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CLINICAL MODULES

Anxiety: Clinical Practice Workbook

Structured assessment, formulation, skills practice, exposure planning, and maintenance tools for adult clients

DSM-5-TR · ICD-11 CLINICAL ALIGNMENT

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How to use this workbook

CLINICAL ORIENTATION

- Use collaboratively with a licensed clinician or as an adjunct to treatment; complete only the pages relevant to the client's goals.
- Treat all inventories as conversation aids rather than diagnostic tests. Review patterns, context, distress, functioning, and change over time.
- Choose one small practice at a time, record what happened, and revise the plan based on learning rather than perfection.
- Photocopy or reuse tracking pages when repeated observations would help identify patterns.

Clinical considerations

- This workbook does not diagnose an anxiety disorder or replace medical or mental health care.
- New or severe chest pain, fainting, marked breathing difficulty, confusion, or other possible medical emergencies require urgent medical assessment.
- Exposure work should be voluntary, collaborative, gradual, and appropriate to the person's health, trauma history, culture, and current stability. Specialized protocols may be needed for OCD, PTSD, eating disorders, substance withdrawal, or medical conditions.
- If there is immediate danger, suicidal intent, or inability to remain safe, contact local emergency services or a crisis service such as 988 in the United States and Canada. Adapt resource information to the client's location.
- Avoid assuming that all anxiety is excessive. Consider realistic threats, discrimination, financial insecurity, unsafe relationships, disability, caregiving demands, and other contextual stressors.
- Use identity-affirming language and adapt writing demands, sensory practices, examples, and pacing for accessibility.

Orientation and Treatment Focus

Clinical aim: Establish a collaborative, contextualized focus and define meaningful indicators of improvement.

Anxiety can be protective, burdensome, or both. Begin by identifying the problem the client wants help with and what life would look like if anxiety had less control.

My reason for using this workbook

Describe the anxiety pattern you want to understand or change. Use specific recent examples and include what matters enough to make this work worthwhile.

Area of life	Current impact	Preferred change	Importance 0–10
Daily functioning			
Relationships			
Work or learning			
Health and rest			
Meaningful activities			

What has been happening, and when did you first notice it becoming a concern?

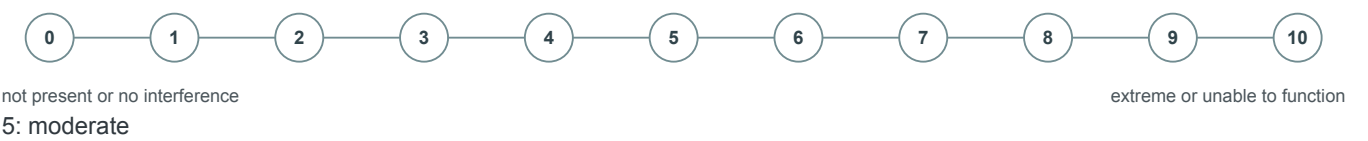
Where does anxiety interfere most: health, sleep, work, education, relationships, caregiving, community life, or recreation?

When is anxiety protective or understandable in your circumstances?

If this work helped, what would you be doing more of in daily life?

Starting-point ratings

Rate the past seven days. These ratings are not a test; repeat them later to notice change and guide discussion.



Domain	Rating 0–10	Example or context
Anxiety intensity		
Avoidance		
Time spent worrying		
Physical activation		
Interference		
Confidence in coping		

What influenced the highest rating?

What helped even slightly?

Which rating would you most like to shift first?

Pattern and Impact Review

Clinical aim: Identify anxiety presentations without turning a worksheet into a diagnosis.

Anxiety may appear as broad worry, panic, social-evaluative fear, a specific fear, health anxiety, or a combination. Similar experiences can also have medical, medication, substance, sleep, trauma, or contextual explanations.

Anxiety pattern check

Check experiences that have occurred repeatedly, then annotate duration, distress, and impact. Leave items blank when uncertain and discuss them with a qualified clinician.

- ☐ Hard-to-control worry across several areas of life
- ☐ Restlessness, fatigue, concentration difficulty, irritability, muscle tension, or disrupted sleep
- ☐ Abrupt surges of fear or discomfort with strong physical sensations
- ☐ Ongoing fear of another panic episode or behavior changes intended to prevent one
- ☐ Fear of scrutiny, embarrassment, rejection, or visible anxiety in social or performance situations
- ☐ Marked fear linked to a particular object or situation
- ☐ Avoidance, endurance with distress, reassurance seeking, checking, or extensive preparation
- ☐ Clinically meaningful distress or interference in daily life

Pattern	Examples	Duration/frequency	Distress or impact	Questions to review
Worry				
Panic				
Social fear				
Specific fear				
Other				

Which cluster best resembles your experience, and which parts do not fit?

How long has this pattern been present, and has it changed over time?

What medical conditions, medications, caffeine, substances, sleep changes, or life events could contribute?

What would require further professional assessment?

Functional impact map

Record what anxiety asks you to do and the immediate and delayed effects. Include subtle forms of avoidance such as procrastinating, overpreparing, staying quiet, or seeking repeated reassurance.

Situation	Anxiety prediction	What I do	Short-term effect	Long-term effect
Example 1				
Example 2				
Example 3				
Example 4				

Which response brings short-term relief?

What does that response cost later?

Where are you already responding flexibly?

Symptoms and Early Signals

Clinical aim: Build awareness of the client's individualized anxiety response across body, emotion, thought, and action.

Recognizing early signals can create time to choose a response. Symptoms vary across people and cultures and are not evidence of weakness or danger by themselves.

Four-domain symptom inventory

Check familiar signals and add your own. Mark early signals with E and signs of high activation with H.

- ☐ Racing or pounding heart
- ☐ Breathlessness or rapid breathing
- ☐ Dizziness or lightheadedness
- ☐ Nausea or digestive changes
- ☐ Sweating, shaking, tingling, heat, or chills
- ☐ Muscle tension, pain, headache, or fatigue
- ☐ Threat-focused or worst-case thoughts
- ☐ Difficulty concentrating or mind going blank
- ☐ Dread, fear, irritability, shame, or overwhelm
- ☐ Avoidance, freezing, escape, checking, reassurance seeking, or overpreparing

What appears first?

Which signals are easiest to miss?

Which symptoms merit medical assessment rather than being assumed to be anxiety?

My activation curve

Describe how anxiety changes from baseline through peak and recovery. Identify useful responses for each stage.

Stage	Body signals	Thoughts/attention	Urges/actions	Helpful response
Baseline				
Early activation				
Rising				
Peak				
Recovery				

At what stage is choice easiest?

What support helps recovery without reinforcing avoidance?

Context, Stress, and Protective Factors

Clinical aim: Develop a whole-person formulation that includes stressors, inequity, health, strengths, and support.

Anxiety does not occur in a vacuum. A useful formulation considers current pressures and realistic threats alongside learned patterns and personal resources.

Contributing-context review

Note recent or ongoing factors. Do not force disclosure; record only what feels useful and safe to discuss.

- ☐ Loss, separation, relocation, or major transition
- ☐ Work, education, unemployment, or financial pressure
- ☐ Relationship conflict, loneliness, caregiving, or parenting demands
- ☐ Illness, pain, hormonal change, disability, or sleep disruption
- ☐ Medication change, caffeine, alcohol, cannabis, nicotine, or other substance use
- ☐ Trauma reminders, unsafe circumstances, discrimination, or minority stress
- ☐ Information overload, distressing news, or environmental stress
- ☐ Reduced access to rest, healthcare, transportation, housing, or community support

Factor	How it affects anxiety	Within my control?	Support or next step
Factor 1			
Factor 2			
Factor 3			
Factor 4			

Strengths and support inventory

Identify resources already helping you cope. Include personal skills, relationships, cultural practices, spiritual resources, accommodations, and professional care.

Resource or strength	How it helps	How I can access it	Next use
Personal			
Relational			
Community/cultural			
Practical			
Professional			

When have you handled a similar period effectively?

What did you do, and who or what helped?

Who can offer emotional, practical, or professional support?

What would you tell someone you care about in this situation?

Anxiety Event Monitoring

Clinical aim: Observe the anxiety cycle accurately and compassionately.

A single event record separates the situation from interpretations, sensations, emotions, urges, and actions. Repeated records reveal patterns and intervention points.

Anxiety event record

Complete soon after an event when possible. Use brief, observable descriptions and rate intensity without judging the response.



Situation	Thought/image	Emotion + 0–10	Body sensation	Urge/action	Immediate outcome
Event					

Where was your attention focused?

What did you predict would happen?

What did you do to control, escape, or tolerate the experience?

What happened next?

Weekly pattern log

Record brief entries across one week. Look for patterns in timing, setting, sleep, substances, demands, and coping rather than trying to eliminate every symptom.

Date/time	Trigger/context	Intensity 0–10	Response	What helped	What I learned
Entry 1					
Entry 2					
Entry 3					
Entry 4					
Entry 5					
Entry 6					
Entry 7					

What pattern is emerging?

What is one small change to test next week?

Emotion-Driven Actions and Avoidance

Clinical aim: Clarify how understandable protective responses may maintain anxiety or restrict valued living.

Avoidance and safety behaviors often work in the short term. The goal is not blame; it is to notice when protection has become costly and expand available choices.

Short-term relief, long-term cost

Choose one recurring behavior such as leaving, delaying, checking, rehearsing, concealing symptoms, using substances, or seeking reassurance. Map its effects.

Protective action	What it prevents or reduces now	Emotional cost later	Relationship/work/health cost	More flexible alternative
Action 1				
Action 2				
Action 3				

What need is this action trying to meet?

When is it genuinely protective?

When does it keep the fear untested?

Safety-behavior inventory

Check behaviors you use mainly to prevent a feared outcome or hide anxiety. Do not remove a safety behavior that addresses a genuine medical, accessibility, or environmental need.

- ☐ Keeping an escape route or safe person available
- ☐ Carrying an item mainly for reassurance
- ☐ Repeated checking, researching, or asking for certainty
- ☐ Overpreparing, scripting, or mentally reviewing
- ☐ Concealing blushing, shaking, sweating, or uncertainty
- ☐ Avoiding eye contact, opinions, food, exercise, crowds, transport, or unfamiliar places
- ☐ Using alcohol, medication outside directions, or another substance to get through
- ☐ Distracting constantly so anxiety cannot be felt

Which behavior could be reduced safely by 10 percent?

What prediction would that test?

What legitimate support should remain in place?

Thinking Patterns and Flexible Appraisal

Clinical aim: Help clients evaluate anxious predictions and develop balanced, credible perspectives.

Anxious thoughts are understandable attempts to predict and protect. Flexible appraisal asks whether a thought is complete, useful, and supported—not whether the person is thinking correctly.

Thinking-pattern reference

Check patterns that may narrow your view. Add a current example without treating the label as proof that a concern is false.

- ☐ All-or-nothing conclusions
- ☐ Drawing a broad rule from one event
- ☐ Treating the worst outcome as the most likely
- ☐ Filtering out neutral or positive information
- ☐ Discounting strengths or successes
- ☐ Assuming another person's thoughts
- ☐ Predicting the future with certainty
- ☐ Magnifying threat or minimizing coping ability
- ☐ Treating a feeling as proof
- ☐ Rigid should/must rules
- ☐ Global labels
- ☐ Taking excessive responsibility

Pattern	My example	Information missing	More complete view
Example 1			
Example 2			
Example 3			

Evidence and coping review

Select one specific prediction. Seek a balanced view that acknowledges uncertainty and real context.

Prediction	Evidence for	Evidence against/other explanations	Coping resources	Balanced response
Review				

What facts support this prediction?

What facts do not support it or suggest another outcome?

Am I treating a thought, image, or feeling as a fact?

What are several possible outcomes, from difficult to manageable?

If the feared outcome occurred, what coping options and supports would I have?

What would I say to a respected friend in this position?

What is a balanced response I can genuinely believe?

Cognitive and Behavioral Experiment Log

Clinical aim: Turn reappraisal into observable learning.

A thought record supports reflection; a behavioral experiment gathers new information. The goal is curiosity, not proving anxiety wrong.

Expanded thought record

Complete one row for a significant event. Re-rate after writing a balanced response and choosing a workable next action.

0

1

2

3

4

5

6

7

8

9

10

none/not believed

maximum/fully believed

Situation	Emotion/body + intensity	Automatic thought + belief	Evidence review	Balanced response	Action and re-rating
Record					

What changed after the review?

What remains uncertain?

Behavioral experiment

Design a small, ethical, safe test of a prediction. Define what can be observed before beginning.

Prediction	Experiment	Observed result	What I learned	Next experiment
Plan/result				

What exactly do I predict, and how strongly do I believe it?

What small action would produce useful information?

What safety behavior will I reduce, if appropriate?

What outcome would support, partly support, or not support the prediction?

Gradual Exposure Planning

Clinical aim: Reduce avoidance and build new learning through consent-based, graded approach practice.

Exposure means approaching a safe-enough situation, sensation, memory, or uncertainty long enough to learn something new. It is not forced confrontation, flooding, or a test of courage.

Approach hierarchy

With appropriate clinical guidance, list 8–10 steps from challenging but manageable to highly difficult. Make steps specific and repeatable. Consider specialized care before exposure involving trauma memories, obsessions/compulsions, eating-disorder fears, substances, or health risks.

0

1

2

3

4

5

6

7

8

9

10

no expected distress

maximum expected distress

Record a value from 0 to 100: _____ 50: moderate

Step	Specific approach task	Expected distress 0–100	Feared outcome	Safety behavior to review	Repetitions
1					
2					
3					
4					
5					
6					
7					
8					
9					

Step	Specific approach task	Expected distress 0–100	Feared outcome	Safety behavior to review	Repetitions
10					

Which first step is meaningful and manageable?

What accommodations or support are legitimate and should remain?

Exposure learning record

Before practice, record a testable prediction. During and after practice, track experience and learning. Success means approaching and learning, not reaching zero anxiety.

Task/date	Prediction + belief %	Distress before/peak/end	Duration	What actually happened	New learning/next step
Practice 1					
Practice 2					
Practice 3					
Practice 4					

What did you learn about the feared outcome?

What did you learn about your ability to cope?

What should be repeated, varied, or adjusted?

Social Anxiety Pathway

Clinical aim: Address self-focused attention, feared evaluation, avoidance, and post-event processing.

Social anxiety often involves threat predictions, strong body awareness, impression management, avoidance, and reviewing interactions afterward. Cultural norms, identity-based threat, communication style, and actual social safety must be considered.

Social situation formulation

Choose one recurring social or performance situation and map the cycle without assuming the threat is imaginary.

- ☐ Fear of visible anxiety
- ☐ Fear of awkwardness, criticism, rejection, offense, or humiliation
- ☐ Self-focused attention or monitoring
- ☐ Rehearsing, concealing, staying quiet, or relying on a safe person
- ☐ Avoiding, leaving early, or enduring with intense distress
- ☐ Post-event replay and self-criticism

Situation	Feared evaluation	Attention focus	Safety behavior	Outcome	Post-event story
Formulation					

What evidence suggests the setting is safe, mixed, or genuinely unsafe?

How might culture, identity, power, or previous discrimination shape this response?

Social approach experiment

Plan one small social action. Use an outward attention anchor, allow some uncertainty, and reduce one unnecessary impression-management behavior.

Action	Prediction	Attention anchor	Behavior reduced	Observed facts	Compassionate review
Experiment					

What valued quality do you want to embody, such as warmth, curiosity, honesty, or courage?

Where will you place your attention?

What behavior will you test?

How will you review facts without prolonged replay afterward?

Regulation and Acute Coping

Clinical aim: Create a flexible plan for tolerating high activation while preserving safety and choice.

Regulation skills can help a person remain present and choose the next action. They are not required to erase anxiety and should not become rituals used to guarantee safety.

Skills practice menu

Select one or two options to practice while relatively calm. Stop or adapt any practice that increases distress, pain, breathlessness, dissociation, or trauma activation.

- ☐ Longer, comfortable exhale without forced deep breathing
- ☐ Orient to named objects, colors, sounds, and contact points
- ☐ Pause: notice body, thoughts, urges, surroundings, then choose
- ☐ Release muscle groups gently rather than straining
- ☐ Brief mindful observation with eyes open or closed
- ☐ Move, walk, stretch, or complete one concrete task
- ☐ Use a believable coping statement
- ☐ Contact a trusted support person

Skill	When/where tried	Effect before/after	Adaptation needed	Use again?
Practice 1				
Practice 2				
Practice 3				

Acute anxiety coping plan

Prepare this plan in advance. It is distinct from a suicide safety plan or medical emergency plan.

Need	My plan	Contact/details
Immediate orientation		
Coping skill		
Support person		
Clinician/provider		
Urgent medical care		
Crisis response		
Follow-up		

My early warning signs are...

A phrase I can believe is...

The first grounding or movement step I will try is...

A safe place or person I can contact is...

I will seek urgent medical help for these symptoms...

I will contact emergency/crisis services if...

After the episode, I will care for myself and follow up by...

Daily Foundations and Support

Clinical aim: Identify realistic routine and environmental changes that support regulation.

Sleep, nourishment, movement, substances, social connection, and workload can affect anxiety, but access and health needs vary. Choose experiments rather than prescribing an ideal lifestyle.

Supportive-habits menu

Check options that are accessible and medically appropriate. Choose only one or two to test.

- ☐ Consistent sleep and wake anchors
- ☐ Regular nourishment and hydration
- ☐ Movement appropriate to health and ability
- ☐ Review caffeine, nicotine, alcohol, cannabis, or other substances
- ☐ Planned recovery time and enjoyable activity
- ☐ Boundaries around distressing media or notifications
- ☐ Time outdoors, daylight, creativity, spirituality, or community
- ☐ Practical organization that reduces avoidable stress
- ☐ Connection with supportive people
- ☐ Medical, medication, or therapy follow-up

Small experiment	Why it matters	When/how	Barrier and support	Review date
Experiment 1				
Experiment 2				

Support conversation plan

Plan a clear request to a partner, friend, family member, colleague, or provider. Support should increase agency rather than provide endless certainty.

Person	Request	Helpful response	Response to avoid	Check-in date
Support plan				

What do I want the person to understand?

What specific support would help?

What response tends to increase anxiety, even if well intended?

What boundary or accommodation is needed?

How will we know whether the support is useful?

Progress, Maintenance, and Next Steps

Clinical aim: Consolidate learning, anticipate setbacks, and clarify when additional care is needed.

Progress may include more valued action, less avoidance, faster recovery, greater willingness, or improved functioning even when anxiety still appears.

Progress review

Compare current functioning with the starting point using specific evidence rather than a good/bad judgment.

Domain	Starting point	Current pattern	Evidence of change	Next focus
Intensity				
Avoidance				
Worry time				
Physical activation				
Functioning				
Confidence in coping				

What skill or insight has mattered most?

What remains difficult?

What progress might be easy to overlook?

Maintenance and care-escalation plan

Record early warning signs, routine supports, and clear thresholds for professional or urgent help.

Warning sign	Response	Support/contact	Timeframe
Early			
Increasing			
Severe			
Urgent/emergency			

What signs suggest the pattern is returning?

Which practices will I resume first?

Who will I tell?

What barriers could prevent me seeking care?

What symptoms or risks mean I need prompt professional, crisis, or medical assessment?

2026 Clinical Alignment

DSM-5-TR (including Sept. 2025 update) · ICD-11 CDDR / 2026 MMS

Classification status

- DSM-5-TR: No single diagnosis named 'anxiety'; anxiety disorders are a family · umbrella/quasi-diagnostic
- ICD-11 CDDR: 6B00-6B0Z Anxiety or fear-related disorders · umbrella category
- This workbook is non-diagnostic. A title, checklist, or completed activity never establishes a diagnosis.

Pages requiring the updated interpretation

- The audit identified source pages 1, 2, 3, 5, 6, 7, 8, 10, 11, 12, 13, 17, 18, 20, 24, 26, 28, 31, 32, 33, 34, 37, 40. The statements below supersede incompatible diagnostic, scoring, safety, or resource wording on those pages.

Diagnostic and differential limits

- A symptom checklist or self-rating cannot establish diagnosis. Any diagnostic discussion must address clinically significant distress/impairment, required course or duration where applicable, developmental and cultural context, substance/medication and medical causes, comorbidity, exclusions, and reasonable differentials without reproducing copyrighted criteria.

Document-specific corrections

- Describe Anxiety as a contextual, functional, occupational, umbrella, or proposed construct-not a confirmed diagnosis-unless a separately recognized disorder is assessed.
- Where Anxiety discusses symptoms, add the missing diagnostic frame: clinically meaningful distress/impairment, relevant course or duration, exclusions, developmental and cultural context, substance/medication or medical causes, and plausible differentials.
- Supersede diagnostic-sounding scoring on pages [1, 2, 5, 6, 8, 10, 13, 20, 24, 40]: disclose whether each tool is validated or author-created, remove unsupported thresholds, and separate symptom monitoring from diagnosis.
- Revise exposure content on pages [1, 2, 26, 28] to require consent, an objectively safe graded hierarchy, condition-specific response guidance, progress review, and stop/reassessment criteria; never equate flooding with effective exposure.
- Revise trauma/protocol material on pages [33]: distinguish stabilization and reflection from trauma processing, state training/scope requirements, and add dissociation, acute-risk, and destabilization safeguards.
- Clinically review medical or treatment statements on pages [2, 7, 12, 20, 34]; remove prescriptive medication advice, clarify coordination with licensed medical care, and update contraindications or urgent warning signs for the specific topic.
- Replace crisis wording on pages [2, 32, 33, 40] with the current U.S. 988 call/text/chat pathway, 911 or nearest emergency department for immediate danger/medical emergency, and a direction to use verified local services outside the United States.

Measures, scoring, and permissions

- Pages [1, 2, 5, 6, 8, 10, 13, 20, 24, 40] contain named, implied, or author-created screening/rating content . These scores are not diagnostic unless the exact instrument, version, validation population, administration, and interpretation are established. Identify provenance for every item set and scoring rule. Obtain publisher permission/license when required; otherwise remove cutoffs and label it as a nonvalidated reflection checklist, or replace it with a properly licensed measure without altering its wording/scoring.

Intervention scope and contraindications

- For Anxiety, exposure must be voluntary, graded, condition-specific, and conducted only in objectively safe and lawful situations. Do not prescribe flooding; screen medical limitations, trauma cues, dissociation, intoxication, and whether avoidance reflects real danger rather than phobic fear.
- Exposure work should be formulation-driven, collaborative, graded, and designed to reduce avoidance and unhelpful safety behavior-not delivered as forced flooding. Screen medical and trauma-related explanations when relevant.

2026 Clinical Alignment

DSM-5-TR (including Sept. 2025 update) · ICD-11 CDDR / 2026 MMS

Crisis and current resources

- For Anxiety, use: ·If there is immediate danger or a medical emergency, call 911 or go to the nearest emergency department. In the U.S., call or text 988 or use 988lifeline.org for 24/7 crisis support. Outside the U.S., use verified local emergency and crisis services.· Verify all topic-specific agencies and links at publication.

Authoritative references

- <https://www.psychiatry.org/psychiatrists/practice/dsm/updates-to-dsm/updates-to-dsm-5-tr-criteria-text>
- <https://www.psychiatry.org/getmedia/b68a5776-f88c-45c7-9535-fd219d7aa5cb/APA-DSM5TR-Update-September-2025.pdf>
- <https://icd.who.int/browse/2026-01/mms/en>
- <https://www.who.int/publications/i/item/9789240077263>
- <https://www.samhsa.gov/mental-health/988>
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