CBT for Anxiety: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



CBT for Anxiety: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

TALKING THERAPIES UK

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First edition, 2026.

This guide accompanies the CBT for Anxiety programme on the Talking Therapies UK self-help platform and its workbook. It is drawn from the programme and is kept current with it: whenever the programme changes, the guide is set again.

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 8. This printing was set on 9 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

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

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How to use this guide

This guide is for qualified practitioners who support clients through the CBT for Anxiety programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: the cognitive behavioural model of anxiety, the cycle that maintains it, and how the eight modules are built
- Chapter 2, What the research shows: the evidence for CBT in anxiety, for guided self-help, for exposure and for the module techniques, with its limits

CHAPTER 1

The model behind the programme

Anxiety as an alarm

The programme begins from an idea that most clients find a relief: anxiety is not a malfunction but an alarm system, evolved to prepare the body to meet danger. The racing heart, quickened breathing and tense muscles that frighten people with anxiety problems are the body's preparation for fighting or running, and they make sense as that. The problem is not that the alarm exists but that it has become too sensitive. It fires at things that are not dangerous, it stays on after the moment has passed, and it starts to shape the person's life around avoiding it. Module 1 gives the client these three tests, and the Work and Social Adjustment Scale measures the third.

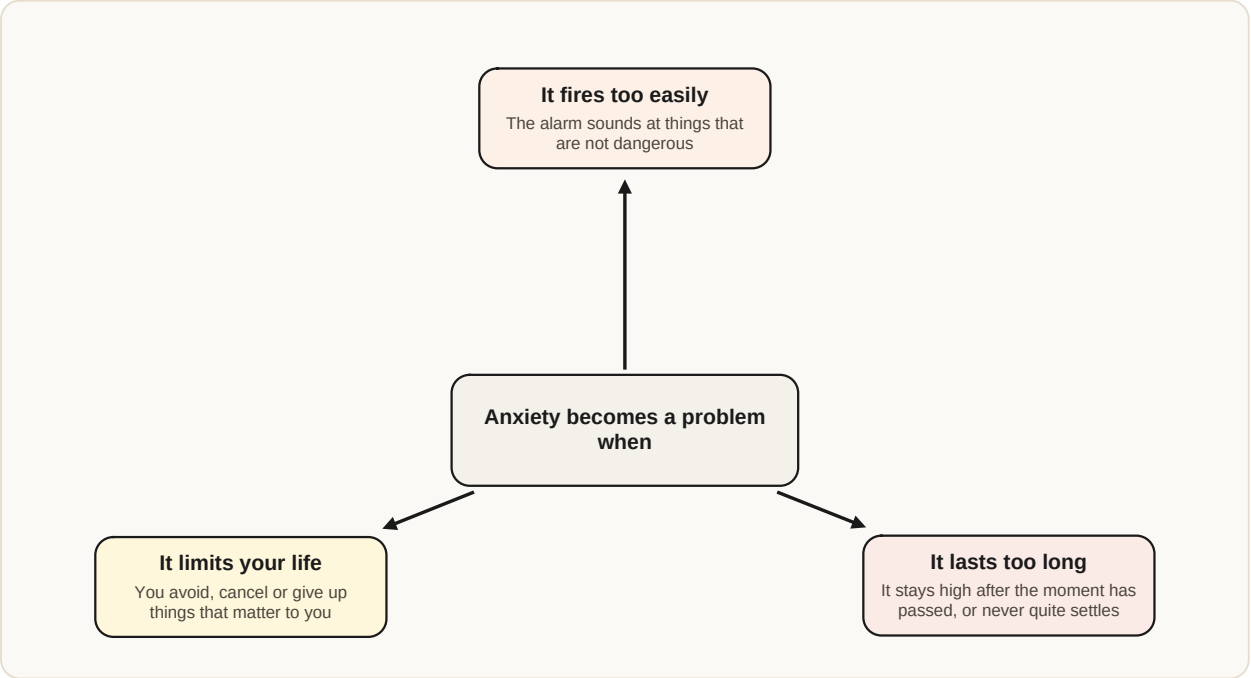


FIGURE 1.1 When anxiety stops being useful
Anxiety is a normal alarm system that prepares the body to meet danger. Module 1 gives three tests of when it has become a problem: it fires too easily, it lasts too long, or it limits the person's life. Most clients recognise all three; the third is the one the programme measures with the WSAS.

The cognitive behavioural model

Cognitive behavioural models of anxiety share a common core. Anxiety follows from the way a situation is appraised: a prediction that something bad is about to happen, often combined with a sense that one would not be able to cope with it. Clark's (1986) model of panic is the clearest example. Bodily sensations, such as a pounding heart or dizziness, are misinterpreted as signs of immediate catastrophe, such as a heart attack or collapse, and the fear produces more sensations, which seem to confirm the interpretation, so that the cycle closes within seconds.

The same models explain why anxiety persists even when the feared outcome never happens. Salkovskis (1991) showed how the things people do to keep themselves safe prevent them from discovering that they were safe all along. A person who sits by the exit at every meeting and never faints concludes that sitting by the exit saved them, not that they would not have fainted anyway. Avoidance works in the same way, more completely: a situation never entered can never show that the prediction was wrong.

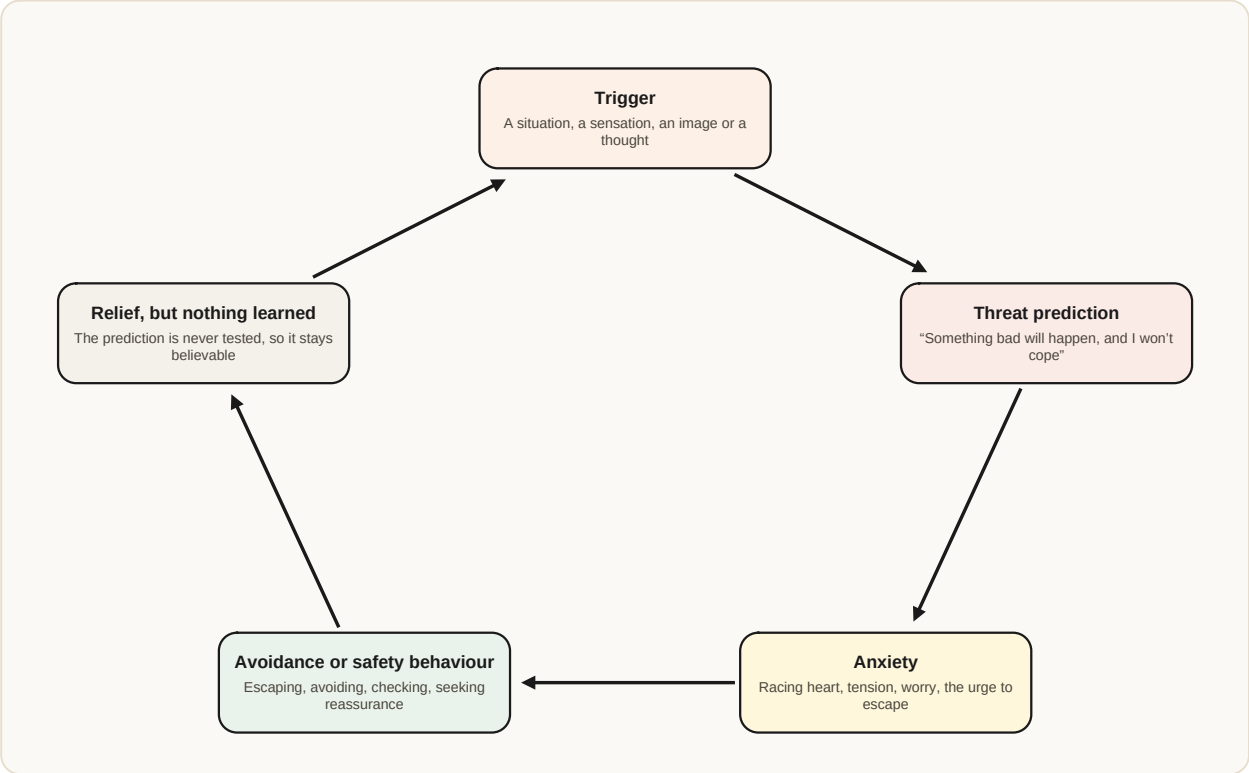


FIGURE 1.2 How anxiety keeps itself going

The maintenance cycle behind most anxiety problems. A trigger brings a prediction of threat; anxiety rises in body and mind; avoidance or a safety behaviour brings relief; and because the feared outcome was never tested, the prediction survives to fire again. The programme breaks the cycle at each point, above all at avoidance.

How the programme breaks the cycle

The programme works on each part of the cycle, and its order reflects the order in which most clients can take on the work. Module 1 explains the cycle. Module 2 teaches three ways of turning the body’s response down, which give the client some confidence that they can tolerate anxiety before they are asked to approach it. Module 3 addresses worry, the mental habit that keeps the alarm primed. Modules 4 to 6 are the centre of the programme: exposure through a graded ladder, the predictions that exposure tests, and the safety behaviours that can quietly undermine it. Modules 7 and 8 are about keeping the gains, and about the client’s longer relationship with a nervous system that will always be capable of anxiety.

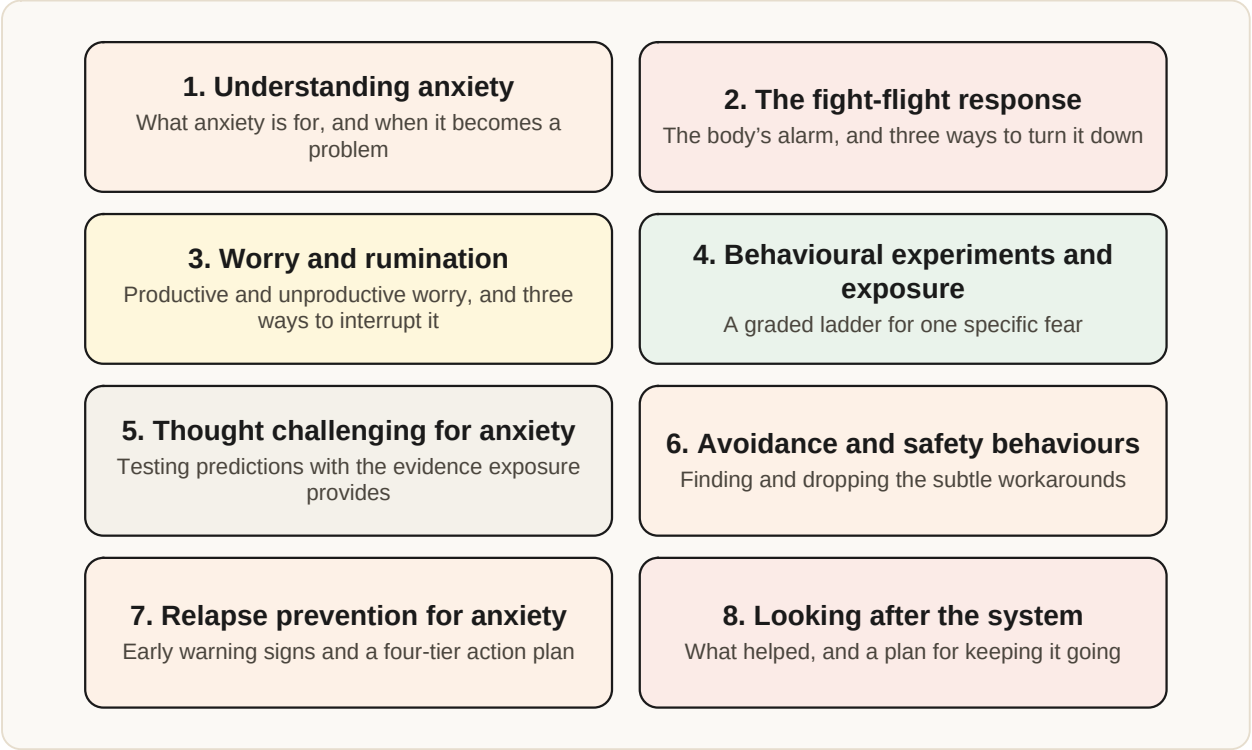


FIGURE 1.3 The eight modules and what each works on
Module 1 explains anxiety and why it persists. Module 2 brings the body down and module 3 works on worry. Modules 4 to 6 work on avoidance: exposure, the predictions behind it, and the safety behaviours that undermine it. Modules 7 and 8 keep the gains. Exposure is the centre of the programme, and the other modules support it.

The programme is transdiagnostic: it teaches the methods common to CBT across the anxiety disorders, rather than a protocol for one of them. It suits clients whose anxiety takes several forms at once, typically worry, physical symptoms and avoidance together. Clients whose difficulty is clearly one disorder, such as panic disorder, health anxiety or social anxiety, may be better served by the practice's programme written for that presentation; the chapter on who the programme is for, later in this part, says more.

How the modules are built

Each module has the same shape: a short introduction, three to five teaching sections, a practical worksheet, a summary headed "What you have learned", and a closing reflection, "Taking this forward", which asks what the client most wants to keep, when it will be hardest to use, and what exactly they will do then. The check-in questionnaires come in modules 1, 4 and 8: the Work and Social Adjustment Scale each time, the GAD-7 in modules 4 and 8, and the PHQ-9 in module 8. The modules use short worked examples rather than recurring characters, including a client working up a ladder to catch the bus again after a panic attack. The worked examples in this guide follow one composite client, Ravi, through all eight contacts.

What the practitioner adds

The programme carries the teaching. The practitioner helps the client apply it to their own fears, and in anxiety work that means three things above all. The first is calibration: exposure steps that are too large lead to escape and a strengthened fear, while steps that are too small teach nothing, and the practitioner helps the client find the right size. The second is noticing when coping has

quietly become avoidance, which clients often cannot see in themselves. The third is refusing, kindly, to become a source of reassurance. Reassurance relieves anxiety for minutes and maintains it for months, and a practitioner who answers every “but what if?” with “that won’t happen” has become a safety behaviour. Chapter 5 shows how a thirty-minute contact keeps its focus on what the client has done.

CHAPTER 2

What the research shows

CBT for anxiety

CBT is among the most thoroughly tested psychological treatments for the anxiety disorders. A meta-analysis restricted to randomised trials that compared CBT with a placebo condition, rather than with a waiting list, found CBT more effective than placebo across the adult anxiety disorders, with the size of the advantage varying between disorders: it was largest for obsessive-compulsive disorder and acute stress disorder and smallest for panic disorder, and the authors noted considerable room for improvement (Hofmann and Smits, 2008). The comparison with placebo matters because it shows that the effect is not simply the result of attention, expectation or the passage of time.

The National Institute for Health and Care Excellence (2011) recommends a stepped approach to generalised anxiety disorder and panic disorder. Low-intensity interventions, including guided self-help based on CBT principles, are recommended for generalised anxiety disorder that has not improved with education and active monitoring, and for mild to moderate panic disorder. High-intensity CBT, applied relaxation or medication are recommended for more marked or persistent difficulties. In comparative trials, guided self-help and face-to-face psychotherapy for anxiety and depression have produced similar effects (Cuijpers et al., 2010).

Exposure and inhibitory learning

Exposure is the technique with the strongest evidence in the treatment of anxiety, and module 4 places it at the centre of the programme. The module teaches it through the habituation curve: anxiety rises, peaks and falls if the person stays in the situation long enough. This is an accessible and largely accurate account of what most clients experience, but practitioners should know that research has moved on from habituation as the explanation of why exposure works. Craske and colleagues (2014) reviewed the evidence that how much fear falls during an exposure session does not reliably predict how well the gains last. What matters more is that the exposure teaches something new, above all that the feared outcome did not happen, and that the new learning is strong enough to compete with the old fear when it returns. They describe ways of strengthening that learning: setting up each exposure to test a specific prediction, varying the situations and conditions in which exposure is practised, and removing safety behaviours.

This matters in the contacts. A client who leaves a situation before their anxiety has halved has not necessarily failed, and a client who waits rigidly for the drop can turn the waiting itself into a safety behaviour. The contact notes for module 4 explain how to use the module's framing while keeping the emphasis on what the client predicted and what actually happened.

The techniques in modules 2 and 3

Slow breathing has been studied mainly in healthy volunteers. A systematic review found that slow breathing techniques were associated with increased activity of the parasympathetic nervous system and with greater relaxation and lower anxiety and arousal, while noting that the

studies were few and varied in quality (Zaccaro et al., 2018). The technique is best presented to clients as a way of steadying the body enough to stay with a situation, not as a cure or a way out of it.

The worry techniques in module 3 have their roots in stimulus control. Borkovec and colleagues (1983) gave people who worried a great deal four weeks of stimulus control instructions, restricting worry to a set period in the same place each day and postponing worries that arose at other times to that period, and found that their daily reports of worry fell significantly compared with people given no treatment. Cognitive defusion comes from acceptance and commitment therapy, in which it describes stepping back from thoughts so that they are experienced as words and pictures rather than as facts that must be obeyed (Hayes, Strosahl and Wilson, 2012).

What the research does not show

No trial has tested this programme in its present form. The evidence above comes mostly from therapist-delivered CBT for specific anxiety disorders, from guided self-help in other formats, and from experimental studies of the individual techniques. The programme applies that evidence with care, and the stepping-up guidance in Part 2 is the safeguard for clients for whom it is not enough.