry of the chronic kind is exhausting in a particular way: it consumes mental energy continuously, it generates physical symptoms (muscle tension, fatigue, disturbed sleep, gut difficulties, headaches), it interferes with concentration on the actual demands of the day, and it produces a felt experience of life as a series of upcoming catastrophes that need to be mentally rehearsed in order to be averted. The conventional advice to people who worry (try not to worry so much, think positive, just distract yourself) tends to be unhelpful because it does not address the underlying mechanisms; it treats worry as a habit that can be broken by direct will, when in fact worry is a self-sustaining cycle with specific maintaining factors that need specific interventions.

The approach in this programme is grounded in the contemporary research literature on Generalised Anxiety Disorder (GAD), which is the clinical name for chronic excessive worry. Three theoretical frameworks have produced the most useful interventions, and the programme draws on all three. Classical cognitive-behavioural therapy for worry, developed across the 1980s and 1990s, addresses the content of worry and the behavioural avoidance that sustains it. The intolerance-of-uncertainty model, developed by Michel Dugas and colleagues at the University of Quebec, identifies that for many chronic worriers the real problem is not any specific worry but a deeper inability to tolerate not knowing how things will turn out. The metacognitive model, developed by Adrian Wells at the University of Manchester, addresses the beliefs about worry that paradoxically maintain the worry cycle, particularly the beliefs that worry is uncontrollable or that worry is somehow useful or protective.

All three frameworks have NICE-recognised evidence bases for GAD, and they are not mutually exclusive; the programme works through them in a sequence designed to build practical skills first and address the deeper structure later. By the end of the eight weeks you will have a working set of tools for interrupting worry cycles in the moment, a clearer understanding of the mechanisms that have been keeping the worry going, and a maintenance plan for the long-term work that lives with a worry-prone mind requires.

A note about what the programme is not. It is a self-directed Step 2 programme appropriate for

chronic worry and mild-to-moderate GAD that is interfering with daily life but has not become severely impairing or bound up with significant depression. If your worry is accompanied by panic attacks, severe avoidance, suicidal thoughts, alcohol or other substance use as a coping mechanism, or has been so disabling that you cannot work or maintain relationships, individual therapy is more appropriate. The final module covers the step-up criteria; for now, the point is that the programme is right for the chronic worrier who is functioning but tired of the worry, and is part of the picture for more severe presentations rather than the whole of it.

CHAPTER 2

What worry actually is

Worry is a specific cognitive process. It is not the same as anxiety, although the two are closely related. Anxiety is an emotional and physiological state; worry is a verbal-linguistic activity, mostly conducted in inner speech, in which the mind cycles through future possibilities, mostly negative, mostly attempting to anticipate and prepare for things that might go wrong.

Worry has a recognisable structure once you start observing it. It starts with a what if thought. What if the meeting goes badly. What if I lose this job. What if my partner leaves me. What if my child is being bullied. What if there is something wrong with my health. What if the noise in the engine means the car is going to break down. What if I have offended my friend. What if the email I sent was misinterpreted. The what-if can be triggered by anything: a piece of news, a body sensation, a remembered conversation, an upcoming event, a sense of unspecified unease.

Once the what-if is present, the mind enters a chain of reasoning in which it tries to address the question. The reasoning is structured around generating scenarios, evaluating the likelihood of each, considering what could be done in response, and frequently jumping to a different but related what-if. What if the meeting goes badly... what if my manager is disappointed... what if this is the meeting where she tells me my performance has been a problem... what would I do... I should probably update my CV... but that means accepting it might happen... but if I do not prepare and it does happen I will be in trouble... what if there is no other job out there... what if I cannot pay the mortgage... what if we have to move... what if the children have to change schools... The cascade can be extraordinary in its reach, moving from a routine meeting to multiple displaced families within minutes, all in inner speech, all without producing any actual decision or action.

The cognitive scientist Tom Borkovec, who did much of the foundational research on worry, identified two features that distinguish chronic worry from ordinary problem-thinking. First, worry is abstract and verbal rather than concrete and imagistic. People worry in words rather than in pictures, which is one of the things that makes worry particularly exhausting and particularly ineffective at producing solutions. The verbal mode does not engage the parts of the brain that actually process emotional and practical information; it cycles through possibilities in language without arriving at the felt understanding that produces decision. Second, worry is avoidant. People worry as a way of avoiding more uncomfortable processing, particularly the felt experience of fear or grief that the underlying concerns would produce if approached directly. Worry feels like engagement with the problem; it is actually a substitute for the deeper engagement that would resolve the problem.

A woman in her late thirties is at her desk at half past two on a Tuesday afternoon when she becomes aware that she has not heard from her teenage daughter, who would normally have texted by lunchtime to confirm her plans for after school. The trigger is a small one and would not, in a non-worrier, produce anything more than a passing thought to text the daughter and check.

In her, the trigger launches a worry chain. The chain is entirely in inner speech and runs as follows, in approximately the order it actually occurs, across roughly thirty minutes during which she is

supposed to be working on a piece of analysis.

What if she has lost her phone. What if it is in someone else's possession. What if she has been mugged. The route home from school goes through the area where there were three muggings last year. What if she is in hospital and they have not been able to find me. What if she has been hit by a car. The crossing by the school is dangerous, the parents' WhatsApp group was discussing it last week. What if she has had a panic attack and is sitting on a bench somewhere unable to get home. What if she has decided to go to someone's house and not come home and is in a situation she cannot get out of. What if the silence is deliberate, what if she is in trouble at school and is avoiding me, what if the trouble at school is something serious. What if it is to do with the boy from year twelve I have been worried about. What if she is pregnant. What if. What if. What if.

By the end of the half hour she has, in inner speech, mentally rehearsed nine distinct catastrophic scenarios, each treated by her body as if it were happening. Her heart rate is up, her shoulders are around her ears, her stomach is tight. She has produced no decision and taken no action. Her phone has been in her hand intermittently throughout, opened and closed without sending a message, because each version of sending a message also produced its own worry chain (if I message her and there is nothing wrong I will look like an over-anxious mother again, but if I do not message her and something is wrong...).

The half hour ends when the daughter walks in the front door at five past three, having lost track of the time at her friend's house after school and not noticed her phone had run out of battery. The daughter is fine. The mother is, after the relief, exhausted in a way that has nothing to do with the work she was supposed to be doing.

This is the abstract verbal cycling Borkovec described. The chain felt like preparation. It was actually thirty minutes of language running on its own, producing physiological consequences but no actionable output. The simplest concrete behaviour available throughout (sending a message at the moment the absence was noticed) was not done, because the worry mode is precisely the mode in which the simplest concrete action becomes hard to take.

A NOTE

Worry is not the same as concern. Concern is the appropriate response to a real problem: you notice the problem, you think clearly about what can be done, you take action where action is possible, you accept where it is not, and the concern resolves. Worry is the abstract verbal cycling that does not resolve and that does not produce action. Most people with chronic worry are perfectly capable of concern; the problem is that the worry layer runs continuously, on top of and around the legitimate concerns, and the worry layer never completes.

CHAPTER 3

Generalised Anxiety Disorder, in clinical terms

Generalised Anxiety Disorder is the clinical name for chronic excessive worry that has reached the threshold of a recognised condition. The diagnostic criteria, similar across DSM-5 and ICD-11, identify several features that, taken together, distinguish GAD from ordinary worry.

Excessive worry, on most days, for at least six months. The duration matters because most people experience phases of intense worry around specific stressors that resolve when the stressor resolves. GAD is the chronic version: worry that is present most days for at least half a year, and that is not just about one thing.

Worry across multiple domains. A defining feature of GAD is that the worry is generalised; it spreads across many areas of life rather than being focused on one theme. Work, relationships, health, finances, family, the future, the safety of loved ones, world events. The mind moves between worries; what is constant is the worrying, not any particular worry. This is a key differentiator from other anxiety conditions, where the worry tends to be focused on a specific theme: in social anxiety the worry is about social situations, in health anxiety about health, in panic disorder about panic itself.

Difficulty controlling the worry. People with GAD typically describe being unable to stop worrying once it starts, or having tried unsuccessfully to control it. The felt experience is one of the worry running on its own, regardless of whether the person wants it to.

Three or more associated symptoms. The clinical criteria require at least three of the following: restlessness or feeling on edge; being easily fatigued; difficulty concentrating or mind going blank; irritability; muscle tension; sleep disturbance. These are the physical and behavioural signatures that distinguish clinical GAD from ordinary worry. Most people with chronic worry have all six.

Significant impairment. The worry causes distress or impairment in social, occupational, or other important areas of functioning. The picture is not just unpleasant; it is interfering with the person's life.

How GAD differs from other anxiety conditions

GAD is the generalised form because the worry spreads across topics rather than focusing on one. People with GAD often describe themselves as worriers since childhood; the trait of worrying is sometimes lifelong, becoming clinically significant during periods of higher demand or stress.

A man in his early fifties has, for as long as he can remember, been someone who worries. The pattern has been the background music of his life. He worries about work in detail, about money, about the children even though they are grown, about his ageing parents, about his own health, about the news, about whether he locked the back door, about whether he left the iron on, about whether the email he sent yesterday read the right way, about whether the friend who has not been in touch is annoyed with him. The worries shift; what is constant is the worrying.

Until he comes to this programme he has never thought of his picture as a condition. The framing

has been that he is a careful person, perhaps a slightly anxious one, someone who takes responsibility seriously. His wife has occasionally suggested he might benefit from talking to someone; he has waved this away on the grounds that the worry has not made his life unworkable.

In Module 1 he reads the criteria and recognises himself in each of them. Excessive worry on most days, for far longer than six months; the picture has been present at this level for at least fifteen years. Worry across multiple domains; not focused on any single theme, generalised across work, family, health, finances, relationships, everyday concerns. Difficulty controlling the worry; he has tried, repeatedly, to talk himself out of worrying and the worry continues regardless. Five of the six associated symptoms: restlessness, easy fatigue, difficulty concentrating, muscle tension that he has carried in his shoulders and jaw for decades, sleep that has been broken for as long as his wife has known him. Significant impairment; not at the level that has stopped him working or maintaining relationships, but enough that he has been functioning on substantially less than he could be functioning on if the worry layer were not running continuously.

The recognition produces a complicated felt response. There is relief, because the pattern has a name and the name is something that has been studied and that responds to treatment. There is also a small wave of something like grief, because he has been carrying this for so long without naming it that the naming reframes a substantial part of his adult life. He writes in his diary that evening: “I have been managing this since I was about thirty. I did not know it had a name. Knowing it has a name does not change what has been happening, but it changes what I can do about it now.”

The recognition is information, not diagnosis-as-life-sentence. GAD responds well to treatment. The eight weeks of the programme are designed to give him the practical skills, and the recognition that the picture is GAD means he can now place those skills in a framework that has been tested at scale rather than improvising responses to a generic difficulty.

GAD is often comorbid with depression. Approximately two-thirds of people with GAD will develop a depressive episode at some point, and approximately half of people with chronic depression have GAD-level worry. The two conditions share underlying features (rumination is closely related to worry, and the brain regions involved overlap substantially) and the treatments overlap as well. A programme that addresses worry effectively typically reduces depressive symptoms alongside, and vice versa.

GAD is also commonly comorbid with chronic pain, fatigue conditions, and gastrointestinal symptoms. The chronic activation of the stress system that worry produces has measurable effects on physical health, and addressing the worry often produces improvement in these physical conditions too.

Why this matters for the programme

If what you have is chronic worry that meets GAD criteria, this is information rather than diagnosis-as-life-sentence. GAD is one of the most treatable conditions in the anxiety family. CBT for GAD, particularly the contemporary versions that incorporate intolerance-of-uncertainty work and metacognitive therapy, produces substantial improvement in 60–70% of people who complete a full course of treatment. The improvement is durable; people who treat GAD effectively typically maintain the gains over years.

The programme is the self-directed version of what an individual CBT-for-GAD course would cover. It is more demanding than the conventional self-help advice but more effective; the trade-off is the work it asks you to do. People who complete the programme typically report substantial reduction in worry, less physical symptom burden, better sleep, and a different relationship with the worry-prone aspects of their mind.

A NOTE

The worry-prone mind does not become a non-worry mind. The aim of the programme is not to eliminate worry, which would not be possible and is not even desirable; some worry, in proportion to actual stressors, is functional. The aim is for worry to operate at the level it does in someone without GAD: present occasionally in response to real concerns, brief, productive when it is, and resolving rather than self-sustaining. The mind that has tended to worry will probably continue to tend to worry; the difference is that the tendency no longer dominates the felt experience of life.

WORKSHEET

Sort each statement into the worry category it represents

Before setting your personal goals for the programme, sort twelve statements by which of three categories each one represents. The distinction between ordinary productive concern, the abstract verbal cycling of chronic worry, and the clinical-level pattern of GAD is the foundation for the rest of the programme; recognising which is which in other people's examples builds the recognition skill you will need when looking at your own patterns.

Concern is the appropriate response to a real problem: you notice, think clearly about what can be done, take action where it is possible, accept where it is not, and the concern resolves. Excessive worry pattern is the abstract verbal cycling described in the cognitive model: it does not resolve, does not produce action, and runs on top of and around legitimate concerns. GAD-level features are the clinical markers that distinguish chronic worry from ordinary worry: duration over six months, generalised across multiple domains, difficulty controlling, associated physical symptoms, significant impairment.

The groups: A Concern (productive, resolves) B Excessive worry pattern C GAD-level feature

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

☐ 1. My annual tax return is due in three weeks; I will set aside this Saturday afternoon to do the bulk of it and resolve the discomfort by getting started

☐ 2. In thirty minutes at my desk this afternoon I have moved, in inner speech, from a missed lunchtime text to mentally rehearsing nine different catastrophic scenarios involving my teenage daughter, with no action taken and no decision reached

☐ 3. I have been worrying excessively, on most days, for the past several years, well beyond any six-month threshold and through periods of both high and low life-demand

☐ 4. My GP appointment for the persistent shoulder pain is on Tuesday; I will write down the timeline and symptoms beforehand so that the consultation is useful

- [ ] 5. My worry moves freely between work, finances, my health, my children's safety, my elderly parents, the news, and small daily concerns; what is constant is the worrying, not any particular worry
- [ ] 6. I have tried, repeatedly and across years, to talk myself out of worrying or to set the worry aside by an act of will, and the worry continues regardless of what I decide
- [ ] 7. The work that we have been doing on the kitchen project is at a stage where I need to choose between two suppliers by Wednesday; I will compare the two quotes properly tomorrow and decide
- [ ] 8. I have been carrying chronic muscle tension that lives in my shoulders and jaw for as long as my partner has known me, sleep that has been broken across years, and a felt fatigue that is not relieved by ordinary rest
- [ ] 9. In response to a small ambiguity, my mind generates a chain of what-ifs that runs for forty-five minutes in inner speech, all without producing any decision or action, and leaves me physiologically activated
- [ ] 10. My friend is having a difficult time at work; I will call her this evening to listen, and I will check in again next week
- [ ] 11. The worry pattern has not stopped me working or maintaining relationships, but I have been functioning on substantially less than I could be functioning on if the worry layer were not running continuously
- [ ] 12. The worry typically feels like preparation, like vigilance, like making sure nothing has been missed, but produces no decision, no action, and no settled sense of having addressed the underlying concern

The answers are at the back of the book.

WORKSHEET

Set three goals for the programme

Take fifteen minutes to set three concrete goals. Specific, observable goals work better than abstract ones; worry less is too vague, be able to put the work emails out of my mind in the evening is workable.

Set three goals. Specific, observable, and modest. The good ones are within reach within the eight weeks of the programme; very long-term goals are appropriate for the maintenance plan in module 8 rather than for the early goals here.

Goal 1

How I will know I am making progress on Goal 1

Goal 2

How I will know I am making progress on Goal 2

Goal 3

How I will know I am making progress on Goal 3

CHAPTER 4

Closing Module 1

You have a working understanding of what worry is, how GAD is structured, and the framework the programme will use. You have three concrete goals.

Looking ahead

Module 2 covers the worry cycle: how worry maintains itself once it starts, the role of behaviours that feel like coping but actually keep the cycle going, and the beliefs about worry that the metacognitive model identifies as the deeper structure underneath the chronic version.

Practice for the week ahead

Notice across the week the moments where worry activates. Do not yet try to do anything about it; just notice when it starts, what triggered it, how long it ran for, and whether it produced any useful conclusion. The point is observation; the interventions begin in module three.

CHECK-IN

Mood check-in (PHQ-9)

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

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

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3

9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total: _____ Date: _____

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

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

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

CHECK-IN

Everyday life check-in (WSAS)

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

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

WORKSHEET

Taking this forward

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

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

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

PART 2

The Worry Cycle

How worry maintains itself, the beliefs that keep it going, and the behaviours that feel like coping but are actually part of the cycle

CHAPTER 5

Why worry does not just stop

A reasonable question for anyone with chronic worry to ask is: if worry is so unpleasant and so unproductive, why does it not just stop on its own? The answer is that worry has its own self-sustaining structure. It is not a habit that can be broken by direct will, because direct will operates at the surface, and the cycle that keeps worry going operates underneath. Until the underlying structure is understood and addressed, worry tends to continue regardless of how much the worrier wishes it would not.

The structure of the cycle has been mapped in detail by several research groups, and the key findings converge. Worry continues because of three reinforcing factors: beliefs about worry, behaviours that prevent disconfirmation, and avoidance of the deeper material that worry is substituting for. Each is covered below.

The reason understanding the cycle matters is that the rest of the programme is essentially about intervening at each point of the cycle. Module 3 introduces worry postponement, which targets the immediate mechanism by which worry takes over attention. Module 4 introduces the practical-versus-hypothetical distinction, which targets the content of worry. Modules 5 and 6 address the underlying drivers: intolerance of uncertainty, and the metacognitive beliefs about worry. Modules 7 and 8 work with the deeper relationship to worry-prone mental life. Each piece addresses a part of the cycle; the combination is what produces the durable change.

CHAPTER 6

The maintenance cycle of worry

The worry cycle has several stages, each of which the rest of the programme will work to interrupt.

Stage 1: A trigger generates a what-if thought

The cycle begins with a triggering event: a piece of news, a body sensation, an upcoming event, an ambiguous situation, a memory, sometimes nothing identifiable. The trigger generates a what-if thought. What if X happens. What if I cannot handle Y. What if Z goes wrong.

In a non-worrier, the what-if either resolves quickly (the brain assesses the actual probability and the realistic options, generates an answer or accepts the lack of one, and moves on) or the what-if is dismissed as not worth dwelling on. In a chronic worrier, the what-if launches the next stage of the cycle.

Stage 2: The worry chain

The mind enters the worry chain. It generates scenarios, considers their consequences, jumps to related what-ifs, and continues the verbal-linguistic cycling described in module 1. The chain feels productive in the moment because it has the appearance of working through the problem. It feels like preparation, like vigilance, like making sure that nothing has been missed.

What is actually happening is the abstract verbal cycling that does not resolve. The chain does not produce a decision, does not produce action, and does not produce the felt sense of having addressed the underlying concern. It produces only more chain.

Stage 3: Anxiety and physical symptoms

The chain triggers the body's stress response. Heart rate increases. Muscle tension rises. The sympathetic nervous system activates. The body is responding to the worry chain as if the imagined scenarios were happening; from the body's point of view, the threat is being processed, and the activation is the appropriate response. Over hours and days, the cumulative activation produces the physical symptoms that are part of GAD: chronic muscle tension, fatigue, sleep disturbance, gastrointestinal symptoms.

Stage 4: Behavioural responses

The anxiety produces behaviours that feel like coping but that maintain the cycle.

Reassurance seeking. Asking other people whether everything is OK. Asking whether you should be worried. Asking the same question multiple times in slightly different forms. Reassurance feels like it helps in the short term (the worry quietens briefly) but the relief is brief and the next worry brings the next request, and over time the pattern increases dependence on external reassurance and decreases the person's ability to tolerate uncertainty on their own.

A woman in her thirties has been worried for several weeks about a small mole on her shoulder that she has been monitoring. The mole has not changed in any clinically meaningful way. Her GP,

at an appointment three weeks earlier, examined it and was clear that it did not need further investigation.

The reassurance the GP gave lasted approximately four hours. By the evening of the appointment she was looking at the mole again, and the what-if had returned: what if the GP missed something, what if it has changed slightly since the appointment and she would not have known what it looked like before, what if a different GP would have referred it on for biopsy.

She then enters a week of reassurance-seeking that she has not previously identified as part of the cycle.

Monday evening. She asks her partner to look at the mole and say whether it has changed since he last looked. He says it looks the same. The relief lasts about ninety minutes. She returns to it in bed and asks him again whether he is sure. He confirms again. Brief relief. She wakes at three in the morning with the worry active.

Tuesday. She texts her sister, who is a nurse, three photographs from different angles asking her to look at them. The sister replies that they look completely normal. Brief relief. She returns to the photographs on her own phone three more times across the afternoon.

Wednesday. She types her symptoms into an online symptom checker, three different ones, looking for one that confirms the GP's assessment. Two reassure her; the third raises a possibility that intensifies the worry. She then spends ninety minutes reading articles on the third possibility.

Thursday. She books a private dermatology appointment for the following week, justifying it on the grounds that she would rather know definitively. The booking produces relief for about an hour, and then a new worry: what if the private dermatologist also says it is fine, will she trust that, what if she does not.

Friday. She asks her partner again whether the mole has changed. He pauses this time, and says gently, "I have looked at it more times in the last week than is helping either of us. I do not think looking at it again is going to settle this." She is briefly hurt by the response and then, sitting with it, recognises that he is right. The pattern she has been running has produced about a dozen reassurance interactions in five days, each providing relief that lasted hours rather than days, with the cumulative effect that her dependence on external reassurance is higher at the end of the week than at the start.

The cost is not the time spent or the imposition on others, though both are present. The cost is the gradual transfer of the work of holding uncertainty from her own internal capacity to the external reassurance machinery. Six months earlier she could hold the kind of low-grade uncertainty the mole presents on her own; this week she could not, and the difference is not that the mole has become more concerning, it is that the reassurance pattern has weakened the capacity that used to hold it.

Avoidance. Avoiding situations that might trigger the worry. Not watching the news. Not having the difficult conversation. Not making the decision. Not putting yourself in situations where you might encounter information that would intensify the worry. Avoidance feels protective but reduces the evidence available to challenge the worry, and the avoided situations build up.

Over-preparation. Researching exhaustively. Checking and rechecking. Making contingency plans

for contingencies. Asking for second opinions. Over-preparation feels responsible but is itself a form of worry; the time spent preparing is time the worry is occupying, and the over-preparation builds the belief that without it disaster would have occurred, when in most cases the basic preparation would have been enough.

Worrying as a strategy. Some people, paradoxically, worry deliberately as a coping strategy. The belief is that worrying will prevent the bad outcome (or at least mean that the bad outcome will not catch them unprepared). This is the metacognitive belief that the next section addresses, and it is one of the most powerful maintaining factors in chronic worry.

Stage 5: Metacognitive beliefs reinforce the cycle

Two kinds of beliefs about worry sustain the cycle, both of which are usually held without conscious examination.

Positive beliefs about worry. The belief that worry is useful, protective, or motivational. If I worry, I will be prepared. If I worry, the bad thing will not happen. Worry shows that I care. Worry helps me solve problems. Worry keeps the people I love safe. These beliefs are usually wrong (worry is not problem-solving, worry does not actually prevent anything, the people you love are safer if you sleep and function well rather than if you worry constantly), but they are deeply held and they justify the worrying.

Negative beliefs about worry. The belief that worry is uncontrollable, dangerous, or harmful. I cannot stop worrying. Worry is going to make me ill. I am losing my mind. The worrying is taking over. I cannot function unless the worry stops. These beliefs themselves trigger anxiety about the worrying, which produces meta-worry (worry about worrying), which is the most exhausting form of worry and the most distinguishing feature of severe GAD.

The two sets of beliefs work together to maintain the cycle. The positive beliefs justify continuing to worry; the negative beliefs produce anxiety about the worry that itself adds another layer of worry. The combination is self-reinforcing and produces the experience of being trapped in worry that chronic worriers describe.

A man in his forties is a chronic worrier whose conscious view of his worry is straightforwardly negative: he wishes it would stop, he knows it does not help, he can articulate clearly that worry is not problem-solving. Asked directly whether he thinks worrying is useful, he would say no, of course not.

The implicit picture, which the exercise in Module 2 brings into view, is more complicated.

The positive beliefs. When he sits with the question carefully, he recognises that part of him does in fact believe the worry is doing something useful. He notices the felt resistance when he tries an experiment of deliberately not worrying about an upcoming work review: the resistance is not just discomfort with the unfamiliarity, it is a felt sense that if I do not worry about this, I will not be prepared, something will be missed, the worry is keeping the review safe. The belief is not conscious in those words; it operates as the gut feeling that drives him back to the worry when he tries to step away from it. He also notices a second positive belief, more interpersonal: when he worries about his daughter who is travelling abroad for the first time, part of him believes that the worrying is itself an expression of his care for her, and that to stop worrying would somehow be to

stop caring.

The negative beliefs. Alongside the positive beliefs runs a parallel set of negative ones. He worries about the effect of the worrying on his health (he has read articles linking chronic stress to cardiovascular disease, and the worry about that is itself a meta-worry). He worries that the worrying is escalating and will eventually become unmanageable (the felt sense that he is losing some kind of internal grip, that the worry is bigger than it used to be). He worries that the worrying means something is wrong with him as a person, that the worrying capacity is taking up the space that other internal capacities should occupy.

How the two layers interact. The positive beliefs make him reluctant to stop worrying, because part of him is convinced the worrying is doing useful work. The negative beliefs add a second layer of worry on top, which is worry about the worrying. The first layer keeps the worry running; the second layer adds to it. The combination has been making the picture worse year on year, and he had not previously seen the structure clearly.

Writing the beliefs down on the page is, for him, the first time the implicit pattern is visible as a pattern. The conscious belief (worry does not help) and the implicit belief (if I stop worrying, I will not be prepared and I will not be caring) have been running simultaneously, in different parts of him, with the implicit one effectively winning every time. Naming both in writing is the first move in the cognitive work the rest of the programme will do.

Where the programme intervenes

The rest of the programme works on every layer of the cycle. Module 3 introduces worry postponement, which intervenes at stage 2 (interrupting the worry chain). Module 4 introduces the practical-versus-hypothetical distinction, which separates the worries that can usefully lead to action from the ones that cannot. Modules 5 and 6 work on the underlying drivers: intolerance of uncertainty (stage 1's vulnerability) and the metacognitive beliefs (stage 5). Module 7 works on the relationship with worry-prone thinking through detached mindfulness. Module 8 puts everything together.

WORKSHEET

Sort each fragment into the cycle layer it represents

Before mapping the cycle in your own life, sort twelve fragments by which of the four cycle layers each one represents. The fragments come from different moments and different episodes, because in a real cycle the layers do not arrive labelled; learning to recognise them in isolation is what makes the cycle visible when you look at your own life in the exercise that follows.

Cognitive cycling is the what-if trigger and the verbal-linguistic worry chain that follows it. Physical-autonomic is the body's stress response: heart rate, muscle tension, sympathetic activation, the somatic symptoms of GAD. Behavioural responses are the reassurance seeking, avoidance, over-preparation, and worrying-as-strategy that feel like coping but maintain the cycle. Metacognitive beliefs are the implicit beliefs about worry (positive and negative) that reinforce the whole pattern.

The groups: A Cognitive cycling (what-if and worry chain) B Physical and autonomic symptoms C Behavioural responses D Metacognitive beliefs

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

☐ 1. What if she has lost her phone, what if she has been mugged, what if she is in hospital, what if the silence is deliberate, what if she is in trouble at school

☐ 2. Asking my partner three times across the evening whether the small mole on my shoulder has changed since he last looked, and each reassurance lasting about ninety minutes before I ask again

☐ 3. A felt sense that worrying about my daughter is the act of caring for her, and that to stop worrying would somehow be to stop caring

☐ 4. Heart rate increased across the half-hour, shoulders raised around my ears, stomach tight, the body responding as if the imagined scenarios were happening

☐ 5. The implicit sense that if I do not worry about the work review, something will be missed, and that the worry is keeping the review safe from disaster

☐ 6. Spending ninety minutes reading articles about the third symptom-checker result, which had raised a possibility the first two had not, after the GP had already examined the situation

☐ 7. Chronic muscle tension in the shoulders and jaw that has been the background state for years, fatigue that ordinary rest does not relieve, sleep that has been broken across most weeks

☐ 8. The mind moving from a routine meeting to multiple displaced families within minutes, in inner speech, all without producing any decision or action

☐ 9. Declining to watch the news at all this week, in case anything raises a worry, and avoiding the specific conversation with my colleague where the difficult subject might come up

☐ 10. The belief that the worry is escalating and will eventually become unmanageable, producing the additional anxiety about the worry that itself is its own worry

☐ 11. A what-if thought arrives in response to a small ambiguous trigger, and within seconds the verbal cycling has begun

☐ 12. Sympathetic nervous system activated, hands cold, breath shallow, a felt-quality of the system being on, that the body is treating the imagined material as real demand

The answers are at the back of the book.

The end of the sample

This is a free sample of “Worry Management for Generalised Anxiety”, and it ends here.

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

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