Portfolio submitted in fulfilment of the requirements for the
Professional Doctorate in Counselling Psychology (DPsych)

Exploring Adults' Experiences of Anxiety

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Abbreviations Used and Definitions

GAD	Generalised anxiety disorder
IPA	Interpretative phenomenological analysis
GAD-7	Generalized Anxiety Disorder 7-Item scale
CBT	Cognitive behavioural therapy
ACT	Acceptance and commitment therapy
GAD-Q-IV	Generalized Anxiety Disorder Questionnaire IV
DSM	Diagnostic and Statistical Manual of Mental Disorders
ICD	International Classification of Diseases
APA	American Psychiatric Association
OCD	Obsessive-compulsive disorder
WHO	World Health Organization
US	United States
NHS	National Health Service
UK	United Kingdom
APMS	Adult Psychiatric Morbidity Survey
MDD	Major depressive disorder
IBS	Irritable bowel syndrome
NCS	National Comorbidity Survey
ED	Emotion dysregulation
IU	Intolerance of uncertainty
ALE	Adverse life event
NICE	National Institute for Health and Care Excellence
SSRI	Selective serotonin reuptake inhibitor
SNRI	Serotonin-noradrenaline reuptake inhibitor
MI	Motivational interviewing
RCT	Randomised control trial
REST	Restricted environmental stimulation technique
GP	General practitioner
BPS	British Psychological Society
PTSD	Post-traumatic stress disorder
ABBT	Acceptance-based behavioural therapy
GET	Graded exercise therapy
NAT	Negative automatic thought
HADS	Hospital Anxiety and Depression scale

CFQ   Chalder Fatigue scale

GSE   Generalized Self-efficacy scale

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Journal article   216-247

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Declaration

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Preface

This DPsych in counselling psychology portfolio is comprised of three sections: a doctoral piece of research, a combined case study and process report, and a journal article. Whilst they are distinct pieces of work, a common theme connects them; they all explore adults' experiences of anxiety. An overview of the three sections is presented below. I conclude this Preface by reflecting on how the common theme relates to my own experiences of becoming a counselling psychologist.

Section A: Doctoral Research

In this section, I present my doctoral research which explores the lived experiences of adults (aged eighteen and over) with generalised anxiety disorder (GAD). Although GAD is the most frequent anxiety disorder and the second most frequent psychiatric disorder in clinical settings (Wittchen, Kessler, Beesdo, Krause, Höfler, & Hoyer, 2002), it is significantly under-detected and under-treated (Wittchen & Jacobi, 2005). Clinicians often struggle to recognise the symptoms as belonging to GAD (Dugas & Robichaud, 2007); a difficulty compounded by the various ways in which individuals with GAD present for treatment (Timulak & McElvaney, 2018) as well as its high rate of comorbidity. The lack of empirical literature on the lived experience of GAD arguably hinders our understanding of it further. This study sought to address this gap in the literature and thus contribute to our understanding of GAD. Eight participants with a formal diagnosis of GAD were interviewed and data were analysed using interpretative phenomenological analysis (IPA). Developed themes reflect the participants' internal struggles (e.g., with uncertainty, absence of perceived control, and fundamental negative self-perceptions) and how they manage these. They also explore how their interpersonal relationships have been affected by GAD. The findings' implications for counselling psychology and the wider context are discussed as well as suggestions for future research.

Notably, whilst this research was driven by a strong desire to understand these adults' experiences and to give them a voice, its conception stemmed from my own encounters with GAD. My first clinical placement during my counselling psychologist training was in a local, private sector counselling service. My first client presented with emetophobia and feared long car journeys. However, it soon became apparent that his anxiety and worry extended beyond these specific foci; they were

generalised across a wide variety of topics. I consequently began researching GAD as, at the time, my professional awareness and understanding of GAD was significantly limited, and I needed to formulate his presenting difficulties and consider how best to approach therapy with him. This experience highlighted the potential complexities and difficulties that can arise in identifying, understanding, and working therapeutically with potential GAD. However, my perceptions of GAD as confusing and mysterious were initially triggered by a close friend's experiences. Her mental health team have mentioned GAD to her, and she has previously met GAD diagnostic criteria on the Generalized Anxiety Disorder 7-Item scale (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006). This left her questioning whether a diagnosis of GAD "applies" to her, and I wonder whether this influenced why she self-identifies as having "generalised anxiety". However, her mental health team letters refer to "mixed anxiety and depressive disorder". My friend, feeling confused, asked her psychiatrist for clarification. Her psychiatrist does not think she has "straightforward GAD", adding "I don't think it's as simple as that". Ultimately then, my interest in this research topic also derived from a personal desire, both as a counselling psychologist and as a friend, to better understand GAD.

Section B: Combined Case Study and Process Report

The second section brings the reader to the clinical component of the portfolio, where a combined case study and process report is presented. It describes a piece of clinical work I conducted during the final year of my counselling psychologist training, whilst working in a specialist fatigue service. The client, who I refer to as Daniel throughout to protect his anonymity, presented with exaggerated fatigue and severe anxiety. Anxiety is a maintaining factor for fatigue (Fernie & Murphy, 2009), thus our primary focus was on helping Daniel identify, challenge, and relate to his anxiety more effectively. To achieve these aims, both "traditional" cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT) interventions were used. In this piece of work, I consider how theory informed these interventions and reflect on our therapeutic relationship, including challenges that arose and my responses to these. I have chosen to present this particular case because it marked a turning point in how I conceptualise and consequently approach anxiety in my clinical work.

Section C: Journal Article

In the final section, I present a journal article that draws on the study presented in Section A. It focuses on one of the four developed super-ordinate themes: "Battling with uncertainty", which captures participants' difficulty tolerating uncertainty and consequent absence of perceived control. This super-ordinate theme was chosen because it illustrates some of the fundamental internal challenges faced by participants. These findings are therefore deemed crucial in aiding our understanding of GAD. The implications of the findings for counselling and clinical psychologists, counsellors, and psychotherapists who may assess and work with adults with GAD are discussed. I have chosen to submit this article to the *Journal of Phenomenological Psychology*, thus it has been formatted according to this journal's submission guidelines. This journal was chosen for several reasons. The article discusses key findings from a study that shares this journal's commitment to furthering the psychological understanding of persons in relation to self, world, others and time (as well as material objects and spatiality). Furthermore, it is the phenomenological journal with the highest impact factor. I believe that the findings have significant implications for all clinicians who may encounter adults with GAD, and I hope that the journal's high impact factor and wide, global audience renders the findings accessible to as many clinicians as possible. Finally, and again in line with this journal's commitment, I hope this article encourages clinicians to consider GAD from a phenomenological perspective. Phenomenology in the mental health field is synonymous with the pure clinical descriptions of symptoms. However, phenomenology considers phenomena as they are experienced, without reference to their psychological origins or causal statements (Denys, 2011). I believe this perspective is crucial in maximising our understanding of GAD and validating individuals' experiences of it.

Personal Reflections

My training to become a counselling psychologist has been a long, challenging, exciting, and humbling process that, linking with this portfolio's common theme, has often caused me significant anxiety. Echoing the research participants' apparent self-doubt, I believe that this level of anxiety was associated with self-pressure and self-doubt; pressure to be the 'perfect' therapist, and thoughts of not being cut out for this career. However, with growing experience in nurturing clinical placements, I have learnt to practice what I preach and to accept and be content with being 'good

enough', not just in my role as a counselling psychologist but personally too. Echoing both the piece of clinical work presented in Section B of this portfolio and some of the research participants' narratives, I am also trying to form a new relationship with my own anxiety. As opposed to fighting and trying to rid myself of it, I am trying to notice and accept it for what it is: an uncomfortable but essential emotion that does not need to govern my self-perceptions, decisions and behaviours. As Rollo May (1977) wrote:

> "We still cling to the illogical belief that mental health is living without anxiety. Anxiety is essential to the human condition" (p. 3).

> "Anxiety indicates vitality. Like fever, it testifies that a struggle is going on within the personality. So long as this struggle continues, a constructive solution is possible. When there is no longer any anxiety, the struggle is over, and depression may ensue" (p. 4).

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Section A: Doctoral Research

The Lived Experience of Adults With Generalised Anxiety Disorder

Supervised by Prof. George Berguno

Abstract

Despite the fact that generalised anxiety disorder (GAD) is the most frequent anxiety disorder and the second most frequent psychiatric disorder in clinical settings (Wittchen, Kessler, Beesdo, Krause, Höfler, & Hoyer, 2002), it is significantly under-detected and under-treated (Wittchen & Jacobi, 2005). There is also a lack of empirical literature on the lived experience of GAD. Considered together, this information highlights the need for a greater understanding of GAD. This study sought to address the gap in the literature, and thus contribute to this need, by exploring the lived experience of adults with GAD. Potential participants with a formal diagnosis of GAD were recruited via purposive sampling. Initial telephone screenings were conducted, during which they completed the Generalized Anxiety Disorder Questionnaire IV (GAD-Q-IV; Newman, Zuellig, Kachin, Constantino, Przeworski, Erickson, & Cashman-McGrath, 2002). A minimum total score of 7.67 was required to meet this questionnaire's GAD diagnostic criteria. Eight participants who met this requirement participated in one semi-structured interview. Data were analysed using interpretative phenomenological analysis (IPA) and four super-ordinate themes were developed. "Battling with uncertainty: What's going to happen next?" captured participants' difficulty tolerating uncertainty and consequent absence of perceived control over their life-worlds. "A struggle for autonomy: You either let it get a hold of you, or you get a hold of it" captured participants' continuous struggle for perceived control over their senses of self, as GAD takes over. "GAD and interpersonal relations: Worrying about what others think" explored the interactions between participants' experiences of GAD and their relationships with others. "The need to create meaning amid uncertainty and loss: GAD is an eye-opener" explored participants' attempts to locate meaning within their distress in order to tolerate the uncertainty, torment, and losses GAD has caused. The findings are discussed in relation to existing literature. Their implications for counselling psychology and the wider context are then considered as well as suggestions for future research.

1. Introduction

1.1 Overview

This study explored the lived experiences of adults (aged eighteen and over) with a formal diagnosis of generalised anxiety disorder (GAD). The following sections provide the context and rationale for this research.

1.2 Defining GAD and key concepts

1.2.1 GAD

The Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system is more widely used to diagnose GAD than the International Classification of Diseases (ICD) system (Hazlett-Stevens, 2008). The following history of GAD's diagnostic criteria is consequently confined to the DSM system. Both systems' current diagnostic criteria are then presented.

GAD as a diagnostic label first appeared in the third edition of the DSM (DSM-III; American Psychiatric Association [APA], 1980) as a residual category, meaning that a diagnosis of GAD was only possible if the individual did not meet diagnostic criteria for any other DSM-III anxiety disorder (Hazlett-Stevens, 2008). The fundamental feature was persistent anxiety. Additional symptoms such as anxious apprehension (including worry), physiological arousal, and hypervigilance that persisted for at least one month, were also required (APA, 1980). This set of criteria had one of the lowest diagnostic reliabilities of the mood and anxiety disorders (Andrews, Mahoney, Hobbs, & Genderson, 2016).

GAD became a separate diagnostic category when DSM-III was revised seven years later (DSM-III-R; APA, 1987). In accordance with supporting data, DSM-III-R made worry the central feature of GAD. To meet diagnostic criteria, unrealistic and excessive worry or anxiety about two or more life circumstances had to be present for a minimum of six months (APA, 1987). This minimum duration was more

consistent with GAD's chronic nature. Despite these improvements, the vague somatic criteria remained with individuals requiring six out of eighteen varied symptoms to meet diagnosis (APA, 1987).

Investigations found that individuals with GAD were more likely than those without GAD to have trouble controlling their worries (Craske, Rapee, Jackel, & Barlow, 1989). Difficulty controlling worry therefore became a diagnostic criterion in the fourth edition of the DSM (DSM-IV; APA, 1994). Whether worries were considered unrealistic or not had little discriminatory ability, thus this criterion was dropped (Mennin, Heimberg, & Turk, 2004). It was also acknowledged that individuals with GAD could have pervasive worry regardless of how many life areas were affected, thus the requirement for two or more life circumstances was removed (Mennin et al., 2004). The six-month minimum duration was retained.

GAD diagnostic criteria were fundamentally unchanged from DSM-IV (APA, 1994) to the fifth edition (DSM-V; APA, 2013) despite the Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group's proposed modifications (Andrews, Hobbs, Borkovec, Beesdo, Craske, Heimberg, Rapee, Ruscio, & Stanley, 2010). They suggested that the terms *generalised worry disorder*, *major worry disorder,* and *pathological worry disorder* more accurately capture GAD's main clinical feature: excessive worry. They also proposed reducing GAD's minimal duration from six to three months on the premise that it may be difficult for individuals, especially children, to recall whether their worry was excessive six months ago. To improve the criteria's discriminant validity, they proposed that only two associated symptoms: restlessness and muscle tension should be retained in DSM-V because these are the only symptoms specific to GAD. Finally, they argued that the addition of the following four behavioural symptoms could significantly improve the diagnostic reliability of GAD: avoidance, overpreparation, procrastination, and reassurance seeking. These symptoms have been shown to be associated with GAD (Andrews et al., 2010). Despite Dugas, Charette, and Gervais' (2018) argument that these suggestions may have increased the diagnostic validity and reliability of GAD, none were retained in DSM-V.

DSM-V (APA, 2013) then, defines GAD as a chronic condition (six-month minimum duration) involving excessive worry and anxiety about a number of everyday events or activities, on more days than not. Individuals with GAD find it difficult to control their worrying. A diagnosis of GAD requires at least three (one for children) of these

six somatic symptoms: restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbance (i.e., difficulty falling or staying asleep, or restless, unsatisfying sleep). The worry, anxiety, or physical symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Such distress or impairment must not result from direct physiological effects of a substance (e.g., drug, medication) or a general medical condition (e.g., hyperthyroidism), nor be better explained by another psychiatric disorder. Although worry is common among individuals with anxiety disorders, GAD is distinguished from other Axis I anxiety disorders because the worry is not confined to topics related to these specific disorders. For example, individuals with social anxiety disorder mainly worry about how others perceive them, while those with obsessive-compulsive disorder (OCD) may worry about whether they locked the front door or whether they are somehow contaminated (Dugas et al., 2018).

DSM-V also contains "associated features supporting diagnosis" (APA, 2013). These include trembling, twitching, feeling shaky, or muscle aches which may accompany muscle tension. Somatic symptoms, including sweating, nausea, and diarrhoea may also be experienced as well as an exaggerated startle response.

The tenth revision of the International Classification of Diseases (ICD-10; World Health Organization [WHO], 1992) uses broader diagnostic criteria. It defines GAD as:

> "Anxiety that is generalised and persistent but not restricted to, or even strongly predominating in, any particular environmental circumstances (i.e. it is "free-floating")" (WHO, 1992).

Associated somatic symptoms include trembling, muscle tension, sweating, and dizziness (WHO, 1992).

Slade and Andrews (2001) analysed Australian National Mental Health Survey data from a sample of 10,641 adults in the Australian population and found that although the weighted prevalence of twelve-month GAD was almost identical when defined by DSM-IV (2.6%) and ICD-10 (3.0%), less than half of those diagnosed by one system were also diagnosed by the other. This raises concerns about both systems' reliability.

1.2.2 Worry

Worry first gained attention in psychological inquiry in test anxiety literature. Morris and Liebert (1970) identified that test responses comprised two distinct factors. Their termed *worry* factor captured self-evaluated negative cognition about test performance.

In the late 1970s, research began that considered worry in its own right. In his study of the psychological aspects of insomnia, Borkovec (1979) observed that many individuals who had difficulty sleeping experienced intrusive, negative cognitions at bedtime; a process he named *worrying*. Since then, Borkovec and colleagues have extensively investigated the nature of the worry process. Borkovec, Robinson, Pruzinsky, and DePree (1983) initially offered a tentative definition of worry that has become widely accepted in GAD research (Clark & Beck, 2010):

> "Worry is a chain of thoughts and images, negatively affect-laden and relatively uncontrollable. The worry process represents an attempt to engage in mental problem-solving on an issue whose outcome is uncertain but contains the possibility of one or more negative outcomes. Consequently, worry relates closely to fear processes" (Borkovec et al., 1983, p. 10).

In 1994, Borkovec amended this definition to capture how "worry is a predominantly verbal-linguistic attempt to avoid future aversive events" (p. 7) rather than a focus on imagery.

Although worry has been labelled the cognitive component of anxiety (O'Neill, 1985), research has demonstrated that worry is a specific construct that is distinguishable from a larger subset of cognitive components of anxiety and can be studied in its own right (Davey, Hampton, Farrell, & Davidson, 1992; Zebb & Beck, 1998).

Despite this distinction, individuals with GAD do not always use the term worry to describe their worries. Some describe them as fears or anxiety (Dugas & Robichaud, 2007).

1.2.3 Worry in GAD is unique

Although individuals with GAD worry about the same topics all humans worry about at times, they tend to worry about most things, most of the time. They can get locked into a vicious worry cycle that is difficult to disengage from. In contrast, individuals without GAD tend to worry in response to a specific trigger and have a subjective sense of greater control over their worrying; rendering it (generally) time-limited (Wilkinson, Meares, & Freeston, 2011). Furthermore, individuals with GAD consistently worry more about minor matters, such as which book to read or what brand of oven to buy than both nonclinical individuals and those with other anxiety disorders (Brown, Moras, Zinbarg, & Barlow, 1993; Hoyer, Becker, & Roth, 2001). They also tend to worry more about unlikely or remote future events such as their plane crashing or how they will pay their unborn child's university fees (Dugas, Freeston, Ladouceur, Rhéaume, Provencher, & Boisvert, 1998).

1.2.4 Distinguishing between existential anxiety, neurotic anxiety and fear

Although anxiety is a universal human emotion (Simpson, Neria, Lewis-Fernández, & Schneier, 2010), a universally accepted definition does not exist (Barlow, 2002). Furthermore, anxiety is so closely related to fear that the two terms are often used interchangeably (Rachman, 2013). DSM-V defines anxiety as "anticipation of future threat" and fear as "the emotional response to real or perceived imminent threat" (APA, 2013). In light of these brief definitions and unclear distinctions, I refer to existential theory.

In his book *The Concept of Anxiety*, which was first published in 1844, the existential philosopher Kierkegaard describes anxiety as the "possibility of freedom" (as cited in May, 2015). He asserts that the distinctive characteristic of humans is the range of possibility and our capacity for self-awareness of possibility. He compares these possibilities to unknown roads that lie ahead and explains that when we confront them, this evokes anxiety (as cited in May, 2015). Put another way, possibility passes over into actuality but in between lies anxiety. Selfhood (sense of identity) relies on the individual's capacity to confront anxiety and move forward despite it (May, 2015). Anxiety involves inner conflict. Kierkegaard asserts: "anxiety is a desire for what one dreads" (as cited in May, 2015). In every

experience, the individual wishes to move forward, actualising his or her possibilities but simultaneously wishes not to. Kierkegaard distinguishes between "normal" and "neurotic" anxiety. An individual with "normal" anxiety moves forward despite this conflict, actualising his or her freedom, whereas someone with neurotic anxiety remains in a "shut in" condition, sacrificing freedom. This involves processes of blocked awareness, inhibition, and other common neurotic responses to anxiety (as cited in May, 2015). All humans experience anxiety because it is possible to create oneself and one's daily activities. If no possibilities existed, humans would not experience anxiety (May, 2015). Existential anxiety then, is an anxiety that belongs to human existence itself, not to an abnormal state of mind, as in neurotic and psychotic anxiety (Tillich, 2000).

Similarly, the existential philosopher and theologian Paul Tillich (2000) defines existential anxiety as the existential awareness of nonbeing. Humans are therefore always anxious. Tillich identified three types of existential anxiety: the anxiety of death, the anxiety of meaninglessness, and the anxiety of condemnation. All are interwoven with each other but usually one type dominates in a given moment. Like Kierkegaard's distinction between existential and neurotic anxiety, Tillich explains that in neurotic anxiety possibilities are not actualised because actualisation of being implies the acceptance of nonbeing and its anxiety.

Tillich (2000) also distinguishes between existential anxiety and fear. He explains that fear has a definite object that can be confronted, analysed, and struggled with. In other words, it can be acted upon. Anxiety, in contrast, does not have an object, or rather its object is the negation of every object, meaning that it cannot be acted upon. The only object is the threat itself but not the source of the threat because the source is "nothingness" (nonbeing). Although fear and anxiety can be distinguished, they cannot be separated (Tillich, 2000). Fear is being afraid of something, for example, a pain, rejection from others, or the moment of dying. In the anticipation of the threat originating in things, it is not the negativity which these things will bring that frightens the individual but the anxiety about the implications of this negativity. Tillich illustrates this distinction using the fear of dying. Fear relates to the anticipated event of being killed by illness or an accident, and thus suffering and loss. Anxiety refers to the absolute unknown after death; the threat of nothingness (nonbeing). The anxiety of not being able to preserve one's being underlies every fear and is the frightening element in it. Humans are consequently driven to establish objects of fear that can be acted upon (Tillich, 2000).

1.3   Literature review

1.3.1   GAD prevalence

The tendency for studies to use different GAD diagnostic criteria, as well as numerous changes to the criteria sets themselves, makes it difficult to reliably draw comparisons between data on GAD prevalence. Many large-scale epidemiological studies in the United States (US) for example, were conducted using DSM-III or DSM-III-R criteria (Dugas & Robichaud, 2007). Furthermore, studies employ different methods and prevalence estimates. Some studies consider point prevalence (the number of individuals in a given population who have the disorder at a particular point in time), while others are based on lifetime prevalence (the number of individuals who have had the disorder at some time in their life). Some studies also report estimates of lifetime morbid risk. This is the number of individuals who will eventually develop the disorder at some time in their life, regardless of whether they have a lifetime history at the time of assessment (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). Ultimately, prevalence figures are estimates that must be interpreted and compared with caution.

Despite this warning, Dugas and Robichaud (2007) argue that general population prevalence rates in the US have remained relatively uniform across community-based studies. The twelve-month prevalence of GAD among adults in the general US population is 2.9%, while the adult lifetime prevalence and lifetime morbid risk are 4.3% and 9%, respectively (Kessler et al., 2012).

Europe's median twelve-month general population prevalence is 1.7% (Lewis-Fernández, Hinton, Laria, Patterson, Hofmann, Craske, Stein, Asnaani, & Liao, 2010). Twelve-month prevalence rates are higher for individuals of European descent than those of non-European descent (Lewis-Fernández et al., 2010).

The National Health Service (NHS) estimates that GAD affects up to 5% of the United Kingdom (UK) population (NHS, n.d.). According to the 2014 Adult Psychiatric Morbidity Survey (APMS), 5.9% of adults (aged sixteen and over) living in England were identified as having GAD in the week prior to interview. GAD was the most commonly identified common mental disorder. Common mental disorders

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were based on ICD-10 diagnostic criteria and also included depressive episode, phobias, OCD, and panic disorder (McManus, Bebbington, Jenkins, & Brugha, 2016). It is noteworthy that the studies represented in this survey only included individuals living in private housing, thus this figure may underestimate GAD's actual adult prevalence in England. Moreover, a different figure may have been obtained if the survey applied DSM-V criteria.

Studies have demonstrated that females are twice as likely as males to experience GAD (Seedat et al., 2009; Vesga-López, Schneier, Wang, Heimberg, Liu, Hasin, & Blanco, 2008). Gender differences in England reached statistical significance in the 2014 APMS with an estimated 4.9% prevalence in males, compared to 6.8% in females (McManus et al., 2016). Various possible explanations for this difference have been proposed including hormonal differences, cultural pressures, and a higher proportion of females than males reporting anxiety (Roe-Sepowitz, Bedard, & Thyer, 2005).

With regards to prevalence across age groups, Kessler et al. (2012) found that GAD's prevalence in the US peaks in middle age (with a median onset age of 30) and declines across the later years of life. Furthermore, they reported that an estimated 69-74% of all lifetime cases of GAD in the US have first onsets in the 18 to 64 age range. The 2014 APMS reported that GAD was more common in individuals living in England aged 16 to 64 than in previous years of the survey, as well as being more common in 16 to 64-year-olds than in those aged 65 or older (McManus et al., 2016). Current NHS website information differs, stating that GAD is more common in individuals aged 35 to 59 (NHS, n.d.). The fact that NHS statistics are based on the entire UK population not just those living in England may, at least partially, account for this difference. Despite indications that GAD is less common in older adults, the Longitudinal Aging Study Amsterdam found that GAD may be the most common anxiety disorder among those aged 55 and older (Beekman, de Beurs, van Balkom, Deeg, van Dyck, & van Tilburg, 2000).

In terms of GAD's prevalence in clinical settings, Maier, Gänsicke, Freyberger, Linz, Heun, and Lecrubier (2000) found that among individuals from fourteen countries (including England, France, Brazil and the US) who visited their physicians for a psychological difficulty, 25% had a diagnosis of pure GAD (no comorbid disorders). Wittchen (2002) reported that in the US, GAD is the most common anxiety disorder in primary care; present in 22% of primary care patients who report anxiety

problems. In a more recent US study involving fifteen primary care clinics, 7.6% of the 965 randomly sampled patients had GAD (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007). GAD is the most frequent anxiety disorder and the second most frequent of all psychiatric disorders in clinical settings (Wittchen, Kessler, Beesdo, Krause, Höfler, & Hoyer, 2002).

1.3.2 Comorbidity

Over 90% of individuals who meet criteria for GAD in a given year also have at least one other psychiatric diagnosis (Dugas & Robichaud, 2007). Mood disorders such as major depressive disorder (MDD) and dysthymia are the most common comorbid conditions, but over 50% of individuals with GAD have an additional anxiety disorder as well (Dugas & Robichaud, 2007). Similar findings have been reported in Europe alone. Wittchen and Jacobi (2005) analysed community studies conducted in sixteen European countries and found that comorbidity with MDD was present in three out of five cases, with a similar proportion having other anxiety disorders alongside GAD.

GAD has also been found to co-occur with personality disorders. Findings from the Harvard/Brown Anxiety Research Project; a longitudinal follow-up study of DSM-III-R defined anxiety disorders, indicated that 37.7% of participants with GAD had at least one personality disorder. Avoidant, obsessive-compulsive, and dependent types were the most common (Dyck, Phillips, Warshaw, Dolan, Shea, Stout, Massion, Zlotnick, & Keller, 2001). Grant, Hasin, Stinson, Dawson, Chou, Ruan, and Huang (2005) investigated the co-occurrence of DSM-IV personality disorders among individuals in the US general population with current DSM-IV mood or anxiety disorders, as well as those seeking treatment for one, and found that 60.6% of those with GAD met personality disorder criteria.

GAD also frequently co-occurs with physical health conditions, particularly gastrointestinal problems such as irritable bowel syndrome (IBS) (Hazlett-Stevens, 2008). Sareen, Cox, Clara, and Asmundson (2005) examined data from the US National Comorbidity Survey (NCS) and found that GAD was associated with gastrointestinal diseases (i.e., ulcers, hernia, stomach problems, liver, or kidney disease), only after adjusting for the effects of other anxiety disorders and MDD. Drews and Hazlett-Stevens (2008) investigated 391 undergraduate psychology

students using self-report diagnostic measures and questionnaires. Sixteen participants met criteria for both GAD and IBS. Gros, Antony, McCabe, and Swinson (2009) found that individuals with a principal diagnosis of GAD had the highest rate of comorbid IBS: 25.8%, compared to those with a principal diagnosis of panic disorder, social anxiety disorder, OCD, specific phobia, or MDD. Individuals with GAD reported more severe and frequent IBS symptoms.

An association between GAD and heart problems also exists. GAD increased the risk of all-cause and cardiovascular disease mortality in Vietnam veterans (Phillips, Batty, Gale, Deary, Osborn, MacIntyre, & Carroll, 2009). It substantially increased the rate of subsequent cardiac problems in individuals with stable coronary artery disease; an association that could not be explained by disease severity, health behaviours, or biological mediators (Martens, de Jonge, Na, Cohen, Lett, & Whooley, 2010).

GAD also co-occurs with chronic pain conditions such as backache, joint pain and migraines, medically unexplained somatic symptoms, and sleep disorders (Nutt, Argyropoulos, Hood, & Potokar, 2006).

GAD's high rate of comorbidity has led some anxiety disorder experts to question whether GAD is an independent disorder or a prodromal condition that promotes the development of other anxiety or mood disorders (Dugas & Robichaud, 2007). As already highlighted, MDD is one of the most common comorbid disorders with GAD and they have a shared genetic origin (Kendler, Gardner, Gatz, & Pedersen, 2007). These findings have promoted suggestions that GAD and MDD should be combined under the umbrella term *distress disorders* (Newman, Llera, Erickson, Przeworski, & Castonguay, 2013). The contention that GAD is not a unique diagnostic entity has been refuted by ample evidence (Newman et al., 2013). For example, when lifetime prevalence is considered, rates of comorbidity among individuals with GAD are similar to those present in individuals with other anxiety disorders (Dugas & Robichaud, 2007). Research has also shown that the onset of GAD does not systematically precede or follow the onset of comorbid conditions (Dugas & Robichaud, 2007), including MDD (Kessler, Gruber, Hettema, Hwang, Sampson, & Yonkers, 2008). Furthermore, order of onset between GAD and MDD does not affect GAD's progression (Kessler et al., 2008).

1.3.3 GAD aetiologies

Numerous theories of GAD's cause, development, and maintenance exist. Although Dugas et al. (2018) suggest that psychological, socio-cultural, and biological factors all play a role, Beesdo, Pine, Lieb, and Wittchen (2010) argue that more research is required to understand these factors' specific contributions. Each factor domain is explored in the following sections.

1.3.3.1 Psychological models

Only psychological models supported by empirical evidence are included in the following subsections.

1.3.3.1.1 Attachment theory

According to Bowlby (1973), attachment is a relational emotion regulation system and attachment processes are therefore central to our understanding of anxiety. Bowlby theorised that during the initial period of human evolution, genetic selection favoured secure attachment behaviours because they increased the likelihood of primary caregiver-infant proximity which, in turn, increased the likelihood of infant survival.

He observed that the attachment and fear systems are particularly activated in times of perceived threat. To increase their chances of survival during these instances, the child seeks proximity to and protection from the attachment figure (the child's primary caregiver, not necessarily the birth parent). Reduction of the child's anxiety relies on this figure being available to protect the child from harm and to offer comfort. According to this theory then, adult anxiety may derive from childhood experiences that leave the individual uncertain of the availability of a protective figure in times of perceived threat.

Section 1.3.3.2.2 explores insecure attachment as a potential risk factor for the development of GAD in more detail, including supporting empirical evidence.

1.3.3.1.2 Avoidance model of worry and GAD

Borkovec, Alcaine, and Behar's (2004) avoidance model of worry and GAD proposes that worry is a cognitive response that, in the short-term, allows individuals with GAD to avoid experiencing distressing negative emotions and concurrent autonomic arousal to otherwise unavoidable perceived internal and external threats. Specifically, catastrophic mental images are replaced by less emotionally distressing, less somatically activating verbal-linguistic activity. The removal of aversive and fearful images, and consequent dampening of negative affect, negatively reinforces worry. Worry is further reinforced by positive beliefs including beliefs that worry aids problem-solving, motivates performance, and facilitates avoidance of future negative outcomes. These beliefs are, in turn, reinforced when aversive events do not occur or are effectively managed (Borkovec et al., 2004). However, in the long-term, worry is thought to maintain anxiety by disrupting the probable beneficial impact of naturally occurring exposure to feared stimuli. Threat associations are consequently maintained (Stapinski, Abbott, & Rapee, 2010).

Empirical support for the model includes evidence supporting the notion that worry is primarily a verbal-linguistic process (Behar & Borkovec, 2005). Borkovec and Roemer (1995) found that individuals with GAD believed that worry functions as a distraction from more emotional topics, suggesting that worry is used to avoid emotional processing and that it is reinforced by such positive beliefs. Despite these findings, Stapinski et al. (2010) argue that additional empirical data is required to build a strong evidence base for the model as mixed results from previous studies, together with their own findings, highlight the need for clarification concerning the mechanisms involved in the maintenance of threat associations and worry in GAD.

1.3.3.1.3 Emotion dysregulation (ED) model

Mennin, Heimberg, Turk, and Fresco (2002, 2005) criticise the avoidance model of worry and GAD because it fails to address what makes the emotional experience so aversive that it prompts the individual with GAD to engage in avoidance strategies such as worry. They suggest that ED may be integral in GAD's development. Their ED model (Mennin et al., 2002, 2005) contains four key dysregulation processes:

heightened emotional intensity, poor emotional understanding, negative reactivity to emotions (e.g. fear of emotions), and maladaptive management strategies. Mennin et al. (2002, 2005) suggest that individuals with GAD experience and express their emotions, particularly negative emotions, more easily and intensely than those without GAD. Being overly expressive of negative emotions on a frequent basis may lead to criticism and rejection from others which, in turn, may elicit higher levels of negative affect. They theorise that individuals with GAD can struggle to identify and differentiate between primary emotions such as fear, anger, disgust, sadness, and joy, and therefore cannot obtain useful information from their emotional experiences. Instead, they are left feeling overwhelmed and confused. Together, these two processes may lead individuals with GAD to experience all emotions as aversive, becoming anxious when they occur. Associated reactions may include extreme hypervigilance for perceived threats and activation of negative beliefs about emotions. They suggest that these three processes make it difficult for the individual to manage their emotions in a manner appropriate to the environmental context. They propose that individuals with GAD have two types of emotional regulation deficit. One is difficulty modulating their emotional experience and/or expression. Intense emotions that are misinterpreted as dangerous may contribute to this difficulty. The second is extensive employment of control mechanisms such as avoidance and blunting which serve to decrease their emotional experience. This is where worry enters the model; as an attempt to cognitively control the regulatory problems associated with subjectively averse emotional experience.

Findings from three studies by Mennin et al. (2005) provide preliminary support for this model. In the first, Individuals with GAD reported higher levels of emotional intensity and negative emotional expressivity than controls. GAD individuals also had significantly greater difficulty identifying and describing their emotions than controls and were less able to understand their emotional experiences. GAD individuals reported more negative beliefs concerning activated emotions, including fears about the consequences of their experiences and the need to control them. This was also the case for MDD, anger, and positive emotions, not just anxiety. Finally, ED was found to effectively predict GAD; more than 75% of individuals with GAD were correctly identified. Mennin et al. emphasise the significance of this finding as there were no items on the emotion regulation scales that measured GAD symptoms. One key limitation of this study is the fact that participants were diagnosed via self-report. Secondly, potential comorbidity was not examined, thus other emotional difficulties could have caused the ED deficits. The second study

consequently compared a clinical sample of individuals with GAD to a community control group. Similar findings were produced, but participants with GAD did not report greater attention to emotions than controls. This may suggest that attention to emotions is not a fundamental variable in the model. The third study attempted to begin delineating the processes involved in ED by experimentally inducing negative emotions. Participants with GAD had greater levels of self-reported physiological anxiety symptoms in response to the negative emotion inductions than controls. Following this induction, participants with GAD had more difficulty understanding and accepting their emotions and believed that they had less influence over them. These findings suggest that individuals with GAD find it difficult to manage their physiological reactions to negative emotions which may, in turn, motivate them to worry to escape distress.

Mennin et al. (2005) acknowledge that although findings from other studies also provide support for their model, ED's specificity to GAD remains unclear; ED has also been associated with other psychiatric disorders. Furthermore, additional investigation is needed to understand the causal links between each of the four ED processes as well as the relationship between ED and worry.

1.3.3.1.4 Contrast avoidance model of worry

Newman and Llera's (2011) contrast avoidance model of worry posits that worry may not enable emotional avoidance per se. Instead, Newman and Llera propose that individuals with GAD use worry as a coping strategy because it is more comfortable for them to experience the chronic distress associated with worry - which enables them to perceive that they are prepared for the worst outcome - than it is to experience a shift from a positive to a negative emotion. They believe that individuals with GAD use worry to avoid a negative affect contrast (a shift from a positive to a negative emotional state) but not a positive one. Their model derives from a review of cognitive psychology literature on affective contrast theory, which states that the impact of an emotional experience is determined by its degree of contrast with the preceding affective state (Bacon, Rood, & Washburn, 1914), together with their own findings. This led them to theorise that individuals with GAD have developed a stronger aversive reaction and are even more sensitive to negative emotional contrasts than individuals without GAD, and that avoidance of negative emotional contrast positively reinforces their worry (Newman & Llera,

2011). To test this theory, they replicated their previous study (Llera & Newman, 2010a) and found that participants with GAD reported finding worry more helpful than neutral or relaxation conditions at helping them cope with the negative emotions evoked by watching film clips. Ironically, participants with GAD also rated their total level of negative affect as being significantly higher than the control group (Llera & Newman, 2010b). Newman and Llera assert that these findings highlight that participants with GAD found the avoidance of negative emotional contrast helpful rather than avoidance of negative emotion per se. They suggest that this may be fundamental in understanding why individuals with GAD neither avoid nor process negative emotions.

Further research is required to identify elements of the model and risk factors that are unique to GAD, as theories for other psychiatric disorders posit similar mechanisms (Newman et al., 2013).

1.3.3.1.5 Cognitive model of GAD

The cognitive model proposed by Dugas and colleagues asserts that intolerance of uncertainty (IU) is fundamental to GAD's development and maintenance (Dugas & Robichaud, 2007). Dugas and Robichaud (2007) define IU as "a dispositional characteristic that results from a set of negative beliefs about uncertainty and its implications" (p. 24). They suggest that it contributes to the other three main components of the model: positive beliefs about worry, negative problem orientation, and cognitive avoidance, and that all four components maintain worry. Negative problem orientation refers to a set of beliefs about one's cognitive approach to problem-solving, such as doubting one's problem-solving abilities, finding perceived problems threatening, and negatively appraising the problem's outcome. Cognitive avoidance refers to strategies employed to avoid threatening cognitions and unpleasant autonomic activation, such as automatic avoidance of threatening mental images, suppressing worrisome thoughts, and avoiding situations that may trigger worry.

A growing body of evidence supports this model (see literature review by Dugas & Robichaud, 2007). IU and negative problem orientation predicted GAD symptom severity in a clinical sample of individuals with GAD (Dugas, Savard, Gaudet, Turcotte, Laugesen, Robichaud, Francis, & Koerner, 2007). However, findings from

other studies indicate that IU is not a phenomenon specific to GAD; it also appears to characterise OCD (Holaway, Heimberg, & Coles, 2006; Tolin, Abramowitz, Brigidi, & Foa, 2003).

1.3.3.1.6 Metacognitive model of GAD

Wells' (1995, 1999, 2004, 2005) metacognitive model places negative metacognitive beliefs about worry and the resultant meta-worry (worrying about worry) as central in GAD's development and maintenance. The model posits that when individuals are initially faced with an anxiety-provoking situation, positive beliefs about worry are produced (e.g., believing that worry will help them cope with the situation). Wells (2005) termed this process *Type 1 worry.* During Type 1 worry, negative beliefs about worry are activated (for Wells' numerous theories on how negative beliefs about worry develop, see Wells, 1995). Individuals with GAD begin to believe that their worry is uncontrollable and inherently dangerous, and consequently begin worrying about worry. Wells (2005) termed this meta-worry *Type 2 worry.* Type 2 worry is posited to be associated with numerous ineffective coping strategies, aimed at avoiding worrying via attempts to control behaviours, cognitions, and emotions (Wells, 1999, 2004). Engaging in these strategies prevents the individual from experiencing events that may provide evidence to disconfirm the belief that worry is uncontrollable and dangerous. Furthermore, the coping strategies employed by individuals with GAD to control their cognitions and worry (e.g., thought suppression) are often unsuccessful. These individuals may consequently lose confidence in their ability to control their worry, thus reinforcing the belief that worrying is uncontrollable and dangerous (Wells, 1999). Meta-worry also increases anxiety symptoms. If individuals misinterpret these symptoms as further confirmation that worrying is uncontrollable and dangerous, meta-worry is maintained (Wells, 2005).

Empirical support for the model is mixed. The specificity of negative beliefs about worry and meta-worry to GAD remains unclear. While several studies have demonstrated that individuals with GAD experience more negative beliefs about worry and meta-worry than individuals without an anxiety disorder diagnosis (Davis & Valentiner, 2000; Ruscio & Borkovec, 2004; Wells, 2005), others have shown that individuals with GAD experience similar levels of negative beliefs about worry and meta-worry as those with OCD (Cartwright-Hatton & Wells, 1997) and panic

disorder (Wells & Carter, 2001). Furthermore, no longitudinal work has examined any components of the model, even though the model attempts to conceptualise the fundamental mechanisms involved in GAD's development and maintenance (Behar, DiMarco, Hekler, Mohlman, & Staples, 2009).

1.3.3.2 Socio-cultural factors

1.3.3.2.1 Adverse life events (ALEs)

Newman et al. (2013) assert that experiencing ALEs can make the individual question their perception of the world as predictable and safe. This results in a continuous state of anxiety that enables the individual to feel prepared for other potentially unpredictable events. Bateson, Brilot, and Nettle (2011) argue that ALEs serve to increase the individual's vulnerability to potential threats in one or more ways which, in turn, induces anxiety. For example, if someone experiences a financial crisis, they are vulnerable to numerous potential situations such as insufficient funds to cover living expenses.

Findings from several studies support this proposed causality. Kendler, Hettema, Butera, Gardner, and Prescott (2003) assessed stressful life events that were blindly rated on the following dimensions: humiliation, entrapment, real or imagined loss of a person, health, material objects, or respect in the community, and danger. Onsets of pure GAD were predicted by higher ratings of loss and danger.

Hoven et al. (2005) conducted a survey of 8236 New York public school students in grades four to twelve with the aim of determining prevalence and correlates of probable anxiety and depressive disorders, six months after the September 11, 2001, terror attack. Higher levels of exposure to the attack corresponded with higher prevalence for all probable anxiety and depressive disorders, including GAD, suggesting that there is a relationship between level of exposure to trauma and likelihood of childhood GAD. However, this finding must be interpreted with caution due to the unavailability of pre-event prevalence rates for the sampled population. Furthermore, this study used a diagnostic assessment measure designed for screening purposes, not diagnosis, thus this finding is restricted to probable, as opposed to definite, cases of GAD (Hoven et al., 2005).

A recent US study tested the hypothesis that ALEs are associated with increased risk of anxiety disorder onset and produced similar findings. Of the 1321 participants with GAD, 916 had experienced at least one ALE three years prior to GAD onset, suggesting that ALEs do play a role. Injury, and illness or death of a family member or close friend had the strongest associations with GAD onset (Miloyan, Bienvenu, Brilot, & Eaton, 2018).

1.3.3.2.2 Family environments and parenting styles

In addition to one-off or infrequent ALEs, negative familial experiences, that are often more chronic in nature, are potential risk factors for the development of GAD (Newman et al., 2013).

Insecure attachment is one such factor. Ainsworth, Blehar, Waters, and Wall (1978) developed the *Strange Situation*: a validated method of determining an infant's attachment behaviours to his/her primary caregiver. During the procedure, the infant's responses to the sequence of episodes detailed in Table 1.1 below, are observed.

Results of the Strange Situation categorise infant behaviours into three attachment styles: secure attachment, anxious-ambivalent insecure attachment, and anxious-avoidant insecure attachment. During the Strange Situation, the securely attached infant engages with the stranger if their caregiver is nearby, cries when their caregiver leaves the room, happily reunites with their caregiver when he/she returns and does not engage with the stranger if the caregiver is not nearby. Ainsworth et al. (1978) theorise that secure attachment is marked by both a positive, close relationship with the primary caregiver (who responds appropriately to the infant's needs), and the infant's willingness to independently explore his/her surroundings. In contrast, the anxious-ambivalent infant becomes distressed when the stranger enters the room, regardless of whether the caregiver is nearby or not. They exhibit extreme anxiety and distress when their caregiver leaves the room. However, when the caregiver returns, the infant is resistant to reuniting with them. Ainsworth et al. propose that infants with this insecure attachment style have inconsistent or intrusive caregivers, and thus likely experience affective fluctuations in response to their caregiver's inconsistent behaviour. Uncertainty about whether their needs will be met, together with the distress evoked by their consequent affective fluctuations,

may lead children with anxious-ambivalent attachment to experience continuous internalised anxiety as a way of preparing themselves for their caregiver's unpredictability (Newman et al., 2013). Finally, during the Strange Situation, the anxious-avoidant infant does not show interest in any of the adults in the room, regardless of which adults are present. They tend to avoid or ignore the caregiver, whether the stranger is nearby or not. Ainsworth et al. theorise that these infants are rejected by their caregivers. Despite the anxiety triggered by this rejection, these infants develop the belief that their caregivers will not respond to their signals of distress and need, and therefore avoid communicating their affect.

Episode number	Brief description of episode	Episode duration
1	Observer introduces caregiver and infant to experimental room, shows caregiver where to sit, shows infant toys, then leaves	30 seconds
2	Caregiver is non-participant while infant explores. If necessary, play is stimulated after two minutes	3 minutes
3	Stranger enters. First minute: Stranger silent. Second minute: Stranger converses with caregiver. Third minute: Stranger approaches infant. After three minutes, caregiver leaves unobtrusively	3 minutes
4	Stranger lets infant play but offers comfort if needed. Episode shortened if infant becomes too distressed	3 minutes or less
5	Mother greets and/or comforts infant. Stranger then leaves. Caregiver tries to settle infant again in play. Caregiver then leaves saying "bye-bye"	3 minutes or more
6	Caregiver leaves infant alone in the room. Episode ended if infant is too distressed	3 minutes or less
7	Stranger enters the room, greets infant and then pauses. Stranger sits or comforts infant if infant is upset. Episode ended if infant is too distressed	3 minutes or less
8	Caregiver enters, greets and picks infant up. Meanwhile, stranger leaves unobtrusively	3 minutes

Table 1.1   Episodes of the Strange Situation (Ainsworth et al., 1978)

Cassidy (1995) drew from Bowlby's (1973) attachment theory to hypothesise that GAD can develop in insecurely attached children because, no matter what the

source of their anxiety, the child may lack confidence that their caregiver will be available to reduce the child's anxiety in times of threat. This leads to negative interpersonal perceptions (e.g., fear of rejection) in adult interpersonal relationships (Cassidy, Lichenstein-Phelps, Sibrava, Thomas, & Borkovec, 2009).

Numerous studies have shown that children with insecure attachments to their primary caregiver are at risk of developing GAD (see literature review by Hudson & Rapee, 2004), but few have examined the relationship between specific attachment styles and GAD development (Newman et al., 2013). Mickelson, Kessler, and Shaver (1997) examined data from the NCS and found that GAD was positively associated with both anxious-avoidant and anxious-ambivalent attachment, and negatively associated with secure attachment. Similarly, in a Dutch sample of 12 to 14-year-olds, those who classified themselves as securely attached had the lowest GAD scores. Participants who classified themselves as ambivalently attached had higher GAD scores than those who classified themselves as avoidantly attached (Muris, Meesters, van Melick, & Zwambag, 2001). In contrast to this last finding, a prospective study examined the degree to which new GAD episodes could be predicted by preceding attachment patterns in adult females. Angry-dismissive attachment (a subdivision of anxious-avoidant attachment, in which individuals are mistrustful of others, exhibit anger, and have little desire for close interpersonal relationships) was most strongly associated with new GAD episodes (Bifulco, Kwon, Jacobs, Moran, Bunn, & Beer, 2006).

There appears to be a lack of conclusive evidence about which of the two insecure attachment styles is more predictive of GAD development. Newman, Shin, and Zuellig (2016) propose a possible explanation; the existence of subgroups within GAD who identify with distinct insecure attachment styles, whereas Newman et al. (2013) suggest that both ambivalent attachment and inconsistent parenting may play a role in GAD's development.

Other studies have demonstrated that high levels of enmeshment with the primary caregiver characterise the childhood experiences of adults with GAD (Cassidy et al., 2009; Peasley, Molina, & Borkovec, 1994). In this context, enmeshed caregiver-child relationships are marked by role reversal, in which the child attends to their caregiver's needs without necessarily having their own needs met in return (Dugas et al., 2018). Children are emotionally ill-equipped to adopt this role. The child's fear is compounded by having to care for their unavailable attachment figure. Moreover,

it is unlikely that an attachment figure unable to care for themselves would instil a sense of security in the child. High levels of enmeshment are thus particularly likely to result in enduring anxiety (Cassidy et al., 2009).

Negative parenting behaviours have also been associated with GAD's development. Controlling behaviours such as love withdrawal, isolating, or shaming the child invalidate the child's emotions and experiencing. This may undermine the child's emotional development, thus contributing to emotion regulation difficulties, negative contrast avoidance, and heightened anxiety symptoms (Newman et al., 2013). Cassidy et al. (2009) found that retrospective reports of maternal and paternal coldness and rejection were associated with adult GAD, while in a Dutch community sample of adolescents, perceived parental behavioural and psychological control was associated with self-reported GAD symptoms (Wijsbroek, Hale, Raaijmakers, & Meeus, 2011). However, this latter finding must be interpreted with caution because it is unclear whether the participants' primary caregivers did become more controlling in response to their child's GAD symptomology, or whether cognitive threat biases (a common characteristic of GAD) increased the participants' perceptions of controlling behaviour (Newman et al., 2013; Wijsbroek et al., 2011).

GAD in children and adolescents has been associated with harsh parental discipline (Shanahan, Copeland, Costello, & Angold, 2008), over-protection, and pressure (Beesdo, Pine, et al., 2010; Nordahl, Wells, Olsson, & Bjerkeset, 2010). Newman et al. (2013) propose that the combination of these three parental behaviours may impede the child's development of autonomy and communicate that he/she is incapable of handling challenging situations without parental intervention. If children internalise this message of being unable to cope with unanticipated negative events and the resultant affect fluctuations, they may anticipate all potential negative events to ensure that they are emotionally prepared for all possibilities.

1.3.3.2.3 Childhood physical or sexual abuse

Physical or sexual abuse may cause the child to develop an aversion to emotional contrast due to the unpredictability of when the next abusive act will occur. Continuous negative affect becomes more comfortable for the individual than repeated fluctuations between euthymic and negative emotional states (Newman et al., 2013). Furthermore, abusive experiences may cause the child to develop beliefs

that the world is a dangerous place and that they have little control over what happens to them (Cougle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010). Safren, Gershuny, Marzol, Otto, and Pollack (2002) examined the prevalence of self-reported childhood physical or sexual abuse in a sample of adults presenting for treatment of panic disorder, Social anxiety disorder, or GAD. 25% of participants with a primary diagnosis of GAD reported childhood histories of sexual or physical abuse, compared to 18% of those with pure GAD. This study's narrow demographic and low sample size (149 participants, 28 of whom had a primary diagnosis of GAD) not only makes it difficult to reliably compare these findings with others but also prevents examination of whether the association between GAD and childhood abuse is due to physical or sexual abuse. A more recent study aimed to address these limitations by examining the unique relationships between anxiety disorders, including GAD, and childhood physical and sexual abuse, using data from the NCS-Replication. Childhood history of physical or sexual abuse was associated with increased risk of lifetime GAD. GAD was uniquely associated with sexual abuse after controlling for physical abuse, but it was not uniquely associated with physical abuse after controlling for sexual abuse (Cougle et al., 2010).

1.3.3.2.4 Family history of anxiety disorders

In McLaughlin, Behar, and Borkovec's (2008) study, 53% of individuals with GAD reported having at least one family member with an anxiety disorder, suggesting that family history of anxiety disorders is a risk factor for GAD development.

Hettema, Neale, and Kendler (2001) conducted a meta-analysis of family and twin studies and found that GAD has significant familial aggregation that is modestly explained by genes. Moreover, a significant number of participants with GAD had first-degree relatives (i.e., a parent, sibling, or child) with GAD. Similarly, Beesdo, Pine, et al. (2010) found that parental GAD is a risk factor for GAD development. However, they also argue that parental GAD is not a risk factor for GAD alone; it is shared among all anxiety disorders.

This last point raises the question of specificity; does having a relative with GAD increase the risk for GAD specifically or any anxiety disorder? Coelho, Cooper, and Murray (2007) found that GAD in participants did not independently predict GAD in their first-degree relatives, suggesting an absence of specificity. Rapee (2012)

proposes that less clear specificity for family aggregation of GAD may be attributed to GAD's lower diagnostic reliability.

1.3.3.3 Biological factors

1.3.3.3.1 Genetic predisposition

Several twin studies have examined the relative contribution of genetic predisposition in GAD's aetiology. Kendler, Neale, Kessler, Heath, and Eaves (1992) conducted a twin study involving 1033 female twin pairs and reported low heritability of GAD (19%-30%). Similarly, a later study that included male and female twins also estimated that heritability plays a relatively modest role; in the 15%-20% range, with no effects of gender-specific genes detected (Hettema, Prescott, & Kendler, 2001). A slightly higher but still moderate estimate of GAD's heritability (37.9%) was found in a study of middle-aged male twin pairs from the Vietnam Era Twin Registry (Scherrer, True, Xian, Lyons, Eisen, Goldberg, Lin, & Tsuang, 2000). As already mentioned, Hettema, Neale, and Kendler (2001) reported that genetics play a modest role in the familial aggregation of GAD. Considered together, these findings indicate that while genetic predisposition may play some role in GAD's aetiology, environmental factors appear to play a predominant role (McLaughlin et al., 2008).

1.3.3.3.2 Neurocognitive factors

Neuroimaging studies have implicated various neural structures and circuitry in GAD's pathophysiology. One group of researchers reported several brain metabolite findings across two studies. Individuals with GAD had elevated concentrations of N-acetylaspartate/creatine in the right dorsolateral prefrontal cortex compared to controls; suggesting prefrontal cortical hypermetabolism in GAD (Mathew, Mao, Coplan, Smith, Sackeim, Gorman, & Shungu, 2004). GAD individuals had decreased choline and creatine plus phosphocreatine concentrations in the white matter of the centrum semiovale, suggesting that centrum semiovale hyperactivity characterises GAD (Coplan, Mathew, Mao, Smith, Hof, Coplan, Rosenblum, Gorman, & Shungu, 2006).

Etkin, Prater, Schatzberg, Menon, & Greicius (2009) found increased amygdala grey matter volume in adult individuals with GAD, suggesting hyperresponsivity of this limbic structure which mediates negative affect reactions, particularly fear. Similarly, Schienle, Ebner, and Schäfer (2011) found that relative to controls, adult participants with GAD had enlarged amygdala and right dorsomedial prefrontal cortex volumes. Furthermore, participants' self-reported symptom severity positively correlated with dorsomedial prefrontal cortex and anterior cingulate cortex volumes. These brain regions are associated with anticipatory anxiety, worry, and emotion regulation. Schienle et al. assert that it is unclear whether these volume abnormalities indicate a genetic predisposition for GAD, or a consequence of GAD-specific behaviour such as chronic worrying.

In contrast, Hettema, Kettenmann, Ahluwalia, McCarthy, Kates, Schmitt, Silberg, Neale, Kendler, and Fatouros (2012) propose that their findings provide preliminary support for the notion that GAD, and its genetic risk factors, are correlated with volumetric and spectroscopic changes in fear-related limbic structures (i.e., the amygdala and hippocampus) and their connections with the frontal cortex. They found that lifetime GAD is associated with increased creatine levels in the amygdala, smaller left hippocampal volume, and reduced fractional anisotropy (the degree of directional dependence of a diffusion process) in the uncinate fasciculus which connects the amygdala and frontal cortex.

These tentative findings and opposing interpretations indicate that further work is required to understand the relationship between GAD development and neurocognition, including research that investigates whether certain neurocognitive abnormalities are associated with GAD's genetic risk specifically or internalising disorders (characterised by a tendency to express distress within the self, not with others) in general (Hettema et al., 2012).

1.3.4   GAD's impact on the individual and society

It is impossible to discuss the numerous ways GAD can affect the individual experiencer or wider society. Indeed, beyond complications such as GAD's high rates of comorbidity and the difficulty in reliably assessing GAD's diagnostic criteria, the reported experiences of individuals who meet criteria, vary greatly (Timulak &

McElvaney, 2018). I therefore provide a snapshot of GAD's impact (see section 1.3.8 for personal accounts of GAD).

Dugas and Robichaud (2007) argue that GAD's interference with daily life is often underestimated because, compared to other anxiety disorders, most individuals with GAD do not display marked behavioural interference, nor do they necessarily appear distressed or impaired by their symptoms. Instead, individuals with GAD tend to experience subtle yet equally persistent interferences (e.g., difficulty enjoying a weekend social event with friends because they are worried about the upcoming working week) that are equally detrimental to the individual's quality of life (Dugas & Robichaud, 2007). Indeed, GAD is a pervasive condition that often lasts more than ten years, with a relapse rate of over 50% (Holaway, Rodebaugh, & Heimberg, 2006).

GAD interferes with work productivity (Dugas & Robichaud, 2007), with one study reporting that approximately 33% of individuals with GAD showed a decrease in work productivity of at least 10%, with 11% reducing their productivity by half due to their GAD symptomology (Wittchen, Carter, Pfister, Montgomery, & Kessler, 2000).

GAD is also independently associated with increased risks of lifetime suicidal ideation and lifetime suicide attempts (Thibodeau, Welch, Sareen, & Asmundson, 2013).

Individuals with GAD have one of the highest rates of healthcare use across the anxiety disorders and psychiatric disorders generally. In the NCS, 66% of individuals with GAD reported accessing professional help for their symptoms (Wittchen, Zhao, Kessler, & Eaton, 1994). Similarly, in the Australian National Survey of Mental Health and Well-being, 57% of individuals with GAD reported seeking help from healthcare professionals. Only 14% of these individuals consulted a mental health specialist (Hunt, Issakidis, & Andrews, 2002). Indeed, Dugas and Robichaud (2007) assert that individuals with GAD are more likely to consult medical specialists such as physicians, cardiologists, or gastroenterologists than mental health professionals, which often results in numerous unnecessary, costly medical tests.

Despite its association with frequent healthcare use, GAD is significantly under-detected and undertreated (Wittchen & Jacobi, 2005). In the 2014 APMS, 48% of

individuals who met diagnostic criteria for GAD were receiving treatment. 30% were receiving medication only, 11% were receiving both medication and psychological therapy, and 7% were receiving psychological therapy only (McManus et al., 2016). These findings prompted me to review the mental health support available for individuals with GAD.

1.3.5   Mental health support for adults with GAD

This study's inclusion criteria consisted of individuals aged eighteen and over, thus the following review is of available mental health support for this demographic only.

The National Institute for Health and Care Excellence (NICE) advocates a stepped-care approach to GAD treatment in the UK (NICE, 2011). Current NICE clinical guidelines (NICE, 2011) recommend one of three "initial, low-intensity psychological interventions" for individuals aged eighteen and over with a diagnosis of GAD, whose symptoms have not improved following psychoeducation about GAD and active symptom monitoring. The options include an individual, non-facilitated self-help course via book or computer program lasting five to fourteen weeks, an individual, guided self-help course supported by a trained practitioner, or six, weekly psychoeducational groups with other individuals with GAD, run by trained practitioners. All three interventions are informed by cognitive behavioural therapy (CBT) principles. In cases where the individual's symptoms are causing significant distress or initial treatment has not worked, NICE (2011) recommend either individual, "high-intensity" psychological intervention or drug treatment. One of two high-intensity psychological interventions are recommended: CBT for GAD or applied relaxation. In terms of pharmacological interventions, NICE primarily recommends the selective serotonin reuptake inhibitor (SSRI) sertraline because it is the most cost-effective. However, it is not licensed for the treatment of GAD in the UK (NICE, 2017). If sertraline proves ineffective, the guidelines state that an alternative SSRI or a serotonin-noradrenaline reuptake inhibitor (SNRI) (e.g., paroxetine, venlafaxine) may be offered instead. If the individual is intolerant of SSRIs or SNRIs, pregabalin is recommended. The guidelines warn against prescribing a benzodiazepine for treating GAD, except as a short-term measure (up to 2-4 weeks) during a crisis. Antipsychotic use is also warned against (NICE, 2011).

CBT is the most widely recognised psychological treatment of adult GAD (Timulak & McElvaney, 2018). It has been found to be more effective than waiting list controls, and slightly more effective than non-CBT therapies (Cuijpers, Sijbrandij, Koole, Huibers, Berking, & Andersson, 2014; Hanrahan, Field, Jones, & Davey, 2013). However, not all clients benefit from CBT (Timulak & McElvaney, 2018). For example, in Hanrahan et al.'s (2013) meta-analysis of cognitive therapy for pathological worry in adults with GAD, 43% of participants were not classed as recovered, twelve months post-treatment. Different psychological therapy modalities and complementary therapies are consequently being developed and trialled with individuals with GAD. Some of these are discussed in the following two sections.

1.3.6 Recent quantitative studies of adult GAD

Advanced online searches of the British Library EThOS catalogue, ProQuest Dissertations and Theses database, and City, University of London's library using the terms *generalised anxiety disorder*, *adults*, and *quantitative*, led me to ample quantitative studies of adults with GAD, conducted within the past five years. Due to the volume of studies, I present a synopsis of this research. To decide which studies to include, I initially wrote a summary of each study in my research journal and then grouped them by research topic. My main objective was to highlight the stark imbalance between the amount of quantitative and qualitative literature on GAD, thus I did not believe it necessary to employ specific inclusion criteria. However, in order to provide a broad synopsis, I wanted to include every quantitative research topic. One or two studies (if there was significant study design variation within the broader, shared topic) on each topic were consequently selected at random.

A substantial body of recent quantitative research has investigated potential underlying psychological processes and neuroanatomical mechanisms involved in GAD's development and maintenance.

Whittaker-Bork (2013) conducted a systematic literature review to investigate how IU, negative metacognitive beliefs, and experiential avoidance are associated with, or predict worry severity and GAD in both clinical and non-clinical adult populations. Findings concerning IU's potential unique role in predicting worry and GAD status were inconsistent, suggesting that it may also be present in other psychiatric disorders. In contrast, negative metacognitive beliefs were found to be a significant

and unique predictor of GAD as well as a significant mediator between worry and GAD. There was minimal evidence supporting the notion that experiential avoidance is an important construct in the development and maintenance of worry and GAD. However, a degree of evidence did indicate that there is an association between experiential avoidance, worry, and GAD, suggesting that experiential avoidance is a shared vulnerability factor among all psychiatric disorders. She also conducted a prospective study that examined the relative and unique contributions of three psychological models (the cognitive model of GAD, the metacognitive model, and the acceptance-based model) in predicting worry and GAD over time in a non-clinical sample. Across the three models, only negative metacognitive beliefs about the danger of worry predicted worry and GAD, in addition to other known predictors (i.e., daily hassles and positive metacognitive beliefs about worry) which were controlled for. This finding suggests that metacognitive theory may increase our understanding of the factors responsible for worry and GAD maintenance.

Webster (2016) investigated whether the relationship between ED and GAD is mediated by resilience. She also sought to contribute to the literature demonstrating that ED is a predictor of GAD development. 187 participants were recruited through online social media platforms, anxiety self-help groups, and forums. Participants completed six online questionnaires measuring resilience, ED, worry, GAD symptoms, and MDD. Based on their Generalized Anxiety Disorder 7-Item scale (GAD-7) scores, participants were split into high and low GAD symptomology groups. Participants in the high GAD symptomology group had significantly higher ED scores, lower resilience scores, and were less likely to engage in adaptive emotion regulation strategies. ED was also a significant predictor of GAD symptomology. Although resilience was not found to mediate between ED and GAD, it partially mediated the relationship between ED and worry. This may indicate that different mechanisms underlie the pervasive worry seen in GAD, and GAD symptoms generally.

Moon and Jeong (2015) evaluated alterations in white matter volume and its correlation with GAD symptom severity and duration in adults. Twenty-two individuals with a formal diagnosis of GAD and twenty-two age-matched, non-GAD controls participated. Individuals with GAD showed significantly reduced white matter volume, particularly in the dorsolateral prefrontal cortex, which is involved in cognitive functions including attention, working memory, and emotion regulation, the anterior limb of the internal capsule, which mediates anxiety, attention, working

memory, and association brain functions, and the midbrain. Dorsolateral prefrontal cortex volume was negatively correlated with GAD participants' GAD-7 scores. Females had significantly less orbitofrontal cortex volume than males. This region plays an important role in regulating anxiety and fear, integrating the senses, and social functioning. Moon and Jeong hypothesise that this gender difference is related to gender differences in GAD prevalence rates. They assert that together, these findings aid our understanding of the neuroanatomical mechanisms associated with the cognitive and emotion dysfunctions seen in GAD.

Numerous recent studies have investigated the efficacy of available psychological treatments, including novel approaches, with a growing number focusing solely on older adults with GAD. This makes sense considering evidence indicating that GAD is the most common anxiety disorder in this age group.

Underwood (2014) conducted a meta-analysis to evaluate the comparative effectiveness of numerous psychological treatments for pathological worry in GAD. Metacognitive-based CBT consistently showed superior effectiveness over all other treatments. However, most individuals who received psychological treatment still reported pathological worry post-treatment, even though clinicians assessed that they no longer met GAD diagnostic criteria. This finding may suggest that current treatments do not sufficiently address GAD's underlying worry mechanisms, thus post-treatment worry may be a GAD relapse predictor.

The rationale for integrating motivational interviewing (MI) with standard CBT in the treatment of GAD stems partly from observations that individuals with GAD hold positive beliefs about the value of worry and are consequently reluctant to relinquish it (Westra, Arkowitz, & Dozois, 2009). Westra, Constantino, and Antony (2016) conducted a randomised control trial (RCT) comparing the efficacy of CBT alone to MI-CBT. MI-CBT participants demonstrated a steeper rate of worry decline and general distress reduction than CBT-only participants. There were twice as many dropouts in the CBT-only group than the MI-CBT group. The odds of no longer meeting GAD diagnostic criteria were five times higher at twelve-months post-treatment for MI-CBT participants than CBT-only participants. The researchers suggest that these findings further support the use of MI-CBT for GAD. They also highlight the importance of training therapists to recognise and respond to in-session signs of resistance and ambivalence using MI principles including empathy, collaboration and preservation of client autonomy.

Although earlier studies have demonstrated that CBT-only is a less effective treatment of GAD in older (aged 55 and over) adults (Gould, Coulson, & Howard, 2012; Hunot, Churchill, Teixeira, & Silva de Lima, 2007), Hall's (2016) meta-analysis of 14 RCTs of CBT for GAD in older adults demonstrated that CBT is effective. However, there was no conclusive evidence to suggest that CBT is superior over other evidence-based psychological treatments.

Miloyan, Byrne, and Pachana (2014) assert that diagnosis and treatment of GAD in older adults is particularly challenging, arguing that this is partly due to insufficient understanding of age influences on symptom presentation and diagnostic status. They consequently investigated the number and type of symptoms that best predict GAD across the lifespan by splitting participants into four age groups: 18-29, 30-44, 45-64, and 65-98. Participants in each group were further divided into GAD and non-GAD worriers. They found that a distinct set of symptoms predicted GAD in each age group. Changes in the type and number of symptoms and sociodemographic variables that predicted GAD occurred gradually across the lifespan, with the fewest symptoms and sociodemographic variables predicting GAD in the 65-98 group. In this group, difficulty concentrating, feeling dizzy, and low personal income were all positive predictors of GAD. The researchers suggest that under-diagnosis of GAD in older adults may be partly attributed to their finding that this age group tend to endorse fewer symptoms that are qualitatively different.

1.3.7 Recent qualitative studies of adult GAD

The same search processes were replicated but this time for qualitative studies of adults with GAD conducted since 2013. Seven results were produced – a substantially lower figure than quantitative studies.

Five studies investigated participants' experiences of various GAD treatment processes and outcomes. One explored physiotherapists' perceptions of their treatment for individuals with GAD, and one investigated the experiences of male partners of women with GAD. Each is summarised below.

Golfinopoulos (2013) conducted semi-structured interviews with six adult females with a diagnosis of pure GAD, primarily exploring their experiences of combining an evidence-based psychological therapy (either CBT, acceptance and commitment

therapy, rational emotive behavioural therapy, exposure and response prevention, interpersonal psychotherapy, behavioural therapy, or cognitive therapy) with a complementary therapy (massage or yoga). Data were analysed using thematic analysis. All participants experienced GAD symptom relief once they had combined a weekly session of massage therapy or twice-weekly yoga with weekly psychological therapy sessions, attributing this to beliefs that the combined treatments complemented one another and addressed the whole person.

Johansson, Michel, Andersson, and Paxling (2015) explored seven participants' experiences of non-adherence (started treatment but did not complete it) to a guided, internet-delivered CBT program for GAD, with the aim of developing a new theory of how non-adherence occurs in internet-delivered psychological treatments. Semi-structured interviews were conducted, and data were analysed using grounded theory. Their developed theory asserts that there is an incompatible relationship between participants' perceptions of treatment (i.e., length of weekly text modules and exercises, difficulty understanding complex content, perceived therapist attitudes) and factors in their daily lives (i.e., how well the effort required to complete treatment fitted into their daily lives).

Jonsson and Kjellgren (2017) investigated participants' experiences of a twelve-session flotation-REST (restricted environmental stimulation technique) program, during which the individual floats on their back in salt-saturated water in a dark, soundproof isolation tank. This treatment has been found to alleviate GAD symptoms (Kjellgren, Sundequist, Norlander, & Archer, 2001). Semi-structured interviews were conducted with nine participants with GAD (as defined by self-report measures), after program completion. Data were analysed using the empirical phenomenological psychological method. As treatment progressed, deep physiological and psychological relaxation states were achieved. Thought processes also appeared to calm down with one participant commenting "when I float, it is just one thought at a time, not thousands" (p. 55).

The following two studies used participants from the Westra et al. (2016) RCT presented in section 1.3.6. Morrison, Constantino, Westra, Kertes, Goodwin, and Antony (2017) used video-assisted interviews to investigate the treatment experiences of ten female participants (five from each treatment condition) who exhibited notable change ambivalence during an early therapy session. Data were analysed using a blended model of grounded theory and consensual qualitative

research. The findings appear to support the theory of resistance as an in-session, reciprocal process triggered by client perceptions of therapist beliefs and behaviours.

Macaulay, Angus, Khattra, Westra, and Ip (2017) conducted post-therapy, semi-structured interviews exploring experiences and explanations of shifts in therapy with eight participants who had achieved and maintained recovery from GAD at 12-month follow-up. Data were analysed using a modified grounded theory approach. Participants experienced an increased sense of control over their anxiety and worry, and associated behaviours, including problematic relationship patterns and ineffective attempts to control uncertain or uncontrollable situations. Perceived shifts derived from new affective and relational therapeutic experiences that enabled participants to perceive themselves as active agents of change with the power to make choices across contexts, beyond therapy. These experiences included the therapist helping them to make sense of their problematic behaviours in terms of their former, perceived adaptive function as well as developing the participants' capacities to differentiate emotions and respond adaptively.

Danielsson, Scherman, and Rosberg (2013) conducted semi-structured interviews with ten physiotherapists working in psychiatry or primary healthcare. Data were analysed using qualitative content analysis. The resultant main category captured the notion that physiotherapy works through immediate, tangible bodily experiences that help individuals with GAD to endure anxiety instead of fighting it and to discern and understand different bodily sensations. This encourages an embodied self-trust in which anxiety is conceptualised as part of oneself rather than overflowing oneself.

Lima (2013) explored the experiences of eight male partners of females with GAD, via semi-structured interviews. Data were analysed using the constant comparative method of grounded theory. All eight participants described altered, negative perceptions of their female partners from initial meeting to time of interview, including a decreased ability to cope with their partners' GAD symptoms. Participants experienced a reduction in social activities, partly attributing this to the guilt they felt in response to their partners' discomfort in social situations.
None of these studies focused solely on the lived experience of GAD. Although Golfinopoulos (2013) did enquire about participants' GAD onsets and believed causes, she primarily explored their experiences of combined therapies with the aim

of highlighting effective, alternative GAD treatments. In fact, I could not find any empirical research that has exclusively explored the lived experience of GAD.

1.3.8 Published (or self-published) personal accounts of GAD

An increasing number of individuals with GAD are publishing personal accounts of their experiences via various mass media resources, all of which help to provide insights into GAD. Here, I present a snapshot of three accounts.

As part of Project UROK (an inclusive community committed to ending the stigma and isolation associated with mental illness in teenagers and young adults), the actor, writer, and producer Wil Wheaton posted a video on YouTube, talking about his experiences of GAD and chronic depression (Wheaton, 2015). He describes being unaware of how his "mental illness" was affecting him until he had been "suffering" from it for "easily" fifteen to twenty years. He sought help from a psychiatrist six or seven years ago following a negative experience at a crowded airport. He describes "freaking out" at the thought of missing his flight and wanted to cancel his upcoming show instead of remaining at the airport. His wife had observed how he would repeatedly make such "irrational decisions". After almost two weeks of starting prescribed medication, he felt like he was on his way to leading a "normal life" in which he was not "constantly worrying about things".

Zoe McWilliams wrote a blog post for Mind. She describes being "finally" diagnosed with GAD and panic attacks in 2007 after "countless doctors' appointments". Following her father's death, she began having thoughts such as "how could dad, at the age of 56, not be here anymore? How will I cope without him?". These thoughts gradually took over her life until her anxiety felt so overwhelming that she thought she was "going mad" (McWilliams, 2016). Now, she describes going through periods of feeling "absolutely fine" and then:

> "BANG, like a bolt out of the blue, the thoughts, the anxiety, the panic, it appears from nowhere as if almost to say; 'here I am, don't forget about me', and so the cycle continues" (McWilliams, 2016).

Rachel Hawkins was diagnosed with GAD in 2015. She wrote a blog post for The Huffington Post UK. She writes about wanting to remain open and honest about

how her mental health affects her daily life, stating that this is not only cathartic but hopefully helps "break down the stigma" (Hawkins, 2017). She summarises her experience of GAD:

> "Generalised anxiety disorder is scary. It makes your fears and your worries seem real. At its worst, it has left me feeling irritable, tense, and exhausted. Exhausted from the incessant worry, exhausted from the constant 'what if's?' circling my brain" (Hawkins, 2017).

1.4 Study rationale and contribution to counselling psychology

Despite the growth in self-publishing, literature (especially empirical research) investigating the lived experiences of adults with GAD is limited. This paucity is concerning considering GAD's high prevalence rates, together with evidence that it is often under-diagnosed and under-treated. Dugas and Robichaud (2007) assert that clinicians often struggle to recognise the symptoms as belonging to GAD; a difficulty compounded by the various ways in which individuals with GAD present for treatment as well as GAD's high rate of comorbidity. Even when GAD is correctly diagnosed, treatment is not always effective. Considered together, this information highlights the need for a greater understanding of GAD.

This study sought to address the gap in the literature, and thus contribute to this need, by answering the following question: what is the lived experience of adults with a formal diagnosis of GAD? My aim was to understand how these individuals make sense of their lived experience.

Exploration of this topic will enable clinicians, including counselling psychologists, to develop a greater understanding of the lived experience of GAD which, in turn, will increase their ability to correctly identify GAD in adults and effectively support individual treatment needs. By giving these individuals a voice and increasing awareness of GAD, I hope that more adults with suspected GAD are encouraged to seek help from clinicians, particularly mental health professionals, sooner.

2. Methodology

2.1 Rationale for a qualitative perspective

In selecting a qualitative paradigm, it was fundamental to consider the answers qualitative research would provide my research question. Qualitative research aims to be exploratory, producing rich descriptions of experience that contain meaning. Unlike quantitative research, it is not interested in establishing causal relationships, universal laws or 'truths', but rather seeks to describe and understand how phenomena are experienced by individuals and how they make sense of their experiences (Finlay, 2011; Willig, 2013). The qualitative paradigm consequently coincides with my research aim of understanding how adults with a formal diagnosis of GAD make sense of their lived experience.

2.2 Employing a phenomenological approach

A phenomenological approach was employed because it argues that in order to understand individuals and their worlds, attention must be paid to their conscious, lived-experiences (Cooper, 2017). Lived experience can be defined as an active, passive living through of experience (van Manen, 2017). A phenomenological research question asks: what is this lived experience like? (van Manen, 2017). This approach consequently aligns with my research aim of understanding the lived experience of adults with GAD. Before introducing my chosen data collection method and method of analysis, I elaborate on the philosophical and psychological perspectives of phenomenology that informed my research strategy.

2.2.1 What is phenomenology?

Phenomenology, in contemporary terms, is the philosophy initiated by Edmund Husserl at the start of the twentieth century. It is the study of activities of consciousness, and the objects that present themselves to consciousness. In basic terms, consciousness is the medium between a person and the world (Giorgi, 2012). In 1874, Franz Brentano proposed that all objects (phenomena) are

correlated with an act of consciousness. The object (phenomenon) in question can therefore be examined in relation to the act of consciousness being directed towards it. He named this principle *intentionality* (Brentano, 1995). Husserl incorporated the notion of intentionality into his philosophical method (Giorgi, 2012). In this method, Husserl was interested in *consciousness as such*. Human consciousness was perceived, like objects, to be mere presences (phenomena). To conduct phenomenological research from a psychological perspective, he adapted his method to coincide with psychologists' interest into how acts of human consciousness relate to a specifically human, social world. While the objects of consciousness are still perceived as phenomena in his phenomenological psychology method, the acts of consciousness to which they are related are construed as belonging to a human, social world-related consciousness (Giorgi, 2007). Phenomenology does not dictate to phenomena, but rather seeks to understand how phenomena present themselves to consciousness (Giorgi, 2012). For phenomenologists, there is no *thing-in-itself,* there are only experienced phenomena. The experience of a phenomenon, as opposed to the perception that the phenomenon itself exists, relies on the phenomenon appearing to the experiencer (Giorgi, 2017). Indeed, Giorgi (2017) describes the key meaning of phenomenon as "that which appears to someone" (p. 104).

In 1936, Husserl introduced the notion of the *Lebenswelt* or *life-world* (Husserl, 1936/1970). Also known as the *world of everyday life* it is:

> "The total sphere of experiences of an individual which is circumscribed by the objects, persons, and events encountered in the pursuit of the pragmatic objectives of living. It is a "world" in which a person is "wide-awake", and which asserts itself as the "paramount reality" of his life" (Wagner, 1970, p. 320).

As humans, we engage in the life-world; doing, being and experiencing. This engagement is largely pre-reflective, meaning that we do not often reflect on what our experience means because we are in, what Husserl termed, the *natural attitude*, where experiences are lived through (Finlay, 2011). Referring back to Husserl's application of intentionality, a focus on the life-world highlights the intentional relationship between conscious, meaning-making humans, and the taken-for-granted, humanly relational (inter-subjective) world, which is full of meanings (Todres, Galvin, & Dahlberg, 2007). Todres et al. (2007) describe how this relational

reality means that "there is no objective world in itself, nor an inner, subjective world in itself; there is only a world-to-consciousness" (p. 55).

Taking the life-world concept further, Todres et al. (2007) describe its holistic quality; it is full of interrelated dimensions. They explain how several theorists further developed Husserl's consideration of the life-world constituents, each person differing slightly in how they named and divided them up. My method of data collection was semi-structured interviews. My interview schedule was informed by five of Ashworth's (2003, 2015) life-world dimensions, which he calls *fractions* to emphasise that they are mutually entailed. The sixth life-world dimension, that of *material objects*, was developed by van den Berg (1972).

In the following two sub-sections, I explain why my interview schedule was informed by the concept of life-world dimensions and introduce the six dimensions I included. I then detail the process of choosing my method of data analysis: interpretative phenomenological analysis (IPA).

2.2.2 Use of life-world dimensions

Ashworth (2015) argues that phenomena are not free-floating. Any experience is "inevitably interwoven with the rest of the individual's life-world" (p. 20). He proposes that in any life-world, there are necessary fractions (dimensions). My participants' lived experiences of GAD are intertwined with these life-world dimensions, thus to understand their lived experiences, I had to examine their life-worlds. Ashworth proposes that actively investigating the life-world dimensions enriches the descriptions of the phenomenon in question. As Giorgi (2012) suggests, descriptions are required to understand how phenomena present themselves to consciousness. I therefore decided to consider the phenomenon of GAD within the context of the participants' life-worlds, and with reference to the following dimensions. The exact phrasing of the interview questions is discussed in section 2.4.3.

Selfhood: This fraction addresses how the experienced phenomenon affects the individual's sense of self (Ashworth, 2015). A person's sense of self is inevitably part of sociality; it is informed by our interactions with others (Ashworth, 2003). I therefore asked participants two questions based on selfhood; one concerning

participants' perceived sense of self, and one concerning their perceptions of how others perceive them.

Sociality: This fraction considers how others are implicated in an experience, and whether the individual's experience affects their interpersonal relationships (Ashworth, 2015).

Embodiment: This fraction addresses how the individual's experience relates to their feelings about their own body; the body as lived (Ashworth, 2003).

Temporality: This fraction considers how the individual's sense of time is affected by their experience of the phenomenon in question (Ashworth, 2003).

Material objects: This dimension addresses how the individual's experience relates to their perceptions of material objects (van den Berg, 1972).

Spatiality: This fraction is concerned with how the experienced phenomenon relates to the individual's perceptions of the geography of the places (situations) they frequent and act within (Ashworth, 2003). This geography is not just physical. There are social norms and multiple meanings associated with situations (Ashworth, 2015).

These particular dimensions were chosen for several reasons. It would have been impractical to ask questions based on every proposed dimension across theorists. It was also important to consider the length and exact phrasing of the interview questions. Certain dimensions were disregarded due to their associated question properties; they were too lengthy or contained connectives; both of which may have confused participants. While I did assume that the chosen lifeworld dimensions would be relevant and of interest to the phenomenon of GAD across participants, my overarching aim was to remain open to their life-world experiences in their entirety (Finlay, 2011). Moreover, I held in mind the phenomenological perspectives that influenced my research design. The phenomenological researcher must first engage in the *phenomenological epoché*. This means that the researcher monitors and restrains all knowledge that is not based on the acts of consciousness being considered (Giorgi, 2017). I therefore restrained personal assumptions that a particular included dimension or set of dimensions would be dominant in the life-world context of GAD (Ashworth, 2015).

2.2.3 Use of IPA

In this section, I discuss the process of choosing IPA. I have not discussed the claims IPA's founders make about its theoretical underpinnings in phenomenology and hermeneutics here, as this merits separate discussion.

In selecting the method of data analysis, it was important for me to consider the types of information concerning the participants' lived experiences the method would provide.

Grounded theory was considered but quickly discarded. It aims to construct theories about the phenomenon in question (Charmaz & Henwood, 2008). More specifically, grounded theorists are interested in how an individual's actions contribute to the way in which he/she manages a particular social situation. This research aim assumes that social events and processes have an objective reality, while simultaneously assuming that the individual's interpretation of events shape their consequences (Willig, 2013). Grounded theory was discarded for two reasons. Its assumptions contradict the phenomenological perspective that there is no thing-in-itself only experienced phenomena (Giorgi, 2017), and that experiencing is pre-reflective (Finlay, 2011). Furthermore, I felt it important to give voice to my participants' idiographic lived experiences of GAD, particularly considering the fact that very little research has been conducted with this aim. I did not wish to construct a new, socially or psychologically contextualised theory of GAD that would provide an explanatory framework with which to understand this phenomenon (Willig, 2013).

Foucauldian discourse analysis was discarded for similar reasons. This approach argues that phenomena are constructed through language and other symbolic practices. It therefore seeks to understand how discursive constructions and practices influence the ways in which individuals experience themselves and their world (Willig, 2013). Like grounded theory, these assumptions contradict the phenomenological perspective that, as humans, we do not think about or phenomenologically reflect on our experiences while we live them. Rather, as soon as we reflect on a lived experience, the living moment has already gone, and we can only retrospectively try to recover the experience and then reflect on the primordiality of what the experience was like in that moment and how it gave itself to our consciousness (van Manen, 2017). I wanted to understand what the

participants' lived experiences of GAD are like. To achieve this aim, the participants' raw moments of lived experience were brought into focus through their retrospective descriptions. My goal was to orient these descriptions to the lived meanings that arise in their lived experiences (van Manen, 2017). I did not wish to understand how their experiences are (retrospectively) constructed through language.

My consideration of phenomenological perspectives, together with my commitment to giving voice to the participants' idiographic lived experiences, narrowed my focus towards two methods of analysis: IPA and reflective lifeworld research.

IPA is idiographic; it is committed to the detailed examination of the particular case. It can inform us of the meaning of an experience for the particular individual (Smith, Flowers, & Larkin, 2009). As already mentioned, experiencing is largely pre-reflective. Participants are therefore privileged concerning what they experienced, but not necessarily its meaning. Participants describe their experiences from the perspective of everyday life; from the perspective of the natural attitude (Giorgi, 2008). To identify the meanings expressed in my participants' descriptions, my own acts of consciousness were required to understand the data. Furthermore, I aimed to understand the data from a psychological perspective (Giorgi, 2017). Interpretation is employed in IPA to identify the meanings (Smith et al., 2009). As opposed to the descriptive attitude, which does not add or subtract anything from the description, but rather describes what presents itself precisely as it presents itself, interpretation involves adding in another factor such as a theoretical perspective, assumption, or hypothesis to account for the data (Giorgi, 1992). IPA's founders do stress however, that researcher interpretations must remain grounded in the participants' descriptions (Smith et al., 2009).

As discussed further in section 2.2.4 below, IPA has been criticised for claiming to be a phenomenological approach despite not being based in the method of philosophical phenomenology (Giorgi, 2010, 2011). In contrast, reflective lifeworld research is rooted in philosophical phenomenology (Dahlberg, Dahlberg, & Nyström, 2007). The aim of reflective lifeworld research is to allow the phenomenon in question and its meanings to be illuminated and understood. To achieve this, the researcher adopts an open, bridled attitude towards the phenomenon (Dahlberg et al., 2007). *Openness* involves having the patience to allow the phenomenon to reveal its complexity rather than imposing an external structure on it (e.g., theories or models). *Bridling* refers to managing the natural attitude so that the researcher's

assumptions and pre-understandings of the phenomenon can be interrogated. This enables the phenomenon's *otherness* to present itself to consciousness (Dahlberg et al., 2007). Reflective lifeworld research can highlight the essential, and therefore general, structure of meanings that constitute the phenomenon in question. Without these characteristics and consequent meanings, the phenomenon would be an entirely different phenomenon. Like IPA, this approach can also highlight the individual meanings contained within this general structure that particularise the phenomenon as a whole (Dahlberg et al., 2007).

I spent considerable time weighing up the pros and cons of both methods. Reflective lifeworld research appealed to me because it is based on philosophical phenomenology and is therefore more truly phenomenological (Giorgi, 2010, 2011; van Manen, 2017). Furthermore, it can highlight the general structure of the meanings of GAD (the lived experience of GAD) as well as the individual meanings that particularise GAD as a whole. However, analysis is less structured than IPA and heavily relies on researcher intuition (Dahlberg, Drew, & Nyström, 2001). As a novice qualitative researcher, relying on my own intuition in the absence of a systematic analytic method felt too unsettling.

IPA not only enabled me to identify the meaning of each participant's lived experience (and thus corresponded with my research aim), its systematic analytic method also provided me a sense of comforting guidance. Moreover, IPA acknowledges that, as a counselling psychologist in training, I inevitably interpreted the data from a psychological perspective. These three factors governed my decision to employ IPA over reflective lifeworld research.

2.2.4 Giorgi's critique of IPA's theoretical underpinnings

While I believe my decision to employ IPA was appropriate because it corresponded with my research aim, I also believe it necessary to acknowledge the criticisms IPA's founders have faced in claiming that its theoretical underpinnings stem from continental philosophical phenomenology and hermeneutics.

Giorgi (2010) criticises IPA's founders for claiming that IPA is phenomenological because "it involves detailed examination of the participant's lifeworld" and "is concerned with an individual's account of an object or event, as opposed to an

attempt to produce an objective statement of the object or event itself" (Smith & Osborn, 2003, p. 51). Giorgi (2010) argues that these *content descriptions* of phenomenology are insufficient in the absence of a theoretical justification of how IPA is related to the method of philosophical phenomenology. Giorgi (2011) argues that there is no reference in IPA to the bracketing of the natural attitude, which is the main meaning of the phenomenological reduction (epoché). The term *bracketing* can be misleading as it implies leaving something outside, but it means to monitor and restrain all prior knowledge and assumptions of the phenomenon in question. In the natural attitude, it is assumed that the phenomenon exists. Bracketing the natural attitude involves considering the phenomenon as it appears to consciousness, without affirming that it exists in the way that it presents itself (Giorgi, 2007). IPA's founders do refer to bracketing in their analytic strategy, but only in the context of bracketing ideas developed from the analysis of a previous case to treat the next case in its own terms (Smith et al., 2009). Giorgi (2011) argues that analyses cannot claim to be phenomenological if they do not employ the phenomenological reduction because the reduction is the entrée to the phenomenological domain.

Referring back to content descriptions of phenomenology, Giorgi (2011) criticises IPA's founders for claiming that IPA is a phenomenological approach because it is concerned with "lived experience", "examination of meanings", and "experience expressed in its own terms" (p. 205). Giorgi argues that these terms are too generic; they are not exclusive to phenomenology. Smith et al. (2009) also describe phenomenological research and IPA as inductive. Phenomenology is not inductive, it is intuitive and descriptive (Giorgi, 2011).

With regards to hermeneutics, Giorgi (2011) argues that IPA's founders do not clarify in sufficient detail how IPA is influenced by the hermeneutic tradition. Instead, Giorgi suggests that IPA's founders are attempting to be hermeneutically eclectic, drawing (limited and general) influence from different aspects of Schleiermacher, Heidegger, and Gadamer's conceptualisations of hermeneutic inquiry. From Schleiermacher, Smith et al. (2009) draw upon the notion that the interpretative researcher can offer a perspective to the author's textual narrative that the author him/herself may not know. From Heidegger, Smith et al. acknowledge that phenomenology may be hermeneutic in the sense that the researcher's own interpretation is required to understand the phenomenon as it appears to human consciousness. Heidegger acknowledged that interpretation should initially focus on

the phenomenon as it presents itself, which can then inform the interpreter's preconceptions about the phenomenon (Smith et al., 2009). Finally, Smith et al. highlight shared similarities concerning the relationship between interpretation and preconceptions, acknowledged by both Heidegger and Gadamer. Smith et al. however, disagree with Gadamer's belief that nothing can be known about the author of the narrative based on the text. Giorgi criticises Smith et al. for appealing to Gadamer as a basis for IPA because Gadamer later explained that he was not writing for the human sciences.

Ultimately, Giorgi (2011) criticises IPA's founders for the way they seem to refer to philosophical phenomenology and the hermeneutic tradition only when they feel that the ideas relate to IPA. He proposes that IPA was developed of its own accord as opposed to being formulated based upon these philosophical traditions.

2.3 Epistemological standpoint

Outlining my epistemological position is challenging due to the opposing perspectives of phenomenology that informed my data collection method, and IPA; my method of analysis. For example, IPA focuses on subjectivity (Smith et al., 2009), while the phenomenological position focuses on intersubjectivity; we live in a humanly-relational world that contains shared meanings (Todres et al., 2007). IPA focuses on reflective (conscious) thought (Smith et al., 2009), while the phenomenological position argues that experience is pre-reflective; experiencing is lived through and taken-for-granted. It is not consciously reflected upon by the experiencer (Finlay, 2011).

Outlining my epistemological position is further confounded by my consideration of the phenomenological epoché. In the phenomenological epoché (reduction), the objective reality of the phenomenon is bracketed; the lived experience of the phenomenon is purely considered as it presents itself as opposed to questioning whether the phenomenon itself exists in the way that it presents itself (Giorgi, 2017). If there is no thing-in-itself, only experienced phenomena, there is no ontology - what there is to be known about the nature of the world; our being and existing, or epistemology - how and what we can know about the nature of the world (Willig, 2013). The phenomenological position then, stays within the confines of experience. It does not make an existential or reality affirmation (Giorgi, 2008). As all knowledge

stems from presuppositions, it could be argued that phenomenology seeks what is prior to knowledge (Berguno, 1998).

The phenomenological position rejects Objective Thought, which argues that we can gain knowledge of the world by dissecting it into units of analysis, measuring these units, and by establishing causal links between them. In Objective Thought, anything that cannot be explained in causal terms is deemed insignificant (Berguno, 2015). Using an example to compare objective thought with the phenomenological position, in Objective Thought the human body is perceived as an object of investigation, while from a phenomenological perspective, the human body is perceived as a unique person who actively engages with his/her surroundings (Berguno, 2015; Carr, 2005). The phenomenological position then, argues that where an individual is situated in the world (their interactions with others, their active engagement with their surroundings), is what constitutes what can be known about that individual's world (Carr, 2005).

For the purposes of this research, I align myself with the phenomenological epistemological position because its assumptions correspond with my research question and aim; a focus on understanding what the lived experience of adults diagnosed with GAD, is like. As Giorgi (2008, p. 3) states: "to limit oneself to experiential claims is to stay within the phenomenal realm." In addition, this study's idiographic commitment highlights the phenomenological perspective of human uniqueness; it acknowledges that the phenomenon of GAD may be experienced differently by each participant. Lastly, this study's consideration of the life-world concept, and more specifically how participants' lived experiences are inevitably intertwined with the life-world dimensions (Ashworth, 2015), corresponds with the phenomenological perspective that to understand an individual's experience of the world, you have to examine their pre-reflective interactions with the everyday, perceptual life-world; the world that we all share (Carr, 2005).

2.4 Research plan

2.4.1 Initial telephone screening

The primary purpose of the initial telephone screening was to ensure that interested individuals all met the same GAD diagnostic criteria. Potential participants were asked the questions on the Generalized Anxiety Disorder Questionnaire IV (GAD-Q-IV; Appendix 1). The GAD-Q-IV was developed by Newman, Zuellig, Kachin, Constantino, Przeworski, Erickson, and Cashman-McGrath (2002). To meet this questionnaire's diagnostic criteria, a minimum total score of 7.67 was required, in line with Moore, Anderson, Barnes, Haigh, and Fresco's (2014) recommendations (see Appendix 2 for the scoring system). The GAD-Q-IV was chosen due to its clinical validity and the quickness and ease with which it can be administered (Moore et al., 2014; Newman et al., 2002). Whilst I acknowledge that this quantitative measure contradicts the phenomenological perspective of taking participants' declarations of GAD at face value, it was employed to minimise potential errors at the data collection stage. If, for example, it became evident during an interview that the participant was not describing GAD, I would not have been able to include their data. I needed to ensure, to the best of my ability, that I was investigating the phenomenon I claimed to be investigating.

2.4.2 Data collection method

Semi-structured interviews were employed because they enabled me to collect rich descriptions of the participants' lived experiences, first-hand. They provided opportunity to discuss participants' lived experiences in the context of the six chosen life-world dimensions, whilst simultaneously allowing participants to speak freely and elaborate. This enabled me to enquire after additional descriptions that arose (Smith et al., 2009).

2.4.3 Developing the interview schedule

In devising the interview schedule, considerable time was spent revising the number of questions and their exact phrasing. To make data analysis possible, I needed to

obtain rich, concrete descriptions that could be visualised. Questions therefore needed to be open and concise. As previously discussed, experiencing is pre-reflective, thus it was important not to enquire directly about meaning.

With these two considerations in mind, I devised the initial schedule (Appendix 3). I decided to ask a broad opening question to encourage participants to begin telling their narratives. To obtain rich, concrete descriptions, it was important to keep participants focused on concrete events. Prompt questions that I could repeatedly ask throughout each interview were therefore devised. These also functioned to make participants feel heard and valuable. Next, I devised questions for each of the six chosen life-world dimensions. These questions were the most difficult to devise because I needed to ensure that I was enquiring about the dimensions in a way that made sense to participants whilst also ensuring that the questions were sufficiently open yet concise. Upon reading through the completed initial schedule several times, it became apparent that there were too many life-world dimension questions. Three considerations led me to this observation. I considered the questions' ability to elicit concrete detail and believed that asking multiple questions on each dimension had the potential to confuse participants, thus increasing the likelihood of the interview coming to a halt or participants' use of abstract words. Furthermore, several life-world questions asked participants to reflect on the present versus the past. This was the case for several dimensions, not just temporality. My research supervisor cautioned that participants often find questions on time particularly difficult to understand. For the temporality question, I consequently decided to enquire about both past and future as opposed to specific future times (e.g., the day ahead, next week). In terms of selfhood, both revised questions asked participants how this dimension has changed '"over time" as opposed to multiple questions that enquired into "now" versus "then". I ensured that questions concerning the other four life-world dimensions did not explicitly ask about time. I hoped that these changes would make the questions easier to understand. My final consideration was interview duration. Ultimately, interview duration is influenced by the number of interview questions.

The final schedule (Appendix 4) consequently contained one question per life-world dimension, except for the dimensions of selfhood and temporality which both contained two questions. The rationale for asking two questions for selfhood has already been explained. Regarding temporality, I wanted to understand how participants' lived experiences relate to their senses of both past and future. The

final schedule was used with both practice participants. As explained in section 2.4.4 below, I made an additional revision following practice participant feedback.

The term *everyday anxiety* when referring to GAD, was used throughout each interview because I inferred that it may be easier for participants to repeatedly hear; an assumption supported by one of my practice participants.

2.4.4 Practice telephone screening and interview

Although I cannot technically claim to have conducted pilot work because the individuals involved did not meet inclusion criteria, it was useful to practice both the screening and interview, and to obtain feedback. Two personal acquaintances participated in these run throughs. My objectives were to ascertain whether the GAD-Q-IV and interview questions made sense, and whether the interview schedule enabled me to gain concrete, rich descriptions within an appropriate time frame. Despite the more informal contact, full consent and debrief procedures were followed with both participants.

Lola[1] participated in the telephone screening. I did not calculate her total GAD-Q-IV score as the purpose of practicing was not to determine whether she met this measure's criteria for a diagnosis of GAD. Lola self-reported being "severely anxious", a description that was backed up by formal letters from psychiatrists which she voluntarily showed me. In her feedback, she felt that the meaning of the word bothered, which appeared in several questions, was unclear; she was unsure if it was asking her whether she had experienced the symptoms described or whether she had been negatively affected by them. I kept this in mind going forward with the full-scale study but decided to read out the questions exactly as phrased initially, to ensure consistent application of the questionnaire across individuals. Lola had consented to participate in the interview immediately after GAD-Q-IV completion, but due to time constraints, we did not have a complete run through. Lola therefore chose to read through my revised interview schedule in its entirety and later provided written feedback. She commented that the questions flowed well but was unsure what concretely meant in the question: what is it, concretely, that you worry about? Concretely was consequently replaced by exactly going forward. In

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[1] Not her real name

response to my opening question, she suggested that it would be useful for me to explicitly inform participants before the interview begins that the questions get more specific, to minimise the possibility of participants feeling pressured to say everything they want to immediately. I applied this suggestion going forward.

Hayley[2] participated in the full, face-to-face interview which lasted thirty minutes. She informed me that she could not remember her general practitioner (GP) specifically diagnosing her anxiety as GAD but commented, "it must be". Hayley reported feeling anxious talking so openly about herself, at times finding it difficult to answer the questions in-depth despite reporting that she understood them. I wondered whether her heightened anxiety was partly due to the fact that we knew each other but had not been in contact for some time. Nevertheless, her feedback highlighted the importance of making my participants feel as comfortable and valuable as possible. She commented that the term everyday anxiety was more relatable than GAD. This term was consequently used in the full-scale study.

2.5 Recruitment

2.5.1 Sampling plan and sample size

Purposive sampling was employed because I wanted to gain insight into the lived experience of a particular phenomenon: GAD. Participants were consequently required to have a formal diagnosis of GAD, rendering the sample homogenous (Smith et al., 2009). They also had to be aged eighteen or over. No other demographic restrictions were applied. Individuals currently undertaking any form of psychological therapy were excluded on the basis that their participation in this study could influence the therapeutic process. Individuals with co-morbid diagnoses were not excluded due to GAD's high rates of comorbidity, which were discussed in the Introduction chapter.

In line with IPA's idiographic commitment and Smith et al.'s (2009) recommendations for professional doctorate research, a minimum sample size of eight participants was deemed sufficient. I decided that if saturation (no new

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[2] Not her real name

developed themes) had not been reached after analysing eight participants' data, and time permitted, I would continue recruiting, ideally until saturation was achieved.

2.5.2 Recruitment procedure

I initially paid Anxiety UK to advertise my research flyer (Appendix 5) on their website. This yielded no responses. I also posted the flyer on their Facebook page. This yielded interest from one individual but after introducing myself and sending her the participant information sheet (Appendix 6) via email, she stopped contact.

Meanwhile, I asked local services such as doctors' surgeries, libraries, cafés, and community centres if I could place a hard copy of the flyer on billboards. Most services granted permission, but this method also yielded no interest.

I then advertised the flyer on my own Facebook profile and asked Facebook friends to share my post. This method yielded interest from one individual but after she did not answer her phone on two mutually-agreed occasions, she messaged to explain that she was "too nervous" to talk via phone and contact stopped.

Finally, I advertised the flyer on local community, selling, and advertising Facebook groups as well as on the following Facebook pages: Mind, Rethink Mental Illness, and Time to Change. I also placed a hard copy of the flyer on noticeboards throughout the Rhind building at City, University of London. Through these methods, I was placed in contact with twenty-four potential participants, seven of whom stopped correspondence after receiving more information about what participation would involve. I lost contact with two more individuals after explaining that the interview would need to occur face-to-face, not via telephone. Six potential participants were excluded because they did not meet inclusion criteria.

The remaining nine interested individuals who met criteria completed the telephone screening. All nine met the minimum required total score on the GAD-Q-IV. One potential participant withdrew from the study on the day of her arranged interview, stating that her anxiety had gotten worse. I thanked her for participating thus far and emailed her the list of relevant support contacts (Appendix 7) should she wish to access additional, professional support.

The initial recruitment process lasted seven months, between June 2016 and January 2017. I decided to analyse the eight participants' data before determining whether to continue recruiting. Between January and March 2017, two more females expressed interest in participating. I thanked them, explained that I had provisionally recruited a sufficient number of participants, and asked if I could contact them should the need to recruit further participants arise. Both individuals stated that they were happy to be re-contacted.

Aware that only one male had participated thus far, I decided to recruit specifically for another male participant in September 2017 to see whether any new themes developed. I re-advertised the research flyer on the same Facebook community and advertising groups I had previously used. One male expressed interest but after sending him the information sheet, I did not hear from him again. I decided to stop recruiting at this point. I had already obtained rich, plentiful data and was aware of the time frame left to complete the write up. Furthermore, as I was not investigating potential gender differences, the unequal gender balance was not deemed detrimental to the study's outcome.

2.6 Participants

Seven females and one male participated in this study. Relevant participant information is detailed in Table 2.1 below. Participant number depicts the order in which they were interviewed.

Participant number	1	2	3	4	5	6	7	8
Participant pseudonym	Emma	Sandy	Rob	Marie	Kirsty	Shelley	Sarah	Chloe
Gender	F	F	M	F	F	F	F	F
Age (at time of interview)	34	46	39	34	24	35	31	27
Interview duration (to the nearest minute)	69	80	64	80	38	86	89	81

Table 2.1   Relevant participant information

2.7 Procedure

2.7.1 Initial contact and telephone screenings

Interested individuals were initially sent the participant information sheet. I asked them to contact me if they were still interested in participating or finding out more about the study, after reading it. A telephone conversation was arranged with those still interested, during which I provided relevant background information about myself, the study's purpose, what participation would involve, how their data would be stored and used, and the outcome of the findings. I then ensured that potential participants met inclusion criteria and answered any questions they had. It was important from this first verbal contact to make potential participants feel valuable. I therefore stressed the importance of this research and their potential contribution. It was equally important however, to ensure that they did not feel coerced into participating, thus I stressed their right to withdraw at any time without consequence or need to provide a reason.

Individuals who were still interested in participating and met this study's criteria completed the telephone screening. Before asking the questions on the GAD-Q-IV, I explained its format, the rationale for its use, and stressed that if they did not meet this measure's criteria for a diagnosis of GAD this did not imply that their previous, formal diagnosis of GAD is incorrect, nor did the screening represent a formal diagnosis of GAD. I wrote their answers on a hard copy of the GAD-Q-IV to make it easier to calculate their total score. Following GAD-Q-IV completion, I informed them that I would phone them back immediately after calculating their total score. I also informed them that their answers and scores would not be used in the research. After determining their total score, the answer sheet was destroyed. All nine individuals met the minimum required total score and wished to participate in the face-to-face interview with myself. Dates, times, and interview locations were mutually agreed. If any individuals had not met GAD-Q-IV criteria, they would have been thanked for participating thus far but not invited to participate in the interview.

2.7.2 Data collection

Four interviews took place at participants' homes, in the relatively neutral space of living room or kitchen. Two interviews were conducted at participants' workplaces, and two took place in my living room. For the interviews conducted in my home, I ensured that the participant and I were alone, to protect their anonymity. The two interviews that took place at participants' workplaces were conducted in quiet offices without interruption. Most interviews conducted in participants' homes also proceeded without interruption; the only exception being one participant whose partner briefly disturbed us twice because her young son was upset that she was out of sight. During these interruptions, the interview and recordings were paused. To ensure participants' and my own personal safety, details regarding the time and location of each interview were left in a sealed envelope with my parents, whom I live with. These were destroyed upon my return. For the two interviews that occurred in my home, I contacted my parents once I was certain that the participant had driven away from the house, to confirm that they could return.

Before each interview began, I asked the participant to re-read the information sheet and provided opportunity to answer any questions. Meanwhile, I tested the two digital audio recorders used to record the interview, to ensure that they were working properly. I hoped that these introductory interventions would make the participants feel more at ease. The only demographic data I obtained was the participant's age. I invited each participant to choose their own pseudonym, all of whom did so. I re-explained that the interview would begin with a broad opening question followed by more specific questions. I sought participants' consent to use the term everyday anxiety when referring to GAD in the interview, explaining the rationale for this. All participants consented to this term's use. I also offered each participant the opportunity to read through the interview schedule prior to commencing the interview. Again, I hoped that this would make the participants feel more at ease. Two participants briefly skim-read the schedule, the others declined. Once the participant was happy to proceed to interview, I reminded them of the limits of anonymity; that I would only break anonymity if I was made aware of danger to the participant's or another individual's personal safety. Once I received verbal confirmation that the participant understood these limits, we both read and signed two copies of the consent form (Appendix 8). Throughout each interview, I called the participant by their pseudonym, as I felt that this made the interaction

suitably personal whilst reassuring them that I was upholding anonymity from the onset.

After the interview, once the recordings were stopped, the participant was thanked and invited to attend a verbal debrief with me to discuss their experience of being interviewed. Two participants chose not to participate in this verbal debrief due to time constraints. All participants were given a written debrief (Appendix 9) and the list of relevant support contacts should the need to access additional support arise.

All recordings and transcripts were stored on a password protected, encrypted (using VeraCrypt software) laptop, with all file names identifiable by participant pseudonym only. Any potential identifiers within the transcripts and write-up were removed or changed. The two recorders and my copies of the consent forms were stored in two locked cabinets at home which only I had access to; one contained the recorders, the other, consent forms.

2.8 Transcription

As already discussed, the main aim of IPA is to interpret the meanings inherent in the participants' accounts, thus Smith et al. (2009) suggest that a detailed transcription of the prosodic features of an interview such as non-verbal communication and pauses is not necessary. I however, felt it important to include these details so that an informed linguistic and psychological analysis could be conducted. Dialectical phrases were transcribed verbatim. Non-verbal communication was included as text in square parentheses. Pauses were indicated by an ellipsis mark, while words stressed by participants were highlighted in bold. I transcribed the interviews in order of participant number.

2.9 Analytic strategy

I rigorously followed the six steps suggested by Smith et al. (2009), not only because of the comfort this systematisation provided, but also to ensure that a critical other or interested researcher could check this study's findings or replicate it (Giorgi, 2010). IPA's founders have been criticised for their lack of apparent definitive clarity concerning IPA's analytic process (Giorgi, 2010, 2011). Giorgi

(2011) argues that to meet the scientific criterion of replicability, the method of analysis must have fixed steps and a fixed order. He proposes that despite this requirement, there is scope for flexibility concerning the steps' implementation. My implementation of these steps is detailed below.

2.9.1 Reading and re-reading

Starting with the first participant I interviewed, I sought to re-familiarise myself with the participant's life-world by listening to the audio recording whilst reading the transcript. This simultaneous process was repeated several times. Smith et al. (2009) suggest that this step allows the researcher to become more aware of the overall structure of the interview, including how the participants' narratives are presented and connected throughout. My initial observations were noted in my research journal because I felt it important to monitor and restrain my evoked reactions and ideas so that I could remain fully immersed with the data in its entirety.

2.9.2 Initial noting

My aim here was to produce a "comprehensive and detailed set of notes and comments on the data" (Smith et al., 2009, p. 83). Explorative comments were noted for each paragraph of the participant's narrative before moving onto the next. The purpose of this was to minimise the possibility of superficial reading. These comments were handwritten in the right-hand margin of the transcript (see sample transcript as Appendix 10). In line with Smith et al.'s (2009) suggestions, I began by noting descriptive comments which captured the explicit content of the participant's disclosures. More interpretative notes were then made which importantly remained grounded in the participant's account. Linguistic comments captured the way in which language was used to present content and meaning, including non-verbal communication, repetition and use of metaphor. Finally, conceptual comments captured the overarching patterns of meaning. Descriptive comments were noted in black, with linguistic and conceptual comments in red and green respectively.

2.9.3   Developing themes

Themes capturing the psychological concepts present in each section of exploratory comments were then developed. Each theme took the form of a brief statement or phrase. These were noted in the left-hand margin of the transcript. As Smith et al. (2009) indicate, theme development involved my psychological interpretations, but remained grounded in the participant's descriptions. Although themes were located at particular points in the transcript, their significance within the whole account was also considered.

2.9.4   Searching for connections across themes

The themes were then listed chronologically on a separate Word document. Alongside each theme, I noted the frequency with which it appeared. The document was then printed to facilitate the process of looking for patterns and connections between themes. In line with Smith et al.'s (2009) suggestions, I explored several connections, moving themes around to form clusters of related themes. Abstraction involved "putting like with like and developing a new name for the cluster" (Smith et al., 2009, p. 96). Subsumption occurs "where an initial theme itself acquires a super-ordinate status as it helps bring together a series of related themes" (Smith et al., 2009, p. 97). Super-ordinate themes were developed using both abstraction and subsumption. Themes were discarded at this stage if they were too vague, or if other themes better captured the participant's descriptions. Frequency was also considered, but following caution from Smith et al., themes were not discarded purely for their infrequency because frequency is not the sole indicator of significance.

Once I was satisfied that my developed super-ordinate themes best appeared to represent the meanings within the participant's account, I compiled a graphic representation of them (Appendix 11). Under each super-ordinate theme, supporting themes were listed and annotated with a brief participant quote and corresponding transcript location.

2.9.5 Moving to the next case

The steps described in sections 2.9.1 – 2.9.4 were repeated for each participant's transcript, in order of participant number. In line with IPA's idiographic commitment, each transcript was reviewed in its entirety before moving to the next. With each new transcript review, I monitored and restrained ideas evoked by prior case analyses, allowing for the development of new themes.

2.9.6 Looking for patterns across cases

To facilitate the process of looking for patterns across cases, I lined up each participant's graphic representation of super-ordinate themes on the floor. All eight participants shared the same three super-ordinate themes. Although supporting themes varied amongst participants, these commonalities aided the process of identifying connections. I then repeated the processes of abstraction and subsumption described in section 2.9.4 whilst simultaneously considering the potency of each theme.

This process resulted in an overall table of super-ordinate themes for the group (Appendix 12). This indicated how themes were nested within super-ordinate themes, with evidence across participants for each theme.

2.10 Ethical considerations

Ethics approval for this study was granted by the Psychology Research Ethics Committee at City, University of London (see Appendix 13 for the approval letter).

Certain measures implemented to ensure informed consent, participant anonymity, and the personal safety of the participants and myself across data collection and analysis have already been acknowledged in sections 2.7.1 and 2.7.2 and are not repeated here.

My decision to recruit via my personal Facebook account increased the possibility of individuals known to me, responding to my research flyer. This occurred with one individual who I thanked for expressing interest before explaining that due to ethical

concerns, and the potential impact her participation could have on the data (e.g., researcher bias), she could not participate.

I decided not to offer participants monetary reward for participating. Both participant and researcher should benefit from participating, thus rendering it unnecessary to offer monetary incentive. Furthermore, the offer of money may have resulted in potential difficulties concerning participant withdrawal or strengthened the sense of power differential between participants and myself.

Throughout this research, sensitivity to the participants' welfare took precedence. I was aware that participation may cause emotional and psychological discomfort. This possibility was addressed in several ways. The term everyday anxiety when referring to GAD was used throughout each interview on the premise that this term may be easier for participants to repeatedly hear. Participants were informed verbally and in writing that they did not have to answer any questions they did not want to, both during the telephone screening and interview. On occasions when participants exhibited potential signs of distress (e.g., verbal disclosures of feeling anxious), I asked them whether they felt comfortable to continue or wished to take a break. Throughout recruitment and participation, I strove to make participants feel heard and valuable. I invited them to attend a verbal debrief with me after the interview as well as establishing ongoing access to support via a list of relevant professional support services and further contact with myself and my supervisor, should the need arise. One participant emailed me prior to our arranged interview disclosing her detailed history. She reported wanting me to have as much information as possible to help me with the research. I replied to her email, thanking her for disclosing this information while gently informing her that I would only be able to use the information she discloses during the interview going forward.

In terms of participants' right to withdraw, Smith et al. (2009) recommend offering participants a time-limited right to withdraw, for example, until data analysis begins. I felt uncomfortable employing this restriction. Although I applied my own interpretations to account for the data, these eight individuals offered their narratives freely and generously, thus it did not feel appropriate to use their data against their will. However, I also acknowledge that it is impossible for participants to withdraw following potential publication (Smith et al., 2009). This exception should have been explained verbally and in writing.

In accordance with British Psychological Society (BPS) guidelines (2010), all data collected, including the transcripts, will be stored securely for five years before being destroyed.

With regards to my own self-care, research supervision and my research journal enabled me to explore my thoughts and feelings throughout the entire research process, while personal therapy ensured that I was monitoring my emotional resilience.

2.11   Evaluation of research

"The criteria traditionally used to evaluate the scientific value of quantitative research in psychology (e.g., reliability, representativeness, validity, generalisability, objectivity) are not, in their current form, meaningfully applicable to qualitative research" (Willig, 2013, p. 169). Qualitative researchers have consequently developed various criteria sets with which to evaluate the quality of qualitative research. The criteria used must fit the type of research being evaluated. Specifically, the study's aims and the kind of knowledge it seeks to generate determines which criteria are most applicable (Willig, 2013). I used Yardley's (2000) four principles as these are frequently used to evaluate qualitative psychological research and are well suited to a phenomenological approach. Indeed, Smith et al. (2009) illustrated how these principles can be addressed by IPA.

2.11.1   Sensitivity to context

Yardley (2000) suggests that to achieve *sensitivity to context*, the researcher should consider relevant theoretical and empirical literature, empirical data, participants' perspectives, the socio-cultural setting, and ethical issues.

In the Introduction, I conducted a thorough review of the theoretical and empirical literature, which enabled me to identify a gap in our knowledge of GAD. The theoretical considerations that shaped this study's design and implementation were discussed earlier in this chapter. Finally, in the Discussion this study's findings are considered in relation to existing literature. My research question, and consequently my method of data analysis (IPA), demonstrated contextual sensitivity from the

offset through their idiographic commitment. With regards to the social-cultural setting, throughout the research process I have reflected upon the "normative, ideological, historical, linguistic and socioeconomic influences on the beliefs, objectives, expectations and talk of all participants" (Yardley, 2000, p. 220) as well as my own (see Reflexivity section). From the offset, the participants' perspectives have been at the forefront of my mind. As already discussed, I aimed to ensure that all potential participants felt valuable from initial contact. My method of data collection (semi-structured interviews) facilitated this process as I was able to draw on my counselling psychologist skills (e.g., active listening, empathy) to make participants feel at ease, identify any interactional difficulties, and sensitively negotiate "the intricate power-play where research expert may meet experiential expert" (Smith et al., 2009, p. 180). Semi-structured interviews enabled participants to describe what was important to them whilst I tried to monitor and restrain my own beliefs and assumptions so that these did not influence the interviews' direction. I also offered to conduct each interview in locations where participants felt most comfortable. Consideration of participants' perspectives continued throughout data analysis; I ensured that my interpretations remained grounded in the participants' words. Inclusion of participant quotes in the Analysis chapter enables the reader to verify this. Finally, ethical issues were also considered (see section 2.10).

2.11.2   Commitment and rigour

According to Yardley (2000), *commitment* "encompasses prolonged engagement with the topic, competence and skill in the methods used, and immersion in relevant data", while *rigour* refers to "the resulting completeness of the data collection and analysis" (p. 221).

I have read extensively around theoretical, empirical, and popular GAD literature, qualitative research methods and IPA. I also attended lectures on IPA and practiced it in seminar groups. I also practiced conducting the initial telephone screening and interview to ensure that the questions made sense and were appropriate, that participants felt comfortable and valued, and to ensure that both were completed in an appropriate time frame. I ensured that the sample was suitably homogenous and, to the best of my ability, matched the research question by including only those participants who had received a formal diagnosis of GAD. As already discussed, I was committed to considering participants' perspectives throughout and this

resulted in rich, concrete data. Smith et al. (2009) state that to ensure rigour, "one needs to be consistent with one's probing, picking up on important cues from the participant" (p. 181). Participant feedback communicated that I had, to a large extent, achieved this. Several participants reported that my ability to pick up on cues and probe further, particularly around topics that had previously been misconceptualised by others, had communicated that I was trying to understand them. Analysis was thorough and systematic. Themes were developed, revised, and occasionally rejected if I felt that another theme more accurately captured the data. I also tried to maintain a balance between idiographic engagement and identifying shared themes. This transferred into the Analysis chapter, where care was taken to ensure that each participant's account was equally represented whilst highlighting important aspects of themes they share. Smith et al. note how novice qualitative researchers tend to complete a first draft analysis write-up that is "pretty descriptive" with "a lot of quotes from participants but not much analysis" (p. 110). Indeed, I revised the Analysis chapter to ensure that my interpretations outweigh participant quotes.

2.11.3   Transparency and coherence

According to Yardley (2000), *transparency and coherence* relates to the "clarity and cogency – and hence the rhetorical power or persuasiveness – of the description and argumentation" (p. 222). This entails transparent methods and data presentation, a good fit between theory and method, and reflexivity.

I have clearly documented all stages of the research process, detailing how participants were recruited, how the interview schedule was constructed, and the interviews conducted, and how I applied Smith et al.'s (2009) six steps of analysis. Transparency was enhanced through including tables and samples in the main body of this write up as well as in the Appendices, detailing key participant information, the analytic strategy, and resulting data. I provided a rationale for every decision made. I believe that the developed themes "hang together logically" (Smith et al., 2009, p. 182), telling a coherent narrative of how each super-ordinate and subordinate theme relate to one another. There is also cohesion between the research question (and consequent research aim) and the phenomenological approach employed. This enabled the study to remain focused on the lived experience of GAD via "consistent and complete description" (Yardley, 2000, p.

222) during data collection, followed by researcher interpretation during analysis, to make sense of these pre-reflective descriptions. While I have conducted this research according to IPA principles in the sense that I have focused on a "significant experiential domain for participants" (Smith et al., 2009, p. 182) and recognise that IPA involves researcher interpretation, I have also acknowledged the tensions between IPA's claimed theoretical underpinnings, philosophical phenomenology and the hermeneutic tradition. Finally, reflexivity was considered throughout. I kept a research journal and discussed it in the Methodology and Discussion.

2.11.4 Impact and importance

Yardley (2000) argues that "it is not sufficient to develop a sensitive, thorough and plausible analysis, if the ideas propounded by the researcher have no influence on the beliefs or actions of anyone else" (p. 223).

This research was conceived due to the lack of existing literature on the lived experience of GAD. To recall, despite GAD's commonality and association with frequent healthcare use, it is significantly under-detected and undertreated (Wittchen & Jacobi, 2005). The findings are consequently important and relevant to particular individuals (e.g., the participants, others with GAD, their families and friends, and healthcare professionals including counselling psychologists, physicians, medical specialists) as well as society (e.g., the findings highlight the potential importance of belonging to a community). Most of these implications are discussed further in the Discussion. With regards to the impact on participants, several expressed "surprise" and "fascination" that I was conducting research on GAD. Reasons given included perceptions that it is not a well-known condition and that it is not often talked about or understood. Some also commented during their verbal debrief that the interview process had facilitated new insight and had consolidated their own understandings of GAD. I hope that the findings strengthen their understanding and help normalise it. I also hope the findings inform loved ones and friends of individuals with GAD about it and how best to support them. Finally, I hope this research communicates that GAD is being taken seriously which, in turn, will hopefully encourage others with GAD to seek professional help sooner.

2.12 Reflexivity

Finlay (2017) describes researcher reflexivity as "the use of a critical, self-aware lens to interrogate both the research process and our interpretation or representation of participants' lives" (p. 1). As Finlay (2011) states, it is "inevitable that researchers bring their subjective selves into the research along with preconceptions which both blinker and enable insight" (p. 23). She compares the reflexive process to a dance that is co-created by both researcher and participant. During this dance, the researcher both restrains his or her preconceptions and uses them to interrogate meanings (Finlay, 2008). Reflexivity began as soon as I started conceptualising this study and has continued throughout the research process, largely in the form of a research journal.

2.12.1 Personal reflexivity

Personal reflexivity involves reflecting upon both the ways in which my personal values, interests, assumptions and experiences have shaped this research, and how conducting it has evoked change within me personally and as a scientist-practitioner (Willig, 2013). Here, I focus on the former. The latter is discussed in section 4.9.

My interest in this research topic was prompted by my first piece of clinical work as a counselling psychologist in training. While working in a local, private sector counselling service, my first client presented with emetophobia and feared long car journeys. However, it soon became apparent that his anxiety and worry extended beyond these specific foci; they were generalised across a wide variety of topics. I consequently began researching GAD as, at the time, my professional awareness and understanding of GAD was significantly limited and I needed to formulate his presenting difficulties and consider how best to approach therapy with him. My only personal, indirect contact with GAD has been through a friend's experiences. She has previously met GAD diagnostic criteria on the GAD-7 (Spitzer, Kroenke, Williams, & Löwe, 2006) and self-identifies as having "generalised anxiety". However, her psychiatrist does not think she has "straightforward GAD", adding "I don't think it's as simple as that". Furthermore, her current mental health team letters refer to "mixed anxiety and depressive disorder". Through working with this

client and considering my friend's experiences, the possible complexities and difficulties in diagnosing, understanding, and working therapeutically with potential GAD became apparent. Existing GAD literature highlighted that I was not alone in this perception; clinicians often struggle to recognise the symptoms as belonging to GAD (Dugas & Robichaud, 2007). I felt like something was missing from the literature and that this was hindering my ability to understand GAD – I craved the context and relatability I believe a phenomenological perspective would have provided. My decision to focus on the lived experience of GAD was consequently not only driven by my motivation to give these individuals a voice and to increase other healthcare professionals' understanding of GAD; I personally wanted to gain a better understanding of GAD from those experiencing it in the hope that I too would become more efficient at recognising and treating it.

Reflecting on my position as researcher, I was largely an "outsider", or different to the participants as I have never had GAD. While I therefore had no direct personal experience of GAD that required restraining, I needed to restrain any theoretical knowledge and assumptions of GAD specifically as well as personal experiences and theoretical knowledge of anxiety and worry. As discussed further in the following two sub-sections, this occasionally proved difficult. This was particularly the case when participants described worrying about what others think about them as I worry about what others' think about me; I worry about being liked. The following steps were consequently taken: I wrote in my research journal after each interview, I ensured that I probed further when necessary, and I grounded my interpretations in the participants' words.

2.12.2 Methodological reflexivity

First, I wish to acknowledge that another researcher may have generated different data from the interviews and another's interpretations of the data may have resulted in different findings. Furthermore, if the participants had been interviewed at a different time, they may have provided alternative descriptions of their lived experiences. Similarly, if different individuals who met the inclusion criteria had participated, they may have described different experiences. This study consequently only claims to report on the participants' lived experiences.
I believe that the combined use of semi-structured interviews and IPA enabled me to successfully capture the rich textures of the participants' lived experiences. Semi-

structured interviews enabled me to obtain plentiful, rich, concrete descriptions while IPA acknowledges that researcher interpretation is required to make sense of these pre-reflective descriptions. More specifically, it explicitly acknowledges that my professional background and research context meant that I inevitably interpreted the data from a psychological perspective.

Willig (2013) questions the extent to which participants can describe the "rich texture of their experience to the researcher" (p. 95). All participants were self-selecting, suggesting that they were motivated to talk. They were articulate and able to convey their narratives in words. I believe that this is reflected in the Analysis chapter, the sample transcript (Appendix 10), and the tables of individual and group super-ordinate themes (Appendices 11 and 12). As already discussed, considerable time was spent revising the phrasing of the interview questions and I ensured that I did not ask about meaning as lived experience is largely pre-reflective. On the odd occasion where participants struggled to convey their experiences, I tried to follow Smith et al.'s (2009) advice of remaining curious and using prompt questions. However, there were times when I jumped in too quickly with my own responses (i.e., paraphrasing, asking a question), particularly when participants disclosed that they were very anxious or believed that they were not explaining themselves well enough. These instances provoked my own anxiety and need to reassure them.

2.12.3 Procedural reflexivity

I decided to exclude those without a formal diagnosis of GAD from participating. While I have already provided a rationale for this decision and believe it was necessary, it contradicts the phenomenological ethos of remaining in the experiential realm, taking participants' declarations of GAD at face value. This contradiction evoked physical and emotional tension within me because a main motivation driving this study was my wish to give adults with GAD a voice. I therefore felt guilty that I had denied those who self-identify as having GAD the opportunity to share their experiences.

Before any contact with each potential participant, I wrongly assumed that they would be anxious and display visible signs of anxiety and was surprised when this did not appear to occur. On occasions where it did, I found myself wanting to contain their anxiety, and in turn, observed my own anxiety as I tried to achieve this.

This was particularly apparent at the beginning of Chloe's interview. She kept repeating that she was not explaining herself well, kept nervously laughing as she spoke and said that she felt silly. Feeling stuck and not wanting to fall into "therapist mode", I found myself reassuring her that she was being coherent despite not feeling like she was before returning to the interview schedule. I hoped that this would make her feel more at ease and challenge her self-conscious perceptions. I believe I achieved this aim to a certain extent as, during the verbal debrief, she reported feeling more relaxed as the interview progressed and forgot about the two digital recorders. Her fidgeting (e.g., tapping the sofa) also lessened as the interview progressed.

Returning to self-conscious emotions, I was struck by the extent of self-consciousness and stark self-criticism displayed by some participants during data collection. For Sandy, this extended beyond the interview itself. Upon meeting and parting she apologised for looking a "mess". When participants disclosed worrying about what others think of them I wondered how this may have affected their interaction with me and the degree of internal and external monitoring that they may have consequently engaged in.

On several occasions during data collection, I failed to restrain my theoretical knowledge and assumptions. I applied CBT theory and terminology in some of my responses. For example, during Rob's interview, I asked whether the "cognitive" symptoms occurred before the physiological. These instances may have strengthened my power as a researcher by falsely communicating that I am the expert of their experiences. Moreover, if participants described applying CBT techniques, sometimes I picked up on this at the expense of ignoring other parts of that section of dialogue. Although, in the majority of cases, I did refer back to these at a later stage, I interrupted the natural flow of the interview and their thought processes, thus possibly preventing important disclosures.

Beyond occasions where I implicitly reinforced my position as a counselling psychologist in training and practitioner-researcher, I sensed that most participants were acutely aware of this throughout their interviews and that this influenced some of their disclosures. I got the impression that some participants spontaneously talked in depth about their experiences of psychological therapy because they assumed that I wanted to hear about them, despite not enquiring about them. I also wonder whether those who had negative experiences of psychological therapy

voluntarily disclosed these because they perceived me as a platform of change. I had conflicting feelings of responsibility (and consequent guilt) and defensiveness when Emma described her dissatisfaction with the counselling she had received. I managed to notice and restrain these thoughts during the interview and explored them thoroughly afterwards in my research journal.

With regards to the process of data analysis, my decision to focus on the lived experience of GAD in relation to six life-world fractions was driven by my extensive consideration of philosophical phenomenology, my first piece of clinical work during my training, and my review of existing GAD literature. While I believe I achieved this aim, it resulted in a significant amount of data to analyse. This, together with my commitment to being rigorous and thorough (Yardley, 2000), meant that analysis was incredibly time-consuming and occasionally stressful.

3. Analysis

3.1 Overview

Analysis resulted in four super-ordinate themes that represent the lived experiences of GAD across participants. While each theme captures particular aspects of the lived experience of GAD, they are all intricately connected with one another. Figure 3.1 below, depicts these interconnections. "Battling with uncertainty: What's going to happen next?" explores participants' difficulty tolerating uncertainty in its various forms. "A struggle for autonomy: You either let it get a hold of you, or you get a hold of it" addresses how participants engage in a constant battle for perceived control over their senses of self, as GAD takes over. "GAD and interpersonal relations: Worrying about what others think" explores the interactions between participants' experiences of GAD and their interpersonal relationships. The final theme is "The need to create meaning amid uncertainty and loss: GAD is an eye-opener". It considers participants' need to locate meaning and purpose within GAD in order to tolerate the psychological and physiological distress it causes them. Within the direct quotations from participants, words in bold were emphasised by them (see Appendix 14 for further information regarding this chapter's format).
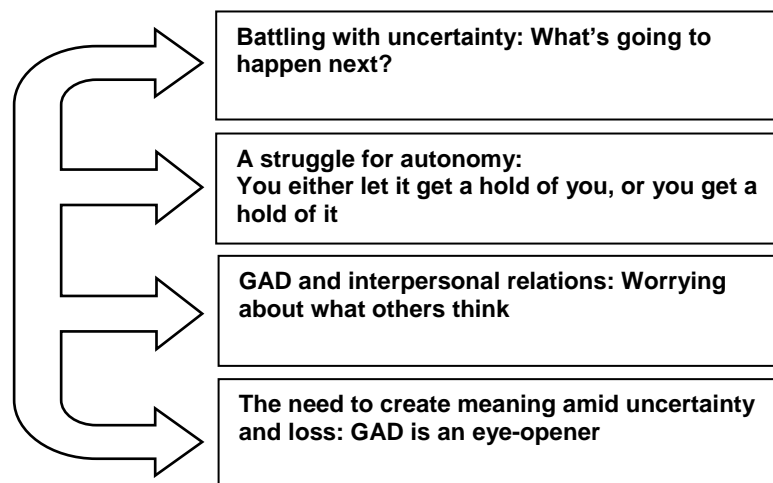
Figure 3.1   Representation of super-ordinate themes

3.2 Battling with uncertainty: What's going to happen next?

This super-ordinate theme captures participants' difficulty tolerating uncertainty and consequent absence of perceived control over their life-worlds. Within the super-ordinate theme fall four themes. "An endless cycle" considers GAD's endless qualities. Little is therefore experienced as finite and certain. "No rhyme or reason" explores participants' experience of GAD as illogical. Participants consequently locate meaning and purpose within GAD, presumably to maintain a sense of certainty. "Grappling with time" addresses participants' difficulty living in the present moment as they ruminate on things they cannot change (past) or accurately anticipate (future). Lastly, "Doubt" explores the various manifestations of doubt GAD evokes.

3.2.1 An endless cycle

All participants describe an endless quality of both specific cognitions; thinking and worrying, and their anxiety.

Emma conveys the extent of her thinking via her stark comparison to her former self:

> I don't even think I **thought** before. I just like did what I wanted, and **now**, yeah, you're always, always thinking. **Over-thinking** is terrible … and that's where it all begins, when you over-think situations. (Emma: 1.4.30)

Emma implies that before GAD she was not consciously aware of her thinking or at least not to the extent where it affected her decision-making ability. Now, she appears to constantly over-think situations. This seems confirmed in her repetition of "always". Her use of the word "terrible" implies the distressing nature of her excessive thinking which triggers her GAD symptomology. Her new sense of distress and disconnection from her former self is indicated in her transition from using the first-person position ("I") when referring to her former self, to second-person position when describing her current sense of self ("you're; you").

Marie's image implies a frantic quality to excessive thinking:

It's almost like ten cars coming in for a collision. (Marie: 4.4.10)

This comparison can be understood on several levels. It signifies both the speed and magnitude of Marie's thinking. It also indicates that all her thoughts occur at once, posing a constant threat of devastating impact. This frantic quality is echoed in Chloe's description of "all these racing thoughts going on" (8.3.8).

Sandy describes how she not only over-thinks "everything", but also finds herself questioning this process:

I'm always think-. I analyse **everything**, so every time I think **anything**, I think: well why is that? What's all that about? And then that's draining. (Sandy: 2.1.2)

Sandy begins to describe how she is "always thinking", but "thinking" is replaced by "analyse". This suggests the degree of methodological scrutiny she engages in concerning stimuli in her lifeworld and the thought process itself. Her account indicates a disconnection between her excessive thinking and rational mind, making it difficult to understand. Her use of the word "draining" implies a mentally exhausting quest for answers that leaves her completely deprived of energy. There appears to be an obsessional element to thinking and this is echoed in other participants' accounts. Marie notes how she "can't stop obsessing with it" (4.4.6) when multiple individuals give her different accounts of a situation, while Shelley describes "overanalysing" (6.7.1) every interaction she has with others.

This sense of endlessly trying to make sense of things that do not make logical sense or are indeterminable is also present in participants' accounts of worrying. Rob describes an "endless cycle of what ifs" (3.2.1) which he later elaborates on:

[*what if?*] It's almost [in-breath] … the unanswerable question [ ] if you answer that one, you come, you go to the next one, so: what happens if? Well that will happen. Well what happens if that happens after that? And you just keep going. (Rob: 3.5.10)

Here, Rob indicates that his answers to: "what if?" never sufficiently convince him to stop worrying. His in-breath followed by the pause in dialogue suggests that this is difficult to acknowledge, as does his use of the second-person position ("you"). His answers introduce more possibilities that lead him to re-ask the question. This cyclic

pattern appears to be compounded by the uncertainty unavoidable in worrying about the future.

This cyclic pattern of worrying is shared by other participants. Kirsty describes how worrying about what might happen if she were to meet up with friends causes a chain reaction that results in her cancelling plans:

> It's a bit of a vicious cycle isn't it? So you think about things that could happen but probably won't, but then instead of concentrating on they probably won't, you concentrate on that they could, so then I think the panic starts, and then [ ] you feel a bit sick and then you kind of talk yourself out of doing it and then [ ] once you've cancelled it, it's quite upsetting because you regret cancelling it, and it's like [laughter] trying again, so sometimes it's the same cycle over and over. (Kirsty: 5.2.3)

Kirsty's use of the word "vicious" implies that this cycle is a form of brutal self-punishment. She is rapidly overcome by fear of dangerous possibilities. She stops herself from meeting her friends to protect herself. Paradoxically however, this act of self-protection quickly turns to one of self-disappointment as she finds herself repeatedly confronted with the same dilemma. Her laughter indicates a need to mask her disappointment.

This sense of worry rapidly escalating is echoed in other participants' accounts. Unlike Kirsty's account of a consistent chain of events, Sarah describes how one worry can trigger other, seemingly unrelated ones:

> Although I might be thinking about: I need to put the washing on tomorrow, erm something about the washing will then remind me of something else, and it might not be clothes related. It might be: last time I did the washing, something else happened and oh my God I didn't, it moves really, really quickly. (Sarah: 7.8.3)

As with earlier participants, Sarah seems to consider infinite possibilities which maintains her worry. She construes worry as something separate from her with its own agency ("it moves"), suggesting that it is difficult to control. This perception of infinite possibilities seems to shed light on the fact that most participants describe worrying about everything.

> I think I still **do** worry about everything. [ ] I am a born, I think, worrier and I still do worry about **absolutely** everything. (Shelley: 6.9.1)

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Despite narratives of feeling more in control of GAD since completing CBT, Shelley implies that her worry has not lessened ("I still do"). While Sarah construes worry as something separate, Shelley construes it as an innate part of her ("I am a born worrier").

Finally, participants construe anxiety with the same perception of endlessness. This is perhaps unsurprising given the infinite nature of their thinking and worrying.

> At least with labour, you know it will come to an end at some point, be it a couple of hours, be it twenty-four hours, you know, be it a week. It will come to an end. With anxiety … no. (Emma: 1.3.11)

Emma describes how she would rather be in constant labour than experience daily anxiety (1.3.10). Here, she implies that despite the pain of childbirth, knowing that there is an endpoint makes the pain bearable. She suggests that she perceives anxiety with equal pain, but the uncertainty of when, or if it will end makes it more difficult to tolerate. This perception of anxiety having no let-up is echoed by other participants. Marie describes how "there's no respite from it" (4.9.1), while Chloe notes that her anxiety is "always there" (8.7.5).

In summary, this theme has explored how participants appear to experience no let-up with regards to their thinking and worrying. One thought or worry always seems to lead to another, resulting in constant anxiety.

3.2.2 No rhyme or reason

This theme explores how GAD is construed as illogical. Participants seem to find this illogicality difficult to tolerate. This is implied in their need to, once more, make sense of GAD.

Participants describe an absence of logical explanation for their anxiety.

> It's strange. [ ] I can't even put my finger on any particular thing that … [in-breath] that happens. [ ] I dunno. Triggers? It could be anything. (Sandy: 2.4.8)

Sandy's use of the phrase "it's strange" can be understood on several levels. GAD is construed as something that takes Sandy by surprise. This makes it a difficult concept for her to understand ("can't even put my finger on", "I dunno"). This difficulty seems captured in the pause in dialogue, immediately followed by an in-breath. Her use of impersonal language ("it's") to describe this strangeness indicates that she construes GAD as something separate and alien to her. There appears to be an unforeseen, foreign quality to GAD, and this is echoed in others' accounts. Sarah describes how her catastrophic thinking happens "in the blink of an eye" (7.7.5), while Shelley states: "I don't know where the thoughts come from" (6.9.2).

Emma also perceives GAD as a separate, unpredictable entity, but her image is of being suddenly and violently attacked by "it":

> You never know when it's gonna strike. You never know **how** it's gonna strike. (Emma: 1.1.1)

There also appears to be temporal fluctuation in anxiety's intensity. Chloe describes sometimes feeling "just a little bit nervous", yet other times feels "really, really nervous" (8.1.3). Kirsty struggles to summarise her experience of GAD due to its daily variation:

> I: What is it like to live with everyday anxiety?
>
> It's probably difficult to describe it as a whole because I think from day to day it changes so, depending on what you know you have to do or just generally how you're feeling, so erm sometimes it can be quite difficult and other days, it's a bit … more **relaxed**. (Kirsty: 5.1.1)

The daily fluctuation in Kirsty's anxiety levels seems dependent on the situations she may face. For example, as will be discussed later, Kirsty's anxiety intensifies in the absence of perceived control. Her emphasised description of some days being slightly more "relaxed" strikingly conflicts with her later description of never having a "completely stress-free day" (5.7.2), suggesting her need to downplay her anxiety.

Several participants explicitly describe their difficulty tolerating GAD's illogicality.

> When you can't understand something, you can't deal with it. [ ] If you lose someone
> or something like through death, you know why you're sad. You know why you're …
> **not** functioning in the way that you normally would, [ ] whereas when you don't know
> **why** you're feeling the way that you are, or **why** your **head's** going off in the way that
> it does, you can't **control that** [ ] there's no rhyme or reason to it. There's no: 'yeah
> you'll be fine', cos you don't know you will. (Emma: 1.11.7)

Emma appears to experience the same degree of sorrow with regards to GAD as she does when mourning. With GAD however, her distress seems amplified because she does not know why she feels anxious, or, as discussed in section 3.2.1, if it will end. She is consequently unable to reassure herself that eventually she will be "fine". Furthermore, she implies a disconnection between her mind and body ("head's going off"), as though she perceives herself to be deranged and therefore incapable of her usual behaviour. Rob also communicates his struggle to understand GAD by contrasting it with something he can understand:

> It's such a **hard** erm thing to describe. [ ] If you've got a broken metatarsal or
> something, you [in breath] can explain what that is, where it is and how it gets treated,
> and I think with this, it's, it's, it's **hard** to explain. (Rob: 3.12.1)

Rob starkly contrasts something tangible; a broken foot that can be seen, understood, and treated, to his opposing experience of GAD. His difficulty explaining GAD to others seems to stem from his own perception of it as "bizarre logic" (3.9.3).

Most participants appear to cope, in part, with this difficulty by identifying causal explanations for their anxiety. It is noteworthy that these accounts were produced unprompted. Marie avoids phoning in sick to work when she is ill because she fears getting in trouble.

> I think part of it stems [ ] from a childhood experience anyway, [ ] when I was about
> eight [in-breath], whereas most parents would take time off to look **after** their child, my
> dad would leave me in the back of his car with a blanket, sick bowl and a teddy bear,
> erm while he went to work. (Marie: 4.1.8)

Marie's account extends our understanding of why this childhood experience continues to influence her adult behaviour. As a child, illness was associated with

punishment and neglect. She still avoids telling others when she is ill from fear of reoccurrence:

> As an adult, I still don't … **unless** I'm physically unable to m-, to get up, I won't tell anybody. I'll just keep going. (Marie: 4.1.9)

Ironically, this fear seems so great that she would rather neglect her own needs ("I'll just keep going"). Some participants propose that their anxiety is either hereditary or a learned behaviour from a parent. Rob, for example, describes his mother as a "worrywart" (3.6.2). Others attribute their anxiety to specific past experiences such as moving home frequently or mentally abusive teachers or partners. Sandy suggests that the "awful progestogen-only pill" triggered a dramatic increase in her existing anxiety levels (2.11.2).

Some participants appear to hold positive beliefs about worry.

> I did get really good grades s-, so it worked. [ ] Like at A Levels, it was a drive to work hard and like the fear kept me going [laughter] to do lots of work. (Chloe: 8.1.5)

Chloe's anxiety became noticeable during A-Levels. She described not taking GCSEs seriously whereas A-Levels held more importance, to the point where she missed social events to study. Here, she attributes her A-Level success to the fear of failing that motivated her to study. Sarah also holds positive beliefs about worry:

> This is **really** wrong. I feel like the reason that things don't happen is because I worry about them. (Sarah: 7.7.5)

Sarah indicates that she realises this belief is irrational ("this is really wrong"), but it is maintained in the absence of concrete proof to dispute it. Such proof cannot be obtained because the belief is based on future predictions that may never have occurred regardless of whether she worried. Positive beliefs about worry appear to allow participants to construe it as useful.

This theme then, has explored GAD's illogicality. Participants seem to struggle tolerating the uncertainty this evokes. They therefore attempt to make some sense of GAD, either through identifying causal and maintaining factors for it, or by attributing usefulness and therefore meaning to it.

3.2.3 Grappling with time

All participants describe a lost sense of self. For most participants, this loss also encompasses ruminations about specific past events. Almost all participants appear to experience anticipatory anxiety. Most participants describe attempts to stay present but appear to find this challenging amid their past and future grapples.

3.2.3.1 Loss of a past self

For all participants, GAD has resulted in a lost sense of self. Some participants mourn their previous identities, while others appear hopeful of re-owning them. Emma describes the magnitude of her lost sense of self:

> I've become probably … a **quarter** of the person that I used to be. (Emma: 1.2.1)

Emma's description evokes the powerful image of being reduced to a quarter fragment of her former, whole self. She compares her former, "life and soul of the party" self (1.2.1) to her current self who feels cautious in social situations, partly due to a perceived loss of control over this new identity.

> I **wanna** go out, **of course I do**. I wanna go out. I wanna get smashed. I wanna be the person that I **was**. (Emma: 1.4.8)

Here, Emma suggests that she is struggling to accept her new identity, instead wishing she could be the person she was before GAD. In Kirsty's extract of pre-planning a recent holiday, she also describes a lost sense of self but appears hopeful of its return:

> I knew like where the local shops were and how far the beach was and what [laughter] the cafés were called, [ ] whereas before, you kind of go and then you explore don't you? Erm so I think it would be nice to get back to being able to do that. (Kirsty: 5.6.2)

Kirsty implies a wish to be a past, more spontaneous self. Her transition from speaking in the first person when talking about her current self: "I knew", to second person when talking about her former self: "before, you kind of go", indicates the

vast distance between her current and former self. Chloe wishes she was her child self:

> That's the thing about being a kid again, being like: oh, I just wanna be a kid forever, sort of thing cos I, I'm scared of the **future**. (Chloe: 8.5.3)

Chloe perceives that being a child involves less responsibilities such as employment which is one of her main worries. Here, she implies an impossible wish to permanently maintain a sense of childhood innocence which would allow her to remain oblivious to such adult responsibilities and the future. Instead, she seems weighed down by her perceptions of both, and perhaps also by fear of the future's inherent uncertainty.

Other participants perceive that they will never be their former selves. Sarah seems to describe the sense of painful loss encompassed in this realisation:

> I've learnt that like this is it. [ ] I'm not gonna wake up one day and [in-breath] I'll be me when I was … what? Twenty-, say twenty-four, when [ ] I didn't get anxious about things. [ ] I used to be really good in interviews. [ ] I didn't feel nervous, and I know that would be a normal level of anxiety, but I didn't really have that. **Now**, I have that like multiplied. (Sarah: 7.4.2)

Sarah's description of learning suggests that this finite ("this is it") realisation is difficult to accept. Her extreme description of a past self who never felt anxious conveys a previous perception of an invincible self that has been replaced by a juxta-posing incredibly anxious, vulnerable self; a transition she is struggling to come to terms with.

Most participants also describe ruminating about past events. Despite their inability to change these events' outcomes, they appear to relentlessly worry about them. Rob's account is notable for the way he construes his perceived mistakes as separate agencies, capable of violent punishment:

> [*Perceived past mistakes*] They'll come back and hit you. [ ] It's like a, a boxer punching you in the stomach every now and then and just saying: 'ooo, you remember that?' You just: 'that happened to you nine years ago.' [ ] 'Blimey', you know, 'give yourself a break.' (Rob: 3.8.3)

By employing the simile of a boxer simultaneously punching and verbally reminding him, Rob suggests that he is repeatedly tortured by his past mistakes. Being punched in the stomach evokes the image of being winded and consequently incapacitated. Rob indicates that this boxer, although separate from him, lives in his mind. He appears surprised by the boxer's relentless attacks ("blimey"), and his more rational, compassionate internal monologue attempts to regain control ("give yourself a break").

3.2.3.2 Anticipatory anxiety

Almost all participants appear to experience anticipatory anxiety, often in the form of catastrophic future predictions.

> If I've got a meeting coming up at work erm … my **instant** thought is: I'm gonna get sacked. **Then** I'm thinking about how I'm gonna pay my bills and it's like all happening at once even though the meeting's not even taken place. (Marie: 4.7.1)

Marie's excerpt extends our understanding of her earlier description of her excessive thinking: "ten cars coming in for a collision". Here, she predicts a catastrophic outcome of a future meeting which then triggers additional catastrophic thoughts of being unable to cope with this fictitious scenario.

Sandy's anticipatory anxiety also results in self-doubt but unlike other participants, she explicitly recognises her inability to foresee the future, thus implying the pointlessness of worrying:

> They [*others*] can't see what **I** see. Well what, what do I see? I don't see anything cos I can't see into the future. It's what I think. It's 'What ifs?' Erm and I daren't do this, that and the other, cos what if that happens? [ ] Erm I don't drive to [*location*] in November cos what if [laughter], what if I can't drive? (Sandy: 2.9.1)

Sandy starts to proclaim that others lack her future insight, before distinguishing between her own inability to foresee the future and her mind's predictions. Her prediction of being unable to drive results in avoidance. Her laughter appears to mask the bewilderment, and perhaps a sense of shame, that her seemingly irrational self-doubt evokes. Sandy seems to confirm its irrationality in an earlier comment: "I've been driving twenty-odd years. I can absolutely drive" (2.4.1).

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Emma's experience of anticipatory anxiety is poignant because she construes the future's uncertainty as a potentially lethal game:

> It's like a hamster's running around on this wheel of: **oh my God, oh my God, oh my God**. What's, what's gonna happen next? And you just don't know. It's like Russian roulette. (Emma: 1.4.20)

The image of a hamster running on a wheel implies that Emma's anticipatory anxiety is frantic and recurring. These qualities are captured in her stressed repetitions of "oh my God". In likening the uncertainty of the future to Russian roulette, Emma seems to perceive it as a dangerous game of chance with a potentially catastrophic outcome.

The future's uncertainty results in a lack of perceived control over it. Most participants engage in pre-planning. This appears to provide them with a degree of perceived control over the future.

> When we [*Marie, family, friends*] **do** go somewhere, it's very particularly planned, so erm simple trip to the zoo, [ ] I packed stuff for migraine stuff, my daughter's inhaler, I got sunscreen, two different sorts of sunscreen, packed lunch, but just in case anyone doesn't like cheese sandwiches, I got five different sandwiches. (Marie: 4.7.1)

Here, Marie seems to describe attempts to prepare for every eventuality, even packing several of the same item "just in case". This detailed preparation is juxtaposed with her description of a "simple" daytrip, implying that such pre-planning is unnecessary. As we will explore later, Marie's need to cater for everyone's requirements partly stems from her desire to feel accepted by others.

While most participants intentionally engage in future planning, Shelley tries not to due to her superstitious thinking:

> I tried not to think about the future **at all** because I didn't wanna think about it and be happy because I was convinced like the universe would think: ooh she can't be happy. Let's stop that from happening. (Shelley: 6.8.1)

In her interview, Shelley explained that her CBT therapist helped challenge some of her superstitious thinking, for example, her belief that if she wrote milestones such as her son's birthday on the calendar, she may die before the event occurs. Despite

this, she still only tentatively plans the short-term future. As explained in this extract, her reluctance is associated with beliefs of not deserving happiness. If she were to excitedly anticipate something, she believes that she would be punished by an almighty, spiritual power.

3.2.3.3 Trying to stay present

Some participants speak more generally about trying to live in the present moment, while others identify specific things to aid this.

> I would always think too far ahead and panic about the future [ ], but now things are a lot better, I'm just kinda taking one day at a time, living more in the moment. I'm trying to at least. (Chloe: 8.6.1)

In her interview, Chloe described feeling less anxious since partaking in various psychological therapies and being on antipsychotic medication which has "dulled down" (8.1.3) her anxiety. Here, she associates this with an increased ability to live each day as it happens as opposed to anxiously anticipating the future. Marie describes attempts to replace her unhelpful pre-planning with impulsivity:

> I try to be spontaneous cos if I plan too much ahead of time [in-breath], the amount of scenarios I play in my head of what can go wrong, is just too much. (Marie: 4.7.1)

Others believe that certain behavioural activities may help ground them in the present. Sandy describes trying to schedule in café visits amid her busy work schedule, noting how she "enjoyed the moment just chilling" (2.4.13) last time she did this. Sarah describes how her mind "can literally be a year ahead" (7.8.1). She hopes that yoga will enable her to "stay in the moment" (7.8.1).

This theme has further highlighted participants' difficulty tolerating absence of control. This appears evidenced in their ruminations over things they cannot change; events that have already occurred and lost identities or predict; the future.

3.2.4 Doubt

GAD evokes several manifestations of doubt. It can result in constant vigilance.

I'm always looking for something that's not right. Like my mind goes into overdrive in an airport because I always think it's going to be bombed. (Emma: 1.10.2)

Emma describes constantly scanning the environment for potential threats, particularly in potentially crowded situations where, linking with earlier themes, her mind seems to jump to catastrophic predictions in the absence of rational proof. Hypervigilance is echoed in Sarah's account of being on "high alert all the time" (7.3.2).

All participants describe feeling more anxious in situations they do not have perceived control over.

If I hit a traffic jam, I'm a **nightmare** [ ] cos I've got no control then over what's going on. I dunno what's gone on for this traffic jam to be there. [ ] **Any** situation that I'm not in control of, makes me anxious. (Emma: 1.10.7)

Here, Emma implies her inability to tolerate uncertainty. The extreme noun she uses to describe herself: "I'm a nightmare", indicates how angry and ashamed this leaves her feeling. Not knowing what caused the traffic jam triggers anxiety, as does not knowing when she will be able to resume driving. Driving facilitates her perceived control of the situation.

Kirsty's account extends our understanding of the lengths participants go to, to feel in control of their environment.

I wouldn't go to London, or I don't know, wherever you live. Like I wouldn't get public transport there because I don't **know** exactly what time the buses come. I can tell you when every single bus will be outside my house throughout the whole day. [ ] If I wasn't sure on which bus I would need to get, how long it would take to get there, erm what time it would come and arrive, and how often they were coming, it's something that I would struggle with. (Kirsty: 5.9.2)

Kirsty feels able to travel locally by bus because she has recited the timetable. She also comments on how it is the "same bus" that "goes round in a circle" (5.9.2), suggesting that the journey's familiarity makes it manageable. The extent of her need for certainty is implied in the number of journey details she needs to know.

Participants' difficulty tolerating uncertainty encourages them to remain in situations they feel in control of and therefore safe. For Rob, this is apparent in his current job:

> I've stayed **here** probably too long … because it's comfortable and I know what I'm doing and the likelihood of erm failure, or likelihood of, of doing something wrong is less likely because I know the job inside and out. (Rob: 3.9.3)

Rob's perception of remaining in the job "too long" indicates his desire to move on. His account suggests that his reluctance to do so is linked to self-doubt and self-pressure. This is indicated in his use of extreme words ("failure"; "wrong") to describe making mistakes. He attributes his job capability to its familiarity ("know the job inside and out") rather than his own self-competence, further suggesting self-doubt. Indeed, in his interview, Rob described how GAD has resulted in a "reduced level of confidence" (3.3.2).

With one exception, all participants describe the self-doubt GAD has triggered.

> Sometimes I **doubt** my ability to do what I'm doing, whatever it is [ ] but I know I can, so I dunno what that's all about. (Sandy: 2.1.2)

This excerpt mirrors Sandy's earlier account of doubting her ability to drive despite her rational mind telling her otherwise. Here, she implies not understanding her self-doubt (" I dunno what that's about"). This appears to result from the apparent conflict between it and her rational mind's perceptions of capability.

While some participants' self-doubt relates to perceptions of capability, others distrust their thoughts.

> I can't trust my thoughts. [ ] The thoughts that I have, that then make that anxious feeling, have to be questioned all the time: are they real? Are they something that I've kind of thought up? (Sarah: 7.2.1)

Sarah describes a continuous process of deciphering whether her thoughts are rational ("real") or imagined by her irrational mind.

Some participants are suspicious of others.

> I've never had a best friend … erm simply for the fact that people just let you down.
> [ ] I've **never** trusted anybody a hundred percent. (Marie: 4.4.1)

Marie's difficulty trusting others seems to stem from being "let down" in the past, for example, by her father whose apparent neglectful behaviour was discussed in section 3.2.2.

This theme has once again demonstrated participants' difficulty tolerating uncertainty and consequent absence of control. They therefore attempt to create certainty through familiarity.

3.3 A struggle for autonomy: You either let it get a hold of you, or you get a hold of it

This super-ordinate theme captures participants' continuous struggle for perceived control over their senses of self. Participants alternate between feeling in control of GAD and GAD taking control of them. GAD's ability to take control of the self is explored in the first theme "GAD takes over self". Within the self, participants' minds and bodies influence one another. These interactions are represented in the second theme "The interplay between mind and body". The third theme "I'm torturing myself" addresses participants' construal of GAD inflicting self-torment which minimises their perceptions of freedom. The final theme "I'm in control" considers participants' attempts to regain and maintain control over GAD, thus enhancing their perceived autonomy.

3.3.1 GAD takes over self

All participants experience GAD as something separate with its own agency, capable of gaining control over them. This sense of being taken over by GAD manifests itself in different ways across participants.

Some participants construe GAD as something that distorts their perceptions of reality.

I have that sense of '**wow**', **full on excitement**. [ ] '**God**, this is, everything's working out **really** well', [ ] and then it, it'll be the other way, that: 'oh it's all **doom** and gloom and I don't know how I'm gonna deal with anything'. It's strange. It's like it really takes over. (Sandy: 2.4.8)

Sandy suggests that her positive feelings are overshadowed by GAD's contrasting monologue, whose perceptions of her lifeworld involve absolute pessimism and self-doubt. In her description of "it" as "strange", Sandy once more implies that this pessimistic voice is separate and alien from her; she cannot make sense of it or its origin.

Chloe also seems to construe GAD as something separate that negatively distorts her perceptions of reality, but her image is of being blinded by it. This extract is taken from her narrative of not wanting to answer the phone at work from fear that she will not be able to help customers:

The anxiety would just blind it and be like: 'nope. This time it's gonna be awful, even though I've done this a million times before [laughter], it's going to be awful this time.' (Chloe: 8.5.1)

Chloe describes how her perceived capabilities are distorted by this separate anxiety ("the anxiety") despite having successfully coped with this scenario numerous times before. Rob also perceives GAD as a separate entity, but his account implies that "it" permanently resides within him.

I've always had this level of worry and anxiety in, in me [ ] it's kind of inbuilt [ ] and when it's just in your professional life, you kind of learn to deal with it, but then when you've got worries outside, [ ] it gets too big, and gets out of control. (Rob: 3.2.1)

Rob's account evokes a sense of trying to keep this "inbuilt" resident at bay. This seems manageable until the worry spreads from work to other aspects of his life. When this happens, it appears he is no longer able to contain this resident as it also spreads and gains power over him. This sense of GAD spreading over and engulfing the self is echoed by Kirsty and Shelley:

If you do cancel something, and then you find out you could have been there on time, it's kind of like the disappointment of letting that consume you again. (Kirsty: 5.10.3)

It's **totally** all-consuming. [ ] It makes it very hard [ ] in **that** moment, [ ] to do anything. (Shelley: 6.11.6)

Their use of the word "consume" can be understood on several levels. It implies a sense of being restricted and smothered by GAD to the point where they cannot "do anything". It also positions GAD as a separate entity that devours them.

Finally, Sarah seems to construe GAD as an opponent. This extract is taken from her narrative of the night before her wedding:

It's the anxiety that's winning, and because I'm so drained, and I'm so tired, and I know that I should be asleep, I can't stop it. (Sarah: 7.7.1)

Sarah described not being able to sleep the night before her wedding because she was worrying about it. Here, she construes anxiety as something separate ("the anxiety") that has won the game or battle because she cannot defeat "it".

There seems to be a fine line between participant's control and GAD's control of the self. Rob's comment captures this: "it doesn't take a lot for it to take control of me" (3.6.14).

3.3.2 The interplay between mind and body

Participants describe experiencing common physical symptoms of anxiety including headaches, nausea, and panic attacks. Marie's description of her frequent migraines is notable because it captures the intense physical pain anxiety can cause:

The pain is **so unbearable** that I cannot physically move with it. [ ] The skin on my face used to go really tight [ ]. My eyeballs felt like they were balls of cotton wool in water. (Marie: 4.5.5)

The image of cotton wool balls in water is striking because it seems to capture the fragility of something so valuable; her eyes, being painfully squeezed and shrunken by the force of the migraine. Indeed, her whole body seems weakened by it, leaving her unable to move.

Shelley describes how anxiety slows her body's self-healing mechanisms:

> I had like another little, small operation and it was day surgery. [ ] You should be back to work like in two days. I think I was off work for like a month. It just took me **so long** to **recover** from **everything**. (Shelley: 6.6.3)

The interaction between mind and body can also work the other way with physiological changes arousing anxiety. Rob, for example, described the "self-fulfilling" prophecy caused by interpreting pain in his left arm as a sign of catastrophic ill health: "you could be having a heart attack" (3.3.6). His resultant anxiety then perpetuates the physiological symptoms, further convincing him that he is seriously ill, and the cycle repeats. This self-fulfilling pattern is echoed by Marie who, in her interview, explained that after five months of ongoing throat infections she was convinced she had cancer.

> I'd caused myself so much anxiety, I was causing the muscles in my neck to clamp. [ ] I was almost choking myself where I was that clamped up with it, yeah, so it's surprising how physically damaging you can be to yourself with anxiety. (Marie: 4.1.4)

Marie's account here, captures how her catastrophic thinking and consequent anxiety paradoxically caused more physiological damage than the perceived cancer prognosis. Marie also indicates however, that she can find herself attributing every physiological change to anxiety:

> If I got the shakes, I'd convince myself it was my anxiety. I'd be like: 'I'm worrying about something, but what am I worrying about?' (Marie: 4.5.7)

Marie concludes that shaking indicates she is worried about something despite being unaware of what that something is. I therefore question the degree with which participants attribute genuine physiological changes to anxiety, particularly changes warranting attention.

Participants also describe physiology's role in anxiety management. Several participants note the importance of eating healthy, regular meals and sufficient sleep. For Sarah, the importance of sleep appears to be linked with her earlier account of otherwise being too tired to control her anxiety.

> If I don't have the right amount of sleep, I **can't** control my mind to stop the anxiety. I don't have the energy and I just feel **so** drained. (Sarah: 7.7.1)

It appears that if Sarah does not sleep sufficiently, GAD "wins" because she is completely deprived of the energy ("feel so drained") required to maintain control of her mind. Many participants, including Sarah, describe how physically and mentally tiring GAD is. Sandy notes how "completely draining" (2.1.1) it is, while Sarah describes being "worn down" (7.9.2) by it. The restorative function of sleep seems to hold even more importance because it is needed to replenish their limited energy resources.

Most participants describe attempts to release anxiety through their bodies.

> I don't know whether you've heard of like an EFT workshop? [ ] You literally tap things out of your body, so like yesterday when I was driving, I was tapping myself, like in my collar bones and then in my temples, you know, and anywhere else that I could, I felt that I would release something. (Emma: 1.4.13)

Emma's account implies a wish to expel her anxiety, and the associated physical tension, from her body ("tap things out"). Her description of tapping any reachable body part implies her desperate need to rid herself of it. Other participants employ physical exercise, writing their worry content and feelings on paper, or talking about their anxiety with others.

This theme has highlighted the vicious cycles participants can become trapped in when their mind-body balance is out of kilter.

3.3.3 I'm torturing myself

It is perhaps unsurprising, given GAD's apparent endless, illogical nature, that participants experience it as something that inflicts psychological and physical torment. For Shelley, as for many participants, GAD involves intense fear.

> It's **so** scary. [ ] I suppose it's like if you have a really bad nightmare and you wake up, and that just **instant** [ ] where you're still in your nightmare, and you've just woken up and you're like [gasp]. It's that **all** the time. (Shelley: 6.12.9)

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By employing the image of suddenly awakening from a nightmare, Shelley seems to imply that her fear feels surreal; where, immediately after waking from a bad dream, perceptions of reality remain distorted and frightening. Emma's account captures the psychological torment GAD inflicts.

> It is, without a shadow of a doubt, the worst thing I've ever experienced in my life. [ ] I would **rather** be in **constant labour** than deal with anxiety every day, so that kind of gives you a **little bit** of an insight as to how bad it is. (Emma: 1.3.10)

Emma implies that this psychological torment is unimaginable. The only way I can begin to imagine its magnitude is by comparing it to a painful experience I may be able to contemplate; childbirth. This seems confirmed in the last line: "that kind of gives you a little bit of an insight as to how bad it is."

Marie construes GAD as a self-torture device. This excerpt derives from our discussion of her physical symptoms.

> It's almost like I'm torturing myself. (Marie: 4.5.1)

Marie implies that she is inflicting these symptoms upon herself. The word "torture" suggests self-punishment involving severe physical, and presumably psychological, pain.

Participants also seem tormented by their moral emotions. All participants spoke about their experiences of GAD with a sense of shame. This was implied in their frequent use of adjectives such as "pathetic" and "silly". In her interview, Kirsty explained how she panics when she has multiple appointments one after another in case she is late to one. Here, she describes contemplating whether to cancel an appointment because she thinks she may be late:

> 'Oh I should phone them and say: … 'I can't come because of this' because you, you don't wanna phone somebody and say: 'I can't come because … I'm anxious', because it kind of makes you feel a bit stupid. (Kirsty: 5.10.3)

The extent of Kirsty's shame is implied in her desire to keep the real reason for cancelling – her anxiety, hidden. Her shame seems to stem from her perception that

she will sound "stupid" for cancelling on these grounds and may therefore be subjected to external ridicule.

All participants describe feeling self-conscious of their physical appearance and actions.

> Little things like pulling my skirt down a lot, like when I'm walking down the street. [ ] I worry about people laughing at me. [ ] In restaurants I still do it. I'll be like: 'oh can we go? cos they're laughing at us or they're laughing at me', and they'll be like: 'no they're not. They're **really** not', and it was like: 'no they're looking **right** at me.' (Chloe: 8.8.2)

The magnitude of Chloe's self-consciousness is indicated in her need to repeatedly adjust her physical appearance. She implies feeling embarrassed at having to fine-tune "little things". The degree of self-consciousness is also captured in her conviction that strangers are ridiculing her despite others' attempts to reassure her otherwise.

In terms of participants' self-consciousness of action, participants appear to take things personally and engage in self-blame. Shelley's account is striking because it captures the stark self-criticism evoked by her perceived wrongdoing:

> People [*friends*] stop asking you to **go** places, but then you think it's something you've done wrong, even though in, the reality is you're the one that's pushing them away, but you twist it in your brain to think: oh, well it's because, you know, I'm a really rubbish person. (Shelley: 6.2.1)

It appears that Shelley's irrational mind has created a false and extreme perception of reality in which her friends have rejected her, not simply because she has done something wrong, but because she is a "rubbish person" to the core.

Self-consciousness also seems to influence participants' self-expectations. With one exception, all participants spoke with a sense of huge self-pressure. In this excerpt, Rob describes insights gained through counselling:

> I think a lot of stuff that came out erm after my son was in hospital, was around failure to **do** something, [ ] and this is where the irrational part of my, my brain takes over is a, **I couldn't do anything** [ ] and it felt **awful**. (Rob: 3.3.3)

Rob's anxiety peaked following his young son's hospital treatment for a non-life-threatening condition. Despite rationally knowing that there was nothing he could have done, with his irrational mind in control ("takes over"), he feels helpless that he "couldn't do anything", presumably to assist his son's recovery or perhaps even cure him. His self-pressure seems to evoke feelings of guilt ("it felt awful"). Indeed, several participants explicitly described feeling guilty in their interviews. Sarah, for example, felt "really guilty" (7.5.1) for extending her work leave following her sertraline withdrawal.

In summary, this theme has explored how tormenting GAD can be. Participants appear to torture themselves through their moral emotions and self-criticism. Guided by their perceived morality, most participants seem to subject themselves to immense amounts of self-pressure. When their codes of conduct are violated, they feel shame and guilt.

3.3.4   I'm in control

All participants describe their difficulty maintaining control of GAD.

> You either let it get a hold of you or you get a hold of it so, that's taken quite a long time for me to **realise** that but now I **am** … so I'm, I'm trying to take **back** the control of my life. (Emma: 1.2.1)

Emma implies a new perceived ability to regain control of her life. She indicates that before, GAD had such a tight grip on her ("get a hold of") it was in full control. She is now "trying" to wriggle free from GAD's grasp, indicating that this is not easy. Her use of the phrase "get a hold of" also implies that she now has more knowledge of GAD and how to control it. There is a sense of an uphill battle to maintain control. This seems echoed in other participants' accounts. Rob explains how "you have to work at it" (3.6.8), while Sandy describes having to "really try hard" (2.9.3) to control her worrying.

Participants employ various GAD management strategies. Several participants describe their increased ability to directly challenge their thinking.

Instead of: 'what if I have a car crash? What if Christmas is awful?' [ ], stopping that and saying: 'but what's the reality?' and sort of breaking it down, and then once you get into that good habit, then obviously that helps quite a lot. (Sarah: 7.1.5)

Sarah perceives that she has "got it (GAD) under control" because she can stop herself (7.9.1). Here, she indicates that this stopping refers to challenging her "what ifs" by questioning their rationality and consequent power. This enables her to stop her thoughts in their tracks ("breaking it down"). She implies that the more she practices this "good habit", the easier it becomes to maintain control over GAD. For Shelley, the stopping process seems to involve acknowledging her catastrophic thoughts without acting on them:

I try and just let the thought cross my mind now and leave my mind, rather than staying in there and worrying about it even more. I **try** and just let it go [ ] let's just move on. (Shelley: 6.9.1)

Instead of being influenced by her catastrophic predictions, it appears that Shelley is trying to recognise them for what they are; thoughts. This enables her to carry on with her day as planned without her thoughts governing her behaviour.

Despite attempts to challenge their thinking directly, participants also spoke with a sense of wanting to avoid anxiety as much as possible. Avoidance strategies include distraction and behaviours that minimise perceived threat. Sandy appears to seek distraction from her self-awareness:

We [*Sandy and her friend*] went and had a coffee and sat [ ] for **hours** talking. **That was good**, and I was thinking: yeah **do this** [ ] **more often**. [ ] We didn't talk about anything that was going on for me, just **random stuff**. (Sandy: 2.5.5)

In her interview, Sandy implied another reason for wanting to keep the focus off her internal world - fear that her friend may respond to it in the same way that others have; with ridicule and rejection. Others' responses to GAD will be explored in detail in super-ordinate theme three.

Participants appear to go to extreme behavioural lengths to protect themselves from perceived threats, thus maintaining perceived control. Shelley for example, turns all electrical appliances off in her house before she goes out from fear that the house

might burn down with her dog inside. Chloe reduces her risk of forgetting something by repeatedly checking that she has everything she needs before going out:

> I worry about forgetting things. Like before I go out, like I check my bag over and over and over again, like in a kind of ritual way. (Chloe: 8.8.2)

Chloe did not elaborate on her fear of forgetting but forgetting signifies ultimate loss of self-control. The word "ritual" suggests an obsessional quality to repeatedly needing to check her bag before she is satisfied that she has not forgotten anything. Chloe's narrative echoes participants' need to prepare for every eventuality.

Participants describe feeling more in control of GAD now, overall. Some participants attribute this to their "inner strength" (Emma: 1.11.1) which has enabled them to "push through" (Shelley: 6.12.7) anxiety-provoking situations as opposed to avoiding them. Others attribute this to their increased ability to challenge their irrational thoughts or their ability to recognise that their thoughts are just thoughts; they do not have to govern emotions or behaviour. Some participants acknowledge others' roles in facilitating or hindering their perceived control over GAD. This leads us to the third super-ordinate theme.

3.4 GAD and interpersonal relations: Worrying about what others think

This super-ordinate theme considers the interactions between participants' experiences of GAD and their relationships with others. "GAD through others' lenses" captures participants' experiences of how others perceive GAD. "Striving to belong" explores participants' apparent need to feel accepted by others and the various approaches they employ to attain this sense of belonging. "Helpfulness of support" addresses participants' experiences of varying degrees of, and total absence of support from others, in both personal and professional capacities. Lastly, "Concern for others' welfare" explores participants' strong desire to protect their loved ones and those who may be living similar experiences from harm.

3.4.1 GAD through others' lenses

With one exception, all participants suggest that GAD needs to be seen by others to be believed. In her interview, Sandy described how her partner is very critical of her for not doing enough to resolve her anxiety.

> Cos he [*partner*] doesn't see an, an actual **illness** of some kind, he can't see it [*GAD*].
> He can't-
>
> I: And he can't understand?
>
> Understand.   (Sandy: 2.5.3 – 2.5.4)

Here, Sandy suggests that her partner does not understand GAD because unlike an "actual illness" that either has visible symptoms or can be visualised, GAD is not tangible and therefore cannot be envisaged by her partner. Emma's account seems to echo this perception that seeing is believing, but she suggests that those who do not believe GAD actively choose not to envision it:

> A lot of people don't believe **it because** … you can't see it. [ ] When it's in ya head, it's
> literally in **your** head, so nobody else can see it, unless they **want** to see it. [ ] A lot of
> people don't want to see it because they don't believe it. (Emma: 1.3.1)

Emma also implies that GAD is not automatically visible to others but can be seen if people look hard enough. She suggests that those who do not want to believe that GAD exists avoid seeing it to maintain denial. This sense of denying GAD's existence is echoed in Chloe's account of her mother's initial response to it:

> My mum had always been like: 'oh, you're just a worrier. [ ] You're just flapping like
> your dad', and it was just disregarded as **petty**. [ ] I guess that had been drummed
> into me as like: 'oh, you're just being silly. Just making it up.' (Chloe: 8.2.10)

While some participants perceive that those who have had similar experiences or have been close to someone who has, tend to understand GAD more, Chloe suggests that this was not the case concerning her mother. She implies that her mother initially did not take GAD seriously, instead reducing it to a common trait her father shares. Chloe consequently started to believe the messages that were

"drummed into" her of imagining GAD. Chloe went on to describe the moment her mother realised that GAD "is really a real thing" (8.3.17). Chloe threatened to cut herself with a knife because her mother was once again pressuring her to get a job, something that causes Chloe great anxiety. Since then, her mother has learnt more about GAD. Chloe also describes society's increasing awareness of mental health generally. This appears to have helped both Chloe and her mother to normalise, and therefore accept, GAD.

> More recently, the last few months or so, I've seen things in the news on the telly.
> [ ] Mental health's just been taken more seriously now than when I was at school.
> (Chloe: 8.2.10)

Several participants suggest that it is not just a case of others believing that GAD exists that facilitates their understanding of it. Actively doing something about GAD seems to promote external validation.

> My wife [ ] has been a-, amazing through it. [ ] She kind of recognises what it is but also the fact that I've done something about it. [ ] We both know people that erm have got into a far worse state because they haven't done things about it. (Rob: 3.6.1)

Rob implies that his wife may not have been as understanding if he had not been proactive about GAD. This is suggested in his comparison to those who have gotten into a "far worse state"; a state that is the perceived direct result of not acting on GAD. He implies that his wife would struggle to cope with GAD in its unrestrained form. Indeed, most participants describe the negative impact GAD has had on those closest to them. Shelley's account is notable for the way GAD can indirectly restrict others:

> When I was ill, really quite ill, he just stopped like going places as well [ ] I would always [ ] have just this **massive** panic attack and I'd be crying and [ ] he was like: 'I can't deal with that.' He said: 'I'd rather just not even **go'**, [ ] it was easier for **him**. (Shelley: 6.4.6)

Here, Shelley construes GAD as a disease with varying degrees of illness. She implies that when she was "really ill" with GAD, her partner could not cope with her extreme anxiety at the thought of leaving the safety of home. He would rather avoid the possibility. Shelley informed me that she used to cancel social plans at the last

minute, even if their friends had put a lot of effort into hosting. The fact that her partner would not go out without her suggests feelings of guilt and embarrassment. Finally, although participants imply that seeing is believing, there is a sense that GAD can never be fully understood by others.

> For people to just **try** and understand it more would be amazing, you know? (Emma: 1.11.1)

Emma implies that the act of trying to understand GAD would satisfy her. This extract emphasises her experience of others who quickly dismiss GAD as "a load of bull" (1.4.1). It also draws parallels with Emma's internal experience of GAD as something which perhaps neither she - nor others - will ever fully understand. Her question ("you know?") suggests that she is seeking reassurance that I am also trying to understand.

3.4.2 Striving to belong

All participants appear to worry about being accepted by others. This is perhaps unsurprising given their prior experiences of others' rejection. The importance placed on others' perceptions of them is summarised by Chloe:

> My colleagues not liking me. I worry about what other people think, **a lot**.
>
> I: Ok, a-, about you?
>
> Yeah.
>
> I: And not being accepted? Cos you mentioned before about fitting in.
>
> Yeah [ ] but [ ] in the job I'm in now, it's like a [ ] happy family sort of thing. It feels very different to any other workplace I've been in.   (Chloe: 8.1.10 – 8.1.12)

The extent of Chloe's concern for others' perceptions of her aids our understanding of her seemingly relentless self-consciousness, discussed in section 3.3.3. This account suggests that she always expects rejection and mistreatment from others, presumably due to previous experiences of this. Indeed, in her interview, Chloe discussed former managers who behaved inappropriately towards her. These past

experiences are starkly contrasted with her construal of her current workplace as a "happy family", suggesting a new, and perhaps exaggerated, sense of intimate belonging.

Fear of not fitting in also seems to stem from participants' perceptions of themselves as different or abnormal. This is bluntly captured in Sarah's narratives of her wedding day:

> Going into make-up feeling very aware that everyone else is very normal and I'm not normal. (Sarah: 7.7.1)

Sarah described feeling "really anxious" (7.7.1) when she woke up on her wedding day. Here, her perceived abnormality stems from comparing herself to those around her. She assumes that she is feeling and behaving differently to the wedding party. These comparisons continued throughout the day:

> 'I'm not enjoying it. [in-breath] **Everyone** else is enjoying it', which probably isn't true [ ] but [ ] you make yourself feel like you're the only one which just makes it so much worse. (Sarah: 7.7.1)

Sarah indicates that this self-other comparison leaves her feeling isolated ("the only one") which further strengthens her perceived abnormality.

Participants consequently appear to go to great lengths to feel like they belong. Kirsty describes frequently "trying to show normal behaviour" (5.5.6). Here, she refers to hosting a dinner party for friends:

> I perhaps ate more than I normally would. [ ] You're perhaps not hungry erm because you're still quite stressed out about the situation, but because everybody **expects** you to be eating, because that's a normal situation, so I think sometimes you overcompensate for that. (Kirsty: 5.5.4)

Kirsty describes not feeling hungry due to the anxiety induced by hosting. She was particularly worried that her friends would not like the food; implying that rejection of food symbolises a rejection of her whole self. Her perceived social norms, which she assumes her friends share, cause her to eat more than usual despite not feeling hungry. Eating also prevents others asking why she is not, thus minimising the possibility of having to explain what is going on internally. Conscious efforts to

conceal GAD presumably derive from a desire to feel accepted by others. Indeed, many participants describe attempts to hide GAD. This makes sense considering others' dismissive responses to GAD and participants' consequent feelings of shame. Like Kirsty, other participants conceal GAD by controlling their external persona. Sandy describes being "really good at managing how I come across" (2.1.7), while Rob's account evokes a sense of intentional isolation via an impermeable, exterior barrier:

> They [*colleagues*] would say that I'm very confident, [ ] what it [*GAD*] does is it puts a façade up, [ ] people will think that I'm ok but I, actually inside I'm, I'm not. [ ] There's like a brick wall that I put up around me that, that just tries to protect myself. (Rob: 3.3.2)

Rob seems to have closed himself off with this "brick wall", rendering his fragile, self-doubting inner self inaccessible to the outside world. His intentional isolation functions as a self-protection mechanism. This is echoed in others' accounts.

> Wanting to be on my own is because if I, if I'm in my own space, then I haven't got to speak to anyone and I haven't got to **talk** about anything. (Sandy: 2.2.3)

Sandy isolates because she perceives that others do not understand her internal experiences. She predicts, for example, that if she told her mother how she was feeling she would starkly reject Sandy: "oh don't be stupid. There's nothing wrong with you" (2.2.1). Sandy's isolation creates internal conflict because she also craves a sense of belonging: "I wanna be on my own, but then I feel lonely" (2.2.3).

For Marie, isolation functions to conserve energy.

> Sometimes I'd just rather be on my own [ ] putting that effort can be more exhausting cos it's more things [laughter] to worry about, especially if [ ] I have someone round, it's er trying to make sure my house is tidy, doesn't smell. [ ] Then it's the conversation content. Making sure that [ ] there's no awkward silent patches. (Marie: 4.4.17)

Social contact introduces more worry topics that appear to relate to others' acceptance of her. Her desire to be perceived in a positive light seems confirmed in her description of wanting people "to have a nice opinion of me" (4.4.14). Some of these worries seem to stem from past experiences. She mentioned that her childhood home was in an "awful state" (4.4.12) and her school peers used to

comment on the fact that her uniform smelt. Marie therefore strives to protect herself from further rejection by ensuring that she does not give anyone reason to perceive her negatively.

This theme then, has highlighted the extreme lengths participants go to to feel like they belong. Paradoxically, this can involve intentionally isolating themselves. It is noteworthy that in most of these accounts, participants switch from using the first-person position ("I") to second person ("you") when referring to themselves. This implies their desire to somehow belong to another, whilst emphasising their perceived differences, and therefore distance, from others.

3.4.3   Helpfulness of support

Participants describe mixed experiences concerning support from those closest to them. For Kirsty, her longer-term friends (ten-plus years) are generally more supportive than those she met more recently. Kirsty attributes this to the fact that her long-term friends knew her before she began experiencing GAD and therefore understand that when she cancels plans at the last minute, it is not because she is "unreliable" (5.4.1). These friends consequently seem more accommodating of Kirsty's needs, particularly when she feels too anxious to leave home:

> They come round like to see me and to spend time with my son and erm maybe take my son out. (Kirsty: 5.4.1)

Emma suggests that others can still be supportive of GAD, regardless of whether they understand it:

> I'm very lucky with my mum and dad erm because they are very supportive even if they don't understand it, [ ] they're still there and I know [ ] they're not going anywhere. (Emma: 1.4.31)

Emma's account suggests that others do not have to do anything in particular to be helpful. Her parents' apparent unwavering presence and investment in Emma's wellbeing, despite not understanding her internal experiences, is sufficient for her to feel supported. It appears that Sandy has not shared this experience. Her partner's

inability to understand GAD seems to have resulted in a total absence of emotional support.

> He's not been there [ ]. When I've stood in front of him, absolutely breaking my heart, hands in my head, and just dunno what I'm doing, he's just walked away, and all I've wanted was him just to hold me. (Sandy: 2.5.1)

Like Emma, Sandy, through her desire to be held, implies that all she needs from her partner is emotional comfort and stability, particularly during moments of intense emotional pain ("breaking my heart") and helplessness ("dunno what I'm doing").

Set against these positive perceptions of emotional support, Chloe suggests that too much soothing, to the point of over-protection, is equally as unhelpful as dismissal.

> One thing he [*her father*] said was like the **worst** advice he could have given me, where he was like: 'if you get **too** nervous, just come home', and I **did**, and I quit that job. [ ] I could have just er pushed on [laughter] maybe, if he hadn't said that, so both my parents very different ways of treating it [*GAD*], and neither seemed [laughter] quite right; of being totally soft or totally harsh. (Chloe: 8.3.2)

Chloe stated that her mother used the "tough love approach" (8.3.2) before she took GAD seriously, whereas her father continues to be "totally soft". Here, she conveys the unhelpfulness of both approaches. She implies that her father's apparent mollycoddling reinforces her self-doubt that she cannot cope with workplace anxiety. Instead of challenging her beliefs by staying in the situation, her father encourages her to flee. He also reassures her that he will always protect her from perceived threats: "you can always come home to us" (8.3.2).

Participants also convey mixed reviews concerning their experiences of professional support. With regards to interactions with physicians, Sarah's account seems to summarise others' narratives of not feeling heard:

> They're [*doctors*] just there to diagnose you. They're not, they don't have an interest in you personally. They just sort of saw it as: 'no, you've got anxiety back' [ ] they were offering to put me on different things and higher doses. I just thought: [ ] all you want to do is put a pill down my neck. (Sarah: 7.1.4)

In her interview, Sarah spoke in detail about her experiences of being put on diazepam followed by various brands and doses of sertraline, as well as her decision to come off medication altogether because she felt that it was increasing her anxiety. Here, she describes how the physicians rejected her claim that the medication withdrawal was responsible for her increased anxiety. She perceives that physicians "don't have an interest in you personally", implying that the complex human existence is reduced to a physiological machine that can be "diagnosed" and fixed. She seems to convey how physicians silence her feelings by putting "a pill down my neck".

For others, their physician's support has been invaluable. Shelley is notable for the way she construes one physician as the initial change catalyst.

> I thank my lucky stars that I saw this doctor on this day because all the other doctors that I'd seen, with all these various, different illnesses, they just … I don't know, do what? Like prescribe like some painkiller or, you know, send you off for a blood test or something [in-breath] but [ ] she said: 'I will test your blood for thyroid levels but [ ] is there any possibility that this is more mental than physical?', and [ ] I was like: 'actually yeah, I think it is.' (Shelley: 6.6.1)

> She referred me to, first of all, to the GP's like counsellor, then onto a psychologist, and then onto the CBT guy. [ ] Thank God for her because I **dread** to think. [ ] I couldn't have carried on as I was. (Shelley: 6.6.5)

Echoing Sarah's perceptions, in the first extract Shelley describes how previous physicians attributed her recurring illnesses to a physiological cause or offered to prescribe medicine. When Shelley proposed her thyroid was to blame, this physician tentatively suggested that it could be anxiety. She listened to Shelley's opinion, presumably making it easier for Shelley to consider anxiety's role, thus facilitating a shift from denial to acceptance. The second extract conveys the physician's investment in Shelley's wellbeing; she directed her to further professional support systems. Shelley seems to struggle to envision her continued existence if she had not seen this physician ("I dread to think"; "I couldn't have carried on as I was"), implying that she was Shelley's saviour ("thank God for her"). Shelley confirms this in a later comment: "I honestly think I'd probably be dead" (6.12.7).

Many participants attribute their positive experiences of psychological therapy to the fact that it helped them challenge their irrational thinking. Echoing Shelley's perception of her physician's invaluable support, Marie describes the life-changing impact of CBT:

> The biggest one I was taught in CBT is to say 'stop'. **[ ]** The best question they used to ask me was: 'what's the worst that can happen? [ ] Face your fear of what's the worst that can happen.' (Marie: 4.1.12)

> The CBT changed my life. **[ ]** Now, [in-breath] I'm a lot more upbeat, a lot more erm flowy with how I **move**, whereas before they [*colleagues*] said you could physically **see** the weight of it on me. (Marie: 4.6.3)

As discussed in section 3.3.4, it appears that the thought challenging Marie was "taught" in CBT has enabled her to regain a level of control over GAD. Her embodied self can move more freely as GAD's constraints weaken. This image of the physical weight of GAD being lifted off her starkly contrasts with her earlier description of sometimes being unable to move due to the severity of her migraines, indicating her need to downplay her distress.

Emma contrastingly appears to feel let down by her counselling experience. She attributes her ability to regain some control over GAD to her self-resilience in the absence of sufficient psychological support.

> **I've** had to build myself up because it took **months** for the counselling referral to come through, erm … and then the counselling stops and then what? They couldn't find the, the root of the problem. [ ] Well how the fuck am I supposed to know? You know, how am I supposed to … [in-breath] **do** anything? [ ] It's just not good enough. (Emma: 1.4.19)

Here, Emma evokes a sense of being left alone to fend for herself, both whilst waiting for counselling and after it ended. She explicitly confirms this perception in an earlier comment:

> It needs to be dealt with [ ] in a lot … more in-depth way, rather than, you know, six counselling sessions and: 'oh yeah, you'll be fixed. Oh deal with it yourself.' (Emma: 1.3.3)

It appears that Emma hoped that if her counsellor could identify the "root cause" of GAD, she could help her fix the "problem". The absence of this preconception seems to leave Emma feeling even more confused and helpless because nobody, not even a trained professional, can offer a logical explanation for her experiences or a solution. Emma seems to mask her vulnerability with anger ("how the fuck am I supposed to know?").

3.4.4 Concern for others' welfare

Participants with children (five participants) express extreme concern, to the point of over-protection, for their children's wellbeing. Kirsty describes excessively worrying about her son's safety:

> I: What is it exactly that you worry about?
>
> [ ] A lot of it kind of centres around my child and the things that could happen to him [ ]. My sister has to take my son to the farm because I … stop him from doing things there because I'm scared that the animals might bite him, even though it's a petting zoo [laughter], and they're like guinea pigs [laughter], and I shouldn't be worried about that because if he gets bitten, he'll cry and then he'll be fine, but I worry that he might get bitten and seriously hurt. (Kirsty: 5.8.1)

Kirsty's catastrophic predictions of threat, even in the apparent absence of danger ("petting zoo"), result in overprotection. Despite acknowledging the irrationality of her worries, they are maintained through her avoidance of the situation. The fact that Kirsty allows her sister to take her son to the farm implies that she does not want him to share her perception of the world as fundamentally dangerous.

Shelley, who also has a young (two-year-old) son, explicitly describes how her motivation to challenge her irrational thinking and consequent behaviour derived from not wanting her son to grow up feeling irrationally fearful of everything:

> You pick up a lot from peoples' behaviour, and obviously at his age, he t-, he takes everything on board, so I didn't want him to think the world was a scary place. [ ] They're not **reasonable** worries so I was **really** determined to **try** and get better for **him**. (Shelley: 6.12.7)

Shelley notes how her son has "given me that motivation to push myself" (6.12.7) to face anxiety-provoking situations and therefore challenge her irrational worries. While Kirsty and Shelley's concerns are rooted in their children's safety, Marie worries that her children will be rejected by others. The following narrative draws parallels with her own fear of rejection:

> I don't want my kids' uniforms to smell, [ ] I'm always going on at my daughter at like antiperspirants and, and stuff like that. You know, I try not to push my anxieties **on** 'em but I'm tryna also protect 'em [ ] cos I know children can be cruel. (Marie: 4.4.13)

Like Shelley, Marie does not want to "push" her worries onto her children. However, she appears torn between this and trying to protect her children from the same "cruel" rejection she experienced as a child. Like Kirsty, Marie seems to over-protect her children via attempts to eliminate any source of threat; this time in the form of ridicule. Despite this, she also tries to shelter her children from excessive anxiety using her own management strategies:

> If my daughter shows any signs of it [*GAD*], [ ] I try and use my techniques to help **her**. (Marie: 4.1.11)

> She [*daughter*] had a problem with school [ ] and I actually said it to her: 'so what's the worst that can happen?', and she'd tell me. [ ] I said: 'and what's the problem with that?', you know, and we'd talk it out, you know, cos I think fear sometimes makes anxiety worse. (Marie: 4.1.12)

Marie employs thought challenging when her daughter catastrophises perceived problems. She suggests that talking about anxiety with another person can reduce its power. However, when it comes to her own anxiety, she does not always talk about it with others despite wanting to, noting "I just don't wanna be a burden to people" (4.8.6). This self-perception of feeling like a burden is echoed by Sandy.

> I wouldn't wanna talk to friends that have had a tough time cos I don't want them to feel they're taking a **burden** of my issues on. (Sandy: 2.3.4)

Sandy expresses her endeavour to protect those friends who have experienced their own difficulties by not imposing her own sense of struggle on them. She implies that sharing her own challenging experiences might reactivate her friends' difficulties somehow. In contrast, Rob hopes that sharing his own experiences with

those who have experienced or are experiencing similar challenges helps them as much as it helps him.

> If me saying that this is happening to me, helps at least one other person, then it's, it's, it's ok because I think [ ] a lot of people suffer in silence, and actually, talking about it [*GAD*] makes me feel better. (Rob: 3.6.6)

Rob indicates a wish to normalise GAD, and perhaps wider mental health difficulties, so that individuals do not "suffer in silence" because they feel alone in their senses of struggle. Rob seems to be slowly destroying the "brick wall" he created to conceal his true, vulnerable sense of self.

Indeed, as already mentioned, participants discussed their altered perspectives of GAD and the consequent changes they have made regarding their responses to it. This leads us to the final super-ordinate theme.

3.5 The need to create meaning amid uncertainty and loss: GAD is an eye-opener

This super-ordinate theme draws upon the previous three. In order to tolerate the uncertainty, torment, and losses (of participants' senses of self, perceived control and external support) GAD has caused, and continues to cause participants, it appears that they need to locate meaning within their distress. Meaning is created through attempts to convince themselves that they have come to terms with GAD, and this is explored in the first theme "Learning to ride with GAD (I suppose)". Meaning is also derived via convictions that GAD has taught them something valuable, and this is addressed in the final theme "Now I appreciate things more".

3.5.1 Learning to ride with GAD (I suppose)

This theme explores participants' narratives of trying to accept GAD. Here, acceptance refers to making (a degree of) peace with GAD as opposed to wanting to eradicate it.

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Some participants explicitly describe their difficulty accepting GAD, while others evoke a sense of trying to convince me – and themselves? - that they have come to terms with it despite counterpart accounts suggesting otherwise.

Kirsty explicitly describes her difficulty accepting GAD, especially when she feels particularly anxious:

> If I'm having a particularly bad day, it kinda makes you feel a little bit hopeless because … [ ] nobody can't, just lives with everyday anxiety [*GAD*] and just says: 'oh that's ok, like no problem.' (Kirsty: 5.7.1)

Emma's apparent difficulty accepting GAD is implicit.

> It's [*GAD*] one of those **things**. You gotta learn to … **ride** with it I s'pose. (Emma: 1.4.34)

The phrase "it's one of those things" suggests that Emma is trying to downplay GAD's challenges despite her earlier description of it as the worst "thing" she has ever experienced. It also implies that GAD is unpreventable and thus something she is reluctantly ("I s'pose") forced to accept ("ride with it"). Her reluctance seems evident in her hope of eventual cure:

> My doctor said: 'one day you might just snap out of it as quickly as you snapped into it', so [ ] that's the hope I will live for, that one day it will just disappear. However, I'm not naïve enough to think: yeah that's gonna happen like the next day, which is what you hope, [ ] and when it doesn't happen, then you get disappointed. [ ] I know it will happen **one** day but I know that that day isn't around the corner. (Emma: 1.11.6)

Here, Emma suggests a need to remain hopeful that "one day" GAD will "just disappear" despite questioning the possibility. Hope seems to enable Emma to continue living a meaningful life ("the hope I will live for"). Emma implies that without hope, she would struggle to cope with the distress GAD causes her. Emma's description of having to "ride with it" suggests that the process of coming to terms with GAD is a journey. This sense of embarking on a journey towards acceptance is echoed in others' accounts. Like Emma, Marie wishes that GAD would suddenly disappear:

I'd love to be able to just sit here and not have all these thoughts in my head all the time. (Marie: 4.1.2)

However, Marie also seems to acknowledge the unlikelihood of this wish coming true. Echoing Shelley's earlier account of allowing thoughts to come into her mind without trying to alter them, here Marie describes forming a similar accepting relationship with her anxious thoughts that allows her to regain power over them:

I have to just ride it out and get through the other side before I can say: 'you know what? Stop.' You know, I have to take the journey before I can say: 'stop.'

I: Uhuh, and in terms of riding it out, do you mean letting those worries-?

I have to let the thoughts go through.   (Marie: 4.7.1 – 4.7.2)

Furthermore, Marie explains how the knowledge gained from CBT aided her ability to accept GAD as well as learning that she is not alone in her experiences of it.

It was just learning that there are other people out there, [ ] I think learning the **medical** side of it [ ] really helped as well cos they explained about the serotonin levels, so that **really** helped [ ] cos I didn't feel like I was so abnormal, you know that there is a medical reason for it and-

I: Ok, so that helped you personally?

Yeah, [ ] it helped me to accept it, you know, and I felt **really empowered** by having the knowledge as well.   (Marie: 4.9.3 – 4.9.4)

Knowledge of something so illogical facilitates Marie's perceived control over it. Attributing a physiological understanding to her GAD symptomology allows her to feel less "abnormal" because she now has another tangible explanation for it that is located outside of her mind. This seems to eradicate her perceived responsibility for GAD. Moreover, it allows her to perceive that these "medical reasons" can occur in anyone, thereby normalising her experience.

Sarah also conveys the long process involved in reaching (a degree of) acceptance.

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There's been a lot of, you know, talking about things and seeing different counsellors and trying to understand it. Getting over the frustration and the annoyance that this has happened to you in the first place. That took a **long** time. (Sarah: 7.7.5)

In her interview, Sarah discussed her initial anger and rejection towards GAD and her negative experiences of medication and medication withdrawal: "this isn't how life should be" (7.5.1). Here, she implies a need to mourn her lost sense of self and life direction before she could begin the acceptance process. This sense of loss is implied in her use of the second-person position to describe her own experience ("happened to you"). Like Marie, Sarah's increased understanding of GAD seems to have facilitated her perceived control over it and therefore her acceptance of it.

If we're gonna have a baby, we're gonna have a baby. If it heightens my anxiety, then we'll deal with it [ ] but spending time obsessing over it and thinking about it, and 'what if-ing', and catastrophising … doesn't do anything for me. (Sarah: 7.2.4)

Sarah worried about becoming pregnant because the hormone changes may increase her anxiety. Here, she suggests that learning about her thought patterns, presumably during her referenced counselling experiences, has enabled her to fear anxiety less. Instead of being governed by her thought patterns, Sarah appears to be regaining control of her decisions, for example, to have a baby. Sarah seems to confirm her increased ability to tolerate anxiety because she no longer perceives it as a threat to her personal safety in a later comment:

Now, it **is** just, I feel **anxious** and I know that that's not gonna hurt me. (Sarah: 7.9.1)

Finally, society's increasing awareness of mental health has helped Chloe to not only accept that GAD exists but has also aided her perceptions of it as "normal".

Seeing it in the news and things, and so like my parents seeing that, and yeah, that's really helped me. [laughter]

I: To feel like-

It's normal. It's a real thing.   (Chloe: 8.10.29 – 8.10.30)

Chloe noted how she "tried to keep it (GAD) hidden for a very long time", partly because she "didn't think it was a real thing" (8.3.5). Her new perception of GAD as "normal" and "real" seems to have enabled her to be more open and accepting of it.

> This is the first job where [in-breath] everyone knows about it, and my boss has seen me **really** bad. Like she's seen me crying and upset and stuff [ ] yet she still wanted me to work for her, and that was **really** shocking to me. [ ] I didn't have to worry all the time about … hiding it. (Chloe: 8.3.29)

It appears that being open about her experience of GAD has challenged Chloe's assumption that others will reject her if she exposes her true self. Acceptance from others seems to have increased her self-acceptance; she no longer feels the need to hide her vulnerability in shame. This leads us to the final theme.

3.5.2 Now I appreciate things more

This theme considers participants' narratives of how their experiences of GAD have taught them something valuable; about themselves, others, or life's meaning.

Several participants convey a sense of increased self-acceptance, including a greater emphasis on self-care. Kirsty describes how she has recently started reading in the evenings, noting "it's important to take some time out for yourself" (5.6.4), while Sandy notes that her café breaks "completely give myself that time" (2.4.13). Emma's apparent transition from perceived failure to self-acceptance seems to have facilitated her self-care:

> Some days, I don't wanna come out the house, and I **love** those days now. I used to feel like a failure for 'em but I love those days because **now**, I see them as me **knowing** that I need to have that time to myself. (Emma: 1.11.12)

Chloe also explicitly, and starkly, describes shifting from self-reprimand to self-appreciation:

> I feel more like my own person now. [ ] I definitely like myself now. Before, I, I like **despised** who I was kind of thing but I've made some big changes. (Chloe: 8.2.2)

In her interview, Chloe explained becoming more independent ("more like my own person") since breaking up with her boyfriend. She goes on to describe other changes that have increased her self-acceptance.

> I'm really into like alternative fashion, like Japanese street fashion, so about a year ago, if you met me, I would've been in like all pink and pastels, tutus, [ ] colourful clips [ ], and I thought: maybe if I try to dress a bit older, I might mentally feel a bit older. [ ] Erm and like not just not having as much toys in my room. [ ] I really like toys. I collect them, but now I've kind of just hidden them in the loft and just kept out a select few, so it feels a bit more grown-up, and that's kind of helping, I think. (Chloe: 8.2.3)

Chloe's previous descriptions of feeling more like her own person and being increasingly open about her vulnerability are extremely contrasted with this narrative of supressing her true self and interests. It appears that Chloe is trying to both convince herself that she does feel "more grown-up" and that self-suppression is beneficial ("kind of helping, I think"). Her attempts to look and feel older and more mainstream appear to stem from her desire to belong. Chloe seems to confirm this in her comment: "I worry that my interests are quite childish" (8.2.7). Furthermore, she perceives that her mainstream self-image has reduced the likelihood of gaining negative attention from others:

> It has been nice going out [ ] thinking: oh, I can just walk down the street and no-one's staring at me. (Chloe: 8.3.26)

Chloe's earlier use of the phrase "like myself" as opposed to "love myself", further suggests that Chloe tried to convince me – and herself – that she accepts herself, despite her drastic attempts to suppress her true self.

Several participants perceive that GAD has altered their perspectives of others. For Emma, GAD has enabled her to distinguish between genuine and fake individuals.

> I've seen through a lot of people since being this way, [ ] I can **see** people who suffer. [ ] Then you can just see the bullshitters [ ] yeah, it's an eye-opener. (Emma: 1.11.11)

Emma indicates that her own experiences of "suffering" have enabled her to detect genuine suffering in others, suggesting her increased ability to empathise. Rob's account echoes this sense of increased empathy.

> I think sometimes it's easy to, for people to jump to conclusions about what, what's going on with individuals in the work scenario, but you never know what's going on inside someone's head. [ ] That person [ ] may be facing some real erm difficult times in their life and **still** trying to come to work, as I was. (Rob: 3.12.3)

Rob implies a shift in attitude from making assumptions about individuals to the importance of trying to find out what may be "going on inside someone's head".

Finally, participants' accounts suggest that GAD has confronted them with the existential nature of human existence, thus facilitating their appreciation for life.

> I'm very **grateful** that I'm still here and I'm still fighting it. Before, I would just took things for granted whereas now I appreciate things more. (Emma: 1.7.3)

In her interview, Emma explained how, before GAD, she did not have to try hard in life because "everything used to fall into place" for her. Now, in contrast, she has to "work really hard just to get out of bed" (1.11.8). Here, she implies that her newfound need to "fight" to survive has led her to value her existence. However, her description of "fighting" GAD seems to further confirm that she has not accepted it. Other participants share this sense of appreciating their current existence despite GAD's challenges. Marie notes that despite "suffering" with anxiety, she still has "a reason to smile every day" (4.6.1), while Sarah describes feeling "really grateful for where I am at the moment" (7.3.2).

For Shelley, perspectives gained through CBT have facilitated her engagement with her life-world. In her interview, she discussed learning that she was not avoiding leaving her home because she does not like people or did not want to go out. She was avoiding having a panic attack. This realisation, together with her determination not to negatively influence her son's perceptions of the world, has encouraged her to go out and socialise which, in turn, has given her the confidence to try other things. It appears that her increased self-confidence has facilitated her self-acceptance:

> It's building up the like evidence in my brain that erm … nothing bad will happen, and that gives you a little bit more **confidence** [ ] to [laughter] do more things. [ ] I feel like just a better person I like. (Shelley: 6.4.8)

Like Chloe, Shelley's use of the word "like" as opposed to "love" suggests a tentative degree of self-acceptance.

3.6 Summary of findings

Participants appear to experience great difficulty tolerating uncertainty and absence of perceived control. Difficulty tolerating uncertainty is not only confined to specific situations. GAD itself evokes uncertainty as it is experienced as unpredictable and illogical. Uncertainty is also located within participants' senses of self (i.e., self-doubt), and is directed towards others (i.e., uncertain of others' intentions). Participants employ various cognitive and behavioural strategies to cope with uncertainty and absence of perceived control. The main cognitive strategy is excessive worrying. Behavioural strategies include pre-planning, checking rituals, and avoidance.

Participants appear to engage in a continuous struggle for control over their senses of self as GAD takes over. There is also a continuous struggle taking place internally as mind and body influence one another. All participants described feeling more in control of GAD, generally, at present. This was attributed to altered responses to GAD. For some, this involves challenging their distorted cognitions directly. Others described acknowledging their distorted thoughts and worries without allowing them to govern their decision-making and consequent behaviours.

Participants appear to hold a strong need to be accepted by others and fear rejection. This results in attempts to either fit in with others or intentionally isolate. Isolation not only protects them from the possibility of others' rejection, it also protects others from GAD's "burden". Participants described how others do not understand GAD. Some participants' loved ones still provide helpful support despite this, while other participants described a total absence of support or unhelpful support in the form of over-protection. Participants also described mixed experiences with regards to professional help from physicians, counsellors, and psychologists. GAD also appears to have had a direct negative impact on participants' loved ones and they appear to excessively worry about their loved ones' personal safety and wellbeing. Worry extends to hypothetical others who may be going through similar experiences.

To cope with the distress and loss GAD has caused, and continues to cause participants, they locate meaning within their experiences. Meaning is construed via attempts to make sense of GAD and come to terms with it, and through identifying its positive implications for themselves, others, and their lives.

4. Discussion

4.1 Overview

I begin this chapter by elaborating on the findings, locating them within the existing literature. This elaboration is organised by the four super-ordinate themes. Despite this, consideration of how the super-ordinate and sub-ordinate themes relate to one another is maintained throughout. Strengths and limitations of the study are then discussed before considering the findings' implications for counselling psychology and the wider context, and opportunities for future research. I conclude this write-up by returning to personal reflexivity, this time reflecting on the impact this research has had on me as a scientist-practitioner and personally.

4.2 Battling with uncertainty

Participants appear to experience difficulty tolerating uncertainty and consequent absence of perceived control over their life-worlds. As discussed in the Introduction chapter, the cognitive model of GAD asserts that IU is key in GAD's development and maintenance (Dugas & Robichaud, 2007; Wilkinson et al., 2011). Dugas and Robichaud (2007) define IU as a "dispositional characteristic that results from a set of negative beliefs about uncertainty and its implications" (p. 24). Similarly, Wilkinson et al. (2011) define it as "negative emotional, cognitive, and behavioural reactions to uncertain situations and events" (p. 13). For the current participants however, difficulty tolerating uncertainty seems to extend beyond specific uncertain situations and events; GAD itself is experienced as uncertain and therefore threatening, and it is located within participants' senses of self (i.e., self-doubt). Uncertainty, in any form, is experienced as intolerable. This discordant finding appears to suggest that participants not only experience IU but also intolerance of ambiguity: the tendency to interpret an ambiguous situation as a threat or source of discomfort (Grenier, Barrette, & Ladouceur, 2005). Although both traits are characterised by discomfort in the absence of certainty and clarity, Grenier et al. (2005) argue that IU refers explicitly to uncertain future events, whereas intolerance of ambiguity refers to ambiguity in the present. Emma's intolerance of both is

apparent in her account of being stuck in a traffic jam. Not knowing what caused it or when it will end triggers anxiety.

The subtheme "An endless cycle" captured how all participants appear to engage in excessive worry in an attempt to reduce future-orientated uncertainty. This supports Wilkinson et al.'s (2011) assertion that one of the cognitive strategies employed by individuals with GAD to reduce future-orientated uncertainty, is to identify as many possible negative outcomes as they can. In other words, they worry about a hypothetical and catastrophic future. This worry usually manifests as "what if?" cognitions. Paradoxically, asking this question increases the number of potential scenarios and outcomes, thus increasing the amount of uncertainty. Wilkinson et al. describe how a distressing cycle consequently develops as worry and uncertainty maintain one another. This cyclic pattern is evident in Rob's description of engaging in "an endless cycle of what ifs?" and Kirsty's description of a "vicious cycle" that unfolds regarding an upcoming meeting with friends. This supports empirical evidence. Buhr and Dugas (2006) found that IU uniquely contributed to worry, after controlling for other factors related to worry such as perceived self-control and positive beliefs about worry. This relationship has also been demonstrated using experimental manipulation. Participants whose level of IU was increased reported more worries than participants whose level of IU was decreased (Ladouceur, Gosselin, & Dugas, 2000).

The cyclic pattern between worry and uncertainty aids our understanding of the participants' tendency to worry about "everything" and their apparent difficulty controlling their worries. Sarah, for example, described how worrying about one topic can trigger worries about unrelated topics. Of particular poignance was her use of the phrase "it moves really quickly" to describe this process. Participants' difficulty controlling their worries seems to stem from their construal of them as separate entities with their own agency. This supports evidence that uncontrollable worry is a central feature of GAD (Abel & Borkovec, 1995; Hallion & Ruscio, 2013). The extent and uncontrollability of participants' worrying appears to provide an explanation for why they experience GAD as infinite, rendering it difficult to control.

The subtheme "No rhyme or reason" explored how all participants construe GAD as illogical and unpredictable which magnifies their difficulty controlling it. Emma explicitly acknowledged this in her account of not being able to control GAD because unlike experiencing the loss of a loved one, an event that triggers an

emotional response that makes sense to her (i.e., sadness), she cannot explain GAD or its impact. This unidentifiable quality echoes Lee, Lam, Kwok, and Leung's (2014) finding that individuals with GAD reported a much higher frequency (71%) of unspecified sources of worry than those without GAD (15.8%). Together, these findings support ICD-10's implication that individuals with GAD can indeed feel anxious and worried for no identifiable reason, that is, they can experience "free-floating" anxiety (WHO, 1992). Grillon, Pine, Lissek, Rabin, Bonne, and Vythilingam (2009) found that anxious reactivity to unpredictable, aversive events was heightened in individuals with post-traumatic stress disorder (PTSD) but not in those with GAD. However, current findings indicate that aversive, unpredictable events (including GAD itself) do induce heightened anxiety in adults with GAD.

Participants' intolerance of ambiguity is further implied in their quests to make sense of GAD and its origins or identify its benefits (i.e., holding positive beliefs about worry). Both processes appear to enable participants to assign meaning to their experiences.

Most participants traced GAD's origins to parental traits or behaviour. Marie attributed GAD to her father's neglect during childhood, while Rob attributed it to the fact that his mother is a "worrywart", suggesting that he believes his GAD is the result of either a learned behaviour from his mother or is hereditary. Similarly, all six participants in Golfinopoulos' (2013) study believed that their GAD was either genetically inherited or behaviourally learned from at least one of their parents. These findings support evidence that familial history of severe anxiety (Hettema, Neale, & Kendler, 2001) and parental rejection can cause and maintain GAD (Cassidy et al., 2009). They also suggest that Bowlby's (1973) attachment theory provides a useful framework for understanding GAD's development and maintenance. Participants' childhood experiences of parental neglect or severe parental anxiety has likely led them to doubt that a stable, protective figure will be available to provide the security and comfort needed to reduce their anxiety in times of perceived threat.

Previous research has demonstrated that childhood physical and sexual abuse are risk factors for GAD onset and maintenance (Cougle et al., 2010). In the current study, two participants attributed GAD's onset and maintenance to psychological abuse in childhood or adulthood suggesting that psychological abuse, at any age, is also a risk factor.

Sandy's belief that the progestogen-only contraceptive pill triggered a dramatic intensification of her existing anxiety and worry also provides new insight. Existing literature suggests that the progestogen-only pill increases risk of depression and other mood disorders (Skovlund, Mørch, Kessing, & Lidegaard, 2016; Svendal, Berk, Pasco, Jacka, Lund, & Williams, 2012), but there appears to be less, if any, empirical evidence to suggest that it increases anxiety or GAD specifically.

Positive beliefs about worry have been implicated in the development and maintenance of excessive and uncontrollable worry (Dugas & Koerner, 2005; Wells, 2005), and individuals with GAD have been shown to hold positive beliefs about worry (Newman & Llera, 2011). Freeston, Rhéaume, Letarte, Dugas, and Ladouceur (1994) investigated individuals' (with or without GAD) reasons for worrying. Worrying was believed to function to avoid negative outcomes, even when the individuals recognised the irrationality of this belief, and to motivate individuals to get things done. Echoing a recurring theme in the current findings, positive beliefs about worry increased the individuals' sense of perceived control (Freeston et al., 1994). Despite acknowledging its irrationality, Sarah believes that worrying prevents "things" from happening, while Chloe believes that worry and "fear" motivated her to study for her A-level exams and that this strategy "worked" because she performed well. Wells (2005) posits that negative beliefs about worry are responsible for maintaining and exacerbating GAD symptomology, not positive beliefs about worry. However, current findings suggest that positive metacognitive beliefs are equally responsible.

As captured in "Grappling with time", participants seem to spend a significant amount of time ruminating on the past or anxiously anticipating the future, thus struggle to live in the present moment. Dwelling on things they cannot change (past) or predict (future) further highlights their difficulty tolerating absence of perceived control.

Existing GAD literature tends to highlight the presence of future-orientated cognitions in GAD, with little to no mention of past rumination. Indeed, Rachman (2013) argues that the tendency for individuals with GAD to worry about past events is often overlooked in GAD literature. Current findings suggest that GAD also entails spending a substantial amount of time ruminating on specific, negatively-appraised past events and lost senses of self.

Borkovec (2002) asserts that individuals with GAD are stuck "living in an illusion" (p. 77), where much time is spent thinking about things that exist only in their minds. Consequently, little to no attention is paid to real life because there is always a new danger that needs to be anticipated. This appears to be the case for most participants, who, as already discussed, anxiously anticipate the future, often in the form of hypothetical, catastrophic predictions. Contrastingly, Shelley's superstitious beliefs result in attempts to avoid future thinking. She believes that if she were to excitedly anticipate her son's birthdays she would be punished in the most fundamental way (death of her or her son). This is an example of a specific form of superstitious thinking called *thought-action fusion*, whereby the individual falsely assumes that a causal relationship exists between their thoughts and external reality (Shafran & Rachman, 2004). Similarly, Borkovec, Hazlett-Stevens, and Diaz (1999) found that individuals with GAD believed that their thoughts and worries could influence external events. Superstitious thinking has mainly been associated with OCD (West & Willner, 2011). However, West and Willner (2011) found that there was no significant difference between the superstitious thinking seen in GAD and OCD. Furthermore, superstitious thinking was significantly higher in individuals with GAD than in non-clinical controls. Current findings support evidence that superstitious thinking, especially thought-action fusion, occurs in GAD. Moulding and Kyrios (2006) posit that individuals may resort to superstitious thinking to restore perceived control in low-control circumstances, for example when they are stressed or anxious. This fits with the recurring theme in the current findings: participants' need for control.

Another strategy most participants employ to maintain a degree of perceived control over the future's uncertainty is behavioural pre-planning. Similarly, Mahoney, Hobbs, Newby, Williams, and Andrews (2018) found that 79.6% of individuals with GAD reported over-planning activities (e.g., preparing for all possible negative outcomes, planning every step of an activity). Maladaptive behaviours were not included in the DSM-V classification of GAD because, at the time, there was not a sufficient amount of empirical data available to determine which behaviours are most relevant to GAD (Andrews et al., 2010). The current finding further indicates that pre-planning is a common behavioural symptom of GAD.

The subtheme "Doubt" captured participants' uncertainty about their physical environments, situations out of their control, their thoughts and capabilities, and others' intentions.

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Consistent with the suggestions that individuals with GAD are highly sensitive to threat (van der Heiden, Methorst, Muris, & van der Molen, 2011) and frequently observe potential threats (Barlow, 2002; Mathews & MacLeod, 1994), participants are hypervigilant; constantly scanning the environment for potential threats. They try to create certainty through familiarity, to feel in control and therefore safe. For Kirsty, this involves restricting her use of public transport to familiar journeys, while Rob remains in his familiar job. This supports Rachman's (2013) safety-seeking perspective. Rachman argues that individuals with GAD constantly search for safety. If the anticipated aversive event (threat) is unpredictable or irregular, a dependable safety signal is difficult or impossible to establish, thus maintaining the individual's hypervigilance and anxiety. Familiarity, in contrast, is a dependable safety signal.

Seven participants described experiencing self-doubt. Six described doubting their capabilities. Research has suggested that negative problem orientation specifically, rather than potentially related personality characteristics (e.g., low self-mastery, pessimism), is closely related to worry (Robichaud & Dugas, 2005). Consequently, negative problem orientation is a key component of the cognitive model of GAD (Dugas & Robichaud, 2007; Wilkinson et al., 2011). Wilkinson et al. (2011) assert that individuals with GAD generally know how to solve problems but have trouble doing so because they negatively appraise the problem. For example, problems are perceived as threatening or unfair, or they doubt their problem-solving ability and are pessimistic about the problem's outcome. According to the cognitive model of GAD then, doubting one's abilities is the result of negative problem orientation, not a fundamental personality trait. This appears to correspond with Sandy's account of doubting her ability to do anything despite rationally knowing that she can.

Although Romero-Sanchiz, Nogueira-Arjona, Godoy-Ávila, Gavino-Lázaro, and Freeston (2017) found that worries were perceived as being more based in reality than obsessions and illness intrusions, Sarah's inability to trust that her thoughts are real (rational) suggests that basis in reality of thoughts and worries should also be considered in the assessment and treatment of GAD, not just OCD.

Finally, some participants reported difficulty trusting others. Newman et al. (2013) posit that individuals with GAD may employ cold behaviours due to the belief that it is better to keep others at a distance than to allow oneself to experience the vulnerability associated with warm behaviours and subsequent risk of being

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confronted with conflict or rejection. This corresponds with Marie's narrative of never having a best friend because people let her down. Marie appears to believe that remaining emotionally distant from others protects her from repeated experiences of rejection. Ultimately, attachment insecurity refers to the difficulty trusting and relying on others in times of need (Cassidy et al., 2009). This finding therefore supports the notion that insecure attachment can cause and maintain GAD. It also makes sense of evidence that individuals with GAD tend to lack close friendships (Whisman, Sheldon, & Goering, 2000).

4.3 A struggle for autonomy

Participants appear to engage in a continuous struggle for control over their sense of self as GAD "takes over". Several participants described how GAD distorts their perceptions of reality. This, once again, resonates with Borkovec's (2002) assertion that individuals with GAD live in an illusion, not reality. Negative problem orientation is apparent in Sandy and Kirsty's accounts of GAD taking over. Pessimism and self-doubt once again ensue despite ample evidence of previous coping, suggesting that distorted appraisals of problems are responsible, not fundamental personality traits. Sandy described an extreme emotional contrast, from excitement to "doom and gloom". This does not align with Newman and Llera's (2011) contrast avoidance model. Newman and Llera posit that individuals with GAD use worry to avoid negative affect contrasts (shifting from a positive to a negative emotional state), but Sandy indicates that she experiences one every time GAD takes over.

Rob, like several other participants, construes GAD as a separate entity that has been residing within him for a long time, capable of gaining control over him when it spreads across multiple life domains. Similarly, one participant in Golfinopoulos' (2013) study described how she had always felt anxious, but after her first child was born, "the anxiety became overwhelming" (p. 57). Another described feeling like she had "no control of my feelings and daily life" (p. 61).

"The interplay between body and mind" captured the continuous exchanges between participants' bodies and minds. Consistent with literature regarding GAD's physiological symptoms (Aldao, Mennin, Linardatos, & Fresco, 2010; Kubarych, Aggen, Hettema, Kendler, & Neale, 2005), all participants reported experiencing somatic symptoms such as nausea, diarrhoea, sweating, muscle tension and pain.

DSM-V asserts that symptoms of autonomic hyperarousal such as accelerated heart rate and dizziness are less prominent in GAD than in other anxiety disorders (APA, 2013). However, several participants described experiencing these symptoms. Furthermore, Marie's description of unbearably painful migraines supports evidence that chronic pain in individuals with GAD can occur in additional areas of the body as well as muscles (Beesdo, Jacobi, Hoyer, Low, Höfler, & Wittchen, 2010; Nutt et al., 2006). Together, these findings highlight the need for accurate diagnosis and management of somatic pain while assessing and treating GAD, particularly considering evidence that its presence in individuals with GAD is significantly associated with functional impairment and poorer quality of life (Romera, Montejo, Caballero, Caballero, Arbesú, Polavieja, Desaiah, & Gilaberte, 2011).

Shelley's account of GAD delaying her body's wound healing ability indicates that GAD impairs the immune system. This supports evidence that stress and anxiety impair the immune system, including wound healing (Cole-King & Harding, 2001; Kiecolt-Glaser, Marucha, Malarkey, Mercado, & Glaser, 1995). This impairment may increase the risk of co-morbid physical conditions such as IBS (Gros et al., 2009) and cardiovascular problems (Martens et al., 2010).

Paradoxically, four participants also reported health anxiety, supporting evidence that health anxiety is common in GAD (Abramowitz, Olatunji, & Deacon, 2007; Sunderland, Newby, & Andrews, 2013). Interestingly, Lee, Ma, and Tsang (2011) found that 78.9% of those with GAD reported health anxiety, and that these individuals were significantly older than those who did not report health anxiety. The researchers consequently suggested that age may affect the degree of health anxiety in GAD. However, in the current study, those who disclosed health anxiety ranged in age from 34 to 46, suggesting that age is not a distinguishable factor.

Linking with the subtheme "I'm in control", participants described physiology's role in managing GAD. They stressed the importance of eating regular, healthy meals and getting sufficient sleep. Consistent with previous findings (Bélanger, Morin, Langlois, & Ladouceur, 2004), several participants described difficulty initiating and maintaining sleep because they were worried about the day ahead. Many also described how physically, emotionally and psychologically exhausting GAD is. Although DSM-V notes how individuals with GAD can be "easily fatigued" (APA,

2013), this does not capture the intensity of the participants' exhaustion which leaves them feeling completely drained and worn down.

Previous research has highlighted the benefits of GAD management techniques including physical exercise (Herring, Johnson, & O'Connor, 2016), and writing about anxiety, worries and associated feelings (Schroder, Moran, & Moser, 2018). However, the motivation driving these strategies for the current participants appears to be their need to completely rid themselves of anxiety and worry rather than manage them. This supports the suggestion that individuals with GAD struggle with their internal experiences (e.g., thoughts, emotions, urges, physical sensations), which often results in attempts to avoid or control them (Roemer, Salters, Raffa, & Orsillo, 2005).

Indeed, as captured in "I'm torturing myself", participants construe GAD as a self-torture device that inflicts psychological and physiological torment. GAD's ability to distort reality is also apparent in Shelley's description of the intense fear GAD triggers. She compares it to waking from a "really bad nightmare", where the line between imagination and reality remains distorted. This echoes Hawkins (2017) description of GAD being "scary" because her fears and worries "seem real".

Participants also seem tormented by two negatively-valanced, self-conscious (moral) emotions: shame and guilt. Lewis (1971) asserts that shame and guilt have differential foci. Shame leads one to focus on the self, whereas guilt leads one to focus on specific behaviours. Tangney and Dearing (2002) believe that this difference produces different associated concerns; shame is related to concerns about others' evaluation of the self, whereas guilt is related to concerns about one's effect on others. Shame is believed to lead to feelings of worthlessness and being exposed, while guilt is believed to lead to feelings of regret and remorse (Tangney & Dearing, 2002). This distinction is apparent in participants' accounts. Kirsty's shame in one narrative stems from her belief that if she were to state the real reason for cancelling an appointment (because she feels anxious), she would be subjected to external ridicule. Feelings of worthlessness are apparent in participants' use of "silly" and "pathetic" to describe themselves and their experiences. Rob's guilt in one account centres around his belief that he was unable to help his son in hospital. He consequently felt regret that he failed to do something.

Gilbert (2007) distinguishes between internal and external shame. He states that external shame relates to concerns about others' evaluations of oneself, whereas internal shame relates to negative self-evaluations. He emphasises how internal shame extends beyond basic self-criticism to "hostile (e.g., anger and contempt) emotions directed at the self" (p. 297). Participants appear to experience both. Furthermore, guilt is usually only maladaptive when it becomes generalised to the self, that is, it becomes shameful (Tangney, Stuewig, & Mashek, 2007). This "shame-fused guilt" (Tangney et al., 2007, p. 353) is present in Shelley's narrative of how her friends stopped inviting her to social events. She believes that her friends did so, not because of her behaviour (non-attendance), but because she is a "really rubbish person".

Recalling participants' self-doubt, Berenbaum (2010) posits that perceptions of self-incompetence which, in turn, elicit moral emotions, play an important role in worry genesis. This corresponds with the current findings. Fergus, Valentiner, McGrath, and Jencius (2010) found that GAD symptoms shared a significant, specific relationship with internal shame-proneness but not with guilt-proneness. They consequently concluded that internal shame is more relevant to GAD than guilt. However, the current findings indicate that guilt, shame-fused guilt, and external shame are equally relevant. Moreover, Gosselin, Ladouceur, Langlois, Freeston, Dugas, and Bertrand (2003) assert that individuals with GAD believe that worry allows them to avoid negative emotions directed towards the self (e.g., if I did not worry, I would be careless and irresponsible). However, the current findings suggest that internal shame and worry co-exist.

Despite their difficulty maintaining control of GAD, participants described feeling more in control of GAD, generally, at present. This was captured in "I'm in control". In addition to the physiological strategies already discussed, various strategies have facilitated this perception. Some participants described directly challenging their "what if?" cognitions. Wilkinson et al. (2011) explain how generic cognitive restructuring techniques, that are based on probability estimates, do not tend to work for individuals with GAD because 100% certainty cannot be guaranteed. Worry and anxiety consequently persist. Sarah, however, noted how asking herself "what's the reality?" does stop her worry.

The acceptance-based behavioural therapy (ABBT) for GAD uses mindfulness exercises to help promote individuals' acceptance of their internal experiences

rather than efforts to control or avoid them (Roemer & Orsillo, 2005). Drawing from valued action in acceptance and commitment therapy (Wilson & Murrell, 2004), individuals are also encouraged to engage in specific activities that are meaningful to them, regardless of internal distress (Roemer & Orsillo, 2005). Similarly, several participants appeared to describe an increased ability to recognise their worries for what they are: thoughts that do not need to govern behaviour or be acted upon. Shelley, for example, described attempts to acknowledge her worries without being consumed by them which enables her to "move on".

Despite reported attempts to accept their internal experiences, participants also engage in cognitive avoidance and safety behaviours to control or avoid anxiety and worry. Dugas and Robichaud (2007) identified four explicit cognitive avoidance strategies: supressing worrisome thoughts, substituting neutral or positive thoughts for worries, using distraction to interrupt worry, and avoiding situations that trigger worry and anxiety. Sandy appears to distract herself from her anxiety-provoking thoughts and feelings by talking about "random stuff" with a friend. Not only does this seem to function to avoid distressing internal experiences, it also protects her from the possibility that her friend, like others in her life, may reject her if she were to disclose them.

Alongside pre-planning, some participants engage in checking behaviours. Chloe repeatedly checks her bag before leaving home to ensure that she has not forgotten anything, while Shelley checks that all electrical appliances are turned off to minimise the possibility of the house burning down. This finding supports evidence of checking rituals in GAD (Mackenzie, Christenson, & Kroll, 1990; West & Willner, 2011). Checking behaviours have been significantly correlated with superstitious thinking (Einstein & Menzies, 2008). This may explain why some individuals with GAD experience superstitious thinking. Shelley's account also supports the suggestion that individuals with GAD worry about topics remote in probability (Wilkinson et al., 2011).

4.4 GAD and interpersonal relations

As explored in "GAD through others' lenses", most participants' close relatives and partners do not understand GAD. Some, like Emma and Rob, noted how those closest to them still support them despite this, while others, like Sandy and Chloe

have received criticism and denial of GAD's existence. This latter finding mirrors Lima's (2013), who explored the experiences of male partners of females with GAD. Many participants in this study described initially not understanding GAD at all or fully. One participant commented: "she got worse, or maybe it was bad all along but I just didn't see it because I was oblivious" (p. 43), his account highlighting how easily GAD can go unnoticed. The stark criticism in this excerpt is echoed in another participant's account: "she is not put together … shambles is more like it" (p. 43). Several participants in the current study implied that being proactive about GAD promotes external validation, again, a finding echoed by Lima. Several participants in Lima's study believed that their partner attending individual psychological therapy was the only way to decrease both partners' distress with one participant commenting: "maybe if she works on herself then I will feel better" (p. 58). Indeed, the negative impact GAD has on those closest was another shared finding between the two studies. Shelley described how her partner also stopped attending social events. I surmise that her partner may have felt embarrassed and guilty when Shelley used to cancel social plans at the last minute, particularly when their friends had put a lot of effort into hosting, and that these feelings influenced his behaviour. Similarly, six participants in Lima's study reported experiencing reduced social activities with friends. Some attributed this to their inability to have fun in their partner's absence, while others felt a great sense of responsibility for their partner's well-being. Many consequently felt guilty, either for going out without their partner or for encouraging them to socialise. Echoing the current participants' lost senses of self, several participants in Lima's study described feeling like they had lost their partners, with one commenting: "it was like that original girl I met disappeared" (p. 43).

The subtheme "Striving to belong" explored participants' apparent deep-seated need to be accepted by others and their constant fear of rejection. This supports evidence that interpersonal concerns (e.g., fearing that their interpersonal needs will not be met) are the most common worry topics in individuals with GAD (Newman, Castonguay, Borkovec, & Molnar, 2004; Roemer, Molina, & Borkovec, 1997). In line with Cassidy et al.'s (2009) assertion that insecure attachment in childhood can cause negative interpersonal perceptions (e.g., fear of rejection) in adult interpersonal relationships, it seems that participants' past experiences of rejection have caused them to fear similar rejection in their current relationships. A further dimension offered by the current study is that participants perceive themselves as different or abnormal which magnifies their sense of not belonging.

Participants consequently go to extreme behavioural lengths to conceal GAD and thus feel accepted by others. Participants' apparent shame may explain these behaviours. Moral emotions can be elicited by failing to live up to personal standards or shared social conventions which, in turn, motivates socially appropriate behaviour (Tangney et al., 2007). Participants' experiences of rejection, together with their self-perceptions of abnormality, appears to have led to feelings of shame. Concealing GAD enables them to demonstrate socially appropriate behaviour which, in turn, increases their sense of belonging and minimises the possibility of repeated rejection. This is apparent in Kirsty's account of over-eating when she hosted a dinner party even though her anxiety had dampened her appetite. Eating is a socially appropriate behaviour in this scenario. Participants either try to fit in or, as already discussed, intentionally isolate, supporting evidence that submissive behaviours (i.e., non-assertive, socially-avoidant) are common in GAD (Przeworski, Newman, Pincus, Kasoff, Yamasaki, Castonguay, & Berlin, 2011). Newman et al.'s (2013) suggestion that submission often serves to appease others and avoid hostility fits with the current findings. Participants' need to be accepted by others is another reason for behavioural pre-planning. Marie, for example, described packing various sandwiches for a zoo trip in case someone did not like a particular filling to reduce the likelihood of hostility.

Participants described mixed experiences concerning the "helpfulness of support" both from those closest to them and professionals. As already mentioned, some feel helpfully supported (emotionally and practically) by their close relatives, partners, and friends, despite their inability to understand GAD. For others, this lack of understanding has resulted in the total absence of external support. Recalling Bowlby's (1973) attachment theory, several participants appear to implicitly communicate their need for warmth and protection from their loved ones; the provision of a secure base. Emma, for example, acknowledged her parents' unwavering support, while Sandy communicated her need to be held during moments of immense emotional pain. Despite this need, Chloe highlighted how maladaptive over-protection from loved ones can be. Her father's apparent mollycoddling reinforces her self-doubt and avoidant behaviours. This shares similarities with Lima's (2013) findings. Participants in Lima's study perceived that their enabling behaviours such as reassuring and taking over tasks helped their partners.

Participants also described mixed experiences concerning their interactions with physicians, counsellors, and psychologists. Several participants indicated that they did not feel heard by physicians, instead silenced by psychopharmacological medication. They described only negative effects of medication, for example, increased anxiety or new suicidal ideation and consequently did not believe that medication was "the answer". Similarly, all six participants in Golfinopoulos' (2013) study were, at some point after receiving their GAD diagnosis, prescribed psychopharmacological medication to treat their symptoms. Not one participant felt that their GAD symptoms completely diminished after taking medication, and they all reported negative side effects such as increased anxiety. Echoing current participants' narratives of being reduced from an embodied person to a mechanical body, one participant described feeling like a "guinea pig" because "the doctor tried so many drugs on me" (p. 62). Another noted that her physician would "see me for less than a minute" (p. 68). One participant commented: "I believe that it is very important that doctors make us aware of different treatment options" (p. 68). The last comment resonates with the current study, where positive experiences involved perceptions of being taken seriously by physicians, including consideration of various diagnostic possibilities and treatment options. These findings hold particular poignancy given that physicians are often the first professional point of contact for individuals with GAD (Dugas & Robichaud, 2007), and psychopharmacological medication is a recommended treatment of adult GAD in the UK (NICE, 2011).

Participants who found psychological therapy beneficial attributed this to the fact that it facilitated the thought challenging process. Others, like Emma, described the inadequacy of available psychological therapy in relation to long waitlists and too few sessions. The fact that Emma's therapist could not identify GAD's cause seemed to emphasise her uncertainty and lack of control over it. Ultimately then, positive therapeutic experiences appeared to derive from increased perceptions of self-control. Echoing this finding, all eight participants in Macaulay et al.'s (2017) study reported that therapy (MI-CBT) had resulted in shifts from feeling powerless and overwhelmed by GAD to feeling more in control of it. Seven participants attributed this to the fact that therapy increased their awareness of distorted thoughts and core beliefs underlying their worry and anxiety. Identifying distortions helped participants challenge their thoughts. Similarly, one participant in Golfinopoulos' (2013) study described how her therapist helped challenge her "faulty and negative thoughts" (p. 64). Another explained how psychotherapy

combined with massage therapy had resulted in her being able to control her anxiety.

The final subtheme "concern for others' welfare" explored participants' concern for others' physical safety and emotional wellbeing. Consistent with the finding that participants excessively worry about close others, including their children, partners, and friends, Lee et al. (2014) found that participants with GAD ranked worry about family and the health of family members even higher than worry about their own personal health. These findings support Wilkinson et al.'s (2011) assertion that individuals tend to worry about the things most important to them (e.g., family and relationships), and that at the heart of these topics lie our goals, aspirations, and values. Wilkinson et al. therefore assert that worry is about potential threats to our goals, aspirations, and values. However, concern in the current study was not only directed at close others but extended to colleagues and strangers who may be in similar situations.

Although all five participants with children appear to worry about them to the point of over-protection, several also described attempts to control their worry from fear that GAD may rub off on them. This possibility is highlighted in Lima's (2013) study. Six of the male partners of females with GAD described how their partner's anxiety had contagiously transferred onto them with one commenting: "I bet they will find out that GAD can be caught" (p. 50). Current participants' intentional isolation not only minimises the risk of rejection, it also functions to protect others from the "burden" of GAD.

Echoing Wilkinson et al.'s (2011) assertion, Wells (1995) posits that worry may be represented in the mind of the worrier as a protective form of care towards goals and values. These theories imply that excessive worriers "care too much" and may consequently believe that they must exhibit caring or affiliative behaviours towards others and predominate in the use of such behaviours (Newman & Erickson, 2010). Indeed, many individuals with GAD are either intrusive, overly self-sacrificing, or exploitable (Przeworski et al., 2011), and endorse heightened empathy (Peasley et al., 1994). This may explain why participants also worry about those who are less well known to them. For example, in his interview, Rob described wanting to talk about GAD in his workplace, not only because it makes him feel better, but also to help colleagues who may be suffering in silence. Linking with this disclosure, in the subtheme "Now I appreciate things more" Rob described how GAD has taught him

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not to make assumptions about what may be going on internally for his colleagues who, like him, may be trying to maintain work despite experiencing "difficult times". Newman et al. (2013) suggest that, like cold behaviours, warm behaviours function to prevent negative responses from others. This fits with participants' need to be accepted.

4.5 The need to create meaning amid uncertainty and loss

This super-ordinate theme explored how participants appear to engage in attempts to locate meaning within their distress in order to tolerate the uncertainty, torment, and losses (of their senses of self, perceived control, and external support) GAD has caused. Meaning is created via attempts to make sense of GAD and come to terms with it, as captured in the subtheme: "Learning to ride with GAD (I suppose)", and through identifying its positive implications, as explored in "Now I appreciate things more". Davis, Nolen-Hoeksema, and Larson (1998) argue that these two construals of meaning are two distinct yet equally important concepts. Individuals are motivated to make sense of negative life events in an attempt to maintain their perception that significant events in one's life should make sense. Such events are presumed to be predictable, comprehensible, and occur for a reason. When events do not make sense, the individual feels vulnerable and highly distressed, and is consequently motivated to find meaning by making sense of the event (Davis et al., 1998; Janoff-Bulman, 1992). Deriving benefit from loss or trauma is a fundamental way of assigning positive value or significance to the event for one's life which helps ease feelings of loss or hopelessness (Davis et al., 1998). These two construals of meaning were also present in the subtheme "No rhyme or reason" – participants identified GAD's origins and hold positive beliefs about worry.

Recalling conflicting accounts of participants' need to eradicate anxiety, it seems that some are trying to convince themselves that they have made (a degree of) peace with GAD. Emma appears to summarise this internal conflict in her description of learning to "ride with it I s'pose". The "I s'pose" emphasises her apparent resistance, as do prior accounts of GAD being the worst thing she has ever experienced. Resistance seems confirmed in participants' hope of cure which, linking with the subtheme "loss of a past self", would hopefully enable them to return to their former senses of self before GAD "struck". Similarly, all six participants in Golfinopoulos' (2013) study wanted to be cured, and five initially believed that this

was possible. However, as treatment progressed, participants appeared to realise that cure may not be possible and instead focused on managing their GAD symptoms more effectively. This mirrors current findings; several participants acknowledged that while cure was unlikely, changing their relationship with anxiety and worry has enabled them to manage GAD more effectively. Marie, like several others, described how she has learnt that she needs to accept her distorted anxious thoughts and worries before she is able to challenge them. This process enables her to regain a degree of control over GAD. Sarah acknowledged the time required to mourn her lost sense of self and life direction before she could begin the journey towards acceptance. Now, echoing Shelley's accounts of not letting anxiety govern her behaviour, she is not allowing it to prevent her from starting a family. It seems that learning that anxiety and worry do not present a rational threat has enabled participants to obtain some distance and power over them. Similarly, all eight participants in Macaulay et al.'s (2017) study transitioned from perceiving GAD as all-consuming and permanent to separate and transient. This enabled them to step back from it and make choices in their daily lives.

Normalising GAD has also helped participants come to terms with it, presumably because it has weakened their self-perceptions of difference and abnormality. One participant in Golfinopoulos' (2013) study explained how she initially did not tell anyone about her severe anxiety, partly because she believed that it was normal but also from fear that others would perceive her as "weird" (p. 57). This mirrors Chloe's prior experiences of GAD. It seems that increasing societal awareness has helped Chloe and her mother shift from denying GAD's existence to accepting that it is real. It has also challenged her assumptions that others will respond negatively. Chloe is consequently becoming more open about GAD, at least with her colleagues. For Marie, this altered self-perception seems to stem from the knowledge that there is a physiological explanation for GAD. This has reduced her sense of perceived responsibility for GAD and thus her shame. This supports Cutrona's (1983) assertion that blaming oneself for a loss increases personal distress and grief.

Ultimately, it appears that participants are making sense of GAD via new, present insights as well as identifying its origins.

In terms of GAD's positive implications, several participants conveyed a sense of increased self-acceptance, including increased self-care. Similarly, five participants in Macaulay et al.'s (2017) study reported increased self-acceptance, while others

described smaller shifts from self-criticism to self-compassion. Several participants indicated hesitancy in these disclosures. For example, one commented: "um, it's ok to be what – to be who I am" (p. 175). This seemingly hesitant comment echoes current participants' apparent tentative degrees of self-acceptance, as suggested in their conflicting narratives. Chloe, for example, described feeling more like her own person but went onto explain how she suppresses her true self and interests to, once again, fit in and be accepted by others. Chloe and Shelley's use of the phrase "like myself" as opposed to "love myself" further implies tentativeness.

GAD also appears to have positively altered several participants' perceptions of others. As already touched upon, GAD has increased Emma and Rob's empathy which enables them to distinguish between genuine and fake individuals and has highlighted the value of enquiring about others' internal experiences as opposed to making assumptions.

Finally, GAD has also strengthened participants' appreciation of life. Davis et al. (1998) suggest that learning about one's strength in the face of adversity can help ease feelings of loss and hopelessness. This mirrors Emma's narratives of self-resilience ("inner strength", "fight") and Shelley's newfound ability to "push through" anxiety. Several theorists have suggested that the perception that one's life has goals and purpose is critical for self-esteem and well-being (Frankl, 1986; Janoff-Bulman, 1992; Thompson & Janigian, 1988). Identifying the positive implications of GAD seems to have restored participants' beliefs that their lives, as Emma suggests, are worth fighting for (Davis et al., 1998).

4.6 Strengths and limitations

The fundamental strength of this study is due to the participants. The willingness and openness with which they shared their experiences produced rich, plentiful data. While this study only claims to report on the experiences of the eight participants interviewed, I believe that important insights derived from this rich data have significant implications (see section 4.7) and are relevant and transferable to other adults with GAD. However, I am also aware that Kirsty's interview was significantly shorter in duration. Upon arriving at her house to conduct the interview, she informed me that she had considered cancelling that morning because she was so anxious and had not slept well. Her willingness to continue despite these internal

challenges demonstrates that she deemed it important and is testament to her bravery. This was reflected in her verbal debrief, where she disclosed being pleased that she had participated. Participants, including Kirsty, also reflected on how I had made them feel comfortable and communicated my attempts to understand them, for example, through asking prompt questions. This seemed particularly poignant when they were talking about topics they perceived to be frequently misunderstood. Such feedback suggests that I had earned their trust which appears to have facilitated their ability to talk, largely in detail, about their experiences.

One limitation concerns the recruitment procedure. Initial difficulty recruiting led me to rely more heavily on one source: Facebook, thus largely restricting potential participants to those who use this social networking platform. Furthermore, Rozmovits and Ziebland (2004) warn that self-volunteering participants may differ from a broader sample in their motivations to participate. For example, in the context of this study, participants may have been drawn to participate because of a particularly positive experience of GAD or a particularly negative one. Although it is impossible to rule out this possibility, the varied textures of experience described, combined with participants' different disclosed reasons for participating (i.e., to raise awareness of GAD generally, to address particular misconceptions, to consolidate their own understandings of GAD), reassure me that there was not one shared motivation driving participation.

Other limitations concern the characteristics of the participant group. Only one male participated compared to seven females. Many possible explanations could account for this. Re-considering my main recruitment source, research has shown that females use Facebook more frequently and for longer durations than males (Shepherd, 2016). Furthermore, it has been suggested that females are, on average, more comfortable discussing more sensitive and emotionally distressing topics (Chester & Glass, 2006). I also wonder whether males feel more comfortable talking to a male researcher. However, research has shown that the majority of both female and male participants do not have a gender preference for researchers (Yager, Diedrichs, & Drummond, 2013) and do not consider this an important factor (Theadom, Fadyl, Hollands, Foster, & McPherson, 2014). The finding that GAD is more common in females than males (McManus et al., 2016; Seedat et al., 2009; Vesga-López et al., 2008) is perhaps a more likely explanation. As indicated by the shared individual super-ordinate themes across all eight participants, Rob's experiences seem to converge, at the broader level, with the female participants'

experiences. However, I cannot ascertain whether divergence between the experiences of male and female participants exists and, arguably more importantly, male insight into the lived experience of GAD remains limited.

Finally, co-morbid diagnoses were not excluded, and I did not inquire about the possibility. While Emma was the only participant to voluntarily disclose having an additional, formal psychiatric diagnosis, I cannot rule out the possibility in other participants. It is therefore unclear whether participants' reported experiences are confined to GAD or are influenced by potential co-morbid psychiatric and/or physical health conditions.

4.7   Implications for counselling psychology and beyond

The findings have useful clinical implications for counselling and clinical psychologists, counsellors, and psychotherapists who may encounter adults with GAD.

Supporting Cassidy et al.'s (2009) suggestion, the findings indicate that Bowlby's (1973) attachment theory provides a useful framework with which to understand GAD's developmental antecedents and maintaining factors. However, following the advice of Hudson and Rapee (2004), it is important to consider attachment as part of a broader etiological model of how anxiety develops that also considers other risk factors including biological (genetic and neurodevelopmental) and stressful life events. Nevertheless, the finding that insecure attachment continues to plague participants' lives now via continued fear of rejection suggests that the therapist's ability to provide a secure base in therapy may aid successful GAD treatment. Bowlby (1988) argued that the therapist should provide the client with a sense of safety, comfort, and acceptance to enable the client to manage the distress evoked by painful exploration during therapy. Indeed, functional magnetic resonance imaging research has demonstrated that the presence of a secure base reduces the perception of threat in the brain (Coan, Schaefer, & Davidson, 2005, 2006). As already discussed, individuals with GAD are highly sensitive to threat (van der Heiden et al., 2011), particularly interpersonal ones (Newman et al., 2004). In relation to the last point, it may also be useful for therapists to address clients' inaccurate assessments of their interpersonal interactions (Cassidy et al., 2009) as these are also associated with insecure attachment styles (see Mikulincer & Shaver,

2007, for a review). Indeed, greater emphasis in the psychological treatment of GAD is now on addressing the client's interpersonal difficulties, whereby the client is encouraged to reflect on their contributions to them (Newman et al., 2004). Reflecting on a key finding from the current study, care must be taken to ensure that the client's feelings of shame are not strengthened.

This study highlighted participants' difficulty tolerating ambiguity (present and future-orientated) and consequent difficulty tolerating absence of perceived control. Although traditional CBT remains the "gold standard" treatment for GAD (Treanor, Erisman, Salters-Pedneault, Roemer, & Orsillo, 2011, p.127), this study's findings support the beneficial impact of other psychological therapies that target these aspects of GAD. ABBT, which was introduced in section 4.3, is one such therapy. It uses targeted interventions for emotion regulation difficulties, IU, and low perceptions of control (Treanor et al., 2011). Treanor et al. (2011) propose that ABBT for GAD may alter the client's expectations and desire for rigid control and encourage them to focus on actions that are more likely under their control, such as clearly stating their needs or choosing their own actions. They found that those who received ABBT reported significantly fewer emotion regulation difficulties, greater tolerance of uncertainty, and greater perceived control over anxiety than waitlist controls. These effects were maintained at three and nine-month follow-up assessments (Treanor et al., 2011).

While ABBT does appear to be an effective treatment option and draws parallels with some of the beneficial therapeutic experiences described by this study's participants, I am struck by their conflicting accounts of struggling to accept GAD and of engaging in a continuous fight for perceived control. These accounts suggest that something is hindering their efforts to manage GAD more effectively. I also find myself reflecting on their self-doubt. Whilst linking the findings to existing literature, it seemed that this was indeed the result of negative problem orientation as opposed to a fundamental personality trait. I drew this conclusion based on their disclosures of rationally knowing that they are capable. In hindsight however, participants' apparent shame suggests that they do in fact hold engrained, negative self-perceptions. These reflections made me question whether an integrative psychological therapy for GAD could address this potential hinderance by targeting its many elements (e.g., interpersonal difficulties, shame, IU, need for rigid control).

This led me to Wolfe's (2005, 2008) integrative psychotherapy for anxiety disorders. Barry Wolfe is a clinical psychologist who has worked with individuals with anxiety disorders for over thirty years. This has led him to draw two conclusions. First, that "anxiety disorders are typically generated by failed efforts to confront and solve a finite number of unavoidable existential dilemmas that every human being will experience" (2008, p. 204). More specifically, he asserts that the roots of anxiety disorders lie in the interaction between the individual, who has a damaged, negative self-perception, and their struggle with an existential crisis (Wolfe, 2008). Existential crises include difficulty accepting one's mortality, difficulty accepting the inevitability of loss, and fear of the rigours and realities of everyday living (Wolfe, 2008). Secondly, he believes that anxiety disorders can be durably treated using his integrative psychotherapy (Wolfe, 2008).

Drawing parallels with this study's findings, Wolfe (2005) asserts that the fundamental damaged self-perception of those with GAD is a deep shame about who they are as humans. They perceive themselves to be defective and unworthy of others' love. He posits that unless this self-perception is healed, there is a high probability that the symptoms of GAD will remain chronic and intermittent, even after successful symptom treatment (e.g., modified worry cognitions, IU improved). This may explain why participants who had completed therapy were still experiencing GAD symptoms. His integrative psychotherapy draws ideas from psychodynamic, cognitive behavioural, and experiential approaches (Wolfe, 2005). The first stage involves symptom alleviation as these are experienced as painful and overwhelming. Then, the behavioural, cognitive, and emotional strategies that prevent the client from confronting their specific existential dilemmas are identified and modified, as contexts in which damaged self-perceptions develop usually involve an existential dilemma that cannot be faced. Finally, process-directive experiential therapy helps the client face, process, and ultimately solve their existential crises (Wolfe, 2008).

It may be beneficial for those offering psychological therapy to individuals with GAD and other anxiety disorders to train in this therapeutic modality or at least consider the theory behind it when working with this client group, as damaged self-perceptions and unaddressed existential crises may be hindering clients' progress. The connection between insecure attachment and existential anxiety should also be considered as one way meaning is acquired is through attachment, thus secure

attachment acts as a buffer against existential anxiety (Iverach, Menzies, & Menzies, 2014).

I also believe that an existential approach to therapy may benefit individuals with GAD. I use the term *existential approach* as opposed to *existential therapy* because a diverse range of existential therapies exist, each with a shared concern: human lived-existence (Cooper, 2017). Existential philosophers have tried to identify the universal, invariant qualities of human existence. Although different, and sometimes contrasting, existential *givens* have been emphasised by different philosophers, several commonalities exist across the existential spectrum (Cooper, 2017). One is the assertion that human existence is fundamentally free (Macquarrie, 1972). According to the existential philosophers Kierkegaard (1844/1980) and Sartre (1943/1958), human existence erupts into the world out of no-thingness and thus cannot be reduced to a set of determinative causes. As touched upon in section 1.2.4, humans are therefore free to make choices (Cooper, 2017). To illustrate this, the reader of this portfolio is not impelled by a set of causes to act in a certain way, for example, to adopt the beliefs and opinions presented throughout. Rather, the reader has the possibility of making choices, for example, to continue reading or take a break. From an existential perspective then, we are our choices; our identity and characteristics are consequences - not causes - of the choices we make (Cooper, 2017). This does not mean that existential philosophers believe that humans are free to do whatever they want. They acknowledge that human existence is confronted with numerous *limit-situations* such as death and suffering (Cooper, 2017). Our freedom is also limited by the particular concrete situations we find ourselves in (Cooper, 2017). For example, we cannot walk through the walls of our homes to directly access the room we want to be in. From an existential perspective, although we cannot fully control our beginnings, our endings, or much of what occurs in between, we can choose how we face these limitations (Cooper, 2017).

Kierkegaard (1844/1980) argues that the more we acknowledge and act on our freedom, the more we experience anxiety. This is because in choosing one thing, we are always choosing against something else, and there is always the possibility that we will choose against the better alternative. Of fundamental importance is the fact that often we cannot know and cannot be certain which option is the better one; we must make important decisions amid uncertainty (Cooper, 2017). Sartre (1943/1958) argues that making choices is made even more anxiety-provoking by

the fact that we not only choose for ourselves but also for others. From an existential perspective, while we alone are responsible for our decisions, we also carry responsibility for others (Cooper, 2017). Our anxiety is further strengthened because we have nothing solid on which to base our choices. We have no fixed identity, no given meanings to guide us, or to blame our decisions on (Sartre, 1943/1958). Fundamentally then, from an existential standpoint, it is not only that freedom and nothingness evoke anxiety but also the fact that our existence is confronted with limit-situations. If these immovable boundaries did not exist, we could make all the choices we wanted to, alternatives would not be excluded, and we would not feel anxious (Cooper, 2017). From an existential perspective, anxiety is a response to the reality of the human condition (Cooper, 2017). It is an immediate yet often unwelcome feeling towards-the-world (Cooper, 2015). The existential standpoint argues that we try to supress this unwelcome anxiety and other 'negative' feelings such as guilt and despair by denying the reality of our existence (Cooper, 2017). At the heart of this self-deception is a denial of our freedom and responsibility. This denial can manifest itself in various ways, such as objectifying oneself, adhering to an ideology, blaming our choices on someone else or on an unconscious, internal urge, or trying to deny the given limitations of our lives (Cooper, 2017). According to existential philosophers, these defences against existential reality inevitably falter, and existential anxiety is sublimated into a neurotic manifestation of anxiety (Holzhey-Kunz, 2014; Tillich, 2000). Consequently, as Wolfe (2008) stated, the individual's deeper existential concerns are not confronted and solved but rather continue to haunt him or her. Using an example from the current study to illustrate this, it can be hypothesised that Kirsty's adoption of a 'likeable' persona (e.g., at the dinner party she hosted) functions to avoid her existential responsibilities. She appears to communicate that she is not in charge and will do what others do. Existentially however, it could be argued that at some level Kirsty knows that this is false. She knows that she is an adult woman with shared responsibility for her son. This awareness evokes anxiety, and it can be hypothesised that one way she attempts to deal with this is to try to fit in with others even more. She increasingly worries that others do not like her. Here, Kirsty's existential anxiety (of being responsible) gets sublimated into a neurotic anxiety (of people not liking her).

Although the existential therapies differ in their influences and clinical practices, they share a common aim: to help clients become more authentic. This involves becoming more aware of their actual existence and living more in line with their true

values, beliefs, and experiences (Cooper, 2017). An existential approach to therapy therefore encourages clients to acknowledge and act on their freedom and responsibility. From an existential perspective, to face our freedom and possibilities we must face our existential anxiety. Existential anxiety is therefore not conceptualised as irrational or pathological but as a teacher and guide that helps us live a more authentic, meaningful existence (Cooper, 2017). An existential approach may not only benefit individuals with GAD but also those presenting with any manifestation of neurotic anxiety. I believe that it would facilitate clients' understanding of, and ability to normalise, both existential and neurotic anxiety. By encouraging clients to acknowledge that it is anxious for them to acknowledge that they have choices, that their decisions will affect themselves and those around them, and that their choices are, to a certain extent, ridden with uncertainty, I believe that they can find the courage to accept and learn from their existential anxiety (and other 'negative' feelings) and begin to decide who and how they want to be (Cooper, 2017).

Given that the presence of somatic pain in individuals with GAD is significantly associated with functional impairment and poorer quality of life (Romera et al., 2011), it would be useful for therapists to inquire about pain and to inform clients about available complementary strategies that may help alleviate it such as physiotherapy, yoga, or massage. Recalling Sarah's account, yoga may have the added benefit of facilitating the client's ability to remain in the present moment.

The findings also have implications for the assessment of GAD. It is important that healthcare professionals are equally aware of GAD symptoms that are commonly associated with OCD, such as superstitious thinking and checking rituals or appear to have been overlooked in existing GAD literature, such as past ruminations and difficulty tolerating present ambiguity. The findings also serve a poignant reminder to healthcare professionals to treat these individuals like persons as opposed to biological machines that require fixing immediately. I appreciate that healthcare professionals' time with patients, particularly physicians and medical specialists, can be limited, but it is still possible to communicate to the individual that they are being heard and respected. Simultaneously, it is important for healthcare professionals to consider all possibilities with regards to diagnosis and preferred treatment options. This is a particularly important message for physicians, given that individuals with GAD often seek professional help from physicians first and tend to present with physiological symptoms (Dugas & Robichaud, 2007). Shorter time between GAD

onset and first treatment seems to be associated with a larger treatment effect (Altamura, Dell'Osso, D'Urso, Russo, Fumagalli, & Mundo, 2008), further highlighting the importance of early detection.

My final suggestion aligns with Strawbridge and Woolfe's (2003) assertion that as counselling psychologists, we have a responsibility to consider how psychopathology is represented or socially constructed. Pearson (2008) was diagnosed with GAD aged twenty-three. She believes that community plays a crucial role in creating a society not plagued by neurotic anxiety (Pearson, 2008). In her memoir, she cites the existential psychologist Rollo May, who once wrote "competitive individualism militates against the experience of community, and the lack of community is a centrally important factor for contemporaneous anxiety" (Pearson, 2008, p. 83). She also draws ideas from psychologists whose cross-cultural research has led them to conclude that the more a culture enforces rational control, the more likely it will generate neurotic anxiety because it is more fearful of losing control. Pearson believes that the intense value Western cultures give rationalism has not helped individuals confront fear but rather has "invalidated meaning" which, in turn, reinforces fear (p. 96). Engaging in "communal rituals" (p. 46), such as dancing at a blues club and belonging to a church community, has helped her cope with her anxiety. For Pearson, community appears to create shared meaning and purpose. In addition, "knowing that you're not alone" provides comfort (p. 46). This sense of meaning, purpose, and togetherness strikes a chord with the participants' narratives in the current study. I therefore wonder whether we, as counselling psychologists, could promote community-based activities to strengthen these individuals' senses of purpose and belonging, and reduce the value placed on rationalism. This, in turn, will hopefully reduce their neurotic anxiety. Such promotion could be achieved by working in direct collaboration with various community organisations such as religious groups and recreational clubs.

4.8 Future research

All participants in this study were of British Caucasian ethnicity. It would be interesting to replicate the study with participants of different ethnicities and cultures to see whether the lived experience of GAD differs across different ethnic and cultural groups. This suggestion stems from considering how cultural influences shape individuals' perceptions and descriptions of their experiences. For example,

Western cultures tend to perceive adversities as "journeys", "struggles", or "battles". Recalling the published accounts of GAD included in the Introduction chapter, McWilliams (2016) described how she has "fought this mental illness for nine years". Current participants also made references to "fighting", "hard work", "struggle", and implied engaging in a journey towards accepting GAD. These narratives are also present in Western individuals' descriptions of experiencing physical illnesses such as cancer. Personal accounts on Macmillan's online community are rife with these terms. HappyEeyore (2018) comments: "I intend to fight", while Rozzieroo (2018) refers to "my bowel cancer journey". When someone dies of cancer, announcements often contain phrases like "X died after a long battle with cancer".

To this end, discourse analysis could be conducted to investigate how individuals with GAD construct their experiences through discourse. Discourse techniques could also be used to analyse the constructions of GAD seen in the media and in organisations that provide information and support to individuals with GAD (e.g., Anxiety UK, Mind). Hawkins (2017) wrote about the importance of being open and honest about her experiences, not only because this is "cathartic", but also to "break down the stigma that still seems to be ever present". Contrastingly, in this study, Chloe noted how increasing coverage of "mental health" in the news has helped her and her mother normalise, and thus accept GAD. It would therefore be beneficial to consider whether these public constructions of GAD do indeed reduce or contribute to the associated stigma.

My final suggestion also stems from participants' references to journeys. Sarah, for example, described the long process involved in reaching a degree of acceptance, while Chloe described feeling "better" now than she did seven years ago when her anxiety "surfaced really badly" (8.1.2). These accounts highlight the potential usefulness of investigating the impact of GAD across time. As Flowers (2008) suggests, meeting with a participant more than once facilitates the development of a trusting relationship in which participants feel comfortable with increasing disclosures. Multiple contacts also enable material to develop from an initial meeting (Flowers, 2008). However, he also warns that the focus on open exploration of lived experience at that time can be lost if significant time is spent reconsidering issues raised previously. One way to reduce this possibility would be to consider supplementing semi-structured interviews with other data collection methods such as personal diaries, as these may enable more spontaneous accounts of

experience. Several participants in the current study described the catharsis achieved through writing their thoughts and feelings down, suggesting that this data collection method may also have additional benefits for participants. While such a longitudinal study would be time-consuming, the findings may shed light on the particular support (both personal and professional) individuals with GAD need at different times following diagnosis.

4.9 Concluding thoughts

This study's findings have further highlighted how diagnostic entities are often simplifications of the complicated clinical and phenomenological profiles of psychiatric disorders (Denys, 2011). Conducting this research has strengthened my resolve as a counselling psychologist to consider the phenomenological perspectives of clients' experiences before theoretical and empirical knowledge. Phenomenology in the mental health field is synonymous with the pure clinical descriptions of symptoms. However, as discussed in the Methodology chapter, phenomenology considers phenomena as they are experienced without reference to their psychological origins or causal statements (Denys, 2011).

With this in mind, I have been struck both professionally and personally by the debilitating extent of participants' need for certainty and control, themes that are more commonly associated with OCD (Denys, 2011). As Denys (2011) asserts "the tragedy of certainty is that it is not based on objective knowledge or on external reality but on a feeling" (p. 9). One can be right but still experience doubt or one can be wrong but feel certain, thus because knowledge cannot guarantee security, absolute certainty can never be achieved. Participants' continuous pursuits of certainty, which leave them feeling "worn down", are consequently useless. Perhaps these two themes have evoked a particularly strong emotional response (i.e., anxiety, sadness) on a personal level because control and certainty are "illusions" (Denys, 2011, p. 9) I think we all, as humans, cling onto at times to protect ourselves from life's harsh "paramount reality" (Wagner, 1970, p. 320).

Linking with the latter point, this research has sparked my personal and professional interest in both existential philosophy and psychology; perspectives that, until conducting this research, were absent from my counselling psychologist training. An existential approach may be best described as a particular ethic: that humans

should be treated, first and foremost, as humans (Cooper, 2015). Echoing the phenomenological standpoint, from an existential perspective, individuals are their lived existing (Cooper, 2017). Both perspectives have consequently reinforced the importance of treating clients as the concrete, unique, irreducible, whole human existents that they are. This involves approaching clients' presenting difficulties as aspects of their existence as opposed to pathological symptoms (Cooper, 2017). The value of approaching my clinical work in this way has been highlighted through my acquired knowledge of existential anxiety. By conceptualising anxiety as an unavoidable basic given of human existence rather than an aspect of pathology that needs to be managed or cured, the client can view it as an opportunity for learning. Knowing that neurotic anxiety has its basis in existential anxiety encourages the client to identify a source of meaning in their life and clarify their personal values (Iacovou, 2011). As already touched upon, while I believe that psychiatric diagnoses help distinguish between presenting difficulties and can facilitate meaning, I believe that they should be approached as an aspect of a much larger, contextualised understanding of the client as a human being. At the heart of my clinical work going forward, I will therefore consider what it means to be human and what each client's presenting difficulties are trying to tell them (Kirkland-Handley, 2002; Steffen & Hanley, 2014).

As a researcher, conducting this study has given me the confidence to use qualitative methods of data analysis that rely more heavily on researcher intuition, such as reflective lifeworld research. Returning to my study rationale, I hope this study has increased awareness of the rich textures that characterise the lived experience of GAD. As I conclude this write-up, I am reminded of one of the first things Chloe said when she responded to my research flyer. She was really surprised that I wanted to talk to individuals with a formal diagnosis of GAD as she did not think it was a well-known "condition". Upon arranging the initial telephone screening, she asked whether many people had expressed interest as she did not know of anyone local with GAD. I hope that this research has communicated that GAD is being taken seriously and has provided some comfort to those with GAD that they are not alone. Considering the significant lack of literature on the lived experiences of GAD, together with the relatively small scale of this study, further research is needed to strengthen these messages and our understanding of GAD.

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Appendices

Appendix 1:   GAD-Q-IV (Newman et al., 2002)

1. Do you experience excessive worry?   Yes   No
2. Is your worry excessive in intensity, frequency or amount of distress it causes?   Yes   No
3. Do you find it difficult to control your worry (or stop worrying) once it starts?   Yes   No
4. Do you worry excessively and uncontrollably about minor things such as
    being late for an appointment, minor repairs, homework etc?   Yes   No
5. Please list the six most frequent topics about which you worry excessively and
    uncontrollably:

6. During the last six months have you been bothered by excessive and uncontrollable worries
    more days than not?

    Yes   No

    IF YES, CONTINUE. IF NO, SKIP REMAINING QUESTIONS

7. During the past six months, have you often been bothered by any of the following
    symptoms? Place a check next to each symptom that you have had more days than not:
-   Restlessness or feeling keyed up or on edge
-   Difficulty falling/staying asleep or restless/unsatisfying sleep
-   Difficulty concentrating or mind going blank
-   Irritability
-   Being easily fatigued
-   Muscle tension

8. How much do worry and physical symptoms interfere with your life, work, social activities,
    family etc? Circle one number:

    0   1   2   3   4   5   6   7   8

       None   Mildly   Moderately   Severely   Very
                                                                       severely

9. How much are you bothered by worry and physical symptoms (how much distress does it
    cause you)? Circle one number:

    0   1   2   3   4   5   6   7   8

      No distress   Mild distress   Moderate   Severe   Very severe

Appendix 2:   GAD-Q-IV scoring system (Newman et al., 2002)

Scored using a sum total response.

All yes answers coded as 1. All no answers coded as 0.

For question 5 which asks for a list of most frequent worry topics, individuals will be given 1 point for each topic listed up to six topics, and then this total will be divided by three.

For question 7, participants will be given 1 point for each physical symptom they experience up to six symptoms, and then this total will be divided by three.

The numbers circled for questions 8 and 9 will each be divided by four and the resultant two numbers will be added together.

Any skipped questions will be scored as 0.

In line with Moore, Anderson, Barnes, Haigh, and Fresco's (2014) recommendations, a total score of 7.67 or above must be obtained to meet criteria for a diagnosis of generalised anxiety disorder.

Appendix 3: Initial interview schedule

Prior to asking the following questions, the researcher will state that she will be using the term *everyday anxiety* when referring to generalised anxiety disorder, throughout the interview.

General opening questions:

What is it like to live with everyday anxiety?

Can you tell me about a memorable event in which you were experiencing everyday anxiety? (Ask this question again later)

Prompt questions:

Can you give me an example of…?

Can you give me some examples so that I can visualise it?

Each chosen lifeworld fraction (in bold) and their corresponding questions:

Selfhood

How would you have described yourself before you experienced everyday anxiety?

How would you describe yourself now?

How do you think others perceived you before you experienced everyday anxiety?

How do you think others perceive you now?

Sociality

Can you tell me about your relationships with others? What were they like before you experienced everyday anxiety? Now what are they like?

Embodiment

What do you notice about your body when you are experiencing everyday anxiety?

Appendix 3:   Initial interview schedule (cont.)

Temporality

When you first wake up, do you worry about what's going to happen during the day?

Do you worry about what's going to happen in a week's time? How about in a month's time?

Are there times when you don't experience everyday anxiety?

Can you give me an example of a time when you didn't experience everyday anxiety?

Material Objects

What are your worries about?

Spatiality

Is there a place where you don't feel anxious? What is this place like?
Is there a place where you feel particularly anxious? What is this place like?

End question:

Is there anything else you would like to add?

Appendix 4: Final interview schedule

Prior to asking the following questions, the researcher will state that she will be using the term *everyday anxiety* when referring to generalised anxiety disorder, throughout the interview.

General opening question:

What is it like to live with everyday anxiety?

Prompt questions:

Can you tell me about a memorable event in which you were experiencing everyday anxiety? (ask about the narrative again later)

Can you give me some examples so that I can visualise it?

Each chosen lifeworld dimension (in bold) and their corresponding questions:

Selfhood

Since experiencing everyday anxiety, how has your sense of self changed over time?

How has the way others perceive you changed over time?

Sociality

How have your relationships been affected by everyday anxiety? (Prompts: Start with the people closest to you. How about your family, friends, work colleagues etc.,?)

Embodiment

How has everyday anxiety affected your body?

Temporality

How does everyday anxiety affect how you think about the past?

How does it affect how you think about the future?

Appendix 4:   Final interview schedule (cont.)

Material Objects

What is it, exactly, that you worry about?

Spatiality

What situations make your everyday anxiety worse?

<u>End question:</u>

Is there anything else you would like to add?

Appendix 5:   Research flyer

CITY
UNIVERSITY OF LONDON
—— EST 1894 ——

Have you been diagnosed with generalised anxiety disorder (GAD)?

Would you be willing to talk about your experience of GAD?

If you have received a formal diagnosis of GAD, are aged eighteen or over and are not currently receiving any form of psychological therapy, I would be very keen to hear from you!

My name is Laura Young and I am doing this research project as part of my Doctorate in Counselling Psychology at City, University of London. This project is supervised by Professor George Berguno, Registered Psychologist and Senior Lecturer ███████████████████████

Participation will involve a ninety-minute (approx.) interview with me. If you are interested in sharing your experience, or would like to find out more, please give me a call on ████ ████████ or email me at: ████████████████████

This project has been reviewed by, and received ethics clearance through the City, University of London Psychology Department Research Ethics Committee, City, University of London [Ref: PSYETH (P/F) 15/16 182]

If you would like to complain about any aspect of this project, please contact the Secretary to the University's Senate Research Ethics Committee on ████████████ or via email: ███████████████████

Appendix 6: Participant information sheet

PARTICIPANT INFORMATION SHEET

The lived experience of individuals with generalised anxiety disorder

My name is Laura Young, and as part of my Doctorate in Counselling Psychology at City, University of London, I am carrying out research exploring the lived experience of individuals with generalised anxiety disorder.

WHAT IS THE PURPOSE OF THIS RESEARCH?

This research aims to explore individuals' experiences of generalised anxiety disorder (GAD) and how they make sense of their experiences. Participants must have received a formal diagnosis of GAD and be aged eighteen or over to take part in this research. Participants must not currently be receiving any form of psychological therapy.

DO I HAVE TO TAKE PART?

Your participation in this research is voluntary and you may choose to withdraw at any time, without any consequences or need to give a reason. Just let me know at the time if you wish to withdraw.

WHAT WILL I BE ASKED TO DO?

If you choose to take part in this research, you will be invited to attend a telephone screening with myself. During this screening, I will ask the questions on the *Generalized Anxiety Disorder Questionnaire IV* (GAD-Q-IV). The purpose of this is to ensure that you meet this questionnaire's criteria for a diagnosis of GAD. The use of this standardised measure ensures that the same criteria are applied to each participant. It is important to note that this screening does not represent a formal diagnosis of GAD. Similarly, if you have previously received a formal diagnosis of GAD but do not meet this questionnaire's criteria, this does not imply that your previous, formal diagnosis is wrong. You do not have to answer any

Appendix 6:   Participant information sheet (cont.)

questions you do not want to. Your answers will be written down briefly so that a total score can be calculated. Your answers will not be used in the research, and they will be destroyed as soon as the telephone screening has ended. If you do not meet this questionnaire's criteria for a diagnosis of GAD, you will be thanked for your participation up until this point but will not be asked to take part in an interview. If you do meet the criteria for a diagnosis of GAD, you will be invited to participate in one face-to-face interview with myself about your experiences of GAD. If you choose to participate in this interview, you will be asked to sign a consent form indicating that your participation is voluntary and that you understand your rights. The interview will take place at a location agreed beforehand, and the interview will take approximately ninety minutes. The interview will be audio recorded using two digital recorders.

WILL THE INTERVIEW AND RESEARCH PROCESS BE CONFIDENTIAL?

Yes. The interview will be recorded and listened to only by me, or an examiner if requested. The interview will then be transcribed. Names and identifying information will be removed and replaced by a code. In accordance with the British Psychological Society's guidelines, all data collected will be stored securely for five years before being destroyed. If you choose to withdraw at any time during the interview, the recording will be stopped and destroyed immediately. The only time I would need to break this confidentiality is if you disclosed that you were planning to commit an illegal act or one that endangers yourself or another person, which I will discuss with you before we start.

DO I HAVE TO ANSWER ALL OF THE INTERVIEW QUESTIONS IF I DO NOT WANT TO?

No. It is up to you whether you wish to answer the questions. Mostly it will be you choosing what you wish to talk about, the questions are simply there to guide the interview.

Appendix 6:   Participant information sheet (cont.)

WHAT IF I FIND THE INTERVIEW UNCOMFORTABLE AND/OR DISTRESSING?

If you find it difficult or uncomfortable to talk about certain things in the interview at any time,

please let me know. You can withdraw completely at any time or take a break if you wish.

You will be invited to attend a ten minute debrief session, after the interview has finished and

recording has stopped, to talk about your experience of being interviewed. A list of

confidential support services will also be given to you after the interview.

WHAT WILL HAPPEN TO THE RESULTS OF THIS RESEARCH?

The results of this research will be written up as part of a formal doctoral thesis portfolio and

may additionally be published in psychological or other scientific books or journals or

otherwise reported scientific bodies. Your identity will not be revealed under any

circumstances. If you would like to receive a summary of the

research findings, please inform either myself or my research supervisor.

WHO HAS REVIEWED THIS RESEARCH?

This research project has been reviewed by, and received ethics clearance through the City,

University of London Psychology Department Research Ethics Committee, City, University

of London [Ref: PSYETH (P/F) 15/16 182]

If you have any questions or would like any further information about this research,

please contact me at ████████████████████ **or my research supervisor, Professor**

George Berguno at ████████████████████

Thank you for taking the time to read this information sheet.

Appendix 7: Relevant support contacts

Resources

Anxiety UK

08444 775 774

www.anxietyuk.org.uk

Provides information, self-help resources and support for individuals with anxiety disorders

Anxiety Alliance

0845 296 7877

www.anxietyalliance.org.uk

Provides advice and support to individuals with anxiety disorders

Samaritans

116 123

www.samaritans.org

Phone service providing emotional support. Available 24 hours a day, 365 days a year

Mind

0300 123 3393

www.mind.org.uk

Provides information, advice and resources on all aspects of mental health

British Association for Counselling and Psychotherapy

01455 550243

To find a therapist: www.itsgoodtotalk.org.uk/therapists

UK Council for Psychotherapy

020 7014 9955

To find a therapist: www.ukcp.org.uk

British Psychological Society

To find a psychologist: +44 (0) 116 254 9568

www.bps.org.uk

Appendix 8:   Consent form

Consent Form

Title of Study: The lived experience of individuals with generalised anxiety disorder

Ethics approval code: [PSYETH (P/F) 15/16 182]

I have read and understood the participant information sheet and have had the opportunity to ask questions. Based on this, I understand the purpose of the study and my role in it, and I agree to participate in this research. I understand that my participation is voluntary and that I am free to withdraw at any time without needing to give a reason and without any consequences. I understand that if I withdraw at any time, the recording of my interview will be destroyed.

I consent to the interview being audio recorded using two digital recorders. I understand that the interview will be recorded and listened to only by the researcher, or an examiner if requested and will then be transcribed. I understand that names and identifying information will be removed and replaced by a code to protect my anonymity. I understand that in accordance with the British Psychological Society's guidelines, all data collected will be stored securely for five years before being destroyed.

I agree to the researcher, Laura Young, recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the researcher complying with her duties and obligations under the Data Protection Act 1998.

I understand that confidentiality will be protected throughout the research.

I understand that this consent form will be kept securely and separate from all other research documents and at no point will I be identifiable by name in any part of the research findings.

I understand that the researcher conducting this research is abiding by the Ethical Principles of conducting Research with Human Subjects, set out by the British Psychological Society (2004).

By signing below, I am agreeing that I am a minimum of eighteen years old, and consent to participate in this research.

Appendix 8:   Consent form (cont.)

Participant name (Please PRINT): _____

Participant signature: _____

Date: _____

Researcher signature: _____

Date: _____

Appendix 9:   Written debrief

The lived experience of individuals with generalised anxiety disorder

DEBRIEF

Thank you for participating in this research.

The interview in which you just participated was designed to explore your lived experience of generalised anxiety disorder. In particular, I am interested in how you make sense of this experience. It is hoped that this will increase understanding and awareness of the meaning of this experience to you.

Please let me know if you have any further questions about this research and what I am hoping to achieve with it.

If anything discussed in this interview, or during your completion of the GAD-Q-IV has caused you any distress, please see the attached resources sheet. This sheet provides contact details for organisations that may be able to offer advice and support. These include services specifically for anxiety disorders and counselling services.

If you have any questions, complaints or would like to receive further information about this research and/or a summary of the research findings, please contact me at
███████████████████ or my research supervisor, Professor George Berguno at
███████████████████

Thank you again for participating in this research.

Appendix 10: Sample transcript

Left margin annotations (handwritten codes):

- GAD is scary
- GAD is unpredictable
- Sudden impact
- GAD takes over self

- GAD is unpredictable
- Panic
- Need to escape
- Sudden impact
- Psychological impairment

- GAD is illogical
- GAD is unpredictable
- Sudden impact
- Panic
- Difficulty regaining sense of agency

Right margin annotations (handwritten codes):

- 'Nightmare': terrifying, challenging, 'testing'
- 'Strike'; sudden unpredictable
- Stops, takes control of her, attacks her

- Unpredictable – doesn't know when it will occur 'random', pauses
- Deep breaths – difficult to talk about
- Panic, need to flee
- 'Hit'; sudden attack
- 'Horrible' nasty
- Terrifying
- Challenging

- Doesn't make sense irrational
- Sudden panic
- No specific trigger unpredictable
- Difficult to control

1.1. I: Erm so first Emma would you be able to tell me what it's like living with everyday anxiety?

1.1.1. E: Erm…in a nutshell it's a nightmare. You never know when it's gonna strike. You never know **how** it's gonna strike and you really – it's, it's a nightmare to plan anything. Erm … like with your best will and intention you can **want** to be somewhere [I: Mmhm] but …then it can just strike and it will stop you and … yeah, it's, it's … it's really testing, [I: Mmmm] really testing.

1.1. I: Mmhm. It kind of feels like it just comes on out of, of nowhere, um

1.1.2. E: Yeah it can come from **absolutely** nowhere. Like yesterday I was sitting [IN BREATH] in a restaurant, [OUT BREATH] I say restaurant like, like loosely. It was a fish and chip place [I: Mmhm] erm … and I was just eating my chips … and then I started to feel **panic** so I had to leave, had to leave my chips [I: Mmmm, mmhm] and it's, it's just, it can hit you at the … the most random of times and the most random of places so yeah … it's, it's, it's horrible.

1.1. I: Mmm. Mmhm. Yeah it just comes out … of nowhere.

1.1.3. E: Yep.

1.1. I: Erm and that, you know there's no kind of planning it just, it

[TALKING AT SAME TIME]

1.1.4. E: No

1.1. I: just happens

1.1.5. E: there's no rhyme or reason to it. There's no like [IN BREATH] I know that s-, some people can have just like specific triggers [I: Mmm, Mm] but mine is … **no**, it's, it's just anything, I can all of a sudden just become panicked so [IN BREATH] it's not … it's not really that controllable.

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Appendix 11:   Table of super-ordinate themes for Emma

Participant pseudonym: Emma		
Super-ordinate theme # 1: GAD as transforming the self. Fragility, self-preservation and finding new meaning	**Text ref.**	**Key phrase**
Fragility		
GAD is scary	1.4.23.	The thought process is a scary process
GAD takes over self	1.5.3.	I couldn't control myself
Panic	1.5.1.	I start to feel panicked
Need to escape	1.1.2.	I started to feel panic so I had to leave
Psychological torment	1.3.3.	It's a horrible, horrible thing to have and to live with every day
Difficulty regaining sense of agency	1.5.3.	You really have to sort yourself out … and it, it's so much easier said than done
Comparison with former self	1.2.1.	I've become probably … a quarter of the person that I used to be
Self-criticism	1.4.1.	I constantly do feel like a failure
Self-pressure	1.4.33.	You put pressure on yourself
Shame	1.3.3.	It does sound pathetic
Isolation	1.4.25.	You're just left on your own
Noise sensitivity	1.4.1.	I can't deal with like massive noises
Irritability	1.4.2.	I do get snappy and I do shout
Mind and body disconnected	1.4.8.	I don't actually know that I'm doing it
Internal conflict	1.8.1.	I try not to think too much … and that sounds really strange because obviously I overthink all the time
Regression	1.4.9.	It's a bit like a child, erm … certain parts of it
Difficulty staying with anxiety	1.9.8.	I'm just interested in s- getting my head right. Getting whatever I've got to do, focusing on that and getting out of there
Negative impact of antidepressants	1.4.18.	I tried them and within four days I was suicidal
Guilt	1.10.9.	I'm like 'can you just like keep quiet?', 'sorry mummy' and then I feel terrible
Difficulty accepting GAD	1.4.34.	You gotta learn to … ride with it I s'pose
Physical impact of GAD	1.5.1.	I can get pins and needles, like my hands, I just feel like everything's all of a sudden hot
Self-consciousness	1.9.3.	'Do my cheek bones look too fat?', you know, 'does my bum look too big in this?
Flying provokes anxiety	1.5.3.	They weren't even gonna let me on the second part of the flight because I was a sweaty mess
Exhaustion	1.5.3.	It's draining
Loss of mind	1.7.1.	You don't realise how much, like how important it is until you've lost your marbles
Fear of failure	1.9.1.	Failure … failure's a massive one
GAD is frustrating	1.9.3.	What am I fucking worrying about it for?
Small spaces provoke anxiety	1.10.1.	[I] Are there any situations that make your everyday anxiety worse? [E] Yeah, small spaces
Job loss	1.11.1.	I lost that job erm because I couldn't, I couldn't get into the office
Talking about GAD is draining	1.11.8.	Talking about it is pretty draining

Theme	Ref.	Quote
Physical pain	1.5.1.	I can get pins and needles
Job provokes anxiety	1.11.4.	It started off with work place stress
Self-preservation		
Avoidance	1.2.1.	I'll leave before it's the end so that you don't have all the awkwardness
Importance of self-care	1.6.3.	I'm gonna need to like, have some me time
Staying in comfort zone	1.4.9.	Sometimes I can't even get in the gym. I can't get past the front door
Safety behaviours	1.5.3.	I have to go in the VIP lounge 'cause I can't sit with that noise and the heat. In the VIP lounge there's aircon and it's quiet
Need for release	1.4.13.	I was tapping myself, like in my collar bones and then in my temples, you know, and anywhere else that I could, I felt I would release something
Importance of physical exercise	1.4.8.	Exercise is a big factor
Distraction	1.4.11.	I kept it out of the forefront of my mind and kept myself busy and busy and busy
Reassurance seeking	1.4.13.	I'll be sitting there and I'll be talking to myself like, 'no, you can do it. You can do it'
Self-resilience	1.11.1.	I had an inner strength
Importance of healthy eating	1.4.13.	I try and eat as clean as possible because it does have a massive effect on your mind
Beta blocker as coping mechanism	1.4.16.	I take propranolol just to sss- like slow everything down
Breathing exercises	1.5.1.	You do … have to do what you can and like … deep breaths
Living in the present moment	1.8.1.	If I have to take things minute by minute, I will
Introspection	1.9.8.	I'm anxious, I don't, I'm not interested in anyone else. I'm just interested in s- getting my head right, getting whatever I've got to do, focusing on that
Hypervigilance	1.10.2.	I'm always looking for something that's not right. Like my mind goes into overdrive in an airport because I always think it's going to be bombed
Diazepam as coping mechanism	1.4.1.	Had to take diazepam to get there
Finding new meaning		
Grateful for current existence	1.7.3.	I'm very grateful that I'm still here and I'm still fighting it
New understanding of GAD	1.2.1.	You either let it get a hold of you or you get a hold of it so, that's taken quite a long time for me to realise that but now I am
Regaining sense of agency	1.2.1.	I'm trying to take back the control of my life
Daughter as agent of change	1.3.11.	Can I be bothered to fight it all again? Can I be bothered to go back to square one? And my reason for saying yes is my daughter
Accepting GAD	1.3.1.	Before I suffered … I was like 'urgh what a load of rubbish', you know, 'there's no way that that could happen. There's no way that you could just suddenly feel like that' but it's … it's very true
Antidepressants aren't the answer	1.4.16.	I won't take antidepressants
Seeking an explanation	1.3.5.	My ex-partner was one of those. He was a batterer so erm I would say, you know, a massive trigger for … a lot of my anxi-, like anxiety and anxious ways

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Appendix 11: Table of super-ordinate themes for Emma (cont.)

	Text ref.	Key phrase
New perspectives about others	1.11.11.	I've seen through a lot of people since being this way
Finding comfort in spirituality	1.4.1.	When you suffer, you look more into what the universe gives back to you, erm so yeah seeing butterflies is a massive comfort for me
Doctor as agent of change	1.4.19.	My doctor has been amazing. Without my doctor I really don't think I would be here
Increased openness	1.11.8.	A lot of people now know that I suffer from anxiety
Negative beliefs about worry	1.5.1.	All these what if's? But's and maybe's, they make you worse
Naming it makes it real	1.5.4.	Because you're talking about it, it becomes real again
New appreciation for mental health	1.7.1.	You really do take your mental health for granted erm and you don't realise how much, like how important it is until you've lost your marbles
New appreciation for life	1.7.3.	Before I would, just took things for granted whereas now I appreciate things more
Searching for positives	1.7.4.	I do try now to look for the positive in everything
Increased engagement with life	1.11.6.	Before I probably didn't even see things, I just went through life, and now I, I do notice things
Need for self-change	1.11.8.	I've had to change because I just think, you know, everything literally used to fall into place for me
From self-hatred to self-acceptance	1.11.12.	I love those days now. I used to feel like a failure for 'em but I love those days because now I see them as me knowing that I need to have that time to myself

Super-ordinate theme # 2: Battling with uncertainty

	Text ref.	Key phrase
GAD is unpredictable	1.1.1.	You never know when it's gonna strike, you never know how it's gonna strike
Sudden impact	1.1.5.	I can all of a sudden just become panicked
GAD is illogical	1.1.5.	There's no rhyme or reason to it
Wish to be cured	1.11.6.	My doctor said, 'one day you might snap out of it as quickly as you snapped into it', so that's the hope I've got
GAD is endless	1.4.27.	Not being able to see the end, it's, it's awful
Need for control	1.10.7.	Any situation that I'm not in control of makes me anxious
GAD is complex	1.4.8.	There's a massive combination of things
Need for routine	1.4.9.	I'm alright if I go and go and go but If I have a break then it's getting back into it so it's like a routine thing
GAD is difficult to explain	1.4.11.	It's so hard to like, explain
Catastrophising	1.4.20.	All I can think is like 'oh my God, if I step out of the front door I'm going to get run over'
Excessive worrying	1.9.5.	Now I walk into a room and I think 'oh my God why is everyone looking at me? Have I got something on my face? Have I got toilet roll on my shoe?'
Anticipatory anxiety	1.4.20.	'Oh my God, oh my God, what's what's gonna happen next?' And you just don't know
Excessive thinking	1.4.30.	You're always, always thinking. Over-thinking is terrible
Pre-planning	1.5.3.	I pre-warned the air–, like the airline and said 'I suffer really badly with anxiety. If I'm having a bad day I will need some assistance to get on and off'
Generalised worrying	1.9.1.	I can't even tell you what I don't worry about
Self-doubt	1.2.1.	My confidence has been shattered

Super-ordinate theme # 3: GAD and interpersonal relations	Text ref.	Key phrase
Protecting others from GAD	1.2.3.	More for the sake of my daughter … because I don't want it to affect her
Others don't understand	1.2.3.	Most grown-ups can't get their head round it
Seeing is believing	1.3.1.	A lot of people don't believe it because … you can't see it
Professional help is insufficient	1.3.3.	It needs to be dealt with a lot differently and in a lot … more in-depth way rather than, you know, six counselling sessions and 'oh yeah you'll be fixed'
Antidepressants are doctor's solution	1.3.3.	The doctor's solution for everything is obviously antidepressants
Associated stigma	1.3.3.	There's so much stigma
Concern for others who don't have support	1.4.19.	It shouldn't have to be like put on suicide watch just to get some support. It shouldn't have to get to that point because a lot of people haven't got the strength to pull them out of it
External support	1.11.1.	My doctor's been very supportive. My mum and dad are amazing
Absence of external support	1.3.7.	It's even harder when you don't have the support and you have somebody there that's just constantly belittling it
Impact of GAD on others	1.4.20.	I have to ring my dad to take my daughter to school because I just can't get my head into the game
Interpersonal impact of GAD	1.4.1.	My relationship with my daughter has been strained
Crowded places provoke anxiety	1.4.6.	I'm normally alright unless there's too many of us, like too many people in a small space
Need to explain self to others	1.6.3.	I'm gonna have to say to them "look it's gonna be an early one girls because I need some me time'
Grateful for external support	1.4.31.	I'm very lucky with my mum and dad erm because they are very supportive
Using own experience to help others	1.4.31.	'There's no, there's no like, I'm not gonna tell you it's all of a sudden gonna disappear but I can help you to change the way that your mind thinks'
GAD is hidden	1.4.33.	You'd probably would look at me and you wouldn't even know
Striving to fit in	1.5.1.	You have to adapt to your surroundings as well because like it's happened when I've been sitting in a funeral. It's happened when I've been sitting at a wedding during the speeches. You know, what do ya do then? Can't get up and walk out
Fear of interpersonal rejection	1.9.1.	Me, you know … not making friends with my college course because I'm just too mental
Confrontation provokes anxiety	1.10.2.	Horrible people … like if there's a … an atmosphere
Wish for others to try to understand GAD	1.11.1.	Just … for people to just try and understand it more would be amazing
Importance of external support	1.11.1.	If I didn't have like my mum and dad, that that, pft, I don't know where I'd be
Controlled external persona	1.11.8.	If people ask, yeah I'll give them snippets but I'm not gonna give them fuel to use at me in an argument or, you know, to make them think I'm weak and let them play on my weaknesses
Concern for daughter's wellbeing	1.10.7.	What if someone just comes along and snatches my daughter out of the car?

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Appendix 12:   Table of group super-ordinate themes

1 Battling with uncertainty: What's going to happen next?		Transcript location
a. An endless cycle		
Emma	With labour, you know it will come to an end. [ ] With anxiety … no	1.3.11
Sandy	Thinking. Constant thinking	2.3.7
Rob	It's like an endless cycle of 'what ifs?'	3.2.1
Marie	The thing with GAD is, is that there's no respite from it	4.9.1
Kirsty	You're always anxious about something	5.7.2
Shelley	I'm just always worrying	6.1.4
Sarah	I worry quite a lot about everything	7.7.5
Chloe	Just worry about everything	8.7.5
b. No rhyme or reason		
Emma	There's no rhyme or reason to it [GAD]	1.11.7
Sandy	I've got certain buzz words I use which is: bizarre, odd, strange, erm doesn't make any sense, confusing	2.6.14
Rob	It's a bizarre logic that goes on in your brain sometimes	3.9.3
Marie	They [triggers] can come at any time	4.1.2
Kirsty	It's probably difficult to describe it [GAD] as a whole because I think from day to day it changes	5.1.1
Shelley	I don't know how, I don't know where the thoughts come from	6.9.2
Sarah	That [catastrophising] happens like literally in the blink of an eye	7.7.5
Chloe	I don't know how to explain it [GAD]	8.3.5
c. Grappling with time		
i. Loss of a past self		
Emma	I wanna go out. I wanna get smashed. I wanna be the person that I was	1.4.8
Sandy	I think about how I've been over the years. What I've done, how, what I've achieved	2.8.3
Rob	It [GAD] doesn't let me let it [the past] go. [ ] Things that you have done, erm and mistakes that you've made	3.8.1
Marie	I'll be thinking about all the, back to all the bits that I regret	4.2.5
Kirsty	That's [previous public panic attacks] something that I think about, even if it happened a while ago, it tends to still play on your mind	5.6.2
Shelley	I do look back on things and I worry about it	6.7.1
Sarah	When I first got the anxiety, thinking about the past and old me, and wanting to go back to that was really hard to swallow	7.2.4
Chloe	That's the thing about being a kid again, being like: oh, I just wanna be a kid forever	8.5.3
ii. Anticipatory anxiety		
Emma	What's gonna happen next? And you just don't know	1.4.20
Sandy	I'm a forward thinker. [ ] I'm always thinking about the next bit	2.8.1
Rob	The minute I get up and start the presentation, everything's fine. It's the worrying about it before	3.5.1
Marie	If I've got a meeting coming up at work, erm … my instant thought is: I'm gonna get sacked	4.7.1
Kirsty	I went on holiday at the end of last month but it's something that I planned for [ ] over a year and a half	5.6.2
Shelley	We did have a party in the end but [ ] I was like: 'oh God, what if he [her son] dies before his birthday?'	6.8.1
Sarah	Worrying about … everything that's gonna happen over the next however many years	7.8.1
Chloe	Worrying about the next day	8.4.5
iii. Trying to stay present		
Emma	I just try and take each day at a time. Some days I have to go hour by hour	1.8.1
Sandy	Have a coffee somewhere, just sit there [ ] enjoyed the moment just chilling	2.4.13
Rob	I've tried to stop looking too much in the future	3.9.1
Marie	I try to be spontaneous cos if I plan too much ahead of time, the amount of scenarios I play in my head of what can go wrong is just too much	4.7.1
Sarah	That's why I wanna do yoga, to try and stay in the moment	7.8.1
Chloe	I'm just kinda taking one day at a time. Living more in the moment. I'm trying to at least	8.6.1
d. Doubt		
Emma	Any situation that I'm not in control of, makes me anxious	1.10.7
Sandy	Sometimes I doubt my ability to do what I'm doing, whatever it is	2.1.2
Rob	My confidence has almost eroded away	3.3.6
Marie	I don't let people in. I don't trust anybody	4.4.1
Kirsty	There's lots of things that I would like to do but I can't or, well, I feel like I can't	5.2.2
Shelley	I don't like … what I don't know and where I don't know	6.10.1
Sarah	I don't trust myself. I can't trust my thoughts	7.2.1
Chloe	I'm really scared, like I don't know if I could do it [job]	8.10.8

Appendix 12: Table of group super-ordinate themes (cont.)

2 A struggle for autonomy: You either let it get a hold of you or you get a hold of it		Transcript location
a. GAD takes over self		
Emma	It's not nice not being in control of your own head	1.4.20
Sandy	It's strange. It's like it really takes over	2.4.8
Rob	I've always had this level of worry and anxiety in, in me. [ ] It gets too big and gets out of control	3.2.1
Marie	It controls every aspect of my life	4.1.1
Kirsty	If you do cancel something [ ] it's kind of like the disappointment of letting that consume you again	5.10.3
Shelley	It's totally all-consuming. [ ] It makes it very hard to [ ] do anything	6.11.6
Sarah	The anxiety sort of got the best of me	7.1.2
Chloe	It can blind you, it really can	8.6.1
b. The interplay between mind and body		
Emma	I can get like jelly legs [ ]. I can feel like I'm just going to pass out, like really dizzy, faint	1.6.1
Sandy	At the conference thing I was thinking: I can't actually breathe. I can breathe but then I panic I can't	2.7.7
Rob	It [*GAD*] really does kind of affect your nervous system, your whole central nervous system	3.7.2
Marie	I'd caused myself so much anxiety, I was causing the muscles in my neck to clamp. [ ] I was almost choking myself	4.1.4
Kirsty	I've made myself literally sick with worry	5.7.2
Shelley	I had like my wisdom teeth out and [ ] it just took me weeks to recover from it	6.6.3
Sarah	If I don't eat regularly, I get anxious, erm so making sure I'm eating healthily, eating regularly	7.1.1
Chloe	The most extreme reaction I've had to anxiety [ ] was like [ ] this really physically painful panic attack. [ ] Heart smashing against my chest and my hands were like seizing up	8.4.1
c. I'm torturing myself		
Emma	I do get snappy and I do shout a lot, and I hate myself for that. [ ] I feel like I'm constantly saying no to my daughter	1.4.2
Sandy	What ifs. Can't stand it. It drives, drives me mad	2.9.1
Rob	I worry about failure. [ ] I worry about erm being erm a good father, [ ] a good husband	3.10.4
Marie	I'm suffering with a lot of migraines. [ ] It's almost like I'm torturing myself	4.5.1
Kirsty	I kind of put a lot of pressure on myself to make sure everything's done	5.7.2
Shelley	The reality is, you're the one that's pushing them [*friends*] away, but you twist it in your brain to think: oh, well it's because, you know, I'm a really rubbish person [ ] they don't want me to come	6.2.1
Sarah	It's that feeling bad, cos that's what I did. Like it was all because of me that [ ] we [*Sarah and her husband*] weren't blissfully happy	7.5.1
Chloe	I worry about people laughing at me. [ ] In restaurants I still do it. I'll be like: 'oh, can we go? Cos they're laughing at us or they're laughing at me'	8.8.2
d. I'm in control		
Emma	You either let it [*GAD*] get a hold of you or you get a hold of it so [ ] I'm, I'm trying to take back the control of my life	1.2.1
Sandy	My daughter's text me the other night about a car crash. When I read it, it's that, it's like a almost knee-jerk: 'ooh.' 'No you don't need to react to that. It's fine. It will be fine'	2.11.7
Rob	I'm worrying about things that I need to do, but let's do the 'to do' list cos it, it makes you feel like there's practical things that you can do to resolve it	3.6.13
Marie	I try and distract myself as best, you know, so that's why I like watching either a film or erm going out and doing something, you know, just to try and get that focus elsewhere	4.6.8
Kirsty	You have goals that you wanna set yourself and you do try and push yourself a bit, otherwise it [*GAD*] would just consume you	5.7.1
Shelley	I try and just let the thought cross my mind now and leave my mind, rather than staying in there and worrying about it even more	6.9.1
Sarah	Instead of: 'what if I have a car crash? What if Christmas is awful?' Dur dur dur, stopping that and saying: 'but what's the reality?' and sort of breaking it down	7.1.5
Chloe	I've got like a song I think about that calms me down [ ] just like a toolkit of things to use for anxiety	8.2.4
3 GAD and interpersonal relations: Worrying about what others think		Transcript location
a. GAD through others' lenses		
Emma	A lot of people don't believe it because … you can't see it	1.3.1
Sandy	Cos he [*partner*] doesn't see an, an actual illness of some kind, he can't see it	2.5.3
Rob	She [*wife*] kind of recognises what it is but also the fact that I've done something about it	3.6.1

Appendix 12: Table of group super-ordinate themes (cont.)

a. GAD through others' lenses (cont.)		
Marie	Because [ ] more people have seen how I've responded to certain situations, I think they're finally understanding the level of anxiety I suffer	4.3.1
Kirsty	Some of the mums that I've met at playgroup, erm when I do go, are quite understanding of it	5.4.1
Shelley	He [*partner*] just stopped like going places as well [ ] I would always just like have just this massive panic attack [ ] and he was like: 'I can't deal with that'	6.4.6
Sarah	Fortunately, the woman that was interviewing me suffered really badly with anxiety as well, so she was really understanding	7.5.1
Chloe	My mum had always been like: 'oh you're just a worrier', [ ] and it was just disregarded as petty. [ ] 'Oh you're just being silly. Just making it up'	8.2.10
b. Striving to belong		
Emma	Not fitting in [ ] I didn't care what people thought of me [ ] I didn't care but now I do	1.9.2
Sandy	Wanting to be on my own is because if I, if I'm in my own space, then I haven't got to speak to anyone, and I haven't got to talk about anything	2.2.3
Rob	They [*colleagues*] would say that I'm very confident [ ] what it [*GAD*] does is it puts a façade up [ ] and people will think that, that I'm ok but I, actually inside I'm, I'm not	3.3.2
Marie	If I have someone round, it's er trying to make sure my house is tidy, doesn't smell	4.4.17
Kirsty	I perhaps ate more than I normally would [ ] because everybody expects you to be eating, because that's a normal situation, so I think sometimes you overcompensate for that	5.5.4
Shelley	It's quite lonely as well because you think you're the only person who feels like that, [ ] so [ ] by its nature, I think you cut yourself off from a lot of people	6.1.3
Sarah	Going into make-up feeling very aware that everyone else [*her wedding party*] is very normal, and I'm not normal	7.7.1
Chloe	My colleagues not liking me. I worry about what other people think a lot	8.1.10
c. Helpfulness of support		
Emma	It [*GAD*] needs to be dealt with [ ] in a lot more in-depth way rather than, you know, six counselling sessions and: 'oh yeah, you'll be fixed. Oh, deal with it yourself'	1.3.3
Sandy	He's [*partner*] not been there [ ] all he's done is shun me away, and been very erm dismissively ridiculous	2.5.1
Rob	I was put on venlafaxine [ ] if you've got that [*GAD*] in your medical history, [ ] it's almost as if the doctors go: 'it's that again'	3.5.4
Marie	The CBT changed my life. [ ] now, I'm a lot more upbeat, a lot more erm flowy with how I move	4.6.3
Kirsty	They [*long-term friends*] come round like to see me, and to spend time with my son, erm and maybe take my son out	5.4.1
Shelley	Thank God for her [*physician*] because I dread to think. I honestly, I couldn't have carried on as I was	6.6.5
Sarah	They're [*physicians*] just there to diagnose you. [ ] They don't have an interest in you personally	7.1.4
Chloe	He [*father*] was very soft on me [ ] he was like: 'if you get too nervous, just come home', and I did	8.3.2
d. Concern for others' welfare		
Emma	My daughter's going back to school on Tuesday, and I'm worried that she's not going to have any friends, that she won't settle in, that she won't like her lunch	1.9.1
Sandy	I wouldn't wanna talk to friends that have had a tough time cos I don't want them to feel they're taking a burden of my issues on	2.3.4
Rob	If me saying that this is happening to me helps at least one other person, then it's, it's, it's ok because I think a, a lot of it is, a lot of people suffer in silence	3.6.6
Marie	I try not to push my anxieties on 'em [*her children*], but I'm tryna also protect 'em as well [ ] cos I know children can be cruel	4.4.13
Kirsty	My sister has to take my son to the farm because I … stop him from doing things there [ ] even though it's a petting zoo [ ], I worry that he might get bitten and seriously hurt	5.8.1
Shelley	I didn't want him [*her son*] to [ ] see me worry about going out because then he would probably worry about it too. [ ] I was really determined to try and get better for him	6.12.7
Sarah	It's nice now, sort of being on the other side of it. Being able to say to people like: 'I know it's really rough but there is a way out, and you know, you just have to kind of find your way'	7.4.3
4 The need to create meaning amid uncertainty and loss: GAD is an eye-opener		**Transcript**
a. Learning to ride with GAD (I suppose)		**location**
Emma	It's one of those things. You gotta learn to … ride with it I s'pose	1.4.34
Sandy	I've had to ride it [ ], I've had really bad times [ ] I've had to say to myself: 'just ride it out'	2.11.3
Rob	I think I've kind of working on the techniques to just try and [ ] understand it and work with it	3.1.2
Marie	I have to just ride it [*anxious thoughts*] out and get through the other side	4.7.1

Appendix 12:   Table of group super-ordinate themes (cont.)

a. Learning to ride with GAD (I suppose) (cont.)		
Kirsty	Nobody can't, just lives with everyday anxiety [*GAD*] and just says: 'oh, that's ok, like no problem'	5.7.1
Shelley	I also learnt [ ] by avoiding things, [ ] I'm avoiding having the panic attack [ ]. Now I think I know that, I can try and work round it	6.12.1
Sarah	If we're gonna have a baby, we're gonna have a baby. If it heightens my anxiety, then we'll deal with it [ ] but spending time obsessing over it [ ] and catastrophising … doesn't do anything for me	7.2.4
Chloe	This is the first job where [in-breath] everyone knows about it [ ] I didn't have to worry all the time about … hiding it	8.3.29
b. Now I appreciate things more		
Emma	I'm very grateful that I'm still here and I'm still fighting it. [ ] Now I appreciate things more	1.7.3
Sandy	I have some time there [*at café*]. [ ] I've built that into my week so that I completely give myself that time	2.4.13
Rob	You never know what's going on inside someone's head. [ ] That person [ ] may be facing some real erm difficult times in their life and still trying to come to work, as I was	3.12.3
Marie	As much as I do suffer with anxiety [in-breath] … I'm still here and [ ] I've still got a reason to smile every day	4.6.1
Kirsty	It's important to take some time out for yourself. [ ] For a long time I kind of stopped doing everything that I enjoyed. Erm I've recently started like reading again	5.6.4
Shelley	I like seeing people, and it's not that I ever didn't like that, so the fact I can now do that again [ ] makes you feel better, and that knocks on, I think, to the next thing	6.4.8
Sarah	I'm also really grateful for where I am at the moment	7.3.2
Chloe	I definitely like myself now. Before, I, I like despised who I was	8.2.2

Appendix 13:   Ethics approval letter

CITY UNIVERSITY LONDON

Psychology Research Ethics Committee
School of Arts and Social Sciences
City University London
London EC1R 0JD

25th April 2016

Dear Laura Young and George Berguno

Reference: PSYETH (P/F) 15/16 182

Project title: The lived experience of individuals with generalised anxiety disorder

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:
     (a) Recruit a new category of participants
     (b) Change, or add to, the research method employed
     (c) Collect additional types of data
     (d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee ██████████████████ in the event of any of the following:
     (a) Adverse events
     (b) Breaches of confidentiality
     (c) Safeguarding issues relating to children and vulnerable adults
     (d) Incidents that affect the personal safety of a participant or researcher
Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Hayley Glasford   Katy Tapper
Course Officer   Chair
Email: ██████████████   Email: ██████████████

Appendix 14:   Analysis chapter format

Direct quotations from participants, including grammatical errors, are used throughout the Analysis chapter. Following each quote, the participant's pseudonym and transcript location are included in parentheses (Emma: 1.1.1). Transcript location is depicted via a three-number system; participant, question, and paragraph number respectively. Omitted material is indicated by: [ ]. Occasions requiring additional explanatory material to provide clarity, are indicated by italicised text in parentheses: [*partner]*. Non-verbal communications are also placed in parentheses: [laughter]. Pauses are indicated by: … and words in bold were emphasised by participants. In selecting material across themes, my aim was to capture the lived experiences of the whole group, whilst ensuring that each participant's voice is present throughout the full analysis. In some themes, I felt it necessary to include a wider range of accounts that capture the various textures of experience. In other themes, I chose to select quotations from a smaller number of participants, whose narratives contain rich descriptions of the phenomenon, or evoke striking insights. A full set of quotes for each theme is included within the table of group super-ordinate themes (Appendix 12).

I found that the four resultant super-ordinate themes were able to contain the range of idiosyncratic experiences across the group. My aim in creating these themes was to ground my psychological interpretations of the data in the participants' words, thus maintaining connection between the 'I' and 'P' in IPA (Smith et al., 2009). Theme titles consequently marry my own interpretations; including psychological language, with participant quotations. Most subordinate theme titles also derive from participants' accounts.

Section B: Combined Case Study and Process Report

Cognitive Behavioural Therapy for Exaggerated Fatigue and Anxiety: Forming a New Relationship With Anxiety

This section of the portfolio has been omitted for confidentiality purposes. It can be consulted on application at the Library of City, University of London

Section C: Journal Article

The Lived Experience of Generalised Anxiety Disorder: Battling With Uncertainty and the Self

Appendix 15: *Journal of Phenomenological Psychology* **instructions for authors**

Instructions for Authors
Last revised on 1 February 2018

Scope

The peer-reviewed *Journal of Phenomenological Psychology (JPP)* publishes articles that advance the discipline of psychology from the perspective of the Continental phenomenology movement. Within that tradition, phenomenology is understood in the broadest possible sense including its transcendental, existential, hermeneutic, and narrative strands and is not meant to convey the thought of any one individual. Articles advance the discipline of psychology by applying phenomenology to enhance the field's philosophical foundations, critical reflection, theoretical development, research methodologies, empirical research, and applications in such areas as clinical, educational, and organizational psychology. Over its four decades, the *Journal of Phenomenological Psychology* has consistently demonstrated the relevance of phenomenology for psychology in areas involving qualitative research methods, the entire range of psychological subject matters, and theoretical approaches such as the psychoanalytic, cognitive, biological, behavioral, humanistic, and psychometric. The overall aim is to further the psychological understanding of the human person in relation to self, world, others, and time. Because the potential of continental phenomenology for enhancing psychology is vast and the field is still developing, innovative and creative applications or phenomenological approaches to psychological problems are especially welcome.

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Prior to submission, authors are encouraged to read the 'Instructions for Authors'. When submitting via the website, you will be guided stepwise through the creation and uploading of the various files.
A revised document is uploaded the same way as the initial submission. The system automatically generates an electronic (PDF) proof, which is then used for reviewing

purposes. All correspondence, including the editor's request for revision and final decision, is sent by e-mail.

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Submission Requirements

Language

Manuscripts should be written in English. Spelling (British or American) should be consistent throughout.

Manuscript Structure

All submissions must be double spaced and fully justified. The beginning of each new paragraph should be announced by an indentation of one tab.

Abstract and Keywords

Each submission should include a 100-150-word abstract in block paragraph form and 2-6 keywords.

Headings

Headings should be flush left. First level headings are bold, second level headings should be in bold italics.

Block Quotes

Quotations longer than 40 words should be placed in an indented block paragraph.

Citation in the Text

In the body of the text, use the author-date method of in-text citation: Surname, 2009.

References and Footnotes

References and footnotes should follow APA guidelines. References are listed in alphabetical order.

Journal Article

Author, A.A., Author, B.B., & Author, C.C. (2009). Title of the article. *Journal Title*, Vol. 12 (4), 1-10.

Books

Author, T.H.E. (2008). *The title of the book*. Location: Publisher.

Edited Book

Author, T.H.E., & Author, A. (Eds.) (2009). *The title of the book*. Location: Publisher.

Article in Edited Book

Author, A.A., & Author, B.B. (2009). Title of chapter. In A. Editor & B. Editor (Eds.), *Title of the book*, (pp. 1-10). Location: Publisher.

Electronic Sources (Periodicals)

Author, A.A., & Author, B.B. (2009). Title of article. Title of Online Periodical, volume number (issue
number if available). Retrieved month day, year, from
http://www.someaddress.com/full/url/.

Electronic Sources (Non-periodicals)

Organization XYZ (2008). Title of article. Retrieved month day, year, from:
http://www.someaddress.com/full/url/

Newspaper Article

Author, A. (2009, January 6). The title of the article. *Newspaper Title*. Retrieved
http://www.someaddress.com/full/url/
Author, A. (2009, January 6). The title of the article. *Newspaper Title,* pp. 3.

Figures

References to figures should consist of the complete word only at the beginning of a sentence and in the figure captions; otherwise the abbreviations "Fig." or "Figs" are used. Figure captions should not be attached to the figures but should be included as a separate page at the end of the manuscript.
Figures should be submitted as separate source files in .eps, .tif, or .jpg format, in a size suitable for the typesetting area of the journal which is 115 x 180 mm; space should also be left for the figure caption. The resolution of these files should be at least 300 dpi for half-tone figures, and 600 dpi for line drawings. Number the files and indicate in the manuscript where they are to appear (Fig. 1 about here).
The text in a figure must be legible and should not be smaller than corps 8. The size of this lettering for any text in a figure should be the same for all figures in the manuscript.
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