

# The Patient with Excessive Worry

STEVEN SHEARER, PH.D., and LAUREN GORDON, M.D., *Franklin Square Hospital Center, Baltimore, Maryland*

Worry is a normal response to uncertainty. Education, empathetic support, reassurance, and passage of time usually ameliorate ordinary worries. However, these common-sense strategies for dealing with transient worries often prove ineffective for patients with excessive worry, many of whom meet the criteria for disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Evidence-based treatments for such disorders can assist family physicians in management of persistent worry as a self-perpetuating habit across diagnostic categories. Antidepressants and cognitive behavioral therapy are effective treatments for various disorders characterized by excessive worry. Cognitive behavioral strategies that may be adapted to primary care contacts include education about the worry process, repeated challenge of cognitive distortions and beliefs that underpin worry, behavioral exposure assignments (e.g., scheduled worry periods, worry journals), and learning mindfulness meditation. (Am Fam Physician 2006;73:1049-56, 1057-8. Copyright © 2006 American Academy of Family Physicians.)

► **Patient information:**  
A handout on excessive worry, written by the authors of this article, is provided on page 1057.

**W**orry is an effective short-term response to uncertainty that can become self-perpetuating with adverse long-term consequences. Worry reduces subjective uncertainty, contributes to a sense of vigilance and preparedness, dampens autonomic arousal, and fuels the belief that uncertain events and overall risk can be controlled.<sup>1</sup> When such relief is coupled with the likely nonoccurrence of low-probability feared events, it can powerfully reinforce the worry response, shaping beliefs that worry is adaptive and somehow preempts bad things from happening. Worry also is a form of emotional suppression and cognitive avoidance that becomes self-perpetuating, in part because it blocks other emotions such as fear or anger. The patient with excessive worry often displays a constellation of maladaptive beliefs and habits involving worry (*Table 1*).

Many patients with excessive worry overvalue, but also fear, their propensity to worry, often with concern that so much worry will harm their health. Although they intentionally indulge in worry at times, their distress about worrying prompts repetitive, unsuccessful efforts to control it. These efforts to suppress intrusive thoughts are usually ineffective and paradoxically may magnify worry and anxiety.<sup>2</sup>

The environmental, neuroanatomic, neurophysiologic, and genetic components of

excessive worry are still being defined.<sup>3</sup> There is consensus that certain areas of the brain (amygdala, prefrontal cortex, cingulate cortex, caudate nucleus, ventral hippocampus) and neurotransmitters (serotonin, norepinephrine, corticotropin-releasing hormone, cholecystokinin, gamma-amino butyric acid) underpin anxiety arousal and worry. The various clinical presentations of worry may reflect the relative activation or availability of these structures and neuro-transmitters, although the issue of cause versus consequence has not been resolved.

## Clinical Presentation

Patients are unlikely to complain of excessive worry unless asked. They may present with another problem (e.g., insomnia) or display vague physical symptoms or a somatic syndrome (e.g., irritable bowel syndrome).

Persistent worry most commonly is evident in patients with certain disorders and similar subthreshold presentations (*Table 2*). Comorbidity and overlap among categories often make it difficult to distinguish among disorders, especially given individual variations over time. Some patients display a single disorder and some will meet criteria for multiple diagnoses, whereas others present with various symptoms or diagnoses over a period of years, all with a common theme of excessive worry. Prevalence figures suggest that generalized anxiety disorder and

## SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	Evidence rating	References
Antidepressants (in particular, escitalopram [Lexapro], paroxetine [Paxil], sertraline [Zoloft] and venlafaxine [Effexor]) are effective treatments for serious worry-prone disorders (e.g., GAD, panic disorder, SAD, OCD, PTSD), even in the absence of major depression.	A	9, 29-33
Psychological treatments, especially cognitive behavioral therapy tailored to the specific diagnosis, are effective for worry-prone disorders (e.g., GAD, panic disorder, SAD, OCD, PTSD, major depressive disorder/dysthymia, hypochondriasis).	A	10, 13, 24-28
Selective serotonin reuptake inhibitors can be considered for treatment of hypochondriasis, although evidence from controlled trials is lacking.	C	17, 18

*GAD = generalized anxiety disorder; SAD = social anxiety disorder; OCD = obsessive-compulsive disorder; PTSD = post-traumatic stress disorder.*

*A = consistent, good-quality, patient-oriented evidence; B = inconsistent or limited-quality, patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, see page 956 or <http://www.aafp.org/afpsort.xml>.*

hypochondriasis, plus subthreshold variations of these disorders, most often characterize patients with excessive worry who are encountered in primary care.

### Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) was once a default category for anxious patients who did not meet the criteria for another more

specific anxiety disorder. The *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., (DSM-IV) focuses on excessive worry and trouble controlling worry more than the somatic manifestations of anxiety.

The lifetime prevalence of GAD in the general population is approximately 5 percent; however, there is an 8 percent cross-sectional prevalence rate among primary care patients, indicating that this is the anxiety disorder most often seen by family physicians.<sup>4</sup> Furthermore, there are indications that symptoms below the diagnostic threshold are just as impairing.<sup>5</sup>

In one sample, 87 percent of primary care patients with GAD did not present with a primary symptom of anxiety; most had non-specific somatic complaints (e.g., insomnia, head or muscle aches, fatigue, gastrointestinal symptoms).<sup>6</sup> Although a high rate of comorbidity with depression often is reported, there also is a high proportion of pure GAD in primary care that is poorly recognized and rarely treated appropriately.<sup>6</sup>

Approximately 90 percent of patients with GAD answer affirmatively to the question, "During the past four weeks, have you been bothered by feeling worried, tense, or anxious most of the time?"<sup>7</sup> More thorough assessment or treatment monitoring can be implemented using the Penn State Worry Questionnaire (Table 3).<sup>8</sup>

Escitalopram (Lexapro), paroxetine (Paxil), sertraline (Zoloft), and venlafaxine (Effexor) are indicated by the U.S. Food and Drug Administration (FDA) for treatment of GAD. According to a Cochrane Database review,<sup>9</sup> imipramine (Tofranil), paroxetine,

**TABLE 1**  
**Cognitive Distortions Characteristic of Patients with Excessive Worry**

Intolerance for uncertainty:

*"If I think about this enough, I should feel a sense of certainty."*

Intolerance for discomfort:

*"If I can just think this through, I won't have to feel this way."*

Inflated sense of culpability:

*"If bad things happen, it is my fault."*

Distorted risk assessments/emotional reasoning:

*"If it feels likely, it is likely. If it feels dangerous, it is dangerous."*

Perfectionism about mistakes:

*"Mistakes mean I screwed up because I was not in control."*

Pessimism/presumed incapability:

*"Bad things will happen to me and I will not be able to deal with it."*

Misconstrued virtue:

*"Worry shows how deeply I care about my children."*

Overvaluation of the thought process:

*"Because I have a thought, it is important and I must give it my full attention."*

Implicit magical beliefs about worry:

*"Worry prevents bad things from happening. It keeps me from being blindsided. It keeps loved ones safer."*

Worry about worrying too much:

*"I am out of control. I am making myself sick. I have got to stop worrying."*

and venlafaxine are the best-evaluated antidepressants that are effective for GAD.<sup>9</sup> In clinical practice, the selective serotonin reuptake inhibitors (SSRIs) and venlafaxine have become first-line treatment.<sup>10</sup>

The benzodiazepines' relatively poor effectiveness for treatment of cognitive anxiety (i.e., worry, as opposed to somatic anxiety symptoms), potential for tolerance, abuse potential, and adverse side effects (e.g., sedation, impact on driving safety) have removed them from first-line consideration for long-term treatment of GAD.<sup>10</sup> Although buspirone (Buspar) is indicated by the FDA for treatment in GAD and has none of the adverse side effects of benzodiazepines, it is not a well-established monotherapy for GAD.<sup>10</sup>

Relaxation training can dampen muscle tension and bodily arousal and has demonstrated effectiveness comparable with cognitive treatment for GAD in some studies.<sup>7</sup>

Because it does not specifically target the excessive worry that is the hallmark of GAD, relaxation training proves inadequate for most inveterate worriers.<sup>1</sup> "Thought-stopping" techniques also have fallen from favor because deliberate effort to suppress worry often promotes it.

Recent controlled trials<sup>11</sup> of worry-focused cognitive behavioral therapy (CBT) have demonstrated effectiveness for GAD. CBT typically includes a combination of education about worry; self-recording of worries; relaxation training; imagined or taped exposure to worries paired with coping strategies; focus on present-moment experience; use of designated worry periods; and challenging the worrier's distorted risk assessments, intolerance for uncertainty, and overvaluation of worry.<sup>12</sup>

One intriguing trend is the integration of mindfulness meditation with CBT for treating GAD.<sup>2</sup> This learned meditation

**TABLE 2**  
**Features of Worry in Patients with Common Psychiatric Disorders**

**Generalized anxiety disorder**

Nearly daily, marked worry with variable content  
Often focuses on: daily hassles; interpersonal conflicts; self-doubts; routine health/safety concerns; potential catastrophes.

Worry as a way of life; worry seems irresistible.

**Hypochondriasis or health anxiety**

Interpret benign bodily signs as potential illness  
Preoccupying worry about getting a serious illness (e.g., cancer, AIDS)

Some patients overuse physicians, medical textbooks, Web sites, or self-checking for reassurance; some patients underuse physicians to avoid potential bad news.

Significant overlap with obsessive-compulsive disorder, panic disorder, and depression.

**Major depressive disorder/dysthymic disorder**

Content of worry often focuses on guilt, self-reproach, and self-perceived incompetence or badness.

Worry often takes the form of dysphoric brooding or rumination.

Self-critical worry about the past; helpless worry about the present; pessimistic worry about the future

**Obsessive-compulsive disorder**

Beyond "ordinary" worries, obsessions often occur as intrusive and frightening thoughts that raise doubt about acting on inappropriate or reprehensible ideas.

Obsessive doubt about possible contamination or disease may dominate worries.

Compulsive reassurance-seeking, checking, or sanitizing may momentarily relieve anxiety at the cost of perpetuating the disorder.

**Panic disorder**

Fear of having a panic attack

Worry that the symptoms of autonomic arousal or panic attacks are dangerous and must be avoided

Thoughts such as: "What if I pass out, go crazy, have a heart attack, or lose control of myself?"

**Post-traumatic stress disorder**

After trauma, all dangers seem more likely and all worries seem more plausible.

Hyperarousal and hypervigilance often fuel the worry process and give it credence.

**Social phobia/social anxiety**

Worry about bungled social performance, interpersonal scrutiny, and embarrassment

*AIDS = acquired immunodeficiency syndrome.*

technique teaches participants to focus on the present moment and accept their thoughts in a nonjudgmental manner. It may be ideally suited to patients with GAD because it offers an alternative to ineffective suppression; it reframes the primarily verbally mediated covert monologues of worry as “just thinking”; and it facilitates a focus on the present moment rather than on compelling, future-oriented worries. Although preliminary outcome data are encouraging, adequate trials are still pending.<sup>2</sup>

**TABLE 3**  
**Penn State Worry Questionnaire**

Enter the number that best describes how typical or characteristic each item is of you:

1	2	3	4	5	
Not at all typical		Somewhat typical		Very typical	
<i>Item</i>					<i>Score</i>
1. If I don't have enough time to do everything, I don't worry about it.					
2. My worries overwhelm me.					
3. I don't tend to worry about things.					
4. Many situations make me worry.					
5. I know I should not worry about things, but I just cannot help it.					
6. When I am under pressure I worry a lot.					
7. I am always worrying about something.					
8. I find it easy to dismiss worrisome thoughts.					
9. As soon as I finish one task, I start to worry about everything else I have to do.					
10. I never worry about anything.					
11. When there is nothing more I can do about a concern, I do not worry about it any more.					
12. I have been a worrier all my life.					
13. I notice that I have been worrying about things.					
14. Once I start worrying, I cannot stop.					
15. I worry all the time.					
16. I worry about projects until they are all done.					
<i>Total Score:</i>					

*Scoring:* Reverse score items 1, 3, 8, 10, and 11, then sum all 16 items. Possible scores range from 16 to 80. Means for groups with generalized anxiety disorder range from 60 to 68.

*Adapted with permission from Meyer TJ, Miller ML, Metzger RL, Borkovec TD. Development and validation of the Penn State Worry Questionnaire. Behav Res Ther 1990;28:488.*

### Hypochondriasis and Health Anxiety

Hypochondriasis is characterized by a persistently distressing preoccupation with fears or thoughts that one has a serious illness. Such worries often prompt the seeking of excessive reassurance from physicians, medical textbooks, and Web sites, or repeated self-inspection and symptom monitoring. Patients selectively attend to benign bodily sensations and to health information that confirms their suspicion while ignoring disconfirming evidence.<sup>13</sup> Hypochondriasis clearly overlaps with obsessive-compulsive disorder, panic disorder, and depression, but it is distinguishable from the repetitive physical complaints of somatization disorder.<sup>14</sup>

Hypochondriasis is at the pathologic end of the broader spectrum of “illness worry” or “health anxiety.” Hypochondriasis is rare in the general population (less than 1 percent occurrence) but is much more common (as much as 5 percent) among patients in the primary care setting.<sup>13</sup> More broadly defined, “health anxiety” is much more prevalent (6 percent) in the general population<sup>15</sup> and associated with greater consumption of health care resources in primary care.<sup>16</sup>

Little is known about the pharmacologic treatment of primary hypochondriasis. SSRIs are promising, but randomized controlled trials (RCTs) are awaited. Small, open trials of paroxetine<sup>17</sup> and fluvoxamine (Luvox)<sup>18</sup> suggest that many patients with marked health anxiety may benefit. Evidence is accumulating that the obsessional cluster of somatoform disorders (e.g., hypochondriasis and body dysmorphic disorder) often responds to treatment with SSRIs.<sup>19</sup>

In a study of patients with hypochondriasis, psychological treatment rather than medication was perceived to be first-line treatment by 74 percent of patients and as the only acceptable treatment by 48 percent of patients.<sup>20</sup> An RCT<sup>13</sup> demonstrated the effectiveness of a scripted, six-session version of CBT specialized for patients with hypochondriasis in primary care. The CBT package specifically targeted amplification of benign symptoms, faulty symptom attributions, errant beliefs about health and disease, maladaptive illness behaviors, and

**TABLE 4**  
**Treatments for Patients with Excessive Worry Disorders**

<i>Disorder</i>	<i>Psychopharmacologic treatment*</i>	<i>Psychological treatment</i>
Generalized anxiety disorder	SSRIs, venlafaxine (Effexor), imipramine (Tofranil) <sup>9</sup> FDA indicated: paroxetine (Paxil), sertraline (Zoloft), venlafaxine, escitalopram (Lexapro), buspirone (Buspar)	CBT <sup>10-12</sup>
Panic disorder	SSRIs <sup>29</sup> FDA indicated: fluoxetine (Prozac), paroxetine, sertraline, venlafaxine, clonazepam (Klonopin), alprazolam (Xanax)	CBT <sup>24</sup>
Hypochondriasis	SSRIs <sup>17-19</sup> FDA indicated: none	CBT <sup>13,21-23</sup> Exposure and response prevention <sup>†13,21-23</sup>
Social anxiety disorder	SSRIs, venlafaxine <sup>30</sup> FDA indicated: paroxetine, sertraline, venlafaxine	CBT <sup>25</sup>
Post-traumatic stress disorder	SSRIs <sup>31</sup> FDA indicated: paroxetine, sertraline	CBT <sup>26</sup>
Major depressive disorder	All antidepressants <sup>33</sup> FDA indicated: SSRIs, venlafaxine, mirtazapine (Remeron), bupropion (Wellbutrin), duloxetine (Cymbalta), TCAs, MAOIs	CBT <sup>28</sup> Interpersonal psychotherapy <sup>28</sup>
Obsessive-compulsive disorder	SSRIs <sup>32</sup> FDA indicated: fluoxetine, paroxetine, sertraline, fluvoxamine (Luvox), clomipramine (Anafranil)	CBT <sup>27</sup> Exposure and response prevention <sup>†27</sup>

SSRIs = selective serotonin reuptake inhibitors; FDA = U.S. Food and Drug Administration; CBT = cognitive behavioral therapy; TCA = tricyclic antidepressant; MAOI = monoamine oxidase inhibitor.

\*—First-line treatments, as recommended in the text, are listed first. FDA-indicated medications for each disorder are listed second.

†—Exposure and response prevention involves exposure to obsessional thought content coupled with delaying or blocking compulsive behaviors or thoughts.

Information from references 9 through 13, 17 through 19, and 21 through 33.

selective attention strategies. The effectiveness of this treatment for patients with hypochondriasis corroborated the results of earlier RCTs.<sup>21-23</sup>

### Other Disorders Characterized by Excessive Worry

Diagnosis-tailored, cognitive behavioral treatments have demonstrated effectiveness for panic disorder,<sup>24</sup> social phobia (social anxiety),<sup>25</sup> post-traumatic stress disorder,<sup>26</sup> obsessive-compulsive disorder,<sup>27</sup> and depression.<sup>28</sup> SSRIs and other antidepressants have demonstrated effectiveness for the same disorders.<sup>29-33</sup> However, combining CBT and medications does not necessarily result in better outcomes among grouped data.<sup>34</sup> Although the evidence base for combined treatments is lacking, physicians may find this approach imperative for individual patients.

### Treatment of Patients with Excessive Worry

The effectiveness of SSRIs and venlafaxine in controlled trials of treatment for the psychiatric disorders most often linked with excessive worry suggests that these medications should be first-line pharmacologic treatments. The effectiveness of CBT for these disorders suggests that such techniques will be adapted successfully to treat excessive worry across diagnostic categories and in subthreshold presentations (Table 4<sup>9-13,17-19,21-33</sup>). There is limited evidence that psychosocial treatments for these disorders can be adapted effectively for use by family physicians in brief contacts.<sup>35</sup> Pending such findings, basic knowledge of CBT for these disorders can increase family physicians' understanding and practical management of patients with excessive worry. These patients may benefit from brief,

## Worry-Prone Patient

intermittent counseling focusing on: accepting uncertainty; curtailing reassurance-seeking; the futility of thought suppression; irrational risk assessment; behavioral strategies (e.g., worry periods, worry recording); and mindfulness meditation.

Although family physicians usually are not formally trained in CBT, the concepts and techniques can be adapted to brief primary care counseling and supplemented with readings and behavioral assignments. *Table 5* summarizes potential teaching points and

practical strategies derived from CBT for use in brief, primary care education and counseling of the patient with excessive worry. These points can be chosen and adapted for adults with various educational levels or for children. Any brief primary care contact may focus on a single counseling point, worry-management strategy, or assignment.

Clinically, some patients will respond quickly (in two to four weeks) to a first trial of an SSRI or venlafaxine. Others may respond minimally across numerous and lengthy

**TABLE 5**  
**Education and Cognitive Behavioral Strategies for Patients with Excessive Worry**

<i>Patient characteristic</i>	<i>Teaching point</i>	<i>Cognitive behavioral strategy</i>
Worry as a warning	Worry rarely saves us from anything. Most things we worry about are unlikely events. The bad things that happen to us are rarely anticipated through worry and rarely allow us any control. A compelling worry is still just a thought that will pass.	Challenge your distorted risk assessments: "Am I overestimating the risk?" "Yes, it feels likely, but how likely is it really?" Remind yourself about the transient nature of worries: "Will this even matter to me next year, or even next week?"
Reassurance seeking	Frequently seeking reassurance (e.g., searching the Internet, checking your body, repeated consultation) often stimulates more worry and doubt. The brief relief provided by reassurance only perpetuates the worry cycle.	If you repeatedly seek reassurance from your physician or spouse, encourage them to gradually withhold the reassurance that only perpetuates the problem. Stop "investigating" on the Internet.
Worry suppression	Controlling thoughts is the problem, not the solution. What we resist persists. We think about what we are striving not to think about. Do not try to eliminate your worries. Worried thoughts can be accepted as background noise without being actively engaged.	Learn mindfulness meditation. It is simple, but not easy. Learning to be in the moment, focusing on your breathing and accepting the contents of your thoughts, can gradually ameliorate worry as you become more skilled.
Worries need immediate attention	This only perpetuates the worry cycle. Strive to experience your worries "on the clock" rather than whenever they intrude and upset you. You can learn to have worries at your bidding rather than having them "chase" you all day.	Try using scheduled "worry periods." Give your worries your full attention during 15- to 20-minute periods at set times during the day. Maximize your distress without reassurance. When worries intrude at other times, try to defer them until your next scheduled worry period, perhaps using a written list.
Seeking control and certainty	More worrying will not yield control or certainty. If a worried thought is truly a signal, it should dictate certain actions. If a worry does not call for action (other than reassurance seeking), it is likely to be merely noise, not a signal.	Learn to challenge your futile quest for certainty and control. Notice the many uncertainties and things you cannot control throughout the day, and practice mindful acceptance of each. Remember, certainty is only a feeling, and rarely is a reality.
Bodily tension; anxious arousal	When you give credence to your worried thoughts, your body will respond with tension, anxiety, and somatic symptoms. When you accept worries as "just thinking," your body will respond accordingly.	Relaxation and diaphragmatic breathing skills can buffer bodily tension. Discover what calms you, (e.g., massage, yoga, exercise, music, a hot bath, journaling, prayer, giving your time to someone).
Worries are a personal weakness	Worries are not the litmus test of strength or religious faith. You are wired for a "sticky brain" that makes you prone to worry. However, unhealthy habits perpetuate worry, and healthy habits can diminish worry.	Give a worried thought your full attention for five minutes, but then do something physical or interpersonal instead. Exercise and social contact (while not seeking reassurance) usually make worry much less compelling.

medication trials. Some patients respond so well to medication that they are not interested in other treatments; others are adamant about not taking medication and will benefit from CBT alone; and still others seem unable to benefit from counseling until their excessive worry is attenuated with medication. Medication for most patients with excessive worry should be started at one half (or less) of the usual starting dose to minimize side effects that can augment worry and preempt adherence. *Table 6* lists books and Web sites that may be helpful for patients with excessive worry. The patient with excessive worry is unlikely to experience sudden insight and abrupt improvement in response to even the most masterful delivery of these ideas and strategies. Because improvement typically occurs in gradual and sometimes erratic increments, these techniques can be well suited to longitudinal family practice. Patients who do not respond to these initial efforts in primary care can be referred to subspecialists for CBT with or without psychopharmacologic consultation.

**EDITOR'S NOTE:** Portions of this article were adapted from Shearer S. Anxiety disorders. AAFP Home Study Self-Assessment Monograph 2005 No. 309, with permission from the American Academy of Family Physicians.

## The Authors

STEVEN SHEARER, PH.D., is the coordinator of behavioral science training in the Family Practice Residency Training Program at Franklin Square Hospital Center in Baltimore, Md., and a founding partner in the Anxiety and Stress Disorders Institute of Maryland in Towson. He completed his doctoral training in clinical psychology at the University of North Dakota, Grand Forks, and the University of Virginia Hospital, Charlottesville. Dr. Shearer completed a fellowship at Sheppard-Pratt Hospital, Baltimore, Md.

LAUREN GORDON, M.D., is a faculty member in the Family Practice Residency Training Program at Franklin Square Hospital Center. She received her medical degree from the University of Maryland School of Medicine, Baltimore, and completed a residency in family practice and a fellowship in obstetrics at Franklin Square Hospital Center.

*Address correspondence to Steven Shearer, Ph.D., Department of Family Medicine, Franklin Square Hospital Center, 9101 Franklin Square Dr., Baltimore, MD 21237 (e-mail: steve.shearer@medstar.net). Reprints are not available from the authors.*

Author Disclosure: Nothing to disclose.

**TABLE 6**  
**Resources for Patients with Excessive Worry\***

### Generalized anxiety disorder

White JR. Overcoming generalized anxiety disorder: a relaxation, cognitive restructuring and exposure-based protocol for the treatment of GAD. Oakland, Calif: New Harbinger, 1999.

### Hypochondriasis/health anxiety

Neuman F. Worried sick? The exaggerated fear of physical illness: how to put physical symptoms into perspective, how to avoid unnecessary worry. Larchmont, N.Y.: Hadrian Press, 2003.

### Mindfulness meditation and worry

Kabat-Zinn J. Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and illness. New York: Delta, 1990.

Kabat-Zinn J. Mindfulness meditation: cultivate mindfulness, enrich your life. Niles, Ill: Nightingale-Conant, 2003.

### Obsessive thoughts/obsessive-compulsive disorder

Baer L. The imp of the mind: exploring the silent epidemic of obsessive bad thoughts. New York: Plume, 2002.

Grayson J. Freedom from obsessive-compulsive disorder: a personalized recovery program for living with uncertainty. New York: Tarcher, 2003.

### Worry in children

Chansky TE. Freeing your child from anxiety: powerful, practical solutions to overcome your child's fears, worries and phobias. New York: Broadway Books, 2004.

Chansky TE. Freeing your child from obsessive-compulsive disorder: a powerful, practical program for parents of children and adolescents. New York: Three Rivers Press, 2000.

### Web sites

Anxieties.com

<http://www.anxieties.com>

Anxiety Disorders Association of America

<http://www.ADAA.org>

National Institute of Mental Health

<http://www.nimh.nih.gov/healthinformation/anxietymenu.cfm>

WorryWiseKids.org

<http://www.worrywisekids.org>

\*—These resources are recommended by the authors. This list should not be construed as endorsement by American Family Physician or the American Academy of Family Physicians.

### REFERENCES

1. Barlow DH. Anxiety and its disorders: the nature and treatment of anxiety and panic. 2nd ed. New York: Guilford Press, 2002.
2. Roemer L, Orsillo SM. Expanding our conceptualization of and treatment for generalized anxiety disorder: integrating mindfulness/acceptance-based approaches with existing cognitive-behavioral models. *Clin Psychol Sci Pr* 2002;9:54-68.
3. Charney DS. Neuroanatomical circuits modulating fear and anxiety behaviors. *Acta Psychiatr Scand Suppl* 2003;417:38-50.
4. Wittchen HU, Hoyer J. Generalized anxiety disorder: nature and course. *J Clin Psychiatry* 2001;62(suppl 11):15-9.
5. Kessler RC, Wittchen HU. Patterns and correlates of generalized anxiety disorder in community samples. *J Clin Psychiatry* 2002;63(suppl 8):4-10.
6. Wittchen HU, Kessler RC, Beesdo K, Krause P, Hofler M, Hoyer J. Generalized anxiety and depression in primary care: prevalence, recognition, and management. *J Clin Psychiatry* 2002;63(suppl 8):24-34.
7. Fricchione G. Clinical practice. Generalized anxiety disorder. *N Engl J Med* 2004;351:675-82.
8. Meyer TJ, Miller ML, Metzger RL, Borkovec TD. Development and validation of the Penn State Worry Questionnaire. *Behav Res Ther* 1990;28:487-95.
9. Kapczinski F, Lima MS, Souza JS, Schmitt R. Antidepressants for generalized anxiety disorder. *Cochrane Database Syst Rev* 2003;(2):CD003592.
10. Allgulander C, Bandelow B, Hollander E, Montgomery SA, Nutt DJ, Okasha A, et al. WCA recommendations for the long-term treatment of generalized anxiety disorder. *CNS Spectr* 2003;8(suppl 1):53-61.
11. Ladouceur R, Dugas MJ, Freeston MH, Leger E, Gagnon F, Thibodeau N. Efficacy of a cognitive-behavioral treatment for generalized anxiety disorder: evaluation in a controlled clinical trial. *J Consult Clin Psychol* 2000;68:957-64.
12. Borkovec TD, Newman MG, Castonguay LG. Cognitive-behavioral therapy for generalized anxiety disorder with integrations from interpersonal and experiential therapies. *CNS Spectr* 2003;8:382-9.
13. Barsky AJ, Ahern DK. Cognitive behavior therapy for hypochondriasis: a randomized controlled trial. *JAMA* 2004;291:1464-70.
14. Magarinos M, Zafar U, Nissenson K, Blanco C. Epidemiology and treatment of hypochondriasis. *CNS Drugs* 2002;16:9-22.
15. Looper KJ, Kirmayer LJ. Hypochondriacal concerns in a community population. *Psychol Med* 2001;31:577-84.
16. Barsky AJ, Ettner SL, Horsky J, Bates DW. Resource utilization of patients with hypochondriacal health anxiety and somatization. *Med Care* 2001;39:705-15.
17. Oosterbaan DB, van Balkom AJ, van Boeijen CA, de Meij TG, van Dyck R. An open study of paroxetine in hypochondriasis. *Prog Neuropsychopharmacol Biol Psychiatry* 2001;25:1023-33.
18. Fallon BA, Qureshi AI, Schneier FR, Sanchez-Lacay A, Verme D, Feinstein R, et al. An open trial of fluvoxamine for hypochondriasis. *Psychosomatics* 2003;44:298-303.
19. Fallon BA. Pharmacotherapy of somatoform disorders. *J Psychosom Res* 2004;56:455-60.
20. Walker J, Vincent N, Furer P, Cox B, Kjernisted K. Treatment preference in hypochondriasis. *J Behav Ther Exp Psychiatry* 1999;30:251-8.
21. Visser S, Bouman TK. The treatment of hypochondriasis: exposure plus response prevention vs cognitive therapy. *Behav Res Ther* 2001;39:423-42.
22. Clark DM, Salkovskis PM, Hackmann A, Wells A, Fenell M, Ludgate J, et al. Two psychological treatments for hypochondriasis. A randomised controlled trial. *Br J Psychiatry* 1998;173:218-25.
23. Warwick HM, Clark DM, Cobb AM, Salkovskis PM. A controlled trial of cognitive-behavioural treatment of hypochondriasis. *Br J Psychiatry* 1996;169:189-95.
24. Rayburn NR, Otto MW. Cognitive-behavioral therapy for panic disorder: a review of treatment elements, strategies, and outcomes. *CNS Spectr* 2003;8:356-62.
25. Hambrick JP, Weeks JW, Harb GC, Heimberg RG. Cognitive-behavioral therapy for social anxiety disorder: supporting evidence and future directions. *CNS Spectr* 2003;8:373-81.
26. Foa EB, Rothbaum BO, Furr JM. Augmenting exposure therapy with other CBT procedures. *Psychiatr Ann* 2003;33:47-53.
27. Jenike MA. Clinical practice. Obsessive-compulsive disorder. *N Engl J Med* 2004;350:259-65.
28. Deckersbach T, Gershuny BS, Otto MW. Cognitive-behavioral therapy for depression. Applications and outcome. *Psychiatr Clin North Am* 2000;23:795-809.
29. Pollack MH, Allgulander C, Bandelow B, Cassano GB, Greist JH, Hollander E, et al. WCA recommendations for the long-term treatment of panic disorder. *CNS Spectr* 2003;8(suppl 1):17-30.
30. Stein DJ, Ipser JC, Balkom AJ. Pharmacotherapy for social anxiety disorder. *Cochrane Database Syst Rev* 2000;(4):CD001206.
31. Stein DJ, Zungu-Dirwayi N, van der Linden GJ, Seedat S. Pharmacotherapy for posttraumatic stress disorder. *Cochrane Database Syst Rev* 2000;(4):CD002795.
32. Greist JH, Bandelow B, Hollander E, Marazziti D, Montgomery SA, Nutt DJ, et al. WCA recommendations for the long-term treatment of obsessive-compulsive disorder in adults. *CNS Spectr* 2003;8(suppl 1):7-16.
33. Geddes JR, Freemantle N, Mason J, Eccles MP, Boynton J. SSRIs versus other antidepressants for depression. *Cochrane Database Syst Rev* 1999;(4):CD001851.
34. Foa EB, Franklin ME, Moser J. Context in the clinic: how well do cognitive-behavioral therapies and medications work in combination? *Biol Psychiatry* 2002;52:987-97.
35. Huibers MJ, Beurskens AJ, Bleijenberg G, van Schayek CP. The effectiveness of psychosocial interventions delivered by general practitioners. *Cochrane Database Syst Rev* 2003;(2):CD003494.