Living with panic disorder and generalised anxiety disorder in South Africa: an explorative study of lived experiences

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Abstract

This study explores the lived experiences of South Africans diagnosed with Panic Disorder (PD) and/or Generalised Anxiety Disorder (GAD). Guided by a relativist ontology and interpretivist epistemology, the study recognises participants' experiences as subjective and shaped by emotional, social, and cultural contexts. An explorative qualitative research design was employed, and eight participants took part in semi-structured interviews exploring how they understand, describe, and manage anxiety within their everyday lives. Data were analysed using reflexive thematic analysis.

Five main themes were identified: understanding participants' experiences with GAD and PD, the link between anxiety and depression, strategies for coping with anxiety, control as trigger and relief, and living with anxiety. Participants often struggled to differentiate between anxiety, PD, and GAD, suggesting limited understanding of diagnostic distinctions. Anxiety was frequently described through metaphors and physical sensations rather than clinical language. Participants also experienced anxiety and depression as closely intertwined, reflecting substantial co-morbidity. Coping strategies ranged from grounding techniques and structured routines to avoidance, emotional withdrawal, and substance use. A strong need for control also emerged across participants' accounts, with anxiety often linked to uncertainty and unpredictability. Living with anxiety further disrupted help-seeking, relationships, work, and daily functioning.

This study contributes to limited qualitative research on anxiety disorders in South Africa by highlighting the emotional, cognitive, and bodily complexity of living with PD and GAD. The findings emphasise the importance of accessible, culturally responsive, and compassionate mental health support.

Keywords: Panic Disorder; Generalised Anxiety Disorder; Lived Experience; Qualitative Research; Reflexive Thematic Analysis; Mental Health Literacy; Coping Strategies; Control; Stigma; South Africa.

List of Acronyms

Acronym	Full Term
APA	American Psychiatric Association
BM	Biopsychosocial Model
CREC	CHS Health Research Ethics Committee Reference Number
GAD	Generalised Anxiety Disorder
GAD-7	Generalised Anxiety Disorder – 7 Item Scale
GMH	Global Mental Health
LMIC	Low- and Middle-Income Country
MHCA	Mental Health Care Act (2002)
NHREC	National Health Research Ethics Council
PD	Panic Disorder
PHQ-PD	Patient Health Questionnaire – Panic Disorder Module
SADAG	South African Depression and Anxiety Group
TPT	Triple Vulnerability Theory

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Chapter 1 Introduction

1.1 Introduction

South Africa has been facing a growing mental health crisis, which was further intensified by the collective trauma and loss of the post-Covid-19 era (Nguse & Wassenaar, 2021). When you consider the country's status as a low- and middle-income country (LMIC), the weight of this crisis becomes even clearer. LMICs are characterised by societal conditions such as high levels of poverty, unemployment, and violence, which often exacerbate mental health challenges among their populations. Despite these growing needs, South Africa's mental health services remain underdeveloped and largely insufficient to handle the actual burden of care (Burns, 2011). While the implementation of the Mental Health Care Act (MHCA) in 2004 was a necessary step toward reform, the reality of care on the ground remains inadequate (Burns, 2011; Nguse & Wassenaar, 2021). To improve the provision of mental health care in South Africa, it is essential that the implementation of the MHCA reflects the views and needs of individuals living with mental disorders (Burns, 2011; de Pinho et al., 2021). This requires a shift in how we develop interventions; as Hertado et al. (2020) emphasise, support must be tailored to the specific challenges of the individual. More responsive mental health care can be achieved by incorporating patients' experiences into the development of treatment and intervention strategies.

Against this backdrop of systemic failure and social stress, this research seeks to gain a deeper understanding of how individuals living with specific anxiety disorders experience their everyday lives. Rather than looking at statistics alone, the study explores the study explored participants lived experiences of anxiety, including how they understand and describe their symptoms, cope with distress, seek help, and navigate daily life.

1.2 Overview

It is important to highlight the growing mental health challenges in South Africa. Data from a national study conducted post Covid-19 by Craig et al. (2022) indicates that mental health issues remain widespread across the adult population. Despite the increasing prevalence of anxiety disorders, individuals presenting with anxiety in primary health care (PHC) settings often receive limited attention. Most individuals are managed as outpatients, which often results in reduced access to the specialized care available to those with more "observable" psychotic disorders (Bandelow & Michaelis, 2015). Although mental health care in South Africa is primarily managed within PHC settings, as stipulated in the National Health Strategic Plan (2019), this means care is primarily provided by general practitioners (GPs) and nurses who may lack the specific training required to navigate complex anxiety disorders (Robertson & Szabo, 2017). While GPs and nurses play a vital role in providing care, the integration of mental health services into PHC without sufficient training in anxiety disorders may compromise the quality of treatment and intervention (Schierenbeck et al., 2013). As a result, anxiety disorders are often under-recognised in PHC settings, as GPs may struggle to distinguish between normal stress responses and chronic anxiety that interferes with daily functioning (Ford et al., 2016). In addition, anxiety disorders are often overshadowed by depression (Archer et al., 2021), and even when diagnosed, the diagnosis may remain non-specific (Hurtado et al., 2020). This suggests that GPs may fail to differentiate between specific anxiety disorders such as Panic Disorder (PD), specific phobia, or Generalised Anxiety Disorder (GAD) (Ford et al., 2016).

Anxiety can be defined as a negative, future-oriented mood state characterised by a subjective sense of unease or worry (Adwas et al., 2019; Wearne et al., 2019). It is often accompanied by physiological symptoms such as mental tension and an elevated heart rate (Bandelow & Michaelis, 2015; Craske et al., 2011). This study focuses on two specific anxiety disorders: PD and GAD. For those with PD, this manifests as a sudden, overwhelming surge of fear (Diagnostic and Statistical Manual of Mental Disorders [DSM-5-TR], American Psychiatric Association, 2022), while GAD involves an uncontrollable, persistent worry that erodes one's quality of life (Anthony & Stein, 2009; Hurtado et al., 2020). Despite these distinct markers, individuals are often diagnosed with multiple anxiety disorders simultaneously (Herman et al.,

2009; Lépine, 2002; Michael et al., 2007; Van Heyningen et al., 2017). This creates a particularly complex relationship between PD and GAD which increases vulnerability to co-occurrence (Hurtado et al., 2020). Furthermore, anxiety disorders frequently co-occur with other mental health conditions, particularly depression. Craig et al. (2022) reported that nearly 60% of participants who were likely to have depression also reported probable anxiety. Beyond co-morbidity, symptoms often overlap across anxiety disorders and other mental health conditions, including depressive and substance use disorders (APA, 2022; Craske et al., 2011; Lépine, 2002).

Individuals diagnosed with more than one mental disorder often experience a reduced quality of life, affecting both social and personal functioning (Lépine, 2002). This co-morbidity often leads to poorer recovery and a higher risk of suicide, yet only a small fraction of South Africans seek the help they need (Barlow & Durand, 2015; Nguse & Wassenaar, 2021). A large portion of this hesitation is rooted in a society where anxiety is minimized as "thinking too much" or normalized as simple stress (Sorsdahl et al., 2010). Stigmatisation continues to persist due to limited knowledge and understanding of mental disorders (Schierenbeck et al., 2013), which influences how mental health concerns are interpreted and supported both socially and within PHC settings. Anxiety disorders are often misunderstood and under-recognised, partly due to the greater attention given to other mental disorders. Public awareness is often higher for psychotic disorders such as bipolar disorder or schizophrenia, which are associated with more observable behaviours. When the "inner world" of the sufferer is branded as 'mad' or dismissed by medical staff, the individual is left unable to make sense of their own symptoms (Abrahams et al., 2021; Radez et al., 2022). Ford et al. (2016) emphasised that how individuals describe their symptoms plays a crucial role in whether these symptoms are accurately identified and diagnosed.

When you consider that many South Africans struggle to even identify their own symptoms due to a persistent lack of information, the necessity of a person-centred approach becomes undeniable. This research shifts the focus to the internal world of the individual. By prioritizing qualitative inquiry, we can begin to uncover the raw, subjective ways that people actually navigate and interpret anxiety within the specific context of their everyday lives.

1.3 Problem statement

Living with an anxiety disorder in South Africa presents unique challenges since cultural beliefs and stigmatisation frequently downplay the struggles of individuals living with this mental health condition (Abrahams et al., 2021). South African literature on anxiety disorders has predominantly analysed the issue through a quantitative lens. These studies remain important, as they provide a foundational understanding of anxiety disorders in South Africa and contribute valuable knowledge regarding risk factors, symptoms, etiology, and treatment approaches (Adwas et al., 2019; Bantjies et al., 2023; Herman et al., 2009; Nel et al., 2018; van Heyningen et al., 2017). In addition to informing mental health statistics, quantitative research studies do more than just generate statistics, they provide the evidence needed to show how exposure to trauma and the weight of the Covid-19 pandemic have exacerbated mental health challenges.

This study, however, advocates for a shift in anxiety research towards a qualitative, person-centred approach. Although limited in number, some South African studies have adopted qualitative methods to explore how anxiety affects individuals. One such study by Ntsayagae et al. (2019) examined the experiences of family caregivers of individuals with mental illness and confirmed the persistent stigma surrounding mental health in South Africa. However, the study primarily focused on caregivers rather than individuals living with the disorder. While it is important to recognise the broader impact of mental illness, it is equally important to understand the experiences of those directly affected. This is particularly relevant for anxiety disorders, which, despite being highly prevalent, are associated with serious psychological consequences, including an increased risk of suicidal ideation and behaviour (Bentley et al., 2016). Furthermore, much of the existing research treats anxiety as a generalised concept. Although anxiety disorders share certain characteristics, each disorder presents distinct challenges. A generalised approach limits the ability to understand the unique features of specific conditions such as PD and GAD, which is essential for developing targeted interventions and treatment strategies (Beesdo-Baum & Knappe, 2012).

In contrast to South African literature, there is a substantial body of international research exploring the lived experiences of individuals with anxiety disorders. While these studies contribute valuable insights into how anxiety affects individuals, many examine anxiety

alongside depression, limiting a focused understanding of anxiety-specific experiences. Moreover, findings from Western contexts cannot be assumed to reflect the lived realities of individuals in LMICs such as South Africa. Understanding the unique social, cultural, and structural context is essential for informing effective policy and mental health strategies (Richter et al., 2021). Consequently, there remains a gap in qualitative research that explores how individuals in South Africa experience anxiety disorders within their specific context. This study therefore aims to address this gap by focusing on the lived experiences of individuals with PD and GAD in South Africa. By centring the perspectives of those directly affected, the study seeks to contribute to a more nuanced and contextually grounded understanding of anxiety disorders, ultimately supporting the development of more effective and responsive mental health interventions.

1.4 Rationale

The reality of nearly 90% of annual suicides worldwide occur in LMICs, it raises significant concerns regarding mental disorders and their treatment in these contexts (Burns, 2011). When you consider that mental illness is also tied to reduced earnings, it becomes clear that these disorders do not just affect the individual, they destabilize the socio-economic foundation of the entire region (Lund & Stein, 2013). Additionally, disparities in access to mental health resources in South Africa represent a significant human rights concern (Burns, 2011). The lack of awareness and persistent misconceptions surrounding mental health, particularly anxiety disorders, are evident both within South African society and at a systemic level. This is reflected in the limited prioritisation of mental health, with only 5% of the overall health budget allocated to mental health services (Docrat et al., 2019). These factors contribute to ongoing barriers in the treatment and management of mental health conditions.

While quantitative studies are necessary to map the scale of this problem, an over-reliance on quantitative data may obscure the subjective realities of individuals living with anxiety (Herman et al., 2009; van Heyningen et al., 2017). This is particularly concerning given the significant psychological consequences associated with anxiety disorders, including an increased risk of suicidal thoughts and behaviours (Bentley et al., 2016). These risks underscore the need to move

beyond research focused primarily on diagnostic patterns and treatment outcomes towards approaches that capture lived experience (Craig et al., 2022; Moitra et al., 2023). The need for a greater emphasis on qualitative approaches becomes evident when examining the treatment landscape in South Africa. While quantitative data has mapped the scale of the problem, it does not fully capture how these conditions are experienced in everyday life. Research suggests that even among those who seek treatment, recovery is often delayed by inappropriate or insufficient care, or failure to recognise anxiety as distinct from other disorders (Lépine, 2002). Since the first point of contact is usually a GP at the PHC level, a doctor's own misconceptions can dictate whether a patient receives an accurate diagnosis or is simply dismissed (Archer et al., 2021; Ford et al., 2016).

The consequences of this mental health illiteracy extend beyond clinical settings into broader society. Stigma remains prevalent, with individuals often labelled as ‘mad’, which further discourages help-seeking behaviour (Abrahams et al., 2021). This stigmatisation also affects families and caregivers, who frequently experience fear, misunderstanding, and a lack of support (Ntsayagae et al., 2019). As a result, individuals and their support systems are often left without the necessary understanding or resources to manage mental health conditions effectively. Furthermore, the lack of knowledge surrounding anxiety disorders affects individuals directly, as they may struggle to recognise or interpret their own symptoms. ltimately, this internal and external lack of knowledge means that many sufferers cannot even articulate their own symptoms, making professional help feel out of reach (Radez et al., 2022). Addressing this requires a shift in focus towards understanding the subjective experiences of individuals living with anxiety, as this can inform both improved service delivery and greater self-understanding among patients.

Mental health care should therefore be responsive to the needs and perspectives of those experiencing mental disorders (Burns, 2011). Local idioms like ‘talking with the heart’ or a ‘hot head’ which correspond to DSM-5-TR symptoms such as excessive worry and mental exhaustion, show that anxiety is not a static experience. Rather it is shaped by cultural factors that must be understood if treatment is to be effective (Mosotho et al., 2011; de Pinho et al., 2021). Historically, research has prioritised clinical and statistical perspectives over the lived

experiences of individuals with anxiety disorders (Kadam et al., 2001). This study aims to address this gap by focusing on the subjective experiences of individuals with PD and GAD in South Africa. By doing so, the study seeks to contribute to a more nuanced understanding of anxiety disorders and support the development of more contextually relevant and effective mental health interventions.

1.5 Theoretical framework

The foundation of this research rests on the biopsychosocial model (Engel, 1980), which emphasises the interaction between biological, psychological, and social factors in understanding mental health. Barlow (2002) provides a framework for understanding the development of anxiety disorders through biological and psychological vulnerabilities. These two frameworks are situated within a Global Mental Health perspective. Consequently, the study acknowledges that mental health experiences are shaped by social and cultural contexts. A more detailed discussion of these frameworks is provided in Chapter 2.

1.6 Purpose of the study

Mental health research in LMICs has been significantly neglected, and this lack of data affects the development of effective mental health resources and services, particularly in underserved communities (Msotho et al., 2011). In South Africa, research on anxiety disorders has often overlooked qualitative approaches, particularly studies exploring the lived experiences of individuals with PD and GAD. This qualitative research was driven by a need to raise awareness about anxiety disorders in South Africa in order to advance the development and implementation of effective mental health strategies. The goal is to understand how people experience and interpret anxiety within their own lives (Whitley & Kite, 2013). This viewpoint allows researchers to gain valuable insight into individuals' perceptions of the world, thereby fostering a deeper understanding from a different perspective (Austin & Sutton, 2014).

The high prevalence of anxiety disorders in South Africa emphasises the importance of understanding how individuals experience these conditions (Adwas et al., 2019; Bantjies et al., 2023; Craig et al., 2022; Herman et al., 2009; Nel et al., 2018; van Heyningen et al., 2017). For

many, living with a mental disorder isn't just a psychological burden, it is a financial one, often resulting in lost income and reduced capacity to work (Lund et al., 2013; Bertilsson et al., 2013). Therefore, daily life becomes a struggle against fatigue, mental tension, and the constant weight of concentration difficulties (Hurtado et al., 2020). Additionally, it is crucial to understand the experience of anxiety within South African culture. Msotho et al. (2011) highlights that culture significantly influences the experience of mental disorders such as PD and GAD, which fundamentally shapes how symptoms are described, presented, and understood. Navigating GAD or PD in this context means facing a society where cultural beliefs and the heavy stigma of "mental illness" often trivialize the sufferer's reality (Abrahams et al., 2021; Schierenbeck et al., 2013).

This study therefore adopted an explorative qualitative approach focused on the lived experiences of South Africans diagnosed with PD and/or GAD. Rather than categorising participants or imposing predefined frameworks, the study aims to understand anxiety as it is experienced subjectively and in its most authentic form. While contextual factors such as stigmatisation, access to mental health care, and cultural beliefs are not the primary focus, they are acknowledged as shaping how these experiences are understood and lived.

1.7 Research question and objectives

In qualitative research, it is generally worthwhile to ask open-ended research questions to allow for a thorough, in-depth exploration of the phenomenon under study (Korstjens & Moser, 2017; Leavy, 2017). When you consider that living with an anxiety disorder in South Africa involves navigating cultural beliefs and the heavy stigma attached to "mental illness," it becomes clear that a purely quantitative approach may not fully capture the most important aspects of these experiences. (Abrahams et al., 2021). In this context, the study seeks to address the following research question: how do South Africans live with PD and/or GAD in an environment where their struggles are so often dismissed or misunderstood?

The objectives of this research were to:

- Explore participants' understanding and awareness of PD and GAD within the South African context

- Explore the lived experiences of the participants living with PD and GAD within the South African context.
- Explore how stigma influences the experiences of individuals living with PD and GAD.
- Explore the coping strategies and help-seeking behaviours of individuals living with PD and GAD.

To achieve this, the study explored: (1) what living with PD and/or GAD subjectively feels like, (2) how PD and/or GAD manifests, (3) how participants cope with these conditions, and (4) whether participants have sought treatment and their reasons for doing so.

1.8 Outline of Chapters

Chapter 1 establishes the context for the study by closely examining the current state of mental health care in South Africa. It builds a rationale for why we need to look past statistics and investigate anxiety disorders—specifically PD and GAD—through a qualitative lens. Beyond defining the core problem and research aims, this chapter introduces the theoretical frameworks that guide the inquiry and provides a roadmap for the rest of the work.

Chapter 2 engages with the existing literature, bringing together research on the prevalence of anxiety and the complexities of co-morbidity in a local context. When you consider both local and international studies, a clear gap becomes obvious, very few researchers have explored the lived experience of anxiety disorders within South Africa. This chapter focuses on the scarcity of qualitative research.

Chapter 3 outlines the methodological approach of the study, explaining how a relativist ontology and an interpretivist epistemology actually shape the way we understand these personal realities. It details the research design, including the sampling strategy, data collection methods, and thematic analysis approach. The chapter also places a heavy emphasis on ethics and reflexivity, ensuring the research remains both rigorous and honest.

Chapter 4 presents the findings derived from the reflexive thematic analysis. The themes provide insight into participants' experiences, including how stigma is described, how anxiety affects

work and personal relationships, and how individuals navigate help-seeking It also examines the physical manifestations of panic and the heavy internal struggle of trying to find help.
Chapter 5 provides a synthesis of the findings by interpreting them in relation to existing literature and the study's theoretical framework. By reflecting on these findings, this chapter identifies exactly where local experiences challenge or expand upon what we already know. It concludes by summarizing the study's contributions and offering practical suggestions for future research, policy, and how mental health is practiced in South Africa.

1.9 Conclusion

This chapter established the foundation of the study by framing the significance of anxiety disorders within the South African mental health landscape. When you consider that nearly one in five South Africans struggle with anxiety every year, the scale of the challenge is impossible to ignore (Bantjies et al., 2023; Craig et al., 2022). These difficulties do not exist in a vacuum; they are fuelled by the daily reality of poverty, unemployment, and community violence—stressors that don't just surround the population, but actively erode their mental well-being (Bantjies et al., 2023; Lund et al., 2013)

Importantly, this chapter acknowledged that existing quantitative research remains essential, as it provides foundational knowledge regarding the prevalence and severity of anxiety disorders in South Africa (Bantjies et al., 2023; Herman et al., 2009; Nel et al., 2018; van Heyningen et al., 2017). However, these numbers primarily provide the clinical markers of the disorder rather than the human story. Beyond the data, cultural stigma and limited mental health literacy continue to shape how anxiety is perceived and understood in South Africa (Abrahams et al., 2021; Schierenbeck et al., 2013), and existing studies have often overlooked the individual with the disorder in favour of those around them (Ntsayagae et al., 2019).

The theoretical framework grounding this study recognises that individuals construct meaning in different ways and therefore supports an approach that values participants' subjective accounts as legitimate forms of knowledge. This framework recognises the importance of understanding lived experience within the specific social and cultural environment in which it occurs,

particularly within LMIC settings like South Africa (Moitra et al., 2023). By centering on the individuals themselves, the study was able to explore what PD and GAD actually feel like and how people interpret their own symptoms. By placing individuals with anxiety at the centre of inquiry, the study aims to contribute to improved mental health literacy and to the development of more responsive and person-centred mental health care in South Africa.

Chapter 2 Literature Review

2.1 Introduction

Chapter 1 sets the stage for the research by looking at why anxiety disorders are such a pressing issue within South Africa's specific mental health context. It makes a case for why we need to move beyond purely statistical data to understand these conditions, focusing instead on the necessity of a qualitative shift. This approach is vital because it allows us to see how individuals actually navigate and interpret anxiety within the visceral reality of their daily lives.

Building on this foundation, Chapter 2 engages with existing literature relevant to the study. It examines the structural failures of the South African healthcare system, the prevalence of anxiety disorders, and the broader socio-economic and cultural factors that shape mental health experiences. This section further explores the conceptual markers of PD and GAD, as well as the complexities of co-morbidity and the lived experience of anxiety.

By comparing international and South African research in order to highlight existing knowledge, key gaps in the literature were identified, particularly, the limited focus on the subjective experiences of individuals living with anxiety disorders in South Africa. The chapter concludes with a discussion of the theoretical framework guiding the study, which supports a contextually grounded understanding of anxiety and reinforces the need for qualitative inquiry.

2.2 Mental health care in South Africa

According to Schierenbeck and colleagues (2013), the right to health is incomplete unless it gives equal weight to both physical and mental well-being. This is a vital distinction to make in South Africa, a country where mental illness is a widespread crisis that ripples through the entire socio-economic structure. When you look at the mounting pressure on mental health services in LMIC's, it becomes clear that South Africa is struggling under a disproportionate share of this global burden (Van Wijk et al., 2021; Craig et al., 2022). The scale of this strain suggests that our current approach is failing to meet the actual needs of a population already navigating the daily realities of poverty and systemic inequality. Although South Africa has made large strides

towards understanding mental health systems and monitoring the progress of the system towards the global mental health goals, there remains significant gaps which are a cause for great concern (Docrat et al., 2019). The mental health care system in South Africa is under significant strain, due to the country's challenging socioeconomic conditions and historical political factors (Bantjies et al., 2023). The country continues to be plagued by high unemployment rates, income inequality, poverty, widespread crime, community violence and high HIV statistics (Bantjies et al., 2023; Lund et al., 2013; Skinner et al., 2019; van Heyningen et al., 2017). As a result, citizens end up relying on the public health care system. South Africa's public health care system is composed of a large public sector that serves more than 80% of the population while a smaller private sector serves the wealthy minority (Docrat et al., 2019). Yet mental health remains a sector of public health that is unnoticed (Nguse & Wassenaar, 2021). The Life Esidimeni tragedy in Gauteng in 2016, leading to the loss of 144 mental health care patients, vividly exposes the inadequacies in South Africa's public mental health care system (Durojaye & Agaba, 2018; Jacob & Coetzee, 2018; Nguse & Wassenaar, 2021).

This unfortunate event follows the South African government's efforts to address the mental health crisis by developing the Mental Health Care Act of 2002 and the National Mental Health Policy Framework and Strategic Plan 2013-2020. These legislation and policies aim to prioritise access to mental health care by placing mental health care within the larger public PHC system. However, the development of the legislation and policies were not met with equally successful implementation strategies due to the lack of a sustainable financing model from the government (Herman et al., 2009; Nguse & Wassenaar, 2021; Robertson & Szabo, 2017; Schierenbeck et al., 2013). Access to healthcare professionals at the national level is concerning, as highlighted by Docrat et al., who found an average of 0.31 public sector psychiatrists and 0.97 public sector psychologists per 100 000 uninsured individuals. Despite the efforts of government to effectively manage mental health care by incorporating it into PHC settings, less than 10% of the mental health budget gets directed towards PHC. A staggering 45% of the national mental health budget is distributed to specialised psychiatric hospitals, indicating that inpatient care forms the primary focus of mental health care provision (2019). Inpatient care involves hospital admission for intensive treatment, whereas outpatient care is delivered without admission, typically within PHC settings. This emphasis on inpatient care is notable, given that anxiety disorders are

predominantly managed on an outpatient basis (Bandelow & Michaelis, 2015). South Africa continues to reflect an emphasis on hospital-centred care, which also reinforces the stigmatising narrative that all mental disorders require hospitalisation for effective treatment. This emphasis contributes to the misconception that mental health conditions can only be managed within inpatient psychiatric settings, despite evidence to the contrary. While the South African Mental Health Care Act mandates the integration of mental health services into PHC, significant barriers persist, as mental health resources remain largely concentrated within hospital-based services (Schneider et al., 2016), as indicated in Table 1. This misalignment between policy and practice further reflects limited awareness and understanding of mental disorders at a governmental level, particularly given that many conditions, including anxiety disorders, are primarily managed on an outpatient basis. The South African government's continued focus on hospital-based care effectively ignores the reality of how mental disorders manifest in the community. This further highlights the gap between how anxiety is clinically managed and how it is experienced in everyday life.

Table 1

Barriers to Adequate Mental Health Services in South Africa

Financing barriers (Schneider et al., 2016)
PHC staff face challenges from heavy patient loads, multiple tasks, to limited referral networks (Abrahams et al., 2021; Jacob & Coetzee, 2018)
Difficulties in obtaining resources to enter private care (Skinner et al., 2021)
Discomfort with mental health issues, perceived lack of confidentiality and cross-cultural understanding (Abrahams et al., 2021; Schierenbeck et al., 2013)
A lack of integration of mental health services in PHC and low mental health coverage (Robertson & Szabo, 2017).
Lack of staff, facilities, and preventive care (Schierenbeck et al., 2013)
Lack of information (Ntsayagae et al., 2019; Schierenbeck et al., 2013)
Stigma (Abrahams et al., 2021; Docrat et al., 2019; Ntsayagae et al., 2019; Schierenbeck et al., 2013)

Common barriers include a cluster of systemic failures, from a shortage of trained staff and specialised rooms to the more personal hurdles of transport, confidentiality, and cross-cultural misinterpretation. The consequences of these barriers are particularly heavy for those navigating

"invisible" struggles like anxiety. For these individuals, a lack of resources or a misunderstanding of their condition doesn't just complicate their recovery and ability to cope (Jacob & Coetzee, 2018). Richter et al. (2021) note that individuals experiencing internalised emotional symptoms, such as anxiety, may experience internal distress that leads to negative human capital outcomes. For individuals with anxiety, these outcomes often include increased psychological distress, as well as adverse educational and employment consequences. In the South African context, Lund et al. (2013) found a strong association between lost income and severe anxiety disorders. When anxiety disorders remain untreated, they can result in psychosocial disabilities that limit individuals' capacity to find and maintain employment (Schneider et al., 2016). This not only affects individuals directly but also has broader socio-economic consequences for LMICs such as South Africa (Lund et al., 2013).

While the costs associated with mental health services are complex, they remain an important indicator of the economic burden of mental disorders in South Africa (Lund et al., 2013). Mental illness is often associated with increased sick leave, reduced work capacity (Bertilsson et al., 2013; Hurtado et al., 2020), reduced earnings (Lund et al., 2013), and, in some cases, job loss (Sorsdahl et al., 2015). Consequently, failing to provide adequate mental health services ultimately costs South Africa more than investing in appropriate and accessible care (Lund et al., 2013). It is therefore essential to understand both the personal and societal impacts of mental health problems in order to inform policy and motivate the development of contextually appropriate interventions (Richter et al., 2021). Such understanding supports the enhancement of culturally appropriate mental health services in South Africa (Jacob & Coetzee, 2018) and contributes to bridging the existing gaps in mental health treatment and care (Docrat et al., 2019; Schneider et al., 2016).

2.3 The prevalence of anxiety disorders in South Africa

The impact of the overlooked mental health sector in South Africa becomes more critical when considered alongside the socio-economic challenges faced by the population. Common socio-economic stressors affecting mental health include poverty, inequality, unemployment, and high levels of violence. Escalating unemployment rates in South Africa coincide with a simultaneous

increase in food costs, creating a challenging environment in which many citizens struggle to sustain themselves on a daily basis. According to a study by Dlamini et al. (2023) on food insecurity in South Africa, a significant number of households face varying levels of food insecurity risk. Among South African households, 20.4% were identified as food insecure, with Coloured and Black South Africans experiencing notably higher levels of food insecurity compared to other racial groups. Importantly, the study also revealed a correlation between food insecurity and symptoms of anxiety. Similarly, Van Heyningen et al. (2017) examined the occurrence of pre-birth anxiety disorders among low-income women facing psychosocial challenges. The study revealed that over 50% of the pregnant women who participated were unemployed, while 43% reported living below the poverty line. Nearly 30% of participants disclosed experiencing at least one life-threatening event in the previous six months, with 19% reporting exposure to two such events. Moreover, the findings demonstrated that difficult life events, food insecurity, and intimate partner violence were linked to increased stress, anxiety, and worry, potentially resulting in mental health conditions such as anxiety disorders (Naidu cited in Nguse and Wassenaar, 2021). This pattern is consistent with more recent research linking socio-economic stressors such as poverty and food insecurity to increased anxiety risk in South Africa (Craig et al., 2022; Dlamini et al., 2023).

The high prevalence of these conditions highlights the necessity for sufficient access to mental health services, as they expose individuals to not only physical health concerns but also emotional and mental struggles. According to the South African Depression and Anxiety Group (SADAG), as referenced in Medicross (2018), anxiety disorders are highly prevalent in South Africa, with about 20% of the population struggleing with some form of anxiety every year. Herman et al. (2009) examined data from the South African Stress and Health (SASH) study and reported a 12-month prevalence rate of 8.1% for anxiety disorders, indicating that approximately 8 out of every 100 individuals experienced an anxiety disorder during that year. Furthermore, the findings revealed that 26% of these cases were classified as severe, 31% as moderate, and 43% as mild. Mkhwanazi and Gibb (2021) who aimed to investigate the risk factors for GAD in young women and men residing in urban informal settlements in Durban, found that high levels of anxiety disorders were linked to poverty, violence, and adverse events. Women showed increased anxiety symptoms due to intimate partner violence, while men's anxiety was associated

with adverse childhood experiences and other events. Poverty was associated with anxiety symptoms in both genders, particularly in cases where theft driven by hunger was reported. This could be attributed to concerns about the repercussions of stealing and the potential legal consequences. However, in women, there was a notable association with anxiety relating to an increase in stress from unemployment. The findings align with a national study conducted by Craig et al. (2022), who found that South Africans who were unemployed (21.9%) presented the highest likelihood of probable anxiety. The discussed findings highlight a significant link between the socioeconomic conditions in South Africa and the prevalence of anxiety disorders (Lund et al., 2013).

Table 2

Prevalence of Anxiety Disorders in South Africa.

Reference	Population	Study Focus	Prevalence (%)		
			AD	GAD	PD
Herman et al., 2009	National	Lifetime prevalence	15.8	1.4	0.8
Van Heyningen et al., 2017	Pregnant women from low income, primary care setting in Cape Towna	Lifetime prevalence	23.0	-	-
Stein et al., 2008	National	Lifetime prevalence	15.8	-	-
Manana et al., 2023	Student nurses in Gauteng province	Anxiety symptoms prevalence	74.7	-	-
Pool et al., 2024	Healthcare workers in South Africa	Probably anxiety	45.9	-	-
Mkhwanazi & Gibbs, 2021	Young women and men in informal settlements in South Africa	Moderate to severe GAD symptoms	-	18.6 Women 19.6 Men	-
Craig et al., 2022	National	Probably anxiety	17.8	-	-
Naidoo et al., 2020	Medical doctors working in Kwa-Zulu Natal	Anxiety symptoms prevalence	20.0	-	-
Mokwena et al., 2023	Orphaned children (8-12 years) in Limpopo	Anxiety symptoms prevalence	34.9	-	-
Poliah & Paruk, 2017	Sex workers in Kwa-Zulu Natal	Anxiety symptoms prevalence	78.4	-	-
Kleintjies et al., 2005	Children, adolescents and adults in Western Cape	12-month prevalence	-	6.0 Adults 11.0 Children	-
Redinger et al., 2018	Antenatal anxiety in urban population in Soweto	Probable anxiety	15.2	-	-

Pappin et al., 2012	Patients enrolled in public sector antiretroviral program in South Africa	Anxiety symptoms prevalence	30.6	-	-
Mkhize et al., 2024	Young school going adolescents in Western Cape	Anxiety symptoms prevalence	20.9	-	-
Mokwena & Madiga, 2023	Family members of nyope users in Tshwane	Anxiety symptoms prevalence	73.0	-	-
Dlamini et al., 2023	National	Probably anxiety	16.0	-	-
Van der Walt et al., 2020	Medical students at the University of Cape Town	Clinically diagnosed with an anxiety disorder	20.5	-	-

Note. AD = Anxiety Disorders

More specifically, living in marginalised communities with poverty may lead to increased anxiety due to prevalent risk factors such as community violence (Mkhwanazi & Gibbs, 2021). In this context, the high lifetime prevalence of mental disorders in South Africa may be attributed to the socioeconomic conditions experienced by the population (Stein et al., 2009). To illustrate this, Table 2 presents a summary of South African studies that have reported prevalence rates for anxiety disorders in the region. Herman et al. (2009) analysed data from the first large-scale population-based study of common mental disorders in South Africa, the South African Stress and Health Study, and found anxiety disorders to be the most prevalent mental disorder, with a lifetime prevalence of 15.8%. Approximately a decade later, two separate national studies reported comparable findings, identifying anxiety as a highly prevalent mental disorder in South Africa, with rates of 17.8% (Craig et al., 2022) and 16% (Dlamini et al., 2023). Although numerous South African studies have examined the prevalence of anxiety disorders, many were not conducted on a national scale and instead focused on specific sub-populations within particular provinces. Nevertheless, these studies continue to offer valuable insights into the prevalence of anxiety disorders in South Africa.

Building on the link between socioeconomic vulnerability and anxiety prevalence, several South African studies have reported notably high rates of anxiety disorders within specific high-risk populations. Poliah and Paruk (2017), Manana et al. (2023), and Mokwena and Madiga (2023) highlighted prevalence rates of anxiety disorders at 78.4%, 74.7%, and 73%, respectively. This

trend may be linked to the nature of their study populations, which included individuals facing particularly challenging circumstances. For example, Mokwena and Madiga (2023) examined anxiety disorders among family members of *nyaope*[1] users, a drug that is becoming increasingly prevalent in South Africa. The high prevalence of anxiety symptoms among family members of *nyaope* users highlights the presence of undiagnosed anxiety within the broader community. Similarly, Poliah and Paruk (2017) investigated the prevalence of anxiety disorders among sex workers in KwaZulu-Natal, a population known to experience high levels of violence exposure. This may help explain why their study reported prevalence rates almost five times higher than those found in the general population in the South African Stress and Health (SASH) study, where lifetime prevalence rates of anxiety disorders were reported at 15.8% (Herman et al., 2009).

In addition to economically and socially marginalised groups, medical professionals in South Africa have also received significant attention regarding the prevalence of anxiety disorders within their community. According to Pool et al. (2024), nearly half (45.9%) of healthcare workers in their study exhibited scores indicative of clinical anxiety disorders during the Covid-19 pandemic. Other studies by Naidoo et al. (2020) and van der Walt et al. (2020) reported similar findings, with prevalence rates of approximately 20% among medical staff. Furthermore, research focusing on children and adolescents has revealed concerning prevalence rates. Mokwena et al. (2023) reported a 34.9% prevalence of anxiety disorders among orphaned children aged 8 to 12 years, while Mkhize et al. (2024) identified a high prevalence (20.9%) of anxiety symptoms among adolescents in South Africa.

The high prevalence rates of anxiety disorders in South Africa emphasise the need to better understand the risk factors, symptoms, causes, and treatment strategies associated with these conditions. The studies discussed are significant, as they establish a foundational body of knowledge that emphasizes the importance of ongoing research on anxiety disorders in the South African context (Adwas et al., 2019; Bantjies et al., 2023; Herman et al., 2009; Nel et al., 2018; van Heyningen et al., 2017). Given that anxiety disorders consistently show higher prevalence

[1] *Nyaope* is a highly addictive street drug in South Africa, typically consisting of a mixture of heroin, cannabis, and other substances (Dada et al., 2016).

rates compared to other mental health conditions, further research remains of particularly great concern (Bantjies et al., 2023; Herman et al., 2009). Moreover, evidence suggests that the prevalence of anxiety disorders has increased over time, influenced by ongoing socioeconomic, political, and environmental changes, especially within LMICs such as South Africa (Bantjies et al., 2023; Dlamini et al., 2023; Mokwena & Madiga, 2023; Poliah & Paruk, 2017). Some scholars have even described anxiety as a hallmark feature of modern life (Bandelow & Michaelis, 2015). However, it is crucial to distinguish between what may be considered "normal" anxiety and chronic or excessive anxiety that significantly disrupts daily functioning (Ford et al., 2016). Understanding this distinction is particularly important when considering how anxiety disorders shape the everyday lives of individuals living with these conditions.

2.4 Anxiety disorders

Simpson et al. (2010) mentioned that "normal" anxiety is a universal human emotion. It serves as a mechanism to help us manage and prepare for daily stress (Barlow & Durand, 2015). It acts as a warning sign for potential danger, triggering a physical and emotional response that shields us from harm (Craske et al., 2011; Miller, 2008; Spielberger, 2013). Therefore, anxiety forms part of everyday functioning and can, in certain contexts, enhance social, physical, and mental performance (Barlow & Durand, 2015). According to Spielberger (2013), Freud was the first to explore anxiety's psychological meaning, viewing it as an unpleasant condition that is "felt". To understand this condition, we have to distinguish it from stress, which typically functions as a reaction to immediate, identifiable pressures. Stress is typically a response to an identifiable external pressure or demand, whereas anxiety tends to persist even in the absence of a clear external stressor and is more closely associated with internal anticipation of future threat (Craske et al., 2017). Non-pathological anxiety is often described by feelings of nervousness, worry, and distress. These "emotions" closely resemble the experience of fear. However, although anxiety and fear may share similar feelings and physical expressions, they are triggered by different categories of stimuli (Pêgo et al., 2010). Another important distinction between fear and anxiety is in how each state is manifested; fear is a complex internal response to an actual, observable, and external danger (Figure 1). The intensity of this reaction corresponds to the level of external danger. Anxiety, on the other hand, involves apprehension and physiological arousal towards an

internal source of perceived danger (Figure 2) (Spielberger, 2013). Normal expressions of anxiety can differ greatly, as some individuals may have elevated levels of anxiety without meeting the criteria for a mental disorder (Ruscio et al., 2018). Hence, the crucial query arises: At what point does "normal" anxiety transition into a pathological state of being a mental disorder? This distinction is particularly important when considering how individuals subjectively experience and interpret anxiety in their daily lives.

Figure 1

The Internal Process of Fear



Note: Adapted from Spielberger, 2013

Figure 2

The Internal Process of Anxiety



Note: Adapted from Spielberger, 2013

According to Pêgo et al. (2010), anxiety disorders arise when emotional and physiological symptoms related to feelings of anxiety, manifest without a clear trigger or when the trigger doesn't justify the response. Pathological anxiety is noticeable, intense, disruptive and triggers self-defeating defensive processes called symptoms (Barlow, 2002). Defined as a negative future-oriented mood state, pathological anxiety is marked by a sense of unease or worry, accompanied by physiological symptoms like mental tension and increased heart rate, and mental symptoms such as general sensations of discomfort and apprehension (APA, 2022; Craske et al., 2011; Pêgo et al., 2010). While these symptoms can be considered a ‘normal reaction’ to daily stress, when people start to experience excessive anxiety, it often leads to

persistent, irrational, and severe anxiety symptoms (APA, 2022; Bandelow & Michaelis, 2015; Craske et al., 2011). Anxiety disorders are thus different from normal anxiety, in a sense that the anxiety is experienced in "excess", thus becoming counterproductive, debilitating, and pathological (Simpson et al., 2010). Pathological anxiety is identified by various mental and physical symptoms that lack a clear explanation (Pêgo et al., 2010) and manifest without external triggers (Shri, 2010). The DSM-5-TR establishes that an anxiety diagnosis is appropriate only when worry becomes so pervasive and intense that it disrupts a person's ability to manage their day-to-day life (APA, 2022).

Kalin (2021) indicates that anxiety disorders develop from a mix of genetic and environmental factors. Around 30-40% of the risk related for developing an anxiety disorder is genetic, with environmental influences like trauma, neglect, poor parenting, and stress also contributing to it. Mkhwanazi and Gibbs (2021) suggest a possible bidirectional connection between poverty and anxiety. Poverty often indicates living in marginalized communities where various risk factors, such as community violence, are more prevalent, thus contributing to increased anxiety. According to Barlow (2002) anxiety is connected to the lasting impact of past perceived dangerous situations that felt real during early stages of development. This clarifies why anxiety disorders usually develop at an earlier stage compared to other frequently encountered mental disorder categories like mood disorders or substance abuse disorders (Kessler et al., 2001). There are various interpretations regarding the development of anxiety disorders. The development of anxiety can be examined from various perspectives, including biology, cognition, psychodynamic, and clinical approaches. Each perspective has a distinct focus: biology emphasises temperament, cognition looks at learned behaviours, psychodynamic delves into unconscious processes, and clinical examines subjective experiences of anxiety (Table 3). However, all approaches share the idea that anxiety is a common experience among normal individuals and is linked to adaptive defences. Individuals must focus on managing and regulating adaptive anxiety to prevent it from evolving into maladaptive anxiety, or as it is more commonly known, an anxiety disorder (Barlow, 2002). As already noted, anxiety is classified as a mental disorder when symptoms arise without a clear trigger (Pêgo et al., 2010) or when it becomes evident, severe, disruptive, and debilitating (Barlow, 2002).

Table 3

The different approaches to understanding of the development of anxiety disorder

Behavioural	The importance of classical conditional and observational learning resulting in anxiety
Cognitive	The way individuals perceive or reflect on stressful life events can be maladaptive, leading to a feeling of uncontrollability at the core of their anxiety.
Cognitive-behavioural	Incorporating associative learning into fear acquisition and dysfunctional thought patterns that initiate and sustain maladaptive anxiety.
Neuro-evolutionary	Adaptive function of anxiety within the broader context of preparing to cope with an external threat. Anxiety can turn into a maladaptive response once the threat shifts from external to internal.
Psychodynamic	Anxiety indicates an unconscious perception of threat or danger, resulting in emotional and physiological responses.
Neurobiological	Temperament, genes and the impact of early experience on brain structure and function which produces and shapes the expression of anxiety.
Clinical	Life narratives surrounding anxiety provides intricate details about an individual's subjective world. Narratives provide useful information about why and when anxiety arises.

(Adwas et al., 2019; Barlow, 2002; Simpson et al., 2010)

The term "anxiety disorder" serves as an umbrella term encompassing various forms of anxiety. The different types of anxiety disorders are distinguishable by their characteristic triggers, distinctive symptoms, course of illness and response to treatment (Simpson et al., 2010). Generalised Anxiety Disorder (GAD), Social Anxiety Disorder (SAD), Panic Disorder (PD), Post-Traumatic Stress Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), and specific phobias collectively fall under the category of an anxiety disorder (Miller, 2008; Shri, 2010).

2.4.1 Panic Disorder (PD) and Generalised Anxiety Disorder (GAD)

Anxiety disorders are complicated, often having various symptoms and multiple causes, which is why the experience of any type of anxiety disorder is not one-dimensional (Anthony & Stein, 2009; Ford et al., 2016; Woodgate et al., 2020). However, authors tend to agree that the experience of anxiety and panic are closely associated with one another, and while they need not occur together, they often do (APA, 2022; Craske et al., 2017; Michael et al., 2007). Panic

attacks are defined by their sudden onset without any obvious environmental, emotional, or situational triggers (Simpson et al., 2010). They can be defined as a sudden feeling of being overwhelmed due to a surge in either intense fear or discomfort. Typical of a panic attack are often three physiological symptoms, most commonly heart palpitations, dizziness, and hyperventilating (Anthony & Stein, 2009; APA, 2022; Craske et al., 2017; De Jonge et al., 2018; Simpson et al., 2010; Tyrer & Silk, 2011). To meet the criteria for a full panic attack, four or more symptoms are required. Panic attacks are scary and often lead to seeking immediate help, since their symptoms usually resemble more severe conditions such as a heart attack. Experiencing panic attacks does not automatically qualify as having an anxiety disorder; recurrent, unexpected attacks are needed for an official diagnosis (De Jonge et al., 2018; Simpson et al., 2010).

The complex relationship between a panic attack and anxiety often leads to a diagnosis of PD. Panic Disorder is a common and debilitating mental disorder and can be defined as an anxiety disorder in which a person experiences recurrent, unexpected panic attacks, and develops anxiety or worry about the chances of having another one (APA, 2022; Craske et al., 2017; Tyler & Silk, 2011). Therefore, to qualify as PD, one panic attack must be followed by at least one month of ongoing anxiety about further attacks or their consequences, along with a significant change in behaviour to avoid panic attacks (APA, 2022). In other words, PD differs from isolated panic attacks in that the attacks are experienced as unpredictable and seemingly occurring without warning. Another significant difference lies in the anxiety surrounding the recurrence for future attacks, which is characteristic of panic disorder but not of isolated panic attacks (Tyrer & Silk, 2011). Panic Disorder results in significant social, occupational, and physical disability, and frequent medical visits. These regular medical appointments result in missed workdays, affecting the individual's livelihood (APA, 2022).

Anxiety, as previously stated, is a common human emotion that signals potential threats and drives us to ready ourselves for upcoming challenges (Simpson et al., 2010). The process for planning for that future threat is associated with worry. Worry can be a normal and an adaptive process but can become maladaptive or pathological if carried to extremes. The distinguishing factor between regular worry and pathological worry lies in the content of worry, the extent of

worry, and how it affects daily functioning (Barlow, 2002). Excessive worry is specified as the core symptom of GAD. Historically, GAD was treated as a residual category, only diagnosed when a patient's symptoms failed to fit into other specific anxiety classifications (Shin et al., 2019; Simpson et al., 2010; Ruscio et al., 2018). Today, the disorder is recognised as a distinct and complex condition defined by a pervasive, uncontrollable worry that is often paired with cognitive and physical strain (Simpson et al., 2010). According to the DSM-5-TR, GAD is characterised by excessive and persistent worry occurring more days than not for at least six months and is accompanied by symptoms such as restlessness, fatigue, irritability, difficulty concentrating, muscle tension, and sleep disturbance (APA, 2022). Cognitive factors involve biased threat perception and a sense of uncontrollability. Patients focus on detecting threats, interpret ambiguous stimuli as threatening, and view threats as greater than non-anxious individuals. Symptoms include anxious mood, uneasiness, arousal, sensitivity to stimuli, irritability, sleep difficulties, catastrophic thinking, muscle tension, fatigue, and tension headaches (Barlow, 2002; Craske et al., 2017; Noyes & Hoehn-Saric, 1998; Shin et al., 2019). To sharpen the separation from other anxiety disorders, the worry in GAD is described as broad (pertaining to various life situations), excessive, unrealistic, and associated with six out of 18 anxiety-related symptoms. This condition needs to persist for a minimum of six months and result in noticeable distress or functional impairment (Ruscio et al., 2018). Among anxiety disorders, GAD stands out as particularly impactful, significantly affecting functioning and quality of life. This is because GAD diagnoses are frequently overlooked or delayed, and even when identified correctly, the condition often goes untreated (Simpson et al., 2010).

While various anxiety disorders can be specifically identified by their unique triggers, symptoms, progression, and treatment response, there is some overlap within these categories (Simpson et al., 2010). The close relationship between PD and GAD frequently leads to the co-occurrence of these two disorders. Therefore, receiving a diagnosis for one anxiety disorder significantly raises the likelihood of receiving a diagnosis for another within the same time frame (McGrath et al., 2020). These patterns of co-morbidity are important indicators of how mental disorders affect individuals, as they contribute to increased personal and economic burdens (Nutt et al., 2006).

2.4.2 Co-morbidity

Co-morbidity is highly prevalent in anxiety disorders, with research suggesting that up to half of individuals with a lifetime anxiety disorder meet criteria for two or more disorders (Stein & Steckler, 2010). According to Saha et al. (2020), the term co-morbidity describes the occurrence of one or more disorders alongside a primary disorder within the same time frame. In the context of this study, the primary disorders are either PD or GAD. The distinctive characteristics of GAD include persistent and uncontrollable worry, whereas PD is characterised by unexpected panic attacks. This diagnostic distinction helps to differentiate the two anxiety disorders from one another. However, despite these differences, there is considerable overlap in the diagnostic features of GAD and PD, which is rooted in shared experiences of physiological arousal and negative affectivity (Goodwin, 2015). The term negative affect (NA) refers to a broad range of subjective distress, encompassing emotions such as fear, anger, sadness, guilt, and disgust (Clark & Watson, 1991; Goodwin, 2015). In contrast, physiological hyperarousal (PH) refers to physical symptoms such as somatic tension, shortness of breath, dizziness, and light-headedness. Individuals diagnosed with anxiety disorders typically exhibit elevated levels of both NA and PH (Anderson & Hope, 2008).

The characteristic PH associated with GAD and PD appears to be relatively specific to anxiety disorders (Clark & Watson, 1991). Therefore, it is understandable that, due to the shared dimensions of PH and NA across anxiety disorders, different types of anxiety disorders frequently co-occur (Goodwin, 2015; Herman et al., 2009; Lépine, 2002; Michael et al., 2007; Van Heyningen et al., 2017). As noted by the APA, (2013), the occurrence of PD is heightened among individuals diagnosed with other anxiety disorders. This pattern of co-morbidity suggests that the presence of one anxiety disorder may exacerbate symptoms or contribute to the onset of another, resulting in a complex clinical presentation. Supporting this, Michael et al. (2007) reported a co-morbidity rate of 92.2% between PD and at least one other anxiety disorder, which is notably higher than the co-morbidity rates observed among other anxiety disorders. This finding suggests that PD, in particular, may serve as a predisposing factor for the development of additional anxiety disorders. Shin et al. (2019) further support this observation, noting that GAD shows a particularly high co-morbidity with PD. In addition, Michael et al. (2007) reported an odds ratio of 12.3 for the co-occurrence of GAD and PD, indicating that individuals with PD are

12.3 times more likely to experience GAD than those without PD. Similarly, Hurtado et al. (2020) found that GAD exhibits high levels of co-morbidity with other common mental disorders, especially PD. Taken together, these findings highlight the particularly complex relationship between GAD and PD, whereby the presence of one disorder increases vulnerability to the development of the other. Earlier research consistently indicates that individuals diagnosed with PD frequently display symptoms of GAD as well. The overlap in symptom presentation between GAD and PD, as illustrated in Table 4, is therefore a key factor contributing to the high levels of co-morbidity observed between these two anxiety disorders (Anderson & Hope, 2008; Clark & Watson, 1991). Importantly, the co-occurrence of PD and GAD has been shown to significantly reduce overall quality of life when compared to individuals diagnosed with only one of these conditions (Bamijoko-Okungbaye, 2020).

Table 4

Overlapping mechanisms between GAD, MDD and PD.*

	Symptoms	**Risk factors**	**Functional consequences**
GAD & MDD	Fatigue Sleep disturbance Concentration difficulties	Genetic risk of neuroticism	-
PD & MDD	-	Adverse childhood experiences	-
PD & GAD	Lack of control Worry Somatic symptoms (e.g. nausea and sweating)	-	-
GAD, PD & MDD	Maladaptive change in behaivour	Negative affectivity (neuroticism)	Physical, social and occupational disability

(APA, 2013)

*MDD – Major Depressive Disorder

Although high rates of co-morbidity among anxiety disorders indicate that these mental health conditions often share common characteristics, such as anxiety and panic (APA, 2022), it is also

crucial to recognise that symptoms frequently overlap between different anxiety disorders and other mental health conditions, including mood disorders (Craske et al., 2017; Lépine, 2002). This overlap can be linked to the strong association between anxiety disorders and mood disorders. Michael et al. (2007) identified strong correlations between PD and mood disorders, as well as between GAD and mood disorders. A mood disorder is characterised by persistent dysregulation of an individual's mood, psychomotor activity and cognitive functioning. Mood disorders include conditions such as bipolar disorder and major depressive disorder (Akiskal & Valkenburg, 1994; APA, 2022). As noted by Barlow and Durand (2015), major depression is a mood disorder that frequently co-occurs with anxiety disorders. Goodwin (2015) further emphasises that many individuals diagnosed with anxiety disorders also meet diagnostic criteria for major depression. This overlap may be explained by the fact that both anxiety and depression are associated with NA, resulting in shared symptoms and the frequent co-occurrence of anxiety and mood disorders (Table 4).

Michael et al. (2007) further found that the onset of an anxiety disorder often precedes, or occurs concurrently with, the development of major depression. More specifically, the onset of PD and GAD frequently coincides with the onset of major depression, suggesting a close relationship between these conditions. Importantly, co-morbidity between anxiety disorders and other mental health conditions is particularly concerning, as it reduces the likelihood of recovery and increases the risk of relapse, even when treatment is successful (Barlow & Durand, 2015). Taken together, these findings highlight that anxiety disorders are rarely experienced in isolation and often involve complex, overlapping symptoms that significantly shape individuals' daily functioning. This complexity underlines the importance of exploring how people live with anxiety disorders.

2.5 Living with an anxiety disorder

Due to the diagnostic overlap of the symptoms of different types of anxiety disorders; as well as the symptoms between anxiety disorders and mood disorders, it is common that a patient will be diagnosed with one or more mental disorders at the same time (Anderson & Hope, 2008; Clark & Watson, 1991; Löwe et al., 2008; McGrath et al., 2020; Saha et al., 2020). These patterns of co-morbidity frequently heighten the mental, physical, social, and economic burden on

individuals, exacerbating an already concerning situation (Nutt et al., 2006). Nepon et al. (2010) shed light on the risks associated with co-morbidity patterns in anxiety disorders, highlighting a notable link between suicide attempts and individuals experiencing co-morbidity, as opposed to those with each disorder on its own. A clear trend observed in the lifetime prevalence data reveals that anxiety disorders, as a collective group, consistently rank as the most frequently occurring type of mental disorders (Stein & Steckler, 2010).

Even with these statistics, The South African College of Applied Psychology reports that only about 27% of the population living with mental health disorders seek treatment (cited in Nguse & Wassenaar, 2021). The tendency for South Africans to not seek treatment is rooted in an intricate network of reasons. A few of them being, lack of access to transport, lack of staff and facilities, and lack of cross-cultural understanding between the 'African' and 'Western' reasons for mental disorders (Abrahams et al.,2021; Boisits et al., 2021; Curan et al., 2012; Schierenbeck et al., 2013; Skinner et al., 2019; Sorsdahl et al., 2010). The prevailing attitudes and beliefs about mental illness in society are undoubtedly the most crucial reason why many South Africans are reluctant to seek mental health care. The stigma surrounding mental disorders frequently leads patients to fear being labelled as 'mad' (Abrahams et al., 2021). Friends and family often express concerns about being stigmatised by association, a phenomenon that is particularly prevalent in non-white communities (Schierenbeck et al., 2013). Moreover, while anxiety disorders frequently coexist with mood disorders (Anderson & Hope, 2008; Clark & Watson, 1991; Löwe et al., 2008; Nutt et al., 2006; McGrath et al., 2020; Saha et al., 2020; Zhout et al., 2017), mood disorders such as major depression often emerge as the primary concern over anxiety disorders (Archer et al., 2021). Despite this, individuals diagnosed with PD commonly report a subjective quality of life that is as poor as that of individuals with major depression (Mendlowicz & Stein, 2000). Similarly, the risk of suicide attempts in people with PD has been shown to be equivalent to that of people with major depression (Bentley et al., 2016). This is particularly alarming given that 65.7% of individuals diagnosed with PD in the past 12 months in the SASH study were classified as having severe cases, leaving them especially vulnerable to suicide attempts (Herman et al., 2009).

According to Schierenbeck et al. (2013), society suffers from a lack of information regarding mental disorders. Although the public is familiar with psychotic conditions such as bipolar disorder and schizophrenia, there is often a significant lack of information concerning other mental health issues, including anxiety disorders. As a result, many individuals may be unaware of the symptoms associated with anxiety disorders, which can lead to help-seeking avoidance. In African communities, beliefs about mental illness presentations are often rooted in psychotic behaviours, such as undressing oneself or urinating in public. Consequently, non-psychotic behaviours, including mental symptoms linked to anxiety disorders, are frequently attributed to stress or excessive thinking rather than being recognised as medical conditions requiring treatment (Sorsdahl et al., 2010). Living with an anxiety disorder in South Africa is therefore particularly challenging due to cultural beliefs and stigma that often downplay the experiences of individuals facing “mental illness” (Abrahams et al., 2021).

In addition to these societal challenges, the South African government similarly demonstrates a lack of understanding regarding mental illness, particularly anxiety disorders. This is reflected in the persistent view of mental health as a relatively minor component of the broader healthcare system, resulting in inadequate and limited access to quality mental health services. Furthermore, the failure to effectively implement mental healthcare frameworks, together with insufficient funding, reflects a disregard for the daily challenges faced by individuals living with anxiety disorders (Nguse & Wassenaar, 2021). This disregard not only intensifies the difficulties experienced by those affected but also contributes to a broader societal context in which mental health is frequently stigmatised and misunderstood. Addressing this issue requires a deeper understanding of how living with anxiety disorders personally affects those who experience them. Such understanding is essential not only for raising awareness but also for laying the foundation for mental health policy reform that reflects the preferences and cultural perspectives of individuals living with anxiety disorders (de Pinho et al., 2021; Mosotho et al., 2011; Richter et al., 2021).

2.5.1 International Studies

As noted by Mendlowicz and Stein (2000), Western research interest has increasingly focused on how anxiety disorders affect Quality of Life (QOL). QOL describes intricate life aspects that cannot be captured solely through measurable indicators; it represents a deeply subjective assessment of overall life satisfaction. Qualitative literature reviews indicate that the QOL challenges experienced by individuals with anxiety disorders are significant and may be like those found in other psychiatric conditions. A study by Olatunji et al. (2007) indicated that individuals with anxiety disorders experience a generally lower QOL. The findings suggest that their subjective assessments of life circumstances—including health, social relationships, work, and family life—are notably diminished compared to those without anxiety disorders. According to Lochner et al. (2003), patients with PD experienced lifetime impairment primarily in their ability to participate in activities. This highlights the maladaptive avoidance behaviour that is linked to PD. For patients with GAD, however, greater impairments were reported in relation to their romantic and social relationships (Henning et al., 2007). These patterns are further supported by more recent research, which demonstrates that anxiety disorders significantly reduce QOL across social, occupational, and emotional domains (Stein et al., 2022).

According to Bamijoko-Okungbaye (2020), participants voiced worries about the potential burdens that their anxiety disorders may impose on their social connections, highlighting how the effects of these disorders extend into their social relationships. Participants noted the ongoing negative perceptions of anxiety disorders in society, which motivated them to join the study. They hoped that sharing their experiences could help change these negative views towards those with anxiety disorders. A study by Baker et al. (2022) indicates that these negative perceptions significantly affect the daily lives of individuals diagnosed PD. Participants voiced concerns about facing negative judgments from others if they were to have one of their panic attacks in public. These negative experiences give rise to experiences of being misunderstood and rejected, contributing to an overall negative self-concept and a sense of not belonging. The lack of understanding further extends into the participants' own awareness about the manifestations of their anxiety disorder, therefore directly impacting their experiences of the disorder. The

symptoms of PD were perceived as confusing, frightening, catastrophic, and utterly overwhelming, leaving adolescents struggling to understand what they were going through.

Hurtado et al. (2020) specifically examined the impact of anxiety disorders on daily life functioning. According to their findings, there are two key areas of life that anxiety disorders interfere with: an individual's profession and an individual's interpersonal life. In their professional life, participants reported difficulties performing job duties. Job performance was often influenced negatively by having to frequently apply for sick leave. For one participant in particular, absence from work due to their mental illness became so serious that it resulted in early retirement. Löwe et al. (2008) made similar discoveries, revealing that individuals with anxiety experienced nearly 12 more disability days than those without anxiety. In the interpersonal dimension, participants often expressed a lack of support and understanding from their families and from those in their social environment (Hurtado et al., 2020). A similar study conducted by Bertilsson et al. (2013) focused on the impact of anxiety and depression on work capacity. This study yielded significant results given that adults spend most of their day at their place of work. Results from the study revealed severe reduced work capacity due to fatigue (because of medication side effects), memory problems and a hypersensitive mind. Participants reported that these mental struggles often affect the ability to multitask, concentrate, and manage their workload. In addition, physical sensations associated with anxiety and depression, would shift their focus from their work towards what is happening in their body. Participants reported that managing their emotions in the workplace was directly impacted by their over sensitivity to criticism which would lead to personal feelings of failure, shame and worthlessness which further intensified the symptoms of their mental state.

The most notable concern for participants in both studies, was the concern about stigma, especially in their place of work, a theme we see across almost all studies relating to anxiety disorders. Participants noted that since symptoms of anxiety is invisible, individuals who are not suffering from a mental disorder find it difficult to understand how their job performance is negatively impacted. Ultimately, this would trigger protective strategies such as masking their mental difficulties especially on "bad days". Which is why the only place participants feel safe and supported is when they are surrounded by people who experience or have experienced an

anxiety disorder themselves (Bertilsson et al., 2013; Hurtado et al., 2020). Masking one's anxiety disorder is a theme we come across even in younger people. An important illustration of this is recognised in a study conducted by Woodgate et al. (2020) which consisted of youth between the ages of 10 to 22 years old. Similar to the results of Bertilisson et al. and Hurtado et al., youth in this study described masking their true self from family and friends to guard themselves against stigmatization. The term "self" refers to abstract mental concepts such as self-esteem, self-image, and self-efficacy and is the central point for how one experiences the world. Since youth are actively figuring out "who" they are during this age period, mental disorders such as anxiety plays a major role in how they find their sense of self. Young people often find themselves conflicted about whether anxiety is a part of their identity or a foreign entity invading their physical framework. This intricate and delicate inner world predisposes youth suffering from anxiety to a particularly vulnerable and complicated mental psyche. Furthermore, youth diagnosed with an anxiety disorder commonly describe themselves as being "broken". A word that seems to be the dividing factor between "them" and their "normal" counterparts.

Findings reported by Kadam et al. (2001) pointed out that participants felt that people in general were not sympathetic to their mental difficulties. Participants reported living with a painful inner world, a world with feelings and thoughts that are often not acceptable or understood by other people. In addition, it was noted that the most difficult part of their daily lives was dealing with the thoughts and emotions associated with their anxiety disorder. A Canadian study by Woodgate et al. (2017), used qualitative participatory research methods to explore the subjective experiences of young people who live with anxiety. According to their results, five themes emerged from their interviews. Young adults with anxiety often; hide their struggle, find everyday tasks more challenging, feel overwhelmed by everyday stimuli which may lead to isolation; experience judgment and feel different from peers, and feel distressed by their daily challenges. Daily challenges for individuals with anxiety disorders, as highlighted by Bernard et al. (2019), differ greatly from those without such disorders. The study found that simple actions like using social media could cause significant distress, as inappropriate content often triggered involuntary recollections of distressing memories. This negatively affected their ability to complete daily tasks. Although these studies offer valuable insights into the personal experiences of individuals living with anxiety, it is essential to recognise that each of them has particular

areas of focus within the Western context. This study aims to reframe the understanding of daily anxiety experiences within the South African context, fostering a more comprehensive and inclusive perspective on experience of this mental disorder.

2.5.2 South African Studies

Many South African anxiety studies provide quantitative data, offering valuable insights into anxiety disorders and their prevalence through objective measurements. This study, on the other hand, promotes a shift in anxiety research towards a qualitative, person-centred methodology. This change enables us to gain insight into the subjective experiences associated with anxiety disorders. Additionally, it's crucial to consider the cultural context of South Africa when examining the subjective experiences of individuals dealing with anxiety disorders. Mosotho et al. (2011) highlights the fact that culture significantly influences mental health, affecting symptom expression, family support, coping styles, and treatment-seeking behaviour. According to their article, cross-cultural studies reveal notable differences in the experience and description of anxiety, with many cultures lacking the term "anxiety". This cultural influence is also reflected in how individuals understand and communicate their emotional distress. Bosits et al. (2022) demonstrated this within the South African context. Their research revealed that participants frequently used the term "stressed" interchangeably to refer to both anxiety and depression, underscoring the lack of familiarity with Western anxiety terminology. Due to this, some women faced challenges in articulating their symptoms. Interestingly, similar to Western literature, many women felt that mental illness was frequently misunderstood or labelled as insanity, highlighting the stigma surrounding mental health conditions like anxiety disorders. These findings highlight how cultural understanding and social perceptions directly shape how individuals experience, describe, and make sense of anxiety within the South African context.

Stigma has been a major area of focus in mental health research in South Africa. A South African qualitative study conducted by Ntsayagae et al. (2019) explored the experiences of family caregivers of individuals with mental illness. Their results were profound in the sense that it confirmed that South Africa continues to battle the stigma which surrounds mental health concerns. A different study by Egbe et al. (2014) studied psychiatric stigma among mental health

service users in South Africa. The study found that participants internalised societal stigmas which directly affected their mental health experiences. They reported mistreatment from health facility staff, family, and community members, with some attributing stigma to cultural views. Misconceptions about mental illness often framed it as a weakness or witchcraft, leading to negative attitudes that hindered users from leading normal lives and engaging in daily activities. A quantitative study by Mokwena and Madiga (2023) examined the impact of anxiety symptoms on everyday activities. The researchers discovered that a significant portion of the participants, 60.5%, experienced challenges in carrying out their daily tasks. This indicates that a large percentage of individuals with anxiety disorders experience considerable challenges in their daily functioning. Furthermore, Field et al. (2020), highlight that stigma is a significant barrier to accessing services. Barriers to treatment represent another key area of focus for qualitative anxiety research in South Africa. Two examples of this are the research conducted by Schierenbeck et al. (2013) and Abrahams et al. (2021). Other studies concentrate on the perspectives on anxiety from teachers (Skinner et al., 2019) or nurses (Schierenbeck et al., 2013). When you look at these findings, it is evident that the impact of anxiety in South Africa goes beyond a simple medical diagnosis. Anxiety disorders fundamentally change how a person handles their day-to-day responsibilities and maintains their emotional health. This is especially important in a context where social stigma and limited access to support services can intensify feelings of isolation and disconnection for the affected individuals. These studies show that living with anxiety is a complex experience that influences nearly every aspect of an individual's life, including occupational functioning, social interactions, and personal relationships.

While acknowledging the importance of South African qualitative research on mental health, it is crucial to recognise that these studies have limitations. While each study focuses on addressing its unique research gap, existing research often targets specific groups. For instance, Msotho et al. (2011) concentrated specifically on Sotho speakers. Another limitation is that the existing qualitative studies do not concentrate specifically on anxiety disorders; instead, they address psychiatric disorders in general, as illustrated by the study conducted by Egbe et al. (2014). Many anxiety disorders exhibit similar symptoms and clinical characteristics (Beesdo-Baum & Knappe, 2012), but each anxiety disorder does present its own set of struggles. Focusing on anxiety as a general concept removes the ability to define the unique aspects of individual

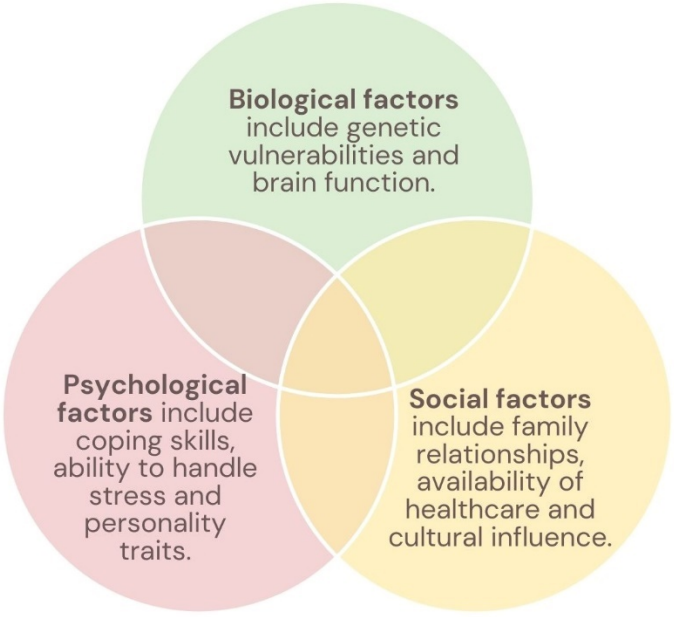
anxiety disorders such as PD and GAD to enhance intervention and treatment strategies. Furthermore, when research delves into anxiety disorders, it emphasises the "other" viewpoint rather than highlighting the experiences of the individual facing the mental health condition. While it is important for society to recognise the multifaceted impact of mental disorders on the population, it is equally important to understand the major impact that it has on the individual. Especially, considering that individuals are often closest to the direct impact of their anxiety disorder (Jacob and Coetzee, 2018).

2.6 Theoretical Framework

To comprehensively grasp an individual's mental health, research studies must consider the entirety of the person.

Figure 3

The Multi-Dimensional Model



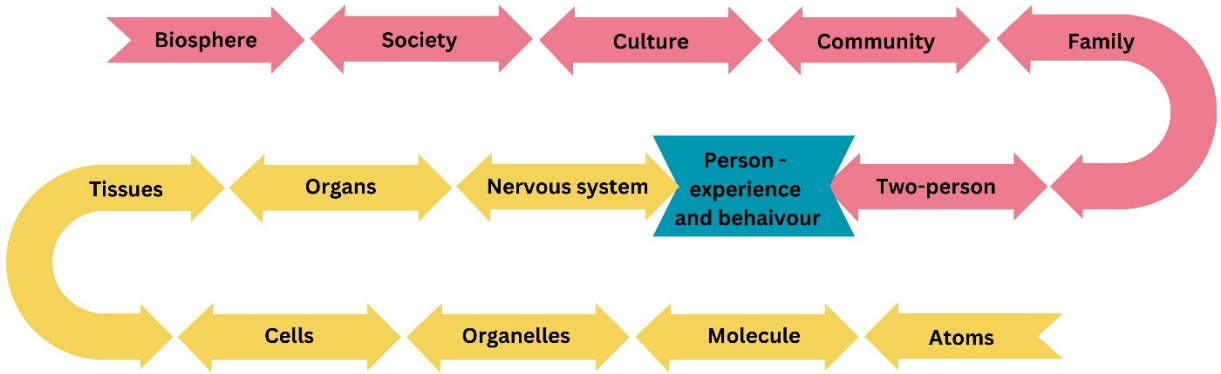
Note. Adapted from Saleeby, 2001

The biopsychosocial approach to mental health prioritizes the relationship between the mind, body, soul and the environment (Saleeby, 2001). According to the Biopsychosocial Model (BM)

our mental health is best understood through a combination of biological, psychological, and social influences, which can be viewed as organised into a hierarchy of systems (figure 3). Each system consists of smaller subsystems while simultaneously forming part of a larger whole (Straub, 2014). Each system represents a dynamic whole with qualities and features that are characteristic of that system (figure 4). At the same time, each system exists in a continuum as a component of higher-level systems. In other words, nothing exists in isolation (Engel, 1980).

Figure 4

Hierarchy of the Systems to which an Individual Belongs



Note: Adapted from Engel, 1980

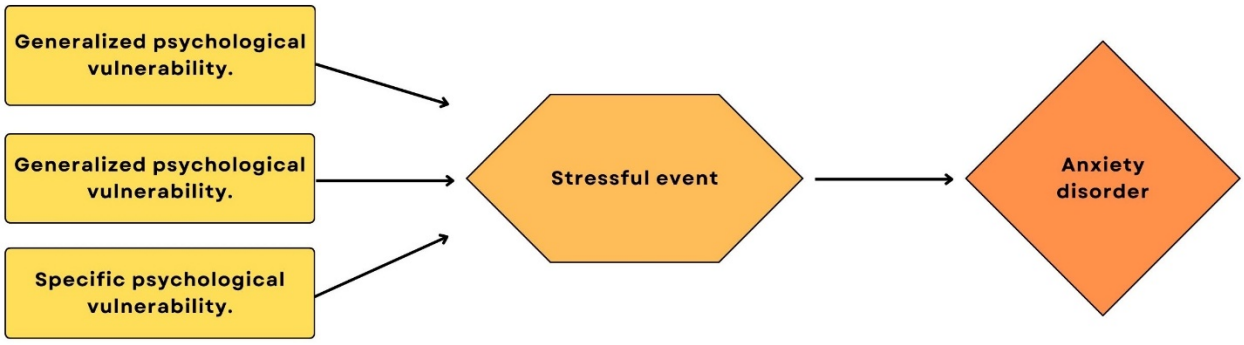
The biological context refers to an individual's genetics and brain chemistry. For example, certain individuals are more genetically vulnerable to anxiety disorders while others are more vulnerable to mood disorders (Straub, 2014). However, the biological context contributes to less than half of the explanation for psychological disorders (Barlow & Durand, 2015). As such, biological factors alone are insufficient to fully understand an individual's mental health experience. Hence, we need to also consider the psychological context refers to how an individual interpret and make meaning of events. Following this, it can be understood that two individuals may interpret the same event in two diverse ways. One may interpret the event as overwhelming and beyond our control, leading to an increased psychological toll, and the other may interpret the event as a minor challenge, resulting in a lesser psychological toll. Researchers should also take into account the social context in which individuals operate. Social context

refers to how people interact with one another and their surroundings, as well as how social and cultural factors may impact mental health (Straub, 2014). Culture is a set of shared behaviours, beliefs and customs that exist among a group of people and have been passed down from one generation to the next (Koydemir & Essau, 2018; Shiraev & Levy, 2010). Our social context can have a significant impact on our mental health, as it provides us with language and tools for understanding and orienting ourselves in the world. It is from our culture that we understand what we are and how we are supposed to behave in this world (Saleebey, 2001).

An approach that is related to the biopsychosocial model, called the Triple Vulnerability Theory (TPT), focuses on three vulnerabilities that could explain the development of anxiety disorders (Barlow, 2002; Sauer-Zavala & Barlow, 2021). The first vulnerability is a Generalised biological vulnerability which means that we inherit a vulnerability to develop an anxiety disorder. The second vulnerability is a generalised psychological vulnerability and refers to our environment. Individuals may grow up believing that the world is dangerous which could lead to a diminished sense of control and an inability to cope when things go wrong. The third vulnerability is a specific psychological vulnerability which shapes the way in which an anxiety may manifest. This vulnerability refers to specific things that happens in an individual's history that teaches them what is dangerous. When these vulnerabilities are combined with a stressful event, it may result in PD and/or GAD (figure 5) (Barlow, 2002; Bentley et al., 2013; Sauer-Zavala & Barlow, 2021).

Figure 5

Triple Vulnerability Model



Note: Adapted from Barlow, 2002

The theoretical framework guiding this research aligns with key principles within the field of Global Mental Health (GMH), which recognise that an individual's mental well-being is shaped by biological, psychological, and social influences operating within specific social and environmental contexts. However, this framework is not used to explain participants' anxiety in terms of contextual factors, but rather to acknowledge that dominant Western theories and diagnostic frameworks may not always fully capture how anxiety is experienced in African settings. Social, cultural, and linguistic environments influence how individuals describe, interpret, and live with mental health challenges. Recognising these influences allows for a more contextually grounded understanding of lived experience, without positioning context as the primary cause of anxiety. Therefore, the theoretical framework supports a focus on lived experience to ensure that interpretations remain grounded in South African realities and do not rely solely on Western assumptions. In doing so, the framework enables this study to centre the voices of individuals living with anxiety, with the aim of informing more contextually responsive policy and intervention development (Moitra et al., 2023).

2.7 Conclusion

The literature reviewed in this chapter demonstrates that anxiety disorders represent a significant and persistent mental health concern within South Africa. Although substantial research has documented the high prevalence of anxiety disorders and identified key socioeconomic and environmental risk factors, much of this work focuses on epidemiological trends. As a result, the personal realities of individuals living with PD and GAD remain underexplored (Craig et al., 2022; Herman et al., 2009). The findings further indicate that anxiety disorders do not occur in isolation but occur within broader structural and cultural conditions. Socioeconomic hardship, exposure to violence, food insecurity, and unemployment contribute not only to increased vulnerability to anxiety disorders but also to ongoing barriers in accessing appropriate mental health care, especially in LMICs such as South Africa (Lund et al., 2013; Mkhwanazi & Gibbs, 2021; Nguse & Wassenaar, 2021).

The way people understand and react to anxiety is also tied to cultural beliefs and deep-seated stigma. In many communities, what we call anxiety symptoms are simply seen as "thinking too much" or everyday stress, which often keeps people from seeking help (Abrahams et al., 2021;

Sorsdahl et al., 2010). While international literature offers valuable theoretical frameworks for understanding anxiety disorders, Western models do not always capture the culturally embedded ways in which distress is experienced and communicated in African contexts (Mosotho et al., 2011; Shiraev & Levy, 2010). This aligns with calls in GMH for research that is grounded in local meanings and lived realities, rather than relying solely on imported frameworks (Jacob & Coetzee, 2018; Richter et al., 2021).

This highlights a major gap in South African research because we lack qualitative work that focuses on the lived experiences of individuals with PD and GAD. While existing research has established the prevalence of anxiety disorders, it provides limited understanding of how individuals make sense of their symptoms, cope with anxiety, and navigate daily life. To develop mental health policies that work the present study seeks to build on this body of literature by centring the voices of individuals living with PD and GAD, offering insight into their lived experiences within the South African context.

Chapter 3 Methodology

3.1 Introduction

This chapter outlines the philosophical and methodological foundations that guide this study. It explains how the researcher's assumptions about reality and knowledge shaped the research design, sampling decisions, data collection, and data analysis. This is important because a truly integrated study requires a clear link between a researcher's assumptions and the methods they choose to use. When you consider how these underpinnings inform the results, it becomes clear why a deep understanding of these connections is necessary for a study of this nature (Helmi et al., 2020). In the following sections, we explore the ontological and epistemological positions guiding the study, the qualitative research approach and exploratory research design, the sampling strategy and participant recruitment process, data collection and analysis procedures, ethical considerations, and the measures used to ensure trustworthiness.

3.2 Ontological and Epistemological Position

This study is informed by a relativist perspective, which means it views reality as something that can be experienced in different ways by different people. From this viewpoint, there is no single fixed truth, but rather multiple realities based on how individuals understand and live through their experiences (Chowdhury, 2014; Kabaji & Mukanzi, 2018). Researchers working within this ontological position aim to understand how people make sense of their world, acknowledging that multiple realities may coexist and that knowledge is co-created through interaction between researcher and participant (Pretorius, 2024; Pulla & Carter, 2018).When you consider the subjective nature of mental health, this viewpoint becomes a necessity for capturing the full picture of a participant's world. As Scotland (2012) explains, researchers who adopt a relativist ontology usually draw on an interpretivist epistemology, which sees knowledge as subjective and rooted in real-world experience. Building on this, the study follows an interpretivist approach, which emphasises understanding the meaning of a lived experience from the viewpoint of participants themselves (Goldkuhl, 2012; Pervin & Mokhtar, 2022). This framework is all about prioritising the meanings participants attach to their experiences, looking at the world through their eyes rather than imposing an outside definition. By its very nature, interpretivism

emphasises the pursuit of qualitative data (Chowdhury, 2014), which offers the researcher the ability to engage with subjective meanings that already exist in the world, to acknowledge them, to make sense of them, and to do so without distorting them (Dicicco-Bloom & Crabtree, 2006; Goldkuhl, 2012; Pulla & Carter, 2018).

This approach aligns with the purpose of this study, which is to explore how people personally experience living with PD and/or GAD. Instead of using fixed categories, it focuses on how participants describe their own feelings, symptoms, ways of coping, and whether they have sought help or treatment. The goal of this study is to understand these experiences in an authentic and contextually grounded way (Hennink & Kaiser, 2022; Subedi, 2021). Finally, little research has been carried out on the subjective lived experiences of individuals with PD and/or GAD in South Africa. Most existing literature comes from Western contexts, leaving a gap in understanding. By working within a relativist ontology and interpretivist epistemology, this study is able to qualitatively explore personal accounts and contribute to closing part of this gap by providing insights into the subjective realities of South Africans living with PD and/or GAD.

3.3 Research approach

There are two main ways to conduct social science research: quantitative and qualitative. A quantitative approach assumes that there is one objective reality (Salvador, 2016), which can be studied by examining the relationship between variables. To promote objectivity, the researcher tries to stay emotionally distant from the data collection process (Creswell, 2009; Korstjens & Moser, 2017; Leavy, 2017). In contrast, within a qualitative study, the researcher cannot be fully objective and is in fact an inseparable part of the research (Korstjens & Moser, 2017; Leavy, 2017). Reality can be experienced in many subjective ways (Salvador, 2016), and qualitative research values the depth of meaning in participants' experiences. This makes the qualitative research approach well suited to exploring both the similarities and differences in how South Africans living with PD and/or GAD interpret and make sense of their lives. Qualitative research offers the researcher the ability to engage with subjective meanings that already exist in the world, to acknowledge them, to make sense of them, and to do so without distorting them (Dicicco-Bloom & Crabtree, 2006; Goldkuhl, 2012; Pulla & Carter, 2018). This approach

enables the researcher to gain insight into the subjective experiences associated with anxiety disorders.

Furthermore, qualitative research is particularly useful when the aim of the study is to explore personal experiences, meanings, and interpretations in depth rather than to measure variables or test predetermined hypotheses (Hennink & Kaiser, 2022; Subedi, 2021). In the context of the present study, a qualitative approach was considered appropriate because the study aimed to explore how individuals living with PD and/or GAD subjectively experience and make sense of these conditions within the South African context. By making use of a qualitative research approach researcher can explore how individuals describe their symptoms, experiences, coping strategies, and help-seeking behaviours in their own words. In addition, the study is able to focus on rich descriptions and detailed personal accounts, because qualitative research creates space for participants to describe experiences that may not always be fully captured through quantitative methods or predetermined categories. This is particularly important within the South African context, where cultural understandings and expressions of anxiety may differ from dominant Western descriptions of mental illness.

While the study made use of two screening questionnaires, namely the Patient Health Questionnaire (PHQ-PD) and the Generalised Anxiety Disorder scale (GAD-7) (Appendix B and C respectively), these tools were used only as part of the participant screening and selection process. The questionnaires were therefore not used as evidence or for quantitative analysis, meaning that the study remained primarily qualitative in nature.

3.4 Research design

A qualitative exploratory research design guides this study. This type of research design is especially valuable when there is little prior research on a topic, as it helps fill knowledge gaps by uncovering new understandings (Leavy, 2017; Stebbins, 2001). This is particularly important in the present study, as limited research has been conducted on the lived experiences of individuals with PD and/or GAD within the South African context. This design offers the flexibility needed to explore participants' experiences in depth while remaining open to new meanings and insights that may emerge throughout the research process.

The design is centred on a three key principles. First, data is collected in the field through interviews, allowing participants to share their experiences in familiar and comfortable settings. This helps generate rich and meaningful data. Second, the focus remains on participants' own meanings, aiming to understand how they interpret living with an anxiety disorder in South Africa. Third, exploratory research is interpretive, with the researcher making sense of the data through their own lens, shaped by background and prior knowledge (Creswell, 2009). For this reason, exploratory qualitative research requires flexibility and open-mindedness (Stebbins, 2001) and, most importantly, reflexivity (Boromisza-Habashi, 2012).

To capture the accounts of the participants, semi-structured interviews were used as the primary method of data collection These type of interviews are valuable because they provide enough structure to guide the conversation while still giving participants the freedom to express themselves in their own words (Dicicco-Bloom & Crabtree, 2006; Hammersley, 2013; Packer, 2010). This method was considered appropriate for the present study because it allowed participants to describe their feelings, symptoms, coping strategies, and help-seeking experiences in a flexible and open-ended manner. In addition, semi-structured interviews created space for participants to discuss experiences that may not have emerged through more structured forms of data collection.

3.5 Sampling Strategy

This study used a non-probability sampling approach, which is common in qualitative research. Unlike probability sampling, where every person has an equal chance of being selected, non-probability sampling focuses on participants who are most relevant to the study. This made it possible to reach individuals with lived experience of PD and/or GAD in South Africa. This sampling strategy was most reasonable to use because the goal wasn't to generalize these findings to every South African, but rather to sit with the detailed, personal accounts of those living with PD and GAD (Stratton, 2021).

The primary non-probability sampling method applied was purposive sampling, which is common in qualitative research. This method allows researchers to deliberately select

participants because they meet specific criteria (Andrade, 2021; Etikan et al., 2015; Stratton, 2021). In this study, participants were included if they were adults over the age of 18, fluent in English, and living with PD and/or GAD, either through a prior clinical diagnosis or self-reported symptoms consistent with PD and/or GAD. In addition, they had to score within the eligibility range on two screening questionnaires: a minimum score of 8 or above on the PHQ-PD and/or a minimum score of 10 or above on the GAD-7. These thresholds were vital for making sure the study stayed focused on those navigating significant mental health challenges. Those who met these thresholds but hadn't been formally diagnosed, were provided with information regarding available mental health support services through SADAG.

In addition to purposive sampling, convenience sampling also played a role. Convenience sampling involves the researcher sharing information about the study and allowing participants to self-select if they wish to take part (Stratton, 2021). To recruit participants, the researcher approached SADAG and requested that the study invitation be circulated within relevant support groups. The study invitation was also shared on social media platforms, including Facebook and WhatsApp, and family and friends were asked to help circulate the invitation further. Permission to share the study invitation within support groups was obtained from the relevant group administrators. The study invitation included a brief description of the study, participation requirements, confidentiality information, voluntary participation details, and the researcher's contact information. Participants had full control over whether to take part, as they were required to contact the researcher directly. This allowed participants to self-select and reach out to participate in the study directly, ensuring that no one felt pressured to join. When you consider the scope of a Master's degree, this approach was a practical necessity as it provided a manageable way to access a hard-to-reach group within the available time and resources (Andrade, 2021).

Altogether, eight participants were interviewed. Although the sample size was relatively small, it was appropriate for an in-depth qualitative study where smaller samples are often preferred to allow for depth and detail. The interviews provided rich insights into participants' personal experiences, and by the time the final interviews were completed, no new major themes were emerging, a point often referred to as data saturation (Guest et al., 2006; Hennink & Kaiser,

2022). This focus on depth and subjective meaning aligns closely with the philosophical foundations guiding the study and supports the use of purposive sampling within qualitative research (Palys, 2008; Subedi, 2021).

3.6 Setting

This study was conducted in South Africa, with participants recruited through community-based and online networks. SADAG granted permission for the study invitation to be circulated within relevant support groups following the submission of the gatekeeper permission letter (appendix D). In addition, the study invitation was shared through social media platforms and community networks. Potential participants voluntarily contacted the researcher if they were interested in taking part in the study. The researcher's contact details were therefore shared publicly, while the contact details of potential participants remained confidential unless individuals consented to participate in the study. Most participants were based in Gauteng Province, although a small number were from other regions within South Africa. Since the broader South African context was the focus of the study, participants' exact locations were not explicitly sought, although this information emerged naturally during the interview process.

3.7 Data collection

According to Singh and Wassenaar (2016), social science research often requires access to institutions that could provide data or participants relevant to the study. Access to these institutions is usually managed by an individual known as a gatekeeper. To meet the objectives of this study, the researcher approached SADAG via email. As an organisation that assists patients and callers across South Africa with mental health queries, SADAG was able to circulate the study invitation to individuals who might participate in the study. Formal communication was sent to the head of the institution, outlining the purpose of the study, the methods and procedures for data collection, and the potential risks and benefits of participation.

Once potential participants contacted the researcher, they were given more information about the study and sent the participant information sheet (appendix E). If they expressed interest, a consent form was provided (appendix F). Once consent was obtained, participants were asked to

complete the PHQ-PD and GAD-7 questionnaires to confirm eligibility. For the PHQ-PD, participants were required to score 8 or above (appendix B). For the GAD-7, participants were required to score a minimum of 10 or above (appendix C). Although copyright for these scales is held by Pfizer Inc. (2010), they are freely available for research use. Participants who met the inclusion criteria were then scheduled for interviews at a time convenient to them. Interviews were conducted via Microsoft Teams or WhatsApp, depending on participant preference. This method supported confidentiality and provided participants with a space in which they could share their experiences openly (Dicicco-Bloom & Crabtree, 2006; Packer, 2010). Eight eligible participants then took part in open-ended, semi-structured, in-depth interviews. Interview questions were developed around the main areas of interest in this study: (1) what living with PD and/or GAD subjectively feels like, (2) how PD and/or GAD manifest, (3) how participants cope with these conditions, and (4) whether participants have sought treatment, and their reasons for doing so or not. The interview guide (Appendix A) provided enough structure to cover the research questions while remaining flexible enough to allow participants to share their perspectives in their own words. Follow-up questions were asked only for clarification or to deepen understanding (Dicicco-Bloom & Crabtree, 2006; Packer, 2010).

To ensure that participants felt comfortable and that power dynamics were managed carefully during interviews, the researcher ensured that, at the start of each interview, participants were reminded of the information provided in the consent form (appendix F) and participant information sheet (appendix E). Participants were informed that participation was voluntary and that they could withdraw from the study or discontinue the interview at any stage without consequence. Interviews were audio recorded with participants' permission to ensure accurate transcription and analysis. Before recording began, formal verbal consent was obtained from each participant. Participants could choose to keep their camera off if they preferred, while the researcher kept their camera on to allow participants to observe non-judgmental reactions and active engagement throughout the interview. Each interview began with an introductory question, "Can you tell me a little about yourself?" to help create a relaxed atmosphere and to allow participants to begin the dialogue in a way that felt safe and personal. This also helped the researcher interpret how open or reserved the participant was and adjust the interview style

accordingly. Participants were reminded throughout the interviews that they only needed to answer questions they felt comfortable responding to.

3.8 Data analysis

All the digitally recorded interviews were transcribed into Word documents. The data was then analysed using Reflexive Thematic Analysis (RTA) in ATLAS.ti software. RTA was chosen because it is a flexible and widely used method that allows researchers to identify, analyse, and report patterns of meaning within data (Braun & Clarke, 2012; Kiger & Varpio, 2020; Braun & Clarke as cited in Lochmiller, 2021). RTA is particularly useful for exploring lived experiences and subjective meanings, as it provides both descriptive and interpretive insights (Lochmiller, 2021). The method was preferred over other approaches because the aim of this study was not to create a new theory, but rather to explore common themes across participants' experiences of PD and GAD in the South African context (Coates et al., 2021).

The analysis followed the six phases of RTA as described by Braun and Clarke (2012). In the first phase, the researcher became familiar with the data by reading the transcripts several times to notice ideas relevant to the research question (Kiger & Varpio, 2020; Zhavi, 2019). In the second phase, initial codes were created in ATLAS.ti to label important features of the data. These codes described both the surface meaning of the text and, where possible, deeper interpretations (Braun & Clarke, 2012; Kiger & Varpio, 2020Coding was conducted within the software and continuously refined as patterns became clearer. A working codebook was also developed to assist with organising and refining codes throughout the analytic process (Coates et al., 2021). In the third phase, related codes were grouped into categories in ATLAS.ti, which formed the basis for identifying potential themes. Thematic maps were then used to visually explore the links between main themes and sub-themes. In phase four, these themes were reviewed and refined in relation to the original codes and the whole data set. Phase five involved selecting extracts that best represented each theme and naming the themes in a way that captured their meaning. The final phase involved writing up the findings in a clear report, showing how the themes answered the research question (Braun & Clarke, 2012; Kiger & Varpio, 2020). This allowed the study to describe the experiences of South Africans living with PD and GAD in a meaningful way (Wertz, 2005).

Reflexivity was maintained throughout the analysis by practicing ongoing self-awareness and reflecting on potential bias in interpreting the data (Boromisza-Habashi, 2012; Pulla & Carter, 2018). The researcher engaged in reflexive note-taking throughout the research process to document thoughts, assumptions, emotional responses, and analytic decisions that emerged during data analysis. The researcher also remained mindful of not imposing meanings onto participants' accounts and aimed to interpret participants' experiences within the context in which they were described. The researcher aimed for transparency by explaining how interpretations were formed and engaged in peer debriefing with a supervisor to strengthen rigour (Coates et al., 2021).

3.9 Ethical considerations

Ethical approval for this study was granted by the UNISA-CHS Health Research Ethics Committee on the 21st of August 2023 (NHREC Registration #: Rec-240816-052; CREC Reference #: 66306906_CREC_CHS_2023), with the requirement that no fieldwork be conducted after the expiry date of 21 August 2024. To ensure the research study adhered to the ethical approval as set by the UNISA-CHS Health Research Ethics Committee, the study included the fundamental ethical principles in qualitative inquiry. This includes informed consent, confidentiality, protection from harm, and respect for participant autonomy (DiCicco-Bloom & Crabtree, 2006; Halai, 2006; Orb et al., 2000).

All participants were over 18 years old and voluntarily provided informed consent. They were reminded of their right to withdraw at any time without repercussions. While institutional gatekeeper permissions were sought when appropriate, these never replaced obtaining individual informed consent (Singh & Wassenaar, 2016). Recognising the sensitivity of anxiety disorders, the researcher created a safe and respectful interview setting. Before each interview, participants were reminded of the study's purpose, methods, and potential risks and benefits, as outlined in the information sheet and consent form. Formal verbal consent was obtained prior to audio recording. Participants were given the option to keep their camera off, while the researcher kept theirs on to foster visible, non-judgmental engagement. Each interview began with a relaxed, open-ended question to help participants feel comfortable and to allow the researcher to adjust

the interview style depending on how open or reserved the participant was. Participants were reminded that they only needed to answer questions they felt comfortable with. To protect confidentiality, pseudonyms were used in all transcripts and reports, and no identifying details were included. Digital data were stored on a password-protected computer, no paper copies were used in this study. In line with university policy, all records will be kept for five years and then securely destroyed (Orb et al., 2000).

Because the participants were a vulnerable group, the researcher put extra measures in place to reduce possible harm. Participants were free to pause or stop the interview at any time. Although the study did not have the resources to provide an on-site counsellor, permission was obtained from the SADAG for participants to contact their free hotline if they experienced distress. If needed, participants were also encouraged to seek further counselling services. At the end of each interview, a short debriefing was held to remind participants of the study's purpose, the researcher was available to answer questions and check whether they were open to future contact (Sharpe & Faye in Whitley & Kite, 2013).

Throughout the study, the researcher practiced reflexivity by maintaining ongoing self-awareness and regularly reflecting on their role and influence in the research to reduce bias and strengthen trustworthiness (Boromisza-Habashi, 2012; Pulla & Carter, 2018). During the reflexive thematic analysis, the researcher often paused to ask questions such as: Am I over-interpreting the data? Am I assuming what the participant meant based on my own perceptions? If this was the case, the data was re-coded to ensure accuracy and fairness. The researcher also aimed to be transparent in the results and discussion sections by explaining how interpretations were shaped and describing the decisions made during coding and theme development. This approach reflects recommendations for reflexive awareness in qualitative research (Karnieli-Miller et al., 2009). Guided by the principle of beneficence, the study ensured that potential benefits outweighed risks, while respecting participants' dignity, privacy, and cultural context (Halai, 2006; World Medical Association, 2013).

3.10 Trustworthiness

Trustworthiness was considered throughout the research process to strengthen the rigour, transparency, and credibility of the study. In line with the interpretivist nature of the research, trustworthiness was approached through ongoing reflexivity, methodological transparency, and careful engagement with participants' accounts.

Credibility was strengthened through the use of RTA, which provided a flexible yet systematic approach for identifying patterns of meaning within participants' experiences (Braun & Clarke, 2012). Semi-structured interviews created space for participants to describe their experiences in their own words, while audio-recorded interviews supported accurate transcription and faithful representation of participants' accounts. Although the study included a relatively small sample of eight participants, interviews continued until no new major themes were emerging, suggesting a point of data saturation (Guest et al., 2006).

Dependability was supported through maintaining a clear and traceable analytic process. Braun and Clarke's (2012) six-phase framework for RTA guided the analysis, while ATLAS.ti software assisted with organising, refining, and managing codes throughout the coding process. A working codebook was continuously refined during analysis to support consistency in coding and theme development. In addition, reflexive note-taking was used throughout the research process to document emerging ideas, assumptions, analytic decisions, and reflections as themes developed.

Confirmability was strengthened by ensuring that interpretations remained closely connected to participants' accounts rather than shaped primarily by researcher assumptions. The study made extensive use of direct participant quotations to support each theme, ensuring that participants' voices remained central to the presentation and interpretation of the findings. Reflexivity also formed an important part of the analytic process. Throughout coding and interpretation, the researcher continuously reflected on whether interpretations were grounded in participants' actual accounts or influenced by personal assumptions regarding anxiety and lived experience. Where necessary, codes and interpretations were revisited and refined to remain closely aligned with participants' intended meanings.

Although the study did not aim for broad generalisation, rich descriptions of participants' experiences, the South African mental health context, and the broader research process were provided to offer contextual understanding of the findings. Participant demographic information, including age, gender, race, and screening outcomes, was also included to provide greater insight into the sample and the contexts within which participants' experiences were explored.

3.11 Conclusion

This chapter explained the methodological approach used in this study. The research is grounded in a relativist ontology, which recognises that people experience reality in different ways (Chowdhury, 2014; Kabaji & Mukanzi, 2018). In line with this, the study follows an interpretivist epistemology, which focuses on understanding how individuals make meaning of their experiences (Goldkuhl, 2012). These philosophical foundations support the use of qualitative methods to explore the lived experiences of individuals with PD and/or GAD and address the research gap mentioned in chapter 1 and 2. A qualitative exploratory design was chosen because it allows for depth, flexibility, and openness during data collection, especially in areas where limited research exists (Grass, 2021; Stebbins, 2001). Semi-structured interviews were used to give participants the opportunity to describe their experiences in their own words (Dicicco-Bloom & Crabtree, 2006).

Participants were selected using purposive and convenience sampling to ensure that individuals with direct experience of PD and/or GAD were included, while also considering practical recruitment challenges (Etikan et al., 2015; Stratton, 2021). Eight participants took part in the study, which is appropriate for qualitative research as smaller samples allow for rich data and data saturation (Guest et al., 2006; Hennink & Kaiser, 2022). Data collection and analysis were conducted in an ethical and respectful manner. Informed consent, confidentiality, and participant wellbeing were prioritised throughout the research process (Orb et al., 2000; Singh & Wassenaar, 2016). The data were analysed using reflexive thematic analysis, following Braun and Clarke's (2012) six-step framework. Reflexivity remained important throughout the process, helping the researcher remain aware of personal influence during interpretation (Boromisza-Habashi, 2012). Together, these methods provide a clear and appropriate approach for exploring the lived experiences of individuals with PD and/or GAD.

Chapter 4 Findings

4.1 Introduction

This chapter explores the findings of this study, based on the rich and detailed accounts shared by South African participants living with PD and/or GAD. The analysis was conducted using ATLAS.ti and followed Braun and Clarke's (2012) RTA approach. Chapter 4 examines how participants make sense of their symptoms and emotional experiences as they navigate daily life. The findings delve into how participants cope while navigating their relationships and the broader mental health system. Since this work is rooted in a relativist and interpretivist perspective, the focus is not on uncovering an objective reality, but on understanding the multiple realities that participants co-constructed during the interview process. Participant accounts illustrate that anxiety isn't just an internal struggle, it is something shaped by a South African environment where stigma and a lack of awareness are very real. The findings directly address the research objectives of the study. First, they explore what living with PD and/or GAD feels like from the participants' perspective. Second, they examine how these disorders manifest physically, emotionally, and behaviourally. Third, they consider the coping strategies participants use to manage anxiety symptoms. Finally, they investigate whether participants sought help or treatment and the reasons that influenced these decisions.

This chapter is organised into themes that reflect participants' experiences. These include understanding anxiety disorders, dealing with stigma and misunderstanding, the connection between anxiety and depression, coping strategies, the role of control, living with anxiety, help-seeking experiences, and the impact of anxiety on daily life, relationships, and work. The following section provides a brief overview of the study participants and the screening measures used to determine eligibility for inclusion in the study.

4.2 Participant overview

The study sample consisted of seven female participants and one male participant. Participants represented diverse South African racial backgrounds, including White, Black, and Coloured participants. The screening outcomes reflected varying degrees of anxiety symptom severity.

Most participants recorded GAD-7 scores within the moderate range, though the full spectrum spanned from mild to severe. Additionally, the PHQ-PD results indicated that most of the group dealt with symptoms specifically tied to PD (Table 5).

Table 5

Participant Demographic and Screening Overview

Participant	Gender	Race	GAD-7 Score	GAD Severity	PHQ-PD Outcome
A	Female	White	13	Moderate	Positive
B	Female	White	14	Moderate	Positive
C	Female	White	9	Mild	Positive
D	Female	White	14	Moderate	Negative
E	Female	Black	17	Severe	Positive
F	Female	Coloured	11	Moderate	Positive
G	Male	Black	13	Moderate	Negative
H	Female	Coloured	10	Moderate	Positive

4.3 An overview of the main themes

The analysis generated six major themes, each addressing a different component of the participants lived experiences. Table 5 offers a concise overview of how the six themes were developed through the coding hierarchy of initial codes, refined codes, and sub-themes.

Table 6

Coding hierarchy: Themes, sub-themes, refined codes, and initial codes

Theme	Sub-theme	Refined Codes	Initial Codes
Theme 1: Understanding participants' experiences with GAD and PD	1.1 Making sense of anxiety terminology	Diagnostic uncertainty; Difficulty self-identifying; Mental health knowledge gaps	Confusion about GAD vs PD; unsure of criteria; "I don't know what to classify myself as"; limited mental health literacy; mislabelled symptoms
	1.2 Metaphors as meaning-making tools	Alarm bells; Moth-in-chest; Feeling bruised; Overwhelm metaphors	"Alarm bells going off"; "house burning down"; somatic metaphors; emotional metaphor language; symbolic descriptions of internal states
	1.3 Navigating misunderstanding and stigma	Invalidation; Symptom minimisation; Social stigma; Misinterpretation by others	"Just pray it away"; misunderstanding in family; trivialising anxiety; dismissive responses; perceived judgment; hesitancy to disclose

Theme	Sub-theme	Refined Codes	Initial Codes
Theme 2: The interconnected nature of anxiety and depression	2.1 Anxiety and depression as interconnected experiences	Anxiety leading to depression; Depressive fatigue; Emotional overlap; Co-morbidity; Chronic struggle	High anxiety leading to emotional shutdown; sadness; exhaustion; multiple diagnoses; overlapping symptoms; cumulative emotional burden; "I don't want to go into depression"
Theme 3: Strategies for coping with anxiety	3.1 Avoidance as coping	Avoidance; Social withdrawal; Procrastination; Trigger avoidance	Avoiding people/places; staying in bed; delaying tasks; avoiding conflict; avoiding threatening media; emotional numbing
	3.2 Maladaptive coping	Substance use; Unhealthy habits; Digital distraction; Emotional escape	Drinking; smoking; overeating; oversleeping; social media as escape; excessive partying; compulsive phone use; "crutching" behaviours
	3.3 Adaptive coping	Structure; Predictability; Grounding; Exercise; Routine planning	Lists; scheduling; keeping busy; breathing exercises; strict organisation; physical movement; distraction as regulation
	3.4 Relational and professional support	Help-seeking; Barriers to help; Therapy engagement; Medication use; Emotional support	GP visits; psychologist support; psychiatric referrals; antidepressants; medication during panic; supportive partners; fears of being judged
Theme 4: Control as trigger and relief	4.1 Control as stability and distress	Predictability; Planning behaviours; Responsibility strain; Loss of control; Emotional dysregulation	Panic when plans change; catastrophising; overthinking; reassurance-seeking; emotional flooding; avoiding abandonment feelings
Theme 5: Living with anxiety in daily life	5.1 Psychological and emotional experiences	Rumination; Overanalysis; Guilt; Self-criticism; Emotional overwhelm	Replay conversations; fear of judgment; intrusive thoughts; catastrophising; guilt cycles; internal pressure
	5.2 Physical and somatic experiences	Panic attacks; Gastrointestinal distress; Chest pain; Migraines; Somatic tension	Nausea; sweating; dizziness; hyperventilation; trembling; stomach cramps; headaches; shortness of breath
	5.3 Navigating help-seeking and treatment	Structural barriers; Misdiagnosis; Minimising symptoms; Medical invalidation	Difficulty accessing care; long wait times; feeling dismissed; crisis-driven help-seeking; stigma in health system
	5.4 Impact on daily functioning and productivity	Concentration difficulties; Fatigue; Executive dysfunction; Workplace anxiety	Forgetfulness; inability to focus; slow task pace; sleep disturbance; mental exhaustion; task overload; fear of evaluation
	5.5 Impact on social life and relationships	Withdrawal; Conflict avoidance; Dependency; Emotional distancing	Avoiding social events; irritability; avoiding eye contact; sensory overwhelm in groups; relationship strain

Theme 1: Understanding participants' experiences with GAD and PD

This theme explores how participants understood and interpreted anxiety, diagnostic labels, and symptom experiences. Participants demonstrated varying levels of mental health literacy, ranging from uncertainty and confusion to more clinically informed understandings of GAD and PD.

Theme 2: The interconnected nature of anxiety and depression

Participants frequently described anxiety and depression as emotionally interconnected and overlapping experiences. Some viewed anxiety as gradually developing into depression, while others experienced both simultaneously. Accounts highlighted how prolonged anxiety contributed to emotional exhaustion, sadness, hopelessness, and psychological strain.

Theme 3: Strategies for coping with anxiety

Participants described a wide range of coping strategies, including avoidance, maladaptive coping behaviours, grounding techniques, structured routines, relational support, and professional mental health care. This theme highlights the varied ways participants attempted to manage emotional distress, uncertainty, and overwhelming anxiety.

Theme 4: Control as trigger and relief

Control emerged as a central aspect of participants' experiences, functioning both as a source of emotional stability and a trigger for distress when disrupted. Structure, predictability, organisation, and productivity often provided reassurance, while unexpected change or loss of control frequently intensified anxiety and panic.

Theme 5: Living with anxiety in daily life

This theme explores the emotional, cognitive, physical, relational, and functional impact of anxiety in everyday life. Participants described anxiety as emotionally overwhelming, cognitively exhausting, and physically debilitating. Anxiety affected participants' relationships, work functioning, social engagement, concentration, emotional regulation, and ability to manage daily responsibilities. Participants also described challenges related to help-seeking, stigma, and navigating mental health support systems within the South African context.

4.4 Theme 1: Understanding participants' experiences with GAD and PD

During the interviews, participants shared their symptoms, understandings, and experiences with both GAD and PD. When you consider how they communicated about their conditions, it is clear that many participants struggled to differentiate between terms such as “anxiety”, “anxiety disorder”, “GAD”, and “PD”. This confusion reflects a larger problem with mental health literacy especially surrounding diagnostic terminology. Most individuals relied on broad, socially familiar idioms to articulate their distress, while only a few demonstrated a more developed understanding of the subtle distinctions between different anxiety disorders. Many participants described navigating these mental states within a South African context where mental health conditions are frequently misunderstood, trivialised, or poorly recognised across both social circles and formal healthcare settings

This theme explores how participants interpreted, labelled, and communicated their experiences of PD and GAD within contexts characterised by misunderstanding, conflicting explanations, and limited mental health awareness. It also explores the ways individuals change how they view themselves and alter their communication styles just to survive these unsupportive environments. Navigating GAD and PD under these conditions means constantly balancing an intense, painful inner world against an outside world that lacks the basic vocabulary to comprehend it.

4.4.1 Theme 1.1: Making sense of anxiety terminology

Participants expressed a wide range of understanding regarding mental health terminology. Many used the term *anxiety* interchangeably to describe symptoms associated with both GAD and PD. This often led to collapsing “anxiety” into a single condition instead of viewing it as a broad category consisting of multiple diagnostic forms. This is important because it shows a clear pattern where participants conflate everyday nervousness or stress with clinical anxiety disorders.

For some individuals, the distinction between disorders was particularly unclear. Participant A, for example, reported difficulty classifying their own experience, noting, *“I do not know what the difference between the two are, so it is difficult for me to say what it is that I classify myself*

as" (Participant A). Similarly, Participant H initially expressed limited knowledge of anxiety disorders, stating, "*No. Not really… Yeah. Not really*" when asked if they understood the different types of anxiety disorders (Participant H). However, when prompted to explain the difference between GAD and PD, they managed to draw a much clear line. They described PD as anxiety triggered by a specific event, while GAD was experienced as a more consistent state of anxiety, "*panic disorder… if something happens and you become anxious. And the other one… is just a person that's all the time anxious, you know, anxious all the time*" (Participant H). This shift suggests that a participant's confusion isn't permanent. With a little bit of space to reflect and talk through their thoughts during the interview, that fuzzy, partial awareness often sharpens into a much more explicit distinction.

Other participants struggled to find the diagnostic language to articulate what they were experiencing. Participant F, for example, described feeling "*fine*" and "*sane*", yet simultaneously becoming "*a nervous wreck*" following distressing experiences. They elaborated that although they referred to these episodes as panic attacks, they remained uncertain about what the term signified: "*I do not know how to put it… I have never put it in words… I just say I can have panic attacks… but I do not know what it is*" (Participant F). This difficulty brings to light a massive hurdle for many in the study: they recognised their own internal distress but simply did not possess the clinical vocabulary to name it.

In contrast, some participants demonstrated a more developed and clinically aligned understanding. Participant C, who described themselves as having GAD but screened positive for PD symptoms during the inclusion process, demonstrated a more clinically aligned understanding of the distinctions between GAD and PD. They distinguished between persistent daily anxiety and more acute panic-related experiences, describing GAD as "functioning with anxiety on a daily basis" linked to routine activities and responsibilities, while PD was associated with more acute and episodic experiences of anxiety (Participant C). Other participants conceptualised anxiety primarily as situational. Participant D described anxiety in terms of everyday stressors such as work, public speaking, or test-taking, explaining that these experiences felt like "*a norm type of thing*" associated with common life events (Participant D).

Similarly, Participant G viewed anxiety as a temporary state, referring to it as an "*anxiety period*" that a person might eventually pass through (Participant G).

Looking at these accounts side-by-side, it is clear that mental health literacy isn't a simple case of either knowing the terms or not. While a few individuals exhibited a textbook understanding of GAD and PD, the majority had to lean heavily on their own raw personal histories, everyday language, or immediate context to make sense of the symptoms they live with.

4.4.2 Theme 1.2: Metaphors as meaning-making tools

Participants frequently relied on metaphorical language to express their experience of GAD and PD. When you consider how difficult it is to vocalise these hidden psychological states, these metaphors are not just simple figures of speech. Instead, they become important communicative tools participants used to name an otherwise invisible struggle. In addition, these metaphors functioned as meaning-making tools, helping participants communicate the intensity and daily discomfort of their symptoms.

Several participants drew on bodily metaphors to describe the physical manifestations of anxiety. Participant B, for example, contrasted the image of a butterfly with that of a moth to convey both the sensation and the emotional quality of their experience. They explained that while a butterfly might appear delicate or pleasant, a moth better represented the distress associated with anxiety:

> *I feel like there is a… butterfly sounds so pretty, so I am going to use a moth… A moth that flies up from my stomach all the way to my chest and then back down again… that anxious fluttering… sometimes I actually hit my chest because it feels like I need to kill whatever is inside of me* (Participant B).

Other participants used metaphors to describe how rapidly anxiety builds and overwhelms their internal world. Participant A compared anxiety to an internal alarm system that becomes unmanageable when overstimulated: "*Anxiety is, to me, alarm bells going off. And if you have too many of them, the house burns down, and I think that is what overwhelms many people, myself included*" (Participant A). This is important because the imagery captures the destructive momentum of a panic response before it completely takes over.

Metaphors also helped participants convey the contrast between outward appearance and internal experience. Participant C described presenting a calm exterior while managing intense internal conflicts, comparing themselves to "*a duck where everything looks very calm and serene on the surface, but… underneath… the flippers [are] going the whole time*" (Participant C). This expression therefore gives us insight in the individual's reality into two distinct worlds: a visible, performative calm meant for the public, and an invisible, exhausting panic hidden just below the water line. This expression therefore gives us insight into the high-functioning, hidden nature of their anxiety. Participant C also used metaphor to communicate emotional sensitivity, explaining, "*I always tell my husband I am feeling bruised today*" to describe periods of heightened vulnerability (Participant C).

When you consider these metaphorical fragments together, it becomes clear that these metaphors do something clinical vocabulary cannot. It allowed participants to communicate sensations, emotions, and daily struggles that might otherwise remain unavailable when expressing complex psychological states within contexts of limited mental health literacy.

4.4.3 Theme 1.3: Navigating misunderstanding and stigma

Participants described a continuous battle against stigma, misinformation, and invalidation while navigating life with GAD and PD. For most, a pervasive sense of being misunderstood by family, peers, professionals, and the public defined their daily routines. When you consider how deeply this misinterpretation cuts, it is clear that it alters their entire approach to communication. Instead of reaching out for help, participants regularly swallow their own distress, masking their symptoms and suppressing their immediate needs simply to stay under the radar and protect themselves from further judgment. For some participants, the lack of understanding from others was a key motivation for participating in the study. Participant A expressed a strong desire for public awareness could lead to improved support and coping strategies for those with anxiety disorders, stating, "*If people understand it better, we can figure out better ways of dealing with it*" (Participant A). Even within intimate relationships, a lack of literacy created significant barriers. Participant B recalled how her partner tried to intervene during a panic attack, but his

complete lack of basic guidance left him powerless to help: "*He was trying to calm me down. Not that it helped, but shame, he tried*" (Participant B).

Misunderstanding was not limited to personal relationships and also emerged in broader social and institutional contexts, where participants expected compassion and professionalism. Participant B recounted a distressing experience after being hospitalised for a mental health crisis, during which she was met with hostility and humiliation from nursing staff. She described requesting a container because she felt nauseous, yet the nurse refused assistance until administrative procedures were completed. She explained, "*I landed up throwing up on her shoes, which landed with me being shouted at even more*" (Participant B). This situation shows how institutional stigma can actively contributed to feelings of humiliation and distress within a healthcare setting, compounding their trauma at the exact moment they need clinical protection. Outside of clinics, everyday environments presented a different set of triggers where public impatience quickly escalated into acute panic. Participant B recalled a situation of stalling her vehicle on a hill, which provoked immediate hooting and swearing from surrounding drivers, followed by a tense confrontation with her boss when her memory lapsed over a routine PIN code. These cumulative stressors eventually triggered a severe panic attack that forced her to contact her husband for assistance.

Misinformation and stigma also affected participants' engagement with support resources. Participant B described an incident in which a member of the support group she facilitated requested a name change for their WhatsApp group because others had teased her after seeing the terms "*depression, anxiety, and PTSD*" on her phone (Participant B). This reflects the social risks associated with visible association to mental health disorders. Furthermore, participants often found themselves needing to educate others about mental health conditions due to widespread gaps in public understanding. Participant B explained that family members did not understand even widely recognised terms such as PTSD, recalling, "*they don't understand depression, anxiety, and PTSD… they didn't know what PTSD stood for*" (Participant B). She further described having to "*really educa*te" them about the condition, illustrating how limited mental health literacy often shifted the responsibility for explanation onto participants themselves.

The stigma associated with diagnostic language itself also shaped how participants viewed their own minds. Participant F described reacting negatively to the term *disorder*, explaining, "*I thought it is a bad word*" and adding that she associated the term with being "*crazy*" despite knowing this association was unfounded (Participant F). Since labels carry this kind of baggage, the pressure to hide symptoms is constant. Participant G pointed out that their internal panic usually goes completely unnoticed by colleagues and friends because, on the surface, they "*still engage well"* (Participant G).

Ultimately, these testimonies reveal that managing GAD and PD is not just about dealing with the internal pathology of the mental illness. Instead, these experiences expose the immense, exhausting emotional labour required to move through a society where anxiety disorders are often poorly understood, minimised, or stigmatised.

4.5 Theme 2: The interconnected nature of anxiety and depression

This theme explores the overlap and development between anxiety and depressive experiences as described by participants. Within public health frameworks, clinical depression is widely recognised as a serious mental health disorder often associated with significant emotional distress and functional impairment. However, the individuals in this study articulated an identical depth of psychological devastation within their day-to-day encounters with GAD and PD. Several participants detailed how significant emotional distress and functional impairments emerged directly from the exhaustion of their mental health states. Participants in this study indicated that anxiety and depression were not only co-occurring but also emotionally intertwined. In some participants, anxiety served as a precursor that gradually developed into depression; for others, the two conditions were experienced simultaneously and as deeply interconnected. Participants described anxiety as emotionally exhausting, overwhelming, and capable of contributing to feelings of sadness, hopelessness, emotional withdrawal, and fatigue over time. When you consider these accounts, it becomes clear that separating these experiences into rigid diagnostic categories does not match the reality of their internal lives.

4.5.1 Theme 2.1: Anxiety and depression as interconnected experiences

Participants frequently described anxiety as emotionally depleting and completely overwhelming. This would often result in feelings associated with depression. Several participants indicated that long-term anxiety led to feelings such as low mood, sadness, apathy, and emotional withdrawal. These emotional responses are all commonly linked to depression. For example, Participant C shared that their experience of extended isolation eventually transformed into depression:

> *Last year, it just stays it just got into this point of avoiding, avoiding people physically for months on end. So not actually leaving the house, not wanting to go anywhere, not wanting to do anything, but, I mean, that eventually spiralled into depression* (Participant C).

Additionally, they observed that experiencing anxiety for long periods can render it unmanageable, which subsequently leads to depression:

> *For me, I think just functioning, and that's something that I can say the, psychologist or psychiatrist mentioned is functioning on a high level of anxiety for that amount of time eventually spirals into depression. So, it fuels depression because anxiety is something you can't, you can't manage (Participant C).*

Similarly, participant F mentioned concern that persistent anxiety might lead to depression: "*I always said to myself, I am not going to go into a depression thing… and have a whole breakdown*" reflecting fear of depression emerging from ongoing anxious distress (Participant F).

Participants also described emotional overlap between anxiety and sadness. Participant C reported, "*I definitely connect a lot of sadness with anxiety*" (Participant C), while Participant G similarly noted that when an anxious episode hit, they would immediately "*feel sad*" linking their emotional state to the presence of anxiety (Participant G). These experiences were accompanied by apathy and fatigue for Participant C who described "*a sense of listlessness and feeling like, what is the point*" and noted that at times they "*slept more than [they] were awake*" to avoid emotional overwhelm (Participant C). Across accounts, anxiety was described not only as a distinct condition but also as a state capable of evolving into depressive symptoms when sustained over time.

Participants also noted that anxiety was frequently misunderstood, both by themselves and by others. This misunderstanding contributed to shame or delayed help-seeking, particularly when anxiety was overshadowed by the more socially recognised label of "depression." But for several participants, two conditions were experienced simultaneously and described as inseparable. Participant A repeatedly emphasised that their anxiety and depression "*work hand in hand*" explaining that although depression was present, it often felt like "*a secondary consequence of the anxiety*" (Participant A). They further stated that depression "*came along with*" their anxiety and that the conditions were "*not one thing out of the ballpark*" but closely intertwined (Participant A). Some participants described beginning their mental health journey believing they were experiencing depression, only later recognising the presence of anxiety or vice versa. Participant B reported living with "*depression, anxiety, Generalised anxiety, and PTSD*" reflecting the co-occurrence of multiple conditions (Participant B). Similarly, Participant C described taking both antidepressant and anti-anxiety medication and receiving psychological support that addressed symptoms across diagnostic categories (Participant C).

Overall, participants described anxiety and depression as emotionally intertwined experiences rather than entirely separate conditions. Anxiety was frequently experienced as exhausting, emotionally draining, and capable of progressing into depressive symptoms over time. These accounts illustrate how participants understand their own mental health is fundamentally shaped by this overlap, which heavily impacts both how they make sense of their internal pain and how they try to articulate that suffering to the world around them.

4.6 Theme 3: Strategies for coping with anxiety

Participants described a wide range of coping mechanisms that varied in long-term effectiveness and daily impact. These strategies ranged from deliberate behavioural techniques to more automatic, impulsive responses developed over time. Four broad coping patterns emerged across participants' accounts: avoidance-based coping, maladaptive coping strategies, adaptive coping strategies, and relational or professional support. Together, these coping responses reflected participants' attempts to regulate emotional distress, manage uncertainty, and maintain functioning in daily life.

4.6.1 Theme 3.1: Avoidance as coping

Avoidance emerged as one of the most frequent coping responses. Avoidance was not limited to a few specific things but extended to people, places, tasks, emotions, and even internal experiences. Participants commonly described withdrawing socially, avoiding responsibilities, or removing themselves from situations that triggered anxiety. For example, participant A explained that they rarely left their home environment, noting, "*I can go down to the gates. Very rarely that I would go outside of the gate*" (Participant A). They further reported, "*I've become more reclusive… I've completely removed myself from society*" (Participant A).

Several participants described avoiding not only physical environments but also emotional processing. Participant G stated, "*Whatever is bothering me and it gets me to that 10 level, I bury it at the backside of my brain*" (Participant G). Along the same lines, Participant C described sleeping as a way to escape emotional overwhelm: "*I literally slept more than I was awake because it felt like at least the time passed… I didn't have to deal with myself or with anything else*" (Participant C). Avoiding crowds or social events was also common. Participant H shared, "*Even when people invite me, I don't really just want to go… I prefer to be at home in my own surroundings with my own family*" (Participant H). This pattern extended to avoidance of communication: "*I am very millennial like that in terms of not wanting to answer phones*" (Participant C). Participants described avoidance as a way of reducing immediate distress, anticipatory anxiety, or exposure to emotionally triggering situations.

4.6.2 Theme 3.2: Maladaptive coping

A second major pattern involved coping mechanisms that provided temporary relief but ultimately intensified anxiety. Participants described using substances, excessive engagement with digital platforms, or overindulgence in distracting behaviours to numb or escape overwhelming emotions. Participant G conceptualised these behaviours as "*crutching*", describing how unhealthy coping mechanisms temporarily reduced emotional distress:

> "*Crutching is whereby if I find something to do and it's not healthy for me, I will do it to get rid of the anxiety… I'm going to over-excessively indulge in whatever is helping me calm down the anxiety*" (Participant G).

This description reflects how maladaptive coping strategies functioned as temporary forms of emotional regulation during periods of heightened anxiety. Participant G further described zoning out on social media or games like Candy Crush as a form of escape, explaining, "*I lose myself in likes and comments and all that kind of validation*" (Participant G).

Substance-based coping was evident throughout participants' responses, with several describing the use of alcohol or smoking to manage overwhelming anxiety or temporarily escape distressing emotions. Participant F described how reconnecting with old friends led to using alcohol to relieve anxiety: "*We started partying and having a drink… and then the partying actually took all that away*" (Participant F). However, they acknowledged that this relief was temporary, as "*the Monday, all the anxiety is back*" (Participant F). Smoking was another coping mechanism participants relied on: "*Then I stopped smoking… and my anxiety is double compared to what it was when I was smoking*" (Participant F). Similarly, Participant G identified smoking as one of their coping strategies, stating, "*I'd say smoking as well*" (Participant G). These maladaptive coping behaviours reflected attempts to regulate unbearable emotional intensity, even when participants recognised that such strategies were ultimately unsustainable.

4.6.3 Theme 3.3: Adaptive coping

In contrast, some participants described coping strategies that they experienced as more constructive or stabilising. These included grounding techniques, structured routines and planning behaviours. In addition, participants reported engaging in physical or cognitive distraction. Several participants relied on grounding practices. For example, Participant B described intentionally redirecting their focus when anticipatory anxiety began to emerge: "*I try and tell myself when I start feeling anxiety… there's no point focusing on the future… I try and ground myself in the present*" (Participant B). In addition, distraction was frequently used as a healthier alternative to avoidance. Participant H explained, "*If I keep myself busy… reading, listening to music… then I don't get focused on these things, then I try and relax a little bit*" (Participant H). They also found relief in work-related busyness: "*This new job, I'm very busy, so I almost don't have time to have, anxiety attacks like I used to. Although it's a lot of work here and there, it's because I'm preoccupied"* (Participant H).

Physical activity was another common coping tool. Participant G listed walking first among their coping methods, describing the physical release of their anxiety as a way to "*burn it until it goes away*" (Participant G). Others used structured routines to feel more in control. Participant C explained, "Constantly making lists… writing it down because of the fear of forgetting" (Participant C). Other participants also coped by organising tasks to reduce uncertainty. For example, participant E shared guidance they had received from a supportive person: "*Do one thing at a time… avoid thinking about things that you cannot control… finish it and then move on to the next thing*" (Participant E). Although these coping strategies did not eliminate anxiety entirely, they provided a vital anchor that kept participants from managing persistent anxiety.

4.6.4 Theme 3.4: Relational and professional support

A second pattern of positive coping was described through interpersonal support, which participants identified as playing a central role in regulating anxiety. Many described relying on trusted friends, partners, or family members for emotional grounding. Participant F explained the role of friendship clearly: "*They know me… they can see when I'm in a panic… and they will say, don't panic*" (Participant F). For some participants, simply having someone physically present was reassuring. Participant G described the paradoxical comfort of company, even when they simultaneously wanted to be alone: "*I feel more reassured when I'm with someone physically… even though I can't wait for you to leave, the fact that you are there still helps*" (Participant G). Participant G also described talking about his experiences as a key coping strategy, even though he acknowledged that he sometimes overshared or shared with people who were not equipped to cope with the information. He explained that this occasionally resulted in him "*reeling it in*" yet he still recognised the value of expressing his feelings:

> *I reel back on that, but I see it… increases my anxiety because just letting it out is… yeah. Just speaking about it, even if I don't get into detail as to what's making me anxious, but if I can talk to someone like, to, my friend today, I'm having a bad day… I feel like, yeah, that helps me. That's how I cope* (Participant G).

Despite the challenges, he emphasised that being able to talk about what he is going through remains an important source of relief.

For some participants, professional support formed part of a broader coping process rather than functioning solely as formal treatment. Participant C reported seeing both a psychologist and psychiatrist and using prescribed medication to manage symptoms: "*The medication helps… I feel a little more balanced to deal with it*" (Participant C). Participant F described forgiveness as an important part of their coping process, noting that working through the trauma that contributed to their anxiety would "*make it easier*". They reflected, "*I think also forgiveness also makes it easier*" (Participant F), suggesting that emotional healing was tied to processing past harm. In contrast, Participant B noted that their family encouraged religious coping practices, even when these did not align with their lived experience of anxiety or provide meaningful relief. They explained that although family members often reminded them of biblical teachings such as "*don't be anxious*" or "*do not worry*" these messages did not address the depth or complexity of their symptoms:

> *They will say, well, here's your Bible… Because there's plenty of passages in scripture which say don't be anxious… they keep on reminding you that God says every day don't worry. But that doesn't take my anxiety. It's good to know that he said don't worry… but it's easier said than done* (Participant B).

Supportive, spiritual, and therapeutic relationships formed an essential component of coping for many participants.

4.7 Theme 4: Control as trigger and relief

This theme examines the central role that control played in the participants' experiences of GAD and PD. The concept of control emerged as a dominant thread shaping how participants understood their symptoms, responded to anxiety, and attempted to manage overwhelming emotional states. Participants frequently spoke of their reliance on rigid schedules, meticulous organisation, extreme punctuality, and predictability to create a sense of stability during periods of anxiety. At the same time, losing control was described as a major source of distress and a common trigger for panic or overwhelm. These experiences also influenced coping methods, with some participants using control-oriented strategies to manage uncertainty, while others described how the loss of control intensified emotional and somatic symptoms. Across participant accounts, control functioned both as a grounding mechanism and as a point of

vulnerability, shaping how individuals navigated uncertainty, responsibility, and emotional overwhelm in daily life.

4.7.1 Theme 4.1: Control as stability and distress

Participants expressed a profound need for structure, predictability, and order as strategies for regulating anxiety and maintaining a sense of emotional stability. Participants described coping by creating strict routines, mapped out future events down to the minute, and turned personal productivity into a metric of mental safety. These strategies were used to manage the uncertainty that increased their anxiety. For example, participant C articulated this pattern vividly, explaining that anxiety shaped both their behaviour and presentation to others: *"I always come across as being this very responsible, very awkward person who has, like, awkward ducks in a row, but it's because of the anxiety… and a feeling of accountability that I link to a lot of it"* (Participant C). This need for order extended to time management, as Participant C further described: *"I think someone with anxiety tends also maybe to be a lot more punctual than other people… someone who's a lot neater on their person… looking like they have things under control in their appearance"* (Participant C). For this participant, personal presentation, neatness, and flawless timekeeping become a unified performance of control designed to mask an internal crisis.

For some participants, productivity and task completion functioned as mechanisms for maintaining emotional control and reducing uncertainty. Participant E noted that accomplishing designated tasks created a sense of stability in their day, stating, *"A good day for me… I've got two tasks allocated to me at work. Tick tick. I do them for the day as I planned to"* (Participant E). The feeling of productivity itself functioned as a regulatory mechanism, reducing anxiety by providing a sense of mastery over the day. Control was also reflected in planning behaviours that extended beyond work-related responsibilities. Participant C described their need to prepare extensively for even routine social arrangements, explaining that:

> *Making appointments, being somewhere on time, arranging, even just a meet with friends, changes into this thing of having to have all the ducks in a row and making sure that I know how late I need to be there, when I need to be there, how am I going to get there* (Participant C).

These high-functioning behaviours were common among participants but varied in intensity. For some, maintaining control led to a strong work ethic and good organisation. For others, it became a heavy expectation that was difficult to sustain.

Several participants described distress when expectations or responsibilities remained unmet. Participant F, for example, experienced significant panic when tasks were incomplete: *"If I haven't done something that I was supposed to do, I go into a very bad panic"* (Participant F). This illustrates differences in how participants experienced control-oriented behaviours. While Participant E experienced structured accomplishment as stabilising, Participant F associated unmet expectations with panic and distress. In addition, participants also differed in the extent to which they relied on strategies such as list-making or rigid organisation. While Participant C repeatedly referenced lists, punctuality, and structured accountability, other participants described more subtle or situational control-oriented behaviours. Participant B, for example, focused on reframing what they could control in each moment: *"Right. I can't do anything about it over the weekend… but I can focus on what I can do"* (Participant B). This approach was different from the more intense, perfectionistic control described by Participant C. It showed that control strategies varied in how rigid or flexible they were across the sample. Yet, despite these structural differences participants consistently relied on control-oriented behaviours to reduce uncertainty and manage emotional distress

While control provided a stabilising structure for many participants, losing control was described as a primary trigger for anxiety or panic. Experiences of sudden change, unpredictability, or feelings of helplessness often triggered intense distress among participants. For some participants, this sense of losing control was not only psychological but also manifested physically. Participants described bodily reactions such as racing heartbeats, trembling, shortness of breath, and gastrointestinal discomfort during moments of heightened anxiety and loss of control. These physical sensations reinforced their perception of being overwhelmed and contributed to the cycle of distress, making the experience of loss of control both mental and somatic. Participant H consistently framed the loss of control as a central component to their anxiety experience: *"If I'm not in control… I go into a panic. The minute I don't have control over something, I start panicking about it because I'm just thinking, what if this happens or that*

happens because I'm not fulfilling it" (Participant H). This participant related panic to any situation in which expected outcomes fell outside their direct management. Their narrative also highlighted anticipatory monitoring as a response to fear of losing control. For example: *"If I'm not physically going to go and fetch him, I start panicking already… I'll start phoning them five, ten minutes before until I know that they have the child in the car"* (Participant H). Participant C similarly described the impact of unexpected changes and last-minute demands: *"If you would confront someone with anxiety about last-minute travel arrangements… it would be in the facial expression of absolute deer in the headlights"* (Participant C). Unlike Participant H, who emphasised panic connected to caregiving responsibility, Participant C focused more on the shock response and cognitive overload caused by unanticipated shifts in routine.

Loss of control was also reported as a physical and somatic experience. Participant G described episodes where the body seemed to shut down under acute anxiety: *"Some of them, their body just starts to malfunction… they can't get up, they're weak… their muscles just… they lose all forms of density"* (Participant G). This participant's description highlighted how loss of physical control was intertwined with emotional overwhelm. Similarly, Participant E spoke to moments when losing control manifested in uncontrollable crying: *"Then I somehow can't control and can't stop crying"* (Participant E). Although participants described different manifestations of losing control, these experiences were consistently associated with heightened anxiety, emotional overwhelm, and destabilisation.

Ultimately, participants described control as both protective and emotionally demanding. While maintaining structure, predictability, and organisation often provided temporary relief from anxiety, disruptions to this sense of control frequently intensified emotional and somatic distress. Across accounts, the need for control emerged as a central component of how participants understood, managed, and experienced anxiety in everyday life.

4.8 Theme 5: Living with anxiety in daily life

This theme explores how living with PD and/or GAD shaped participants' emotional experiences, physical wellbeing, relationships, help-seeking experiences, and daily functioning.

Participants described anxiety as a persistent presence that influenced how they thought, felt, interacted with others, and managed ordinary responsibilities. Their accounts reflected the interconnected psychological, emotional, somatic, social, and occupational impact of anxiety in everyday life. Participants further described anxiety as emotionally exhausting, cognitively overwhelming, and physically debilitating, often affecting their ability to function within social, familial, and workplace environments. Together, these accounts illustrate the complex and deeply personal nature of living with anxiety disorders within the South African context.

4.8.1 Theme 5.1 Psychological and emotional experiences

Participants described anxiety as emotionally persistent, cognitively overwhelming, and psychologically exhausting. Anxiety was frequently associated with symptoms such as sadness, emotional vulnerability, fear, and cognitive overload. Several participants communicated that living with anxiety involved carrying a constant psychological weight, which often escalated during periods of stress or unpredictability. Several participants specifically described sadness and emotional heaviness as central to their anxious experience. Participant C offered one of the most detailed accounts of this emotional burden, explaining: *"I definitely connect a lot of sadness with anxiety… sometimes it just results in apathy, a sense of listlessness and feeling like, what's the point"* (Participant C). Fear of emotional decline also featured prominently. Participants expressed concern that persistent anxiety might lead to further psychological deterioration or an emotional "*collapse".* Participant F articulated this fear clearly: *"I always said to myself, I'm not going to go into a depression thing… and have a whole breakdown"* (Participant F). Participants described being highly emotionally reactive, where even small triggers could result in strong emotional responses. Participant H explained this emotional volatility: *"When my anxiety is bad… the slightest thing will trigger me to be very emotional. Like even if it's something small, I just… feel overwhelmed emotionally"* (Participant H).

In addition to emotional distress, participants reported significant cognitive symptoms. Anxiety was described as an ongoing internal tension involving constant worry, intrusive thoughts, and rumination. Participant G demonstrated this intensely in a full description of mental and physiological escalation: *"Sometimes my head just runs… It's like my thoughts just run everywhere… and I can feel it in my chest, and it just keeps building"* (Participant G). Several

participants also described anxiety as being accompanied by a sense of internal pressure, emotional fragility, and difficulty regulating thoughts. These accounts reflected the participants' descriptions of continually anticipating potential problems or feeling unable to quiet their thoughts, contributing to psychological and cognitive fatigue. Participants' descriptions reveal anxiety as multifaceted, involving sadness, fear, heightened sensitivity, emotional depletion, and persistent cognitive strain. These experiences formed part of participants' everyday lived realities, illustrating how anxiety was experienced not as momentary or situational, but as a continuous internal state influencing emotional and mental functioning.

4.8.2 Theme 5.2: Physical and somatic experiences

Participants described anxiety as deeply embodied with physical sensations that ranged from uncomfortable to debilitating. Somatic symptoms included shortness of breath, chest tightness, gastrointestinal distress, hyperventilation, trembling, headaches, and temporary loss of bodily control. Panic attacks represented the peak of these physiological experiences. One of the clearest descriptions of panic-related physical symptoms came from Participant C, who stated: *"The panic side is where you have intense physical sensations of anxiety… heart racing, shortness of breath, sweating… and there's a physical experience of anxiety that isn't consistent but overwhelming when it comes"* (Participant C). Participant A echoed severe chest symptoms, explaining: *"Extreme chest tightness… having to lie flat on the floor because my chest just closes up completely"* (Participant A). Participant F described respiratory restriction during panic as the body entering a shutdown state: *"I go into a terrible state… to a point where I can't breathe"* (Participant F).

Participant B provided a detailed account of panic manifesting physically when overwhelmed by financial stress, saying: *"I couldn't sleep… the bills… I started getting nauseous… I got sick… and I started hyperventilating. My whole body just went into panic mode***"** (Participant B). Gastrointestinal distress was also frequently reported. When asked about their symptoms, Participant E responded directly and without hesitation: *"Diarrhea? Diarrhea"* (Participant E). Other participants described additional digestive and physical reactions, including stomach cramps, headaches, and bodily tension. Participant G explained: *"Stomach cramps, a slight*

headache… it's like my whole body just reacts" (Participant G). Together, these accounts illustrate how anxiety was experienced not only psychologically, but also physically, with participants describing symptoms that were often abrupt, intense, and debilitating.

4.8.3 Theme 5.3: Navigating help-seeking and treatment

Participants' experiences of seeking help for anxiety were complex, often marked by uncertainty, fear, stigma, and contradictory treatment encounters. Help-seeking was rarely simple; it often involved cycles of crisis, hesitation, and limited access to care. Many participants sought help only when their symptoms had escalated to a point of physical or emotional crisis, while others avoided or delayed treatment due to confusion about mental health services or internalised stigma surrounding diagnosis. For some participants, help-seeking only occurred once anxiety symptoms escalated into frightening physical experiences. Participant A explained that this marked a turning point where she realised "*something is wrong*" and needed professional support (Participant A). However, help-seeking was not driven solely by crisis. Some participants described long-term but gradual attempts to engage with support. Participant F, for example, reflected on years of therapy and medical visits, noting that despite earlier treatment, the underlying anxiety remained: *"I've gone to the doctor, like, years ago. I was in therapy… but I don't think I ever got over it"* (Participant F).

Participants frequently emphasised confusion about treatment pathways, particularly regarding the roles of mental health professionals. This confusion often resulted in misdirected appointments or unmet expectations. Participant C described how online searches blurred distinctions between psychologists and psychiatrists, leading her to schedule the wrong type of appointment:

> *When you type in psychiatrist or psychologist, a lot of stuff comes up… sometimes a clinical psychologist is listed as a psychiatrist… I made an appointment thinking she could prescribe medication, but she said she doesn't know too much about the medications she took on* (Participant C).

This confusion prompted a trial-and-error process before she eventually reached the appropriate care*: "I went to a GP initially because I couldn't get an appointment… but what the GP gave me made my anxiety ten times worse, and I wasn't prepared for it at all"* (Participant C).

In addition to emotional barriers, participants also described structural and financial challenges that complicated access to treatment and ongoing support. Participant B explained that limitations within medical aid systems affected both diagnosis and treatment access, stating: "*They had to put it up as bipolar disorder just so the medical aid would be willing to pay… because they don't cover depression*" (Participant B). This highlighted how participants were often required to navigate complex healthcare systems while simultaneously managing psychological distress. Such barriers contributed to delayed or disrupted treatment experiences and added further strain to participants' efforts to seek support. Living with anxiety therefore involved not only managing symptoms but also navigating complex and sometimes distressing pathways to support and treatment.

4.8.4 Theme 5.4: Impact on daily functioning and productivity

Participants described their day-to-day functioning as frequently marked by overwhelm, mental fatigue, and difficulty completing routine tasks. Mundane responsibilities—such as planning a basic meal, organising a calendar, or simply initiating a daily activity—frequently shifted into emotionally and cognitively demanding operations. Several participants explained that anxiety made ordinary routines feel heavier, more complicated, and more draining than they otherwise would be. These experiences suggest that anxiety affected not only major life events, but also the ability to manage everyday responsibilities consistently and with ease. Although both Theme 4 and Theme 5.4 engage with issues relating to productivity and daily responsibilities, they focus on different dimensions of participants' experiences. Theme 4 explored how participants used structure, organisation, and control-oriented behaviours to regulate anxiety, this theme focuses on the ways anxiety nevertheless disrupted participants' ability to function effectively in everyday life.

Participants frequently described workplace environments as especially difficult to navigate while experiencing anxiety. Several participants explained that they often entered work

environments already emotionally depleted or overstimulated, which further affected their capacity to handle normal occupational pressures as the day progressed. Participant H described becoming emotionally reactive at work, stating, *"At work, I'll just become a bit irritated… I can feel that I'm not in my normal state"* (Participant H). Similarly, Participant C outlined the heavy cognitive burden that anxiety imposes on basic focus, stating, *"You can't focus… you can't get to the task, because there's all these other things going on in your head"* (Participant C). This constant internal noise made routine tasks feel mentally demanding and often slowed productivity.

Unpredictable deadlines and structural workplace pressures were also experienced as significant sources of distress. Participant A described how this mental clutter made simple tasks feel unmanageable, stating, *"I can't multitask anymore… everything feels like too much at once"* (Participant A). Beyond eroding concentration, anxiety also affected participants' workplace communication and interpersonal engagement. Participant G reflected on how anxiety gradually changed the way they interacted with others at work, explaining, *"I don't speak to people the same way… I distance myself without even realising it"* (Participant G). These accounts suggest that anxiety affected both participants' practical functioning and their social engagement within professional environments.

Beyond workplace challenges, participants also described the ongoing emotional burden of trying to manage daily responsibilities while living with anxiety. Many participants explained that mundane chores and family obligations quickly became mentally and emotionally overwhelming, particularly when combined with persistent worry and pressure to remain functional. Participant H described feeling constantly burdened by responsibility, explaining, *"I almost feel, like, responsible for everything… Everything is on my shoulders"* (Participant H). Similarly, Participant D described becoming overwhelmed by accumulating responsibilities and limited time, stating, *"Yeah… you're also a little bit stressed and not happy, and you're freaking out a little… you have to get everything done… and there's just not enough hours in the day"* (Participant D). These ongoing pressures often contributed to emotional exhaustion, reduced motivation, and feelings of hopelessness. Participant B reflected this emotional flattening and disinterest in daily life, stating, *"I feel nafi about my everyday life. Nafi meaning no ambition*

and fuck all interest" (Participant B). Together, these accounts illustrate how anxiety contributed to sustained feelings of pressure, emotional exhaustion, and difficulty coping with everyday demands.

Cognitive difficulties formed another important aspect of daily functioning. Participants frequently described overthinking, mental overload, and difficulty concentrating when anxious. Participant H detailed how racing thoughts physically derailed their focus during a routine morning: *"I would say that when I can't concentrate, like, typically, like, this morning… a lot of things that are going on in my mind… I'm overthinking…"* (Participant H). Similarly, Participant G described moments of cognitive shutdown when overwhelmed, stating, *"My brain is completely offline"* (Participant G). Across accounts, anxiety was described as requiring continuous emotional regulation and mental effort. Everyday responsibilities, workplace demands, and social interactions were frequently experienced as exhausting, overwhelming, and cognitively demanding.

4.8.5 Theme 5.5: Impact on social life and relationships

Participants highlighted how deeply invasive anxiety can be, noting that its consequences rippled out into their daily social routines and closest relationships. Fear of judgement, emotional sensitivity, sensory overwhelm, and anticipatory worry often affected participants' ability to engage comfortably in social environments and maintain interpersonal relationships. Several participants explained that social situations became emotionally demanding spaces that intensified feelings of anxiety, self-consciousness, discomfort, and emotional exhaustion. Over time, this pressure caused many individuals to pull back from their networks entirely. Participant A explained that anxiety had gradually made them *"more reclusive"* and had ultimately led them to feel as though they had *"completely removed [themselves] from society"* (Participant A). This physical and emotional detachment was echoed by Participant C, who recalled avoiding any face-to-face contact *"for months on end"* and *"not wanting to go anywhere"*, which they explained eventually *"spiralled into depression"* (Participant C). These experiences suggest that anxiety significantly affected participants' social participation and contributed to feelings of isolation and disconnection from others.

Participants also described social environments as emotionally and physically overwhelming. Crowded settings, loud environments, and expectations to appear emotionally composed were experienced as particularly distressing. Participant B, for example, explained that they avoided attending church because *"the music's gonna be too loud"* and because others would expect them to *"smile through it all"* despite barely managing to smile even around family members (Participant B). This account highlights how anxiety affected not only participants' comfort within social spaces, but also their ability to fulfil expected social and relational roles. In addition to withdrawal and sensory overwhelm, several participants described heightened self-consciousness during social interactions. Participants often reported feeling watched, judged, or emotionally exposed when interacting with others. Participant D reflected on this experience by explaining that social situations could feel as though *"they're all looking at you"* (Participant D). Ultimately, this intense feeling of being watched and judged reinforced the urge to stay isolated, creating a painful cycle where anxiety continually fractured interpersonal connections, deepened emotional withdrawal, and left individuals feeling completely disconnected from the world around them.

4.9 Summary of findings

This chapter explored the lived experiences of South Africans living with PD and/or GAD. What emerges from these narratives is that anxiety is rarely experienced as a single psychological condition. Instead, it functions as an ongoing presence that shaped participants' emotions, relationships, physical wellbeing, work functioning, coping behaviours, and help-seeking experiences. This reflects how deeply these accounts intertwine, it becomes obvious that anxiety does not exist in a vacuum; it constantly collides with symptoms of depression, historical trauma, and chronic socioeconomic stress, highlighting just how complex these mental health realities truly are.

A strong need for control emerged throughout the findings, with participants often relying on structure, predictability, and routine to create a sense of stability. However, disruptions to this sense of control frequently intensified anxiety and emotional distress. Participants described using a wide range of coping strategies, including avoidance, emotional suppression, grounding

techniques, structured routines, relational support, and professional mental health care. However, reaching out to the healthcare system was rarely straightforward. For many, the decision to look for professional help was driven by a breaking-point crisis, and the process itself was complicated by intense community stigma, deep confusion about where to find appropriate mental health services, and financial or structural barriers.

The findings also demonstrated the significant impact anxiety had on participants' daily functioning and interpersonal relationships. Participants described difficulties with concentration, emotional regulation, social participation, productivity, and maintaining everyday responsibilities. This is important because it highlights that while anxiety is a multifaceted internal struggle, for the participants in this study, the experience of anxiety was often inextricably linked to the specific social and cultural challenges they navigated within their South African contexts. Overall, these findings contribute to a richer understanding of the lived experience of PD and GAD and help address the limited body of qualitative South African research on anxiety disorders.

Chapter 5 Discussion

5.1 Introduction

This study responds directly to the gaps identified in Chapters 1 and 2 by exploring the lived experiences of South African participants diagnosed with PD and/or GAD. It focused on how participants understood, described, and managed their symptoms within the context of their everyday lives. The findings suggest that anxiety was experienced as emotionally overwhelming, cognitively intrusive, and physically distressing. In addition, anxiety often affected relationships, work and daily functioning. Participants also described a strong overlap between anxiety and depression, often viewing the two conditions as interconnected emotional rather than separate diagnostic categories.

The findings further highlight how limited mental health literacy, stigma, and structural barriers shaped participants' experiences of PD and GAD, influencing both coping and help-seeking processes. Coping strategies were often complex and contradictory, the routines and safety behaviours participants established to find comfort often reinforced their anxiety. Help-seeking was commonly described as difficult and confusing, with participants reporting fear, uncertainty, and inconsistent experiences within the healthcare system. At the center of these narratives sits an ongoing battle for control. Predictability, routine and emotional order served as a source of comfort and stability, while disruptions to control often intensified their experience of anxiety.

Collectively, these findings support the theoretical frameworks used to guide this study, namely the BMand the TPT. More specifically, participants' experiences reflected how anxiety was shaped not only by psychological distress, but also by interpersonal relationships, social environments, cultural understandings, and structural challenges (Engel, 1977). In addition, participants' strong reliance on predictability, routine, and emotional control reflects aspects of the TPT, particularly the role of generalised psychological vulnerability and perceived uncontrollability in anxiety-related distress (Barlow, 2002). Together, these frameworks provide a useful lens for understanding how biological, psychological, and social experiences interacted within participants' lived experiences of PD and GAD. By focusing on the lived experience, this

study contributes to the limited qualitative literature on anxiety disorders within South African contexts and highlights the importance of culturally responsive mental health care. The findings highlight the value of incorporating lived experience perspectives into clinical practice, policy development, and future research relating to anxiety disorders.

5.2 Mental health literacy and meaning-making

One of the main findings of this study was that participants struggled to tell the difference between normal anxiety, anxiety disorders, PD, and GAD. This confusion is also reflected in South African research showing that mental health literacy remains limited in many communities. For example, Boisits et al. (2021) found that pregnant women in Cape Town often confused everyday stress with clinical anxiety because they had not received clear explanations in PHC settings, while Sorsdahl et al. (2010) reported that traditional healers and community members frequently relied on cultural or familiar expressions to describe distress rather than formal psychiatric terminology. This interpretation does not suggest that cultural or familiar expressions are incorrect. Instead, it highlights the importance of research that considers how anxiety is understood and communicated within the specific cultural and social contexts participants navigate. Participants often struggled to express what they were feeling, second-guessing their own descriptions or relying on broad and uncertain language because they were unsure how to explain their symptoms. One participant associated the word "*disorder*" with stigma or "*craziness*" echoing earlier findings by Hugo et al. (2003), who noted that psychiatric terminology can feel alienating within some South African contexts. Even when participants demonstrated some understanding of diagnostic terms, they often lacked confidence in this knowledge, revealing a deeper sense of misunderstanding or misinterpreting their own symptoms. Craig et al. (2022) similarly observed that limited mental health literacy influenced how individuals recognised, interpreted, and responded to experiences of psychological distress.

To support this finding of participants struggling to express their symptoms, the study also showed that many relied on metaphors to describe what they were feeling. Participants used phrases such as "*a moth in the chest*" or "*alarm bells going off*" to communicate sensations that were difficult to put into words. These metaphors demonstrate how anxiety was experienced not

only emotionally but also physically, reflecting culturally shaped ways of expressing distress through imagery and bodily sensations. Similar patterns were identified among Sesotho speakers, where emotional distress was frequently communicated through figurative and somatic expressions rather than formal psychiatric language (Mosotho et al., 2008; 2011). The metaphors participants used also reflected a distinction between their internal experiences and their outward presentation to others. Participant accounts suggests that anxiety was often concealed or masked in social settings, reinforcing participants' experiences of feeling misunderstood or unseen by others. Ultimately, participants' accounts showed that understanding anxiety involved far more than recognising clinical symptoms or diagnostic labels. The ways participants described, interpreted, and communicated their distress were closely shaped by social interactions, cultural understandings, stigma, and the language available to them. This reflects the social dimension of the Biopsychosocial Model, which proposes that psychological distress is influenced not only by internal emotional processes, but also by broader interpersonal and sociocultural environments (Engel, 1977).

5.3 Intersections of anxiety and depression

Participants frequently described anxiety and depression as deeply interconnected experiences rather than separate conditions. For many participants, anxiety appeared to intensify feelings of emotional exhaustion, hopelessness, and overwhelm. At the same time, depressive symptoms often reduced motivation and increased social withdrawal. Together, these experiences created a cyclical relationship in which anxiety and depression appeared to reinforce one another over time. Similar patterns of comorbidity between anxiety and depression have been widely documented in existing literature. Craske et al. (2017), for example, noted high levels of shared emotional distress across anxiety and depressive disorders, while Michael et al. (2007) reported particularly strong associations between PD, GAD, and mood disorders. The DSM-5-TR (APA, 2022) similarly acknowledges symptom similarities between these conditions, particularly in relation to sleep disturbances, concentration difficulties, and emotional dysregulation. Participants in this study, however, often described the experience of anxiety and depression as blending into one another in ways that extended beyond merely sharing symptoms or diagnostic features.

Rather than viewing anxiety and depression as separate disorders, several participants understood them as emotionally interconnected states that influenced one another over time. One participant described depression as something that "*comes along with the anxiety*" while another explained that prolonged anxiety eventually left them feeling emotionally drained and unable to cope. These accounts suggest that participants experienced anxiety and depression less as isolated conditions and more as overlapping emotional states that gradually intensified one another. Similar experiences of emotional exhaustion and psychological burden have also been identified in qualitative studies exploring chronic anxiety, where individuals frequently described anxiety and depression as becoming increasingly difficult to separate over time (Bertilsson et al., 2013).

In many cases, participants did not clearly distinguish between anxiety and depression. Instead, they described feelings of emotional overwhelm, exhaustion, and an inability to cope. These experiences are commonly associated with both anxiety and depressive disorders, particularly in relation to chronic emotional distress, fatigue, and impaired daily functioning (Craske et al., 2017; APA, 2022). This reflected how the boundaries between the two experiences frequently became blurred within everyday life. Participants' descriptions of anxiety and depression as interconnected experiences also support a biopsychosocial understanding of psychological distress, where emotional difficulties emerge through the interaction of cognitive, emotional, interpersonal, and environmental factors rather than existing as isolated conditions (Engel, 1977).

5.4 Coping strategies and emotional regulation

Coping with anxiety was described by participants as involving a wide range of strategies, reflecting how complex efforts to manage PD and GAD could become within everyday life. These strategies ranged from adaptive approaches, such as grounding techniques and social support, to more maladaptive responses including avoidance, emotional withdrawal, distraction, and substance use. This variety supports existing research suggesting that coping with anxiety is highly personal and shaped by individuals' emotional resources, life experiences, as well as the available support systems (Antony & Stein, 2009; Miller, 2008).

In this study, avoidance emerged as one of the most common responses to anxiety. Participants described avoiding certain environments, conversations, or even their own emotions when they felt overwhelmed. One participant described emotionally "*shutting down*" while another explained that they would distract themselves to avoid distressing thoughts and feelings. These responses appeared linked to participants' attempts to manage emotional overwhelm and regain a sense of control during distressing moments. Avoidance also extended to participants' reluctance to speak openly about their emotional experiences. Many participants feared being judged, misunderstood, or stigmatised when expressing distress, mirroring South African findings that stigma often discourages open discussions about mental health difficulties (Schierenbeck et al., 2013). As a result, some participants appeared to withdraw emotionally or socially as a form of self-protection.

Additionally, participants described using distraction and emotional escape to manage anxiety. One participant explained that when anxiety became overwhelming, they would immerse themselves in social media, games, or other forms of distraction. Participant G described engaging in excessive or unhealthy behaviours as a form of "*crutching*" explaining that they would overindulge in behaviours that temporarily reduced the anxiety. This metaphor highlighted the extent to which participants were attempting to stabilise themselves emotionally during periods of distress. Similar patterns have been identified in previous research, where individuals experiencing chronic anxiety often engage in excessive distraction, overworking, or emotional avoidance in attempts to regulate internal distress (Hurtado et al., 2020).

Substance use such as alcohol and smoking also emerged as maladaptive strategies participants used to numb emotional discomfort or "*take the edge off*" overwhelming feelings. One participant explained that drinking temporarily made the anxiety "*go away*" while another described smoking as something that helped calm intense emotional distress. Participants often recognised that these forms of emotional regulation provided only short-term relief. Similar associations between anxiety disorders and substance use have been documented in both South African and international literature, particularly where psychological support is difficult to access or emotional distress becomes difficult to manage (Michael et al., 2007; Poliah & Paruk, 2017). The current study extends these findings by showing that substance use was often experienced

less as reckless behaviour and more as an attempt to cope with the psychological distress of anxiety.

On a more adaptive level, participants described using grounding exercises and social support to manage anxiety symptoms. Although these strategies are commonly recommended alongside therapeutic interventions (Campbell-Sills & Brown, 2010), participants often described discovering and implementing them independently. These findings demonstrate that coping behaviours were deeply intertwined with participants' emotional experiences and daily attempts to manage distress. Coping did not fit neatly into "positive" or "negative" categories. Instead, many strategies appeared to provide emotional relief in the short term while also contributing to longer-term emotional strain or avoidance. These findings provide insight into participants' reliance on routine and predictability. In many cases, structure appeared to function as a way of managing uncertainty and reducing emotional vulnerability within everyday life.

5.5 Control, predictability, and emotional regulation

A central theme emerging from participants' accounts was the role of control in shaping the lived experience of anxiety. Participants described routines, predictability, punctuality, and completing tasks as ways of creating emotional stability and reducing feelings of overwhelm. While disruptions, unexpected changes, or perceived failures often triggered intense anxiety, panic, or emotional distress. One participant, for example, described moments of overwhelm as feeling as though "*the house is burning down*" reflecting how strongly experiences of uncertainty and loss of control were emotionally experienced. Similar patterns have been identified in international literature, where individuals with GAD frequently report heightened discomfort with uncertainty and a strong need for predictability and control (Barlow, 2002; Campbell-Sills & Brown, 2010). Within the current study, however, the need for control appeared across participants regardless of diagnosis and extended beyond cognitive processes into emotional, relational, and embodied experiences.

For many participants, control appeared closely linked to emotional regulation and maintaining daily functioning. When participants felt unable to manage situations effectively, they often described becoming emotionally overwhelmed, hypervigilant, or shutting down entirely. Several

participants also described relying heavily on routines, structure, and productivity to create a sense of predictability when their thoughts felt chaotic or emotionally overwhelming. These responses appeared linked to participants' attempts to manage emotional overwhelm and regain a sense of control during distressing situations, reflecting the TPT's emphasis on perceived uncontrollability and vulnerability to emotional threat (Barlow, 2002). Participants' accounts therefore suggest that maintaining structure and predictability functioned not only as practical routines, but also as ways of managing emotional vulnerability and uncertainty within everyday life.

Control was also closely connected to participants' responsibilities and social roles. Participants who occupied caregiving or demanding occupational roles often described feeling pressure to "*hold everything together*" even when emotionally distressed. Productivity and outward orderliness appeared to function as ways of managing internal chaos, mirroring findings by Hurtado et al. (2020), who found that individuals experiencing anxiety often maintain outward functioning while concealing significant internal distress. One participant similarly described appearing calm externally while internally feeling overwhelmed, comparable to "*a duck on the surface*" while struggling intensely underneath. Participants' accounts further suggest that these pressures were shaped by broader contextual realities, including financial strain, limited access to mental health support, and interpersonal responsibilities. Within these contexts, losing control was often experienced not only as stressful, but as emotionally threatening and destabilising.

Control and predictability therefore emerged as deeply embedded within participants' experiences of anxiety. While structure and routine often created emotional stability and helped participants maintain daily functioning, any disruption to this sense of control frequently intensified feelings of distress. Participants' accounts further suggest that anxiety was not experienced only through thoughts or emotions, but also through interpersonal responsibilities, and ongoing efforts to maintain stability within everyday life. These findings contribute to a more nuanced understanding of how control, uncertainty, and emotional regulation intersect within the lived experience of anxiety.

5.6 The lived experience of anxiety in everyday life

Participants described anxiety as an emotionally, cognitively, and physically overwhelming experience that disrupted multiple aspects of everyday life. This aligns with literature conceptualising anxiety disorders as involving interconnected emotional, cognitive, and physiological systems (Pêgo et al., 2010; Shin et al., 2019). Emotionally, participants described persistent sadness, irritability, emotional fragility, numbness, and fears of "breaking down". Participants also frequently described anxiety and depression as emotionally interconnected experiences, reinforcing earlier discussions relating to co-morbidity (Kalin, 2021; McGrath et al., 2020). Participants often described feeling emotionally overwhelmed, exhausted, or unable to cope, suggesting that anxiety shaped their emotional experiences in continuous and deeply personal ways.

These emotional experiences were closely connected to cognitive difficulties. Participants described racing thoughts, mental overload, hypervigilance, difficulty concentrating, and a constant anticipation that something might go wrong. While these experiences are consistent with cognitive models of anxiety (Ruscio et al., 2018), participants emphasised how significantly they disrupted everyday functioning. Tasks such as concentrating at work, making decisions, socialising, or completing ordinary responsibilities were frequently experienced as mentally exhausting. Several participants also described reduced productivity, irritability, and difficulty maintaining focus within occupational settings, mirroring broader findings relating to reduced QOL and impaired functioning among individuals living with anxiety disorders (Bertilsson et al., 2013; Olatunji et al., 2007).

Participants further described anxiety as a profoundly somatic experience. Experiences of nausea, chest tightness, trembling, stomach discomfort, exhaustion, and breathing difficulties were commonly reported. These findings echo research suggesting that emotional distress within many African contexts is often communicated through bodily experiences and somatic language (Mosotho et al., 2011). Within the current study, however, participants' accounts suggest that these bodily sensations were not experienced merely as secondary symptoms, but as central components of how anxiety was understood and communicated.

Help-seeking formed another important aspect of participants' experiences. Many described seeking support as confusing, emotionally difficult, and shaped by systemic barriers. Participants often sought help only once symptoms reached crisis levels, including severe panic attacks, or emotional breakdowns. Similar delays in help-seeking have been documented in previous literature, where individuals frequently postpone seeking support until distress becomes overwhelming (Field et al., 2020). Participants also described confusion surrounding the roles of psychologists, psychiatrists, and general practitioners, which often complicated help-seeking. Several participants further described feeling dismissed, invalidated, or misunderstood by healthcare professionals. These experiences reflect broader concerns identified within South African mental health literature relating to stigma, limited service availability, and barriers to accessing appropriate care (Nguse & Wassenaar, 2021; Robertson & Szabo, 2017; Schierenbeck et al., 2013). Anxiety therefore appeared deeply embedded within participants' everyday lives, shaping their relationships, responsibilities, bodily experiences, and ability to function. These findings highlight the importance of understanding anxiety not only through diagnostic categories, but also through the emotional, physical, and contextual realities within which it is experienced.

5.7 Strengths of the study

This study contributes to the growing body of qualitative research exploring the lived experience of anxiety disorders by providing an in-depth exploration of how individuals diagnosed with PD and GAD experience anxiety within their everyday lives. Through the use of semi-structured interviews and RTA, the study was able to capture rich and nuanced accounts of participants' lived experiences of anxiety. This qualitative approach allowed participants to describe their experiences in their own words, providing insight into aspects of anxiety that may not be fully captured through quantitative or symptom-focused approaches alone.

A further strength of the study lies in its exploration of both PD and GAD within the same qualitative investigation. While previous literature often examines these disorders separately, participants in the current study frequently described anxiety, panic, emotional distress, and depressive experiences as interconnected and overlapping. Exploring these experiences together

therefore contributed to a more nuanced understanding of how anxiety may be experienced across different diagnoses and contexts, particularly within participants' everyday lives.

The study also contributes valuable contextual insight into how participants in this study experienced anxiety within their South African contexts. Participants described how interpersonal expectations, financial stress, stigma, and barriers to mental healthcare shaped their experiences of anxiety. Rather than understanding anxiety solely as an individual psychological experience, the findings highlighted the ways emotional distress was shaped by broader social and contextual realities within participants' everyday lives. In doing so, the study supports the value of using frameworks such as the BMand the TPT to understand anxiety as a multifaceted and deeply contextual experience.

A final strength of the study was the use of RTA, which strengthened the interpretive depth of the findings. This approach allowed for flexibility and ongoing engagement with participants' accounts while encouraging reflexive consideration of the researcher's role in shaping the interpretation of the findings.

5.8 Limitations of the study

Despite its contributions, this study has several limitations. Firstly, the study included a relatively small sample of participants. While this is appropriate within qualitative research that prioritises depth and rich exploration over statistical generalisation, the findings reflect the experiences of a specific group of participants and may not represent how anxiety is experienced across all South African contexts. Participants from different cultural, linguistic, socioeconomic, or geographical backgrounds may describe and interpret anxiety differently.

Another limitation relates to the recruitment process. Participants were recruited through SADAG, which may have resulted in a sample of individuals who were already more comfortable discussing mental health experiences or who had greater access to mental health information and support. As a result, the findings may not fully reflect the experiences of individuals with lower mental health literacy, more severe psychological distress, or limited access to mental healthcare services. The use of convenience sampling may also have excluded

individuals who were less willing or able to participate in reflective discussions surrounding anxiety.

Additionally, the study relied on participants' self-reported experiences and interpretations of anxiety. Although participants met the inclusion criteria for PD and GAD, experiences of anxiety remain subjective and may differ across individuals and contexts. The interpretive nature of RTA also means that the findings were shaped through the interaction between the researcher and the findings. While reflexive journaling, repeated coding cycles, and ongoing engagement with participants account were used to strengthen trustworthiness, complete objectivity is neither possible nor expected within interpretivist qualitative research (Braun & Clarke, 2012). Another researcher may therefore have interpreted certain experiences or themes differently. Although the study explored anxiety within participants' broader social and contextual realities, it was not possible to fully capture the complexity of all the environmental, interpersonal, and structural factors shaping participants' experiences. As a result, some aspects of participants' lived experiences may not have been fully represented within the scope of the study.

Lastly, an additional limitation and ethical consideration relates to participant support and referral pathways during the research process. Although participants were provided with SADAG contact details and information regarding available mental health support services, the study did not have access to a formalised private referral network for participants who may have experienced significant emotional distress during or after participation. Given that some participants discussed emotionally overwhelming experiences and that clinical screening tools were used during recruitment, this highlighted the importance of carefully considering the ethical responsibilities involved when conducting research with individuals experiencing psychological distress. The absence of a formalised referral network therefore represented an important limitation of the study and points to the value of establishing clearer referral pathways and participant support structures in future research.

5.9 Reflexivity

This study was conducted from an interpretivist perspective, which recognises that meaning is socially constructed and shaped through interaction between the researcher and participants (Braun & Clarke, 2012). As such, the findings presented in this study were not viewed as objective truths, but rather as interpretations co-constructed through participants' narratives, the interview process, and the researcher's own interpretive lens.

Throughout the research process, RTA encouraged ongoing reflection on how the researcher's assumptions, perspectives, and engagement with the participants' account may have shaped the interpretation of participants' experiences. The researcher continuously reflected on the interpretive process during coding and analysis. This included actively questioning whether interpretations were grounded in participants' accounts or influenced by the researcher's own assumptions and understandings of anxiety. The researcher remained particularly aware of the possibility of unintentionally overinterpreting participants' experiences or attempting to fit participants' narratives into existing theoretical frameworks. Conscious effort was therefore made to remain close to participants' own words, meanings, and descriptions throughout the analysis process rather than adding layers of interpretation that were not clearly reflected within the data. Repeated engagement with the accounts and ongoing self-reflection formed an important part of maintaining interpretive awareness during the development of themes.

The researcher's interest in lived experience also influenced the way participants' accounts were interpreted. Greater emphasis was placed on understanding how participants experienced, described, and made meaning of anxiety within their everyday lives rather than focusing solely on clinical or diagnostic understandings of anxiety disorders. It is acknowledged that another researcher may have interpreted certain experiences differently or emphasised alternative themes within the findings.

5.10 Recommendations for practice and research

The findings of this study offer several implications for mental health practice, policy, and future research. In clinical settings, greater emphasis should be placed on person-centred approaches that recognise metaphors, bodily expressions, emotional fluctuations, and contextual experiences as meaningful ways individuals communicate anxiety. Participants frequently described anxiety through physical sensations, emotional language, and metaphorical expressions. This suggests that practitioners should remain attentive to multiple forms of emotional communication rather than relying solely on clinical terminology. This may be particularly important within PHC settings, where anxiety symptoms are often overlooked or misunderstood (Archer et al., 2021).

The findings also highlight the importance of strengthening psychoeducation and mental health literacy. Participants frequently described confusion surrounding anxiety disorders, help-seeking processes, and the roles of different mental health professionals. Providing clearer and more accessible information regarding anxiety symptoms, available support services, and referral pathways may assist individuals in seeking support earlier and navigating mental healthcare systems more effectively. Public mental health initiatives that are informed by local research and sensitive to cultural and contextual realities may further contribute to reducing stigma and improving awareness surrounding anxiety and mental health difficulties (Honikman et al., 2020).

At a systemic level, participants' experiences point to the importance of more compassionate, accessible, and people-centred mental healthcare services (van Rensburg & Brooke-Sumner, 2024). Experiences of feeling dismissed, invalidated, or misunderstood by healthcare professionals suggest the need for improved communication and greater sensitivity toward individuals experiencing psychological distress. Strengthening trauma-informed approaches and task-sharing models within resource-constrained settings may also improve access to mental healthcare support, particularly within underserved communities (Boisits, 2022).

Future research should continue exploring the lived experience of anxiety across a broader range of South African contexts and populations, including rural communities, adolescents, older adults, and individuals with limited access to mental healthcare services. Additional qualitative and longitudinal research may also provide deeper insight into how experiences of anxiety, emotional regulation, co-morbidity, and help-seeking evolve over time and across different social

environments. Such research may contribute to more contextually responsive and accessible approaches to understanding and supporting individuals living with anxiety disorders.

5.11 Conclusion

This chapter explored and discussed the findings relating to how participants experienced and made sense of anxiety within the context of their everyday lives. Participants described anxiety as emotionally overwhelming and mentally intrusive. Anxiety was also experienced as physically draining and deeply intertwined with participants' relationships, responsibilities, and broader social environments. Across the discussion, anxiety rarely emerged as a purely psychological experience. Instead, participants described anxiety through emotional distress, bodily sensations, interpersonal strain, uncertainty, and ongoing efforts to maintain stability and emotional control within daily life.

The discussion further illustrated how participants' experiences were shaped by broader contextual realities, including stigma, financial pressure, demanding social roles, barriers to mental healthcare, and difficulties navigating help-seeking processes. Participants frequently described anxiety and depression as emotionally interconnected experiences, while themes relating to control, predictability, and emotional regulation appeared central to how anxiety was understood and managed. These findings therefore emphasise the complex and deeply contextual nature of anxiety within participants' lived experiences.

The findings also highlighted the value of the BMand the TPT in interpreting participants' experiences. Participants' accounts reflected the interaction between emotional, cognitive, physiological, interpersonal, and contextual factors, while experiences of uncertainty, emotional overwhelm, and perceived loss of control resonated strongly with aspects of the TPT. Together, these frameworks provided a useful lens through which to understand anxiety beyond diagnostic definitions alone. Ultimately, this chapter demonstrates the importance of approaching anxiety not only as a clinical diagnosis, but also as a lived and deeply personal experience that influences multiple areas of everyday functioning.

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Appendices

Appendix A: Interview Guide

Interview Guide

- Do you understand the difference between types of anxiety disorders? Specifically panic disorder and Generalised anxiety disorder?
- Many people living in Gauteng has an anxiety disorder, do you consider yourself to be one of the people? Why or why not?
- If you had to choose a term that best describes your mental disorder, would it be the term anxiety disorder, panic disorder or Generalised anxiety disorder. Why?
- Considering your answer to the earlier question (mention what disorder that best describes their experience), how has living with this affected your daily life? What are some of the challenges you experience because of it?
- How do you think someone with an anxiety disorder, panic disorder, Generalised anxiety disorder behaves? What would they do or not do?
- What are some of the symptoms you experience because of your disorder? Do you experience any physical symptoms? Any emotional symptoms?
- Could you please you give me an example of a good day?
- How do you cope with your disorder?
- If you think about days when these feelings are bad. Can you tell me what a day like this feels like?
- Can you describe situations that may make your experience of the disorder worse? For example, are there certain things that you avoid doing or things that you feel are not good for you?
- How does living with your disorder affects how things go between you and the people in your social circles such as your community, family, and friends?
- How does living with your disorder affects how things go in your professional life or at school? (If participant is still studying)
- Could you please answer the following question by filling in the space: In general, I am (blank) about my everyday life? Could you elaborate on your answer?

- Have you ever sought professional help for you disorder? Why or why not?
- Would you like to share any other experiences that you think will help me understand what it is like to have an anxiety disorder?
- Can you please tell me what made you decide to take part in this study?

Appendix B: PHQ-PD scale

Personal Health Questionnaire – Panic Disorder 15-item (PHQ-PD)		
1. Questions about anxiety	**No**	**Yes**
a. In the last 4 weeks, have you had an anxiety attack – suddenly feeing fear or panic?	0	1
If you checked "NO", do not answer the remaining questions		
b. Has this ever happened before?	0	1
c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	0	1
d. Do these attacks bother you a lot or are you worried about having another attack?	0	1
4. Think about your last bad anxiety attack	**No**	**Yes**
a. Were you short of breath	0	1
b. Did your heart race, pound, or skip?	0	1
c. Did you have chest pain or pressure?	0	1
d. Did you sweat?	0	1
e. Did you feel as if you were choking?	0	1
f. Did you have hot flashes or chills?	0	1
g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	0	1
h. Did you feel dizzy, unsteady, or faint?	0	1
i. Did you have tingling or numbness in parts of your body?	0	1
j. Did you tremble or shake?	0	1
k. Were you afraid you were dying?	0	1

(Witkampf et al., 2011)

Appendix C: GAD-7 scale

Generalised Anxiety Disorder 7 – item (GAD-7)				
Over the last 2 weeks, how often have you been bothered by the following problems	Not at all	Several days	More than half of the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(Sapra et al., 2020)

Appendix D: Permission Letter to SADAG

PERMISSION LETTER

Research title: Daily life experiences as a South African living with Panic-Disorder or Generalised Anxiety Disorder: An explorative study

Researcher: Miss Kearns

Request for permission to conduct research at the South African Anxiety and Depression Group.

"Daily life experiences as a South African living with Panic-Disorder or Generalised Anxiety Disorder: An explorative study"

21 December 2023

Zane Wilson
Founder of SADAG
011 234 4837
zane@sadag.org

Dear Ms. Zane Wilson,

I, Ilusca Kearns, am doing research with Monika Dos Santos, a professor, in the Department of Psychology towards a MA at the University of South Africa. We are inviting you to participate in a study entitled daily life experiences as a South African living with Panic-Disorder or Generalised Anxiety Disorder: An explorative study.

The aim of the study is to collect important information that could help society understand the daily lived experiences of South Africans who are living with Panic Disorder and Generalised Anxiety Disorder. To improve the provision of mental health care in South Africa, it is crucial that we tailor mental health interventions to the persons who struggle with mental health issues. We can accomplish more responsive mental health care if we consider the experiences of the patients in the treatment and interventions strategies. With the purpose of improving the mental health services in South Africa, the aim of this study is to gain an understanding of how people living with specific anxiety disorders experience their everyday lives so that we gain a deeper understanding of their unique views. The focus of this study is to explore how participants perceive their anxiety, how they live with stigma and difficulties accessing mental health care, and how they deal with cultural beliefs around mental illness.

Your organisation has been selected because SADAG works tirelessly to address the mental health crises in South Africa. Patient advocacy, mental illness awareness and fighting the stigma

surrounding mental illness is the main objectives of the organisation. These objectives closely mirrors the objectives of this research study.

The study will entail a screening questionnaire for Panic Disorder or Generalised Anxiety Disorder using a self-report screening test (PHQ-PD and GAD-7). In addition, it involves open-ended, semi structured in depth interviews. The interviews will be conducted face-to-face at a private location, where the participant feels most comfortable, at a time that is most appropriate for the participant. The screening questionnaires will require approximately 15 minutes to complete. Participation in the interviews will require an additional 60 minutes.

The benefit of this study is the contribution this study will have on society. The stigma associated with mental disorders are particularly difficult in the South African community. This study aims to bring new hope for patients suffering from anxiety disorder, as well as to bring about change within the mental health sector so that mental illness is taken seriously. Mental health services are grossly inadequate, and this study could provide a different perspective on how to improve implementation and treatment strategies. Furthermore, participants will get the opportunity to share their experience in a safe space without fear of being judged. Participants may also gain psychological benefits from participating in this panic disorder and/or Generalised anxiety disorder study. For example, they may learn something valuable about themselves and their experiences with these disorders.

Potential risks are related to the fact that participants have anxiety disorders which are linked to complex emotional experiences. Participants may be asked questions that may be stressful or upsetting. Participants who have both an anxiety disorder and depression may be more susceptible to the risk.

There are also some social risks that come with identifying that an individual participated in the study. Anxiety disorders are still taboo in the South African community, especially in the non-white community. Therefore, participants may experience social stigma if their participation in the study was identified.

Participants are allowed to withdraw from the study at any point without incurring any negative consequences to themselves. The researcher will debrief each participant after the interview has been conducted. If a participant has experienced any distress during the interview process, then the participant will be referred to counselling to mitigate any negative effects.

Feedback procedure will entail the overall findings of the study being published in a scientific journal. If SADAG would like to receive information about the results of the study, please let us know, and we will forward a summary of the findings to you at the end of the study.

Yours sincerely



Ilusca Kearns
MA student

Appendix E: Participant Information Sheet

Request to participate in the study

Research title: Daily life experiences as a South African living with Panic-Disorder or Generalised Anxiety Disorder: An explorative study

Researcher: Miss Ilusca Kearns

Ethics clearance reference number: NHREC Registration #: Rec-240816-052; CREC Reference #: 66306906_CREC_CHS_2023

<date>

Title: Daily life experiences as a South African living with Panic-Disorder or Generalised Anxiety Disorder: An explorative study

Dear Prospective Participant

My name is Ilusca Kearns and I am undertaking research under the supervision of Professor dos Santos a professor from the Department of Psychology at the University of South Africa, towards a MA in Psychology. You are invited to participate in a study entitled Daily life experiences as a South African living with Panic-Disorder or Generalised Anxiety Disorder: An explorative study

WHAT IS THE PURPOSE OF THE STUDY?

This study is expected to collect important information that could help society understand the daily lived experiences of South Africans who are living with Panic Disorder and Generalised Anxiety Disorder. To explore this, the study intends to place emphasis on how participants live with concepts such as stigmatization, accessibility difficulties to mental health care, and cultural beliefs around mental illness.

WHY AM I BEING INVITED TO PARTICIPATE?

The study would like to gain an understanding from South Africans who have been living with an anxiety disorder. Participants are persons who have specialised knowledge about living with Panic Disorder and Generalised Anxiety Disorder in South Africa. The approximate number of participants is 10.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study involves a screening questionnaire for Panic Disorder or Generalised Anxiety Disorder using a self-report screening test (PHQ-PD and GAD-7). In addition, it involves open-ended, semi structured in depth interviews. The interviews will be conducted face-to-face at a private location, where the participant feels most comfortable, at a time that is most appropriate for the participant.

The screening questionnaires will require approximately 15 minutes to complete. Participation in the interviews will require an additional 60 minutes.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

You will contribute to the wellbeing of society. The stigma associated with mental disorders are particularly difficult in the South African community. As a participant of this study, you will be providing new hope for patients suffering from anxiety disorders. Furthermore, you will get the opportunity to share your experience in a safe space without fear of being judged. You may also gain psychological benefits from participating this panic disorder and/or Generalised anxiety disorder study. For example, you may learn something valuable about themselves and their experiences with these disorders.

ARE THEIR ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There are medium emotional risks associated with anxiety disorders since they are linked to complex emotional experiences. Participants may be asked questions that may be stressful or upsetting. Participants who have both an anxiety disorder and depression may be more susceptible to the risk.

There are also some social risks that come with identifying that an individual participated in the study. Anxiety disorders are still taboo in the south African community, especially the non-white community. Therefore, participants may experience social stigma if their participation in the study was identified.

Participants are allowed to withdraw from the study at any point without incurring any negative consequences to themselves. The researcher will debrief each participant after the interview has been conducted. If a participant has experienced any distress during the interview process, then the participant will be referred to counselling to mitigate any negative effects.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Your name will not be recorded anywhere and no one, apart from the researcher ,will know about your involvement in this study. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report. Your answers will be given a code, number or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings.

Participants confidentiality will be protected. Their identity, personal information, responses will not be disclosed to anyone outside of the research team. Your answers may be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a minimum period of five years in a locked cupboard/filing cabinet for future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. After 5 years all hard copies will be shredded, and electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

HAS THE STUDY RECEIVED ETHICS APPROVAL

This study has received written approval from the Research Ethics Review Committee of the College of Human Sciences, Unisa. A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Ilusca Kearns on +27 72 598 6070 or email Ilusca.ck@gmail.com.

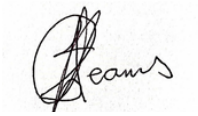
Should you require any further information or want to contact the researcher about any aspect of this study, please contact Ilusca Kearns on +27 72 598 6070 or email Ilusca.ck@gmail.com.

Should you have concerns about the way in which the research has been conducted, you may contact Professor dos Santos on +27 12 429 8577 or email dsantmml@unisa.ac.za.

Contact the research ethics chairperson of the College of Human Sciences Research Ethics Committee, Professor Khan- at email: khankb@unisa.ac.za or tel: +27 124296549 if you have any ethical concerns.

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.



Ilusca Kearns

Appendix F: Consent Form

CONSENT TO PARTICIPATE IN THIS STUDY

Research title: Daily life experiences as a South African living with Panic-Disorder or Generalised Anxiety Disorder: An explorative study

Researcher: Miss Ilusca Kearns

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty.

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the interview.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname…… (please print)

Participant Signature……..Date……

Researcher's Name & Surname……(please print)

Researcher's signature……..Date……