



## THEME

Mental health



### Sarah Edelman

BEc(Psych), MA, PhD, MAPS, is Lecturer, Department of Medical and Molecular Biosciences, University of Technology, Sydney, New South Wales. sarah.edelman@uts.edu.au

### Grant Blashki

MD, MBBS, FRACGP, is Senior Research Fellow, Department of General Practice, University of Melbourne, and Honorary Senior Lecturer, Kings College London.

# Managing anxious patients

## Cognitive behaviour therapy in general practice

### BACKGROUND

It is well established that some individuals have an inherent disposition toward experiencing anxiety more readily than others. These individuals are prone to high levels of autonomic arousal, exaggerated threat perception and dysfunctional coping strategies. In general practice these patients present frequently with a broad range of physical and psychological concerns that are often time consuming and challenging for general practitioners to assess and manage.

### OBJECTIVE

In this article we suggest some management strategies based on a cognitive behavioural therapy approach.

### DISCUSSION

Cognitive behavioural therapy strategies such as cognitive reframing, behavioural experiments and graded exposure have been shown to be effective in the treatment of anxiety. We also present some examples and worksheets to illustrate how these techniques can be applied in general practice.

**Anxiety disorders account for 24% of the burden of mental disorders<sup>1</sup> and are the most common reason for seeking out mental health services. The prevalence is reflected in Australian general practice surveys, with patients citing anxiety as a common reason for attendance to the general practitioner.<sup>2</sup> Anxious patients frequently present with somatic symptoms (eg. gastrointestinal problems, headaches, chest or muscular pain, dizziness, insomnia, tremor) that have no apparent biological cause. While they are usually concerned about the possibility of serious illness, in many instances the symptoms are the physical and psychological concomitants of anxiety.<sup>3</sup> These individuals are also more likely to develop anxiety in relation to other areas (eg. work, finances, relationships and personal safety) and GPs are at times called upon to assist with these problems. Therefore developing skills for helping patients to better deal with anxiety can be helpful in their management, and in some cases, might reduce their use of health care services.**

Although there are a number of psychological treatments used to manage anxiety, in this article we focus on cognitive behaviour therapy (CBT) approaches. This model of psychotherapy has been shown to be effective in the treatment of anxiety disorders<sup>4,5</sup> and is well suited for use in general practice settings in that it is time limited and allows patients to do much of the work between sessions.<sup>6</sup> Cognitive behaviour therapy targets unrealistic threat appraisals and aims to help individuals develop more accurate evaluations of life events. A basic tenet of the cognitive model is that anxious individuals have biased information processing that causes them to overestimate the perceived probability and costs of negative events and to underestimate their ability to cope.<sup>7</sup> These exaggerated threat perceptions frequently precipitate high levels of autonomic arousal and inappropriate behavioural responses.

The role of behaviours is particularly critical to maintaining anxiety disorders and is therefore an important area to be addressed in therapy. Anxious individuals are prone to avoiding or fleeing many relatively benign

**Table 1. Common faulty thinking**

<b>Black and white thinking</b>	Seeing things in black and white, with no middle ground. Situations are either good or bad; one's performance is either good or terrible
<b>Predicting catastrophe</b>	Expecting negative future outcomes, without considering other more likely or less negative possibilities
<b>Awfulising</b>	Making negative assumptions and interpreting events in a negative way. Perceiving that the very worst is happening or has happened
<b>Personalising</b>	Assuming that other people's responses are directed at oneself – that if people behave in certain ways, it means that you are at fault
<b>Shoulds</b>	Holding rigid, inflexible beliefs about how people (self and others) should behave, and overestimating how bad things are if those expectations are not met
<b>Labelling</b>	Putting a global label on oneself or others on the basis of specific behaviours or characteristics (eg. self or others may be perceived as 'bad', 'defective', 'incompetent', 'a failure', 'stupid' or 'a misfit')
<b>Mind reading</b>	Assuming one knows what others are thinking; often that they are making negative judgments about you
<b>Emotional reasoning</b>	Assuming that something must be true because you 'feel' it so strongly, ignoring evidence to the contrary
<b>Overgeneralisation</b>	Making sweeping negative conclusions that go far beyond the current situation. For example, 'bad things always happen to me', 'doctors just want to make money – they are not interested in helping their patients'
<b>Filtering</b>	Paying undue attention to one negative detail instead of seeing the whole picture
<b>Discounting the positive</b>	Assuming that positive experiences, deeds or qualities don't count
<b>Comparing</b>	Using other people's behaviour or achievements as a basis for assessing one's own circumstances
<b>Jumping to negative conclusions</b>	Interpreting events in a negative way; assuming the negative, in spite of insufficient evidence

situations (eg. driving beyond familiar territory, crowds, being alone, social situations, tunnels, flying) due to perceived danger. More subtle avoidance includes procrastination and emotional numbing with alcohol, benzodiazepines or illicit drugs. In addition, anxious patients frequently engage in excessive safety behaviours that aim to protect them from perceived harm.<sup>8</sup> These might typically include reliance on others to accompany them, frequent use of mobile phones for reassurance, carrying tranquilisers or herbal remedies 'just in case', sitting close to an exit or deliberately keeping busy and using distraction to avoid threat related thoughts.

While avoidance and safety behaviours frequently reduce anxiety in the short term, they are ultimately counter productive because they maintain misperceptions about danger and therefore reinforce threat focused appraisals.<sup>8</sup> The nonoccurrence of feared outcomes is attributed to the avoidance or safety behaviours rather than to the fact that the situation was not inherently dangerous. Therefore, by preventing disconfirmation of dysfunctional thoughts and assumptions, the perception of threat and accompanying emotional disturbance is maintained.<sup>8</sup>

Many anxious patients also resort to excessive reassurance seeking in an effort to reduce their anxiety.<sup>9</sup> This type of safety behaviour is typically directed at friends, family members and people with specialist knowledge, as well as information seeking via the internet. Individuals with health anxiety frequently engage in excessive self monitoring and reassurance seeking from a range of sources. Therefore GPs frequently encounter patients who repeatedly seek reassurance through verbal questioning, self monitoring (eg. numerous daily blood pressure checks), unnecessary consultations, 'doctor shopping' and demands for unwarranted tests and specialist referrals.<sup>9</sup> Verbal or written reassurance may provide only temporary relief, as they do not change the underlying threat focused perceptions that maintain the disorder.<sup>10</sup>

## CBT for anxious patients

The role of CBT for anxious individuals is to reduce threat expectancies and improve appraisals in relation to coping. We present a number of CBT strategies for treating anxious patients and describe how they can be adapted for use by GPs.

### Psycho-education

In order to work on cognitive and behavioural change, patients need to understand the factors that cause and maintain dysfunctional anxiety, and the things they can do to reduce it. For this reason psycho-education is a key component of CBT treatment. Useful information covers the nature of trait anxiety, functional versus dysfunctional anxiety, the fight or flight response, effects of hypervigilance, the role of avoidance and safety behaviours, and basic strategies for managing anxiety. The fact that perceptions can be biased or 'faulty' and therefore result in unrealistic threat appraisals is also an important concept for patients to understand. This can be explained with reference to common 'thinking errors' (*Table 1*), which most patients can easily relate to. Finally, providing a clear rationale for homework exercises is important, as these are frequently anxiety provoking, and patients may otherwise be reluctant to comply. Information provided in written format can help to reinforce and add to information provided verbally (see *Resources*).

### Cognitive reframing

Thought monitoring and reframing techniques are widely used in CBT and can be useful for challenging threat focused cognitions of anxious patients. In basic terms, they involve identifying and challenging the patient's dysfunctional perceptions. This can be done in-session, and patients can also be taught to identify and challenge their biased or 'faulty' perceptions as part of 'homework' exercises assigned to be done between sessions. In the first instance, patient's immediate or 'automatic' thoughts are established through questions such as:

- When you discovered that [perceived threat], what thoughts went through your mind?
- What did you fear might happen next?

Once threat focused thoughts are identified, these can be challenged using 'Socratic questions', which aim to help patients cast doubt on their perceptions and consider alternative possibilities. For example:

- What is the evidence that [catastrophic interpretation] is correct?
- Is there any evidence that does not support that view?
- Is there another way of looking at this situation?
- Even if some of your assumptions turn out to be correct, realistically what is most likely to happen?
- Think of a calm, rational friend. What would they think if they were in this situation?

Providing specific labels for cognitive distortions, such as 'predicting catastrophe', 'black and white' thinking, 'awfulising', 'filtering', 'jumping to negative conclusions' and 'mind reading' (*Table 1*) helps patients to recognise biased

perceptions more readily, and introduces an element of doubt about the veracity of their perspective. Patients are asked to write down their thoughts whenever their anxiety escalates and then identify any distortions that are present, examine the evidence for and against their assumptions, and suggest an alternative, more balanced perspective. The use of forms such as the 'Realistic thinking record' (*Table 2*) can help patients to develop skills in challenging catastrophic perceptions and to consolidate cognitive change achieved through verbal questioning in-session (for more examples see Edelman, 2006<sup>11</sup>).

It should be noted that cognitive reframing techniques are not always effective when used in isolation, as many patients have rigid threat focused cognitions that are not easily challenged. For this reason behavioural experiments are a key component of therapy as they challenge the patient's unrealistic perceptions through direct experience.<sup>12</sup>

### Behavioural experiments

According to the cognitive model, threat focused beliefs are maintained by habitual, unquestioned and untested biases in perception and interpretation of events.<sup>13</sup> Behavioural experiments are a powerful tool for modifying 'catastrophic' cognitions because individuals test their assumptions in the real world and learn experientially that they are incorrect. In order to challenge existing beliefs, behavioural experiments require the patient to undertake a 'disconfirmatory manoeuvre', which allows the belief to be tested and ultimately disconfirmed.<sup>14</sup> In the case of anxiety, this typically involves abandoning safety behaviours or taking action that increases the perceived risk so that the catastrophic prediction can be unambiguously tested.

The steps involved in setting up a behavioural experiment are as follows:

- Identify the dysfunctional belief, as well as the patient's feared consequences, and turn this into a prediction, in an 'if, then' format. For example: 'If I don't keep monitoring the taxi driver, he will have an accident'
- Suggest an alternative perspective, eg. 'If I don't keep monitoring the taxi driver it will make no difference to my safety'
- Describe an experiment to test the belief, eg. 'For the next seven taxi rides, I will sit back, relax, think about my holiday and ignore the traffic'
- Make a specific prediction, eg. 'We will have an accident'
- Do the experiment and record the results, eg. 'We arrived safely each time; by the fifth trip I started feeling less anxious'
- Draw general conclusions, eg. 'Monitoring other

people's driving makes me think that it keeps me safe, but it actually makes no difference to my safety, and only makes me feel more anxious'.

Using a monitoring form for planning the experiment and recording the outcomes and conclusions helps the patient to consolidate the learning experience and provides clear evidence that their catastrophic assumptions are incorrect (Table 3). The behavioural experiment should be planned collaboratively during the consultation and the form should be filled in (except for results and conclusions) during

this time. When designing a behavioural experiment it is important to clearly define the catastrophic prediction that the patient fears in a way that can be tested. For instance 'I won't be able to cope' or 'I will be a bad mother' cannot clearly be tested, however specific predictions such as 'I will collapse' or 'one of my children will have an accident' can clearly be disproved. Similarly, when patients predict 'I will feel very anxious' as a feared outcome, it is important to probe for negative consequences of feeling anxious, as the prediction may well come true, but the associated

**Table 2. Realistic thinking record**

Situation/event What are the facts?	I designed a product that did not fully meet the job specifications, and the customer is unhappy	
What are my subjective perceptions?	People in management will find out Everyone will know that I've made a mistake and they will think I'm incompetent This will damage my reputation and future job prospects I will end up stuck in a dead end job I am incompetent	
How likely is it? %	80%	
Distress levels? %	Worry = 90% Despondent = 80%	
Is there evidence to support my perceptions?	The job that I did was incorrect – the design does not fully match the specifications The customer is unhappy and has complained	
Is there any evidence that does not support my perceptions?	My supervisor has been supportive and told me not to worry about it – that it was an understandable error. The people that I have told have all said that it was an easy mistake to make, and Jo said that he has done something very similar on a previous project. Most of the work that I do is highly appraised, and the majority of feedback I receive is very positive	
Am I using faulty thinking?	<div> <input checked="" type="checkbox"/> Black and white thinking           <input checked="" type="checkbox"/> Mind reading         </div> <div> <input checked="" type="checkbox"/> Predicting catastrophe           <input checked="" type="checkbox"/> Emotional reasoning         </div> <div> <input checked="" type="checkbox"/> Awfulising           <input checked="" type="checkbox"/> Overgeneralising         </div> <div> <input checked="" type="checkbox"/> Personalising           <input checked="" type="checkbox"/> Filtering         </div> <div> <input checked="" type="checkbox"/> Shoulds           <input checked="" type="checkbox"/> Discounting the positive         </div> <div> <input checked="" type="checkbox"/> Labelling           <input checked="" type="checkbox"/> Comparing         </div>	
What is a more balanced way to think about this situation?	There were a number of factors that contributed to this error, including an excessive work load and constant interruptions, poor communication by the customer, and unreasonable time constraints. Others in the company have made similar mistakes and people don't think less of them. I do a good job with 98% of the projects that I manage, and making a mistake on this occasion does not make me incompetent. Management have been very supportive, and it is unlikely that they will suddenly think less of me, or that this will have any serious consequences on my career. People are rarely as critical of me as I am of myself	
Even if some of my perceptions turn out to be correct, realistically what are the most likely consequences?	Even if some people do think less of me, I can live with it Over time it is likely to be forgotten In the end, I will cope, regardless of what happens	
Upon reflection, how likely is it that my fears will be realised?	10% (unlikely that this will have any serious long term consequences)	
Degree of distress %	Worry = 50% Despondent = 40%	

catastrophic assumptions are unlikely to be true:

**GP: 'So what bad things could happen if you feel extremely anxious?'**

Patient: 'I don't know... I won't be able to cope'

**GP: 'And if you're not able to cope, what specific things would be happening? What does it look like when you don't cope?'**

Patient: 'I might go mad or collapse... I might babble uncontrollably in the meeting'.

Once the specific catastrophic consequences of anxiety are identified, these predictions can be tested.

## Facing fears: graded exposure

Repeated exposure to feared situations is one of the most consistently demonstrated treatments for anxiety disorders.<sup>15</sup> The key underlying principle is that exposure in the absence of feared consequences leads to extinction of those fears through a process of habituation.<sup>16</sup> Therefore the patient is encouraged to confront feared situations repeatedly, commencing with less threatening situations and gradually progressing to those that invoke higher levels of anxiety.

While there are similarities between behavioural

**Table 3. Examples of behavioural experiments**

Belief	Alternative perspective	Experiment	Specific prediction	Results	Conclusion
If I don't check my blood pressure five times a day, it might sky rocket, and I might have a stroke	If I check my blood pressure no more than once every 2 days, it is unlikely to change substantially, and will make no difference to my risk of having stroke	Check my blood pressure once every second day for the next 3 weeks	I will have a heart attack or stroke	I checked my blood pressure once every second day for 3 weeks, and I didn't have any medical problem during this time	Checking my blood pressure very frequently increases my anxiety but does not make any difference to my symptoms
If I don't head straight home when I have a panic attack, I will collapse, go mad or die	If I don't head straight home when I have a panic attack I might be very anxious, but I will not collapse, go mad or die	Next time I have a panic attack, stay put, slow down my breathing and let my body do what it needs to do	I will collapse, go mad or die	Initially it was very unpleasant, but after a few minutes my symptoms diminished	If I don't run away, nothing terrible happens, and after a while the panic starts to fizzle out on its own
If I have to stay alone in the house I won't be able to cope	If I have to stay alone in the house I will feel anxious, but I will cope	Don't sleep over at daughter's place for the next week – sleep at home	I will go crazy with anxiety	I felt extremely anxious, but after a while I calmed down and got to sleep. After the third night it became easier	When I stay alone in the house I feel anxious, but I don't go mad and I can cope with the anxiety. The more often I do it, the more my anxiety seems to drop
If I go out on my own, I may get lost and not be able to find my way back home	If I go out on my own, I may or may not get lost, but even if I do, I will be able to find my way back	Drive to the new shopping centre on my own	I will get lost and won't be able to find my way back home	I kept checking the street directory, but managed to find it, and to find my way home	I can go to unfamiliar areas and find my way home by checking the street directory or asking for directions
If I don't keep worrying about my children, something bad might happen to them	If I don't keep worrying about my children, it will make no difference to their wellbeing, but I will feel less anxious	Every time I catch myself worrying about my children, say 'stop!' and focus on the task at hand. Refuse to engage in the worrying	They will have an accident or some severe harm will come to them	I have been stopping myself from worrying about the children over the past month, and nothing bad has happened to them	Worrying about the children does not protect them from harm – it only makes me feel anxious

**Table 4. Exposure schedule and monitoring chart (example: for patient suffering from panic attacks and agoraphobia)**

Exposure exercise	Trial 1	Trial 2	Trial 3	Trial 4	Trial 5	Trial 6	Trial 7
Go to supermarket with wife	4 May	7 May	11 May	16 May	22 May	24 May	
	15 mins	20 mins	35 mins	45 mins	15 mins	10 mins	
	70	65	45	30	10	10	
Go to supermarket alone	12 May	14 May	15 May	17 May	20 May	23 May	26 May
	15 mins	25 mins	10 mins	25 mins	15 mins	25 mins	15 mins
	50	60	50	30	20	10	0
Catch bus for three stops during quiet period	20 May	22 May	23 May	26 May	29 May		
	5 mins	5 mins	5 mins	5 mins	5 mins		
	70	80	65	20	10		
Catch bus all the way to the city during quiet period	26 May	29 May	31 May	6 June	9 June	13 June	17 June
	25 mins	25 mins	25 mins	25 mins	25 mins	25 mins	25 mins
	70	50	60	30	10	0	0
Catch bus to city during peak hour	10 June	12 June	15 June	16 June	19 June	22 June	
	35 mins	30 mins	35 mins	30 mins	35 mins	35 mins	
	90	60	20	40	10	10	
Go shopping in large department store	1 June	6 June	9 June	12 June	19 June	26 June	
	1.25 hours	1.5 hours	1.5 hours	2 hours	2 hours	1.5 hours	
	80	70	40	20	20	10	

Record: 1. Date 2. Length of exposure (mins) 3. Level of anxiety or symptoms experienced (0 = no symptoms 100 = unbearable symptoms)

Increasing difficulty for patient to confront

experiments and graded exposure, the former is a cognitive strategy (where patients' beliefs are tested, disproved and reframed) while the latter is based on learning theory (ie. exposure to a conditioned stimulus in the absence of the conditioned response leads to extinction of fear).<sup>16</sup> There has been some debate regarding the mechanisms underlying the effects of these two strategies, however it is clear that both can be helpful in the treatment of anxiety disorders including panic disorder, agoraphobia, specific phobias, post-traumatic stress disorder, and obsessive compulsive disorder.<sup>5</sup>

In providing a rationale for graded exposure, it is helpful to refer patients to examples of habituation from their own experience. The potential benefits of exposure may be better understood when patients recall events that they had previously feared (eg. making phone calls, driving, going to social functions, public speaking or speaking up in class) and that they no longer fear due to repeated exposure.

To plan exposure exercises, the situations and behaviours that the patient most fears and/or avoids need to be identified and subsequently ordered from the least to most anxiety provoking. This can be done through collaboratively generating a list of situations that the patient fears or avoids, or by asking patients to monitor and record feared situations as they become aware of them between sessions. Patients are then asked to rate the degree of

anxiety associated with confronting each situation, and to then arrange them in order from least to most anxiety provoking. Once a hierarchy of feared situations has been established, the patient is invited to confront each situation, starting with those at the low end of the fear hierarchy.

When performing these exercises it is important that patients maintain exposure for sufficient time to allow their anxiety to diminish. Terminating exposure before anxiety levels drop prevents habituation from occurring. In addition, exposure exercises often need to be repeated several times before full extinction of fear will occur.

To help plan and execute graded exposure exercises, an exposure schedule is recommended. The tasks are listed on the left column, and following each exposure, patients should record the date and length of exposure, and the maximum level of anxiety experienced on each occasion. *Table 4* provides an example of an exposure schedule for a patient with panic disorder and agoraphobic avoidance.

## Conclusion

Anxious patients commonly present to GPs and make up a significant part of their clinical workload. We have described some CBT based strategies that may be helpful in the management of these patients. These techniques are particularly suitable for use within a time limited general practice context because much of the treatment



occurs outside of consultation time, with patients taking responsibility for completing set exercises between sessions. Knowledge about the nature of these disorders and some of the useful treatment strategies may help GPs not only in formulating psychological treatments, but also in deciding when to refer patients for more specific psychological intervention.<sup>17</sup>

Undoubtedly, a proportion of patients will require referral to specialist mental health practitioners and/or commencement of an anti-anxiety or antidepressant medication (see the article *Depression and anxiety: Pharmacological treatment in general practice*, this issue). While familiarly with CBT for anxiety enables GPs to reinforce concepts and support the goals of treatment, it is generally advisable to involve a mental health specialist with expertise in CBT when patients present with more severe or intractable anxiety related conditions.

Finally, it is worth noting that in addition to CBT, other psychotherapeutic models are emerging as potentially effective treatments for anxiety disorders, most notably 'interpersonal psychotherapy'<sup>18</sup> and 'mindfulness meditation'.<sup>19</sup> While methodologically sound evaluations of these approaches for the treatment of anxiety disorders are very few in number, further good quality research may give rise to other useful treatments within the coming decade.

## Resources

- Interactive treatment program: Climate.TV – [www.climate.tv](http://www.climate.tv)
- Free manuals: [www.crufad.com](http://www.crufad.com) (click on 'clinician support')
- Online Anxiety Prevention Project: [www.psy.uq.edu.au/~jkweb](http://www.psy.uq.edu.au/~jkweb)
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