

REVIEW ARTICLE

# Workplace Phobia

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## Abstract

***Background:** Anxiety is a stimulus-bound phenomenon. Workplaces are complex stimuli which are especially prone to provoke anxiety. Workplace phobia is defined as a phobic anxiety reaction with symptoms of panic occurring when thinking of or approaching the workplace. People suffering from workplace phobia regularly avoid confrontation with the workplace.*

***Method:** This article reviews recent findings on workplace phobia and offers a conceptual framework for understanding the specific clinical value of this domain-specific disorder.*

***Results:** Little empirical research is published on workplace phobia. Recent findings support the assumption that workplace phobia can be distinguished differential diagnostically from conventional anxiety and other mental disorders. Workplace phobia is in a special way related to (long-term) sick leave.*

***Conclusions:** Among the spectrum of mental disorders, workplace phobia has an own clinical value which is mainly defined by its specific negative consequences for occupational participation. Workplace phobia requires special therapeutic attention and treatment instead of purely "sick leave" certification. In primary medical care and psychotherapeutic and socio-medical practice, the diagnosis of workplace phobia should be used explicitly in order to better communicate the problem (German J Psychiatry 2009; 12: 45-53).*

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## Introduction

The relation between work and mental disorders has been an important topic in clinical and occupational medicine and psychology: research on work stress, burnout, anxiety and depression in the workplace (e.g. Haslam et al., 2005; Hobson & Beach, 2000; Kawakami et al., 1996; Lindblom et al., 2006; Maslach & Jackson, 1981) and their influence on work performance (Bakker et al., 2008; O'Brien et al., 2008) are frequently studied topics. Employees in social service and helping professions were found to be suffering from work-

stress-related mental disorders more often than employees in other professional domains (Eriksen et al., 2006; Wieclaw, 2006).

Beside situational aspects as possible releasing factors, there are also the individual personality disposition and coping strategies for overcoming work loads (Schaarschmidt & Fischer, 2001) which must be expected to play an important role in the development of workplace-related mental health problems.

Although widespread research seems to be carried out in the field of workplace and mental health, the terms "workplace-related anxieties" (Linden & Muschalla, 2007) and "work-

place phobia” (Haines et al., 2002; Linden, 2006) appear as a new clinical concept which until now has not been studied from a differential diagnostic perspective.

Investigations on workplace-related mental disorders until now focused on (inter)personal and environmental work conditions in order to explain specific phenomena of mental health problems, but there are only few approaches which call these mental health problems explicitly “workplace-related” (Helge, 2001; Mezerai et al., 2006; Moore et al., 2001; Ryan & Morrow, 1992). Instead, often general concepts like “anxiety” or “depression” are used (Hansen et al., 2006; Sanderson & Andrews, 2006; Strazdins et al., 2004; Turnipseed, 1998) but without defining them as a domain-specific disorder.

In this paper, workplace phobia will be described as an anxiety syndrome which - in contrast to the *conventional mental disorders* as defined in the diagnostic classification systems DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organization, 1992) – is defined mainly in respect to its relation to a specific domain of life, namely the workplace.

The article reviews recent findings on workplace phobia and offers a conceptual framework for understanding the specific clinical value of this domain-specific anxiety phenomenon.

## Workplace and anxiety

Workplaces usually contain stimuli which are especially prone to provoke anxiety: There are social hierarchies (Thomas & Hynes, 2007), there can be conflicts with colleagues or superiors often described in terms of mobbing or bossing (Bilgel, Aytac, & Bayram, 2006; Yıldırım & Yıldırım, 2007), which may provoke social anxiety. There may be uncertainty about the future and keeping the job (Strazdins et al., 2004), which may provoke generalized worrying and existential threat. There are also demands for achievements which may provoke perception of high work load and overtaxation, or perception of insufficiency (Nishikitani, Nakao, Karita, Nomura, & Yano, 2005; Turnipseed, 1998). Perception of high work load is one aspect that stands in narrow relationship with degree of perceived workplace-related anxiety (Muschalla, 2008).

There can be environmental factors and physical endangerments (MacDonald, Colota, Flamer, & Karlinsky, 2003; Munir et al., 2007), or structural changes (Campbell & Pepper, 2006; Nagata, 2000) which can provoke anxiety. It has been found that work stress appears to precipitate diagnosable depression and anxiety in previously healthy young workers (Melchior et al., 2007).

Anxiety in relation to the workplace has often been described by using the conventional categories of anxiety disorders or the sense of general anxiety (Haslam et al., 2005; Melchior et al., 2007; Wieclaw, 2006). However, there are also specific anxiety qualities, related to specific stimuli or work conditions, like performance anxiety in artists (Fehm & Schmidt, 2006) or posttraumatic stress reactions in nurses (Laposa et al., 2003; MacDonald et al., 2003), or computer-

and technology-related fears in older-aged employees (Beutel et al., 2004). Regarding the latter, the aspect of competency deficits as one trigger for workplace-related anxiety must be considered. There is evidence that general competency deficits are related to workplace-related anxiety: patients without any professional certification were more likely to suffer from workplace-related anxiety than patients with any completed professional training and certification (Muschalla, 2008).

Within a differential diagnostic approach, it has been found that workplace-related anxieties can be distinguished from conventional anxiety disorders (Linden & Muschalla, 2007). In several samples of psychosomatic and cardiac rehabilitation inpatients, there were

- patients who did only suffer from conventional anxiety disorders according to a DSM-IV based structured interview (Sheehan et al., 1994),
- patients who suffered from both workplace-related and conventional anxiety disorder, and
- patients who fulfilled criteria of workplace-related anxiety only (Linden & Muschalla, 2007; Muschalla, 2008).

Mental disorders and anxiety in the workplace can have negative impact on work participation, this is to be seen in either increased sick leave, or reduced productivity or reduced safety at work (Haslam et al., 2005; Kessler & Frank, 1997). Therefore the assumption arises that in the context of workplace, not only the symptomatologic quality of anxiety has to be studied, but more its specific consequences for work participation. This is especially true for workplace phobia, which has been found to be the most severe form of workplace-related anxiety which in more than 80% of cases goes along with an enduring sick leave or even loss of the workplace (Muschalla, 2008).

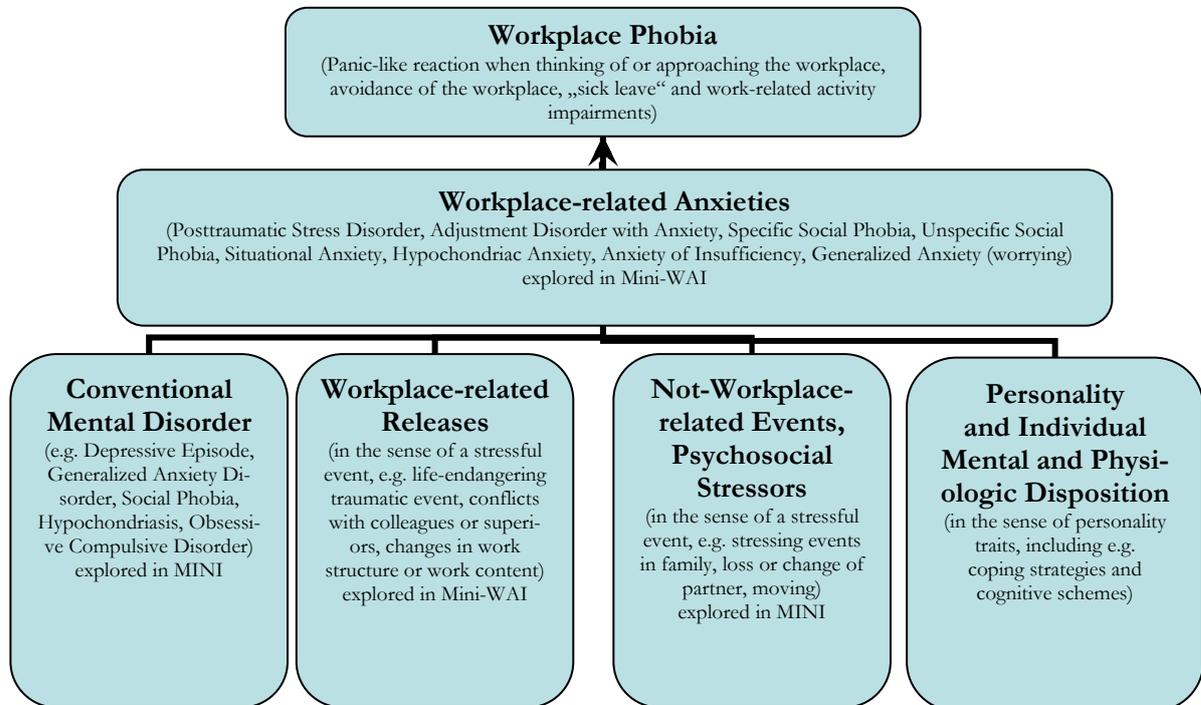
## Workplace phobia

Workplace phobia is the most severe form of workplace-related anxiety. It can be defined as follows: Workplace phobia is characterized by a classical phobic anxiety reaction concerning the stimulus workplace. It occurs with a panic-like reaction with physiological arousal when thinking of the workplace or approaching. The person shows clear avoidance behaviour towards the workplace. Due to the symptoms, there must be severe subjective suffering and/or impairment in carrying out daily duties at work.

A first empirical research study mentioning the term “workplace phobia” was the investigation of Haines et al. (2002). In this work especially the physiological mechanisms of workplace phobia were studied experimentally. The diagnosis of workplace phobia was given by clinical judgement. Participants were separated in three groups: workplace phobic, work-stressed and non-work-stressed. Criteria for diagnosing workplace phobia were:

- self-reported intensive fear when approaching or passing the workplace,

**Figure 1. Aetiology of workplace phobia.** In this aetiology model, individual dispositions (mental disorder, personality and individual constitution) as well as acute workplace-related or non-workplace-related releases and stressors are expected to be in interaction. Unfavourable conditions and dispositions in multiplication may lead to or support the development of workplace-related anxieties and eventually workplace phobia. Diagnostic interviews for the assessment of workplace-related and conventional mental disorders are mentioned beside (*Mini International Neuropsychiatric Interview* MINI (Sheehan et al., 1994), *Mini-Work-Anxiety-Interview* Mini-WAI (Linden & Muschalla, 2007).



- inability to enter the workplace because of severe anxiety symptoms and
- reduction of symptoms when going away from the workplace.

The aim of this study was to determine if a group of individuals who exhibited phobic avoidance of the workplace could be identified in terms of their psycho-physiological and psychological responses to stressful work events. All participants demonstrated increased psycho-physiological arousal and psychological response to stressful work events in comparison with neutral events. The workplace phobic group demonstrated a markedly elevated heart rate response and subjective reports of fear that distinguished them from the other groups. The development of the phobic avoidance response was discussed by the authors in terms of learning theory.

Another approach is now done by focusing on differential diagnostic aspects and a description of workplace phobia as a clinically and socio-medically relevant phenomenon (Linden, 2006) which occurs partly independent from conventional mental disorders: Investigations in samples of psychosomatic as well as cardiac rehabilitation inpatients have shown that there were patients with workplace-related anxieties and workplace phobia who at the same time had no

conventional anxiety disorder (Linden & Muschalla, 2007; Muschalla, 2008). On the other hand, there were also patients who fulfilled the criteria of one or more conventional anxiety disorder, but did not report anxiety at the workplace. It was also found that patients with workplace phobia had higher job-anxiety self-rating scores and longer sick leave duration than patients without workplace phobia, but did not differ significantly concerning general psychosomatic symptom load.

Workplace phobia must be distinguished from neighbored concepts like mobbing or burnout. Mobbing is not an illness, but a perception of specific interaction processes at work characterized by intentional actions by work colleagues or superior directed towards a specific person (often called victim) in order to make damage to him/her. Burnout is a rather unspecified syndrome of vital and psychological exhaustion often related to overtaxation in employees working in the helping social professions (Maslach & Jackson, 1981). In contrast, workplace phobia is a phobic anxiety syndrome with physiological arousal when confronted with the stimulus workplace in vivo or in sensu and a clear (tendency for) workplace avoidance.

In the following a theoretical framework for understanding the clinical phenomenon of workplace phobia is developed, covering the aspects of aetiology, diagnostic criteria and

differential diagnosis, specific consequences for work participation and specific requirements for therapy:

## Aetiology of workplace phobia

Different primary workplace-related anxiety qualities (Linden & Muschalla, 2007) are expected to potentially appear together with (or lead to) workplace phobia (Figure 1). Similar to conventional anxiety disorders, these primary workplace-related anxieties can occur as different phenotypes, like anxiety of insufficiency, generalized worrying, specific social fears, panic in specific non-social working situations, post-traumatic stress or adjustment reactions, health-related anxieties.

Workplace phobia can be seen as a kind of global workplace-related anxiety, including the workplace as a whole and going beyond specific anxiety provoking stimuli like certain demands for achievements (Beutel et al., 2004), major changes (Chevalier et al., 1996; Griffin et al., 2002), specific colleagues or superiors (Bilgel et al., 2006), dangerous work situations (Laposa et al., 2003; Price et al., 2005) or environmental aspects (Nakazawa et al., 2005; Nicholson & Vincenti, 1994). To know the primary anxiety provoking stimuli is necessary for the specification of the quality of workplace-related anxiety, which becomes relevant for treatment. Workplace phobia has been found to occur in comorbidity with on average two basic workplace-related anxieties, like specific social anxiety towards a special superior or colleague, or anxiety of insufficiency after changes at work (Muschalla, 2008).

From a specific anxiety that has originally manifested at the workplace, a complex system of phobic avoidance behaviour may develop, exceed the workplace and generalize to other domains of life. This is due to the fact that anxiety often tends to generalize (Kolassa et al., 2007; Lissek et al., 2008). Thus workplace phobia may result in an agoraphobic symptomatic with avoidance of public places, whereby the fear is to be confronted with workplace-associated stimuli, mostly colleagues or superiors, but also objects or places which remind the person of the workplace.

However, also primary conventional anxiety or other mental or somatic disorders (Haslam et al., 2005; Munir et al., 2007) or an inadequate coping style (Schaarschmidt & Fischer, 2001) or personality accent (Cramer & Davidhizar, 2000; Girardi et al., 2007; Sakai et al., 2005) can cause problems at the workplace and trigger workplace-related anxiety and avoidance behaviour.

Workplace phobia often appears as a secondary symptom or complication of an underlying primary disorder or vulnerability. Therefore, workplace phobia can be seen in analogy to a cerebral insult which occurs in the context of a metabolic syndrome or a thromboemboly or a tumor disease. In this diction, it can be seen as an additional complication of a primary disorder. A metabolic syndrome with a cerebral insult would be diagnosed and treated in a different way than a metabolic syndrome without a cerebral insult. Furthermore, the prognosis is worse in a person with both meta-

bolic syndrome and cerebral insult than in a person with metabolic syndrome only.

## Prevalence of workplace phobia

Until now, there are no prevalence rates known concerning the frequency of workplace phobia in the general working population. Clinical samples have been investigated currently (Muschalla, 2008): in a sample of 230 psychosomatic rehabilitation inpatients (71% women), 17% fulfilled the criteria of a workplace phobia. Patients working in the domain of education were least often suffering from a workplace phobia (9% of patients working in that domain fulfilled the criteria of workplace phobia). Workplace phobia was found most frequently in employees in office and administration (22%), as well as in non-academic practical health care employees (21%). In the domain of service, trade, assurances and banks 16% were suffering from workplace phobia, and 11% in the domain of building, manufacturing and industrial production. In a sample of cardiac rehabilitation inpatients, there were 5,6% out of 210 patients who suffered from workplace phobia (Linden, Muschalla, Markova, Dirks, Herm, 2008).

## Workplace phobia - diagnostic criteria

The question is which status workplace phobia could get within the classificatory systems of mental disorders. Speaking of "workplace phobia", the term "specific phobia" comes to mind. In that sense, workplace phobia can be described as a phobic syndrome related to a specific, but very complex stimulus. Table 1 shows a suggestion for diagnostic criteria of workplace phobia which have been adopted from the DSM-IV (American Psychiatric Association, 1994) category of specific phobia (300.29).

Most of the original criteria of the "Specific phobia" according to DSM-IV have been transferred for the description of the symptomatic of workplace phobia. However, the original criterion C, the recognition of the anxiety reaction as unreasonable and exaggerated by the affected, cannot be adopted for workplace phobia, as most patients suffering from workplace phobia describe a reason why they are frightened. They usually *do not* perceive their anxiety as exaggerated. Nevertheless, they suffer severely from it and have meaningful participation impairments which in return cause even more trouble at work.

Criterion C is a major reason for justifying the special clinical value of workplace phobia and its differential position in comparison to the conventional anxiety disorders. In fact, workplace phobia can in many cases be understood as a subtype of "Pathological Realangst" (Linden, Dirks, Glatz, 2008), that is perception of anxiety which leads to severe impairment and suffering while a realistic endangering stressor is present. Within this concept, the consequences (activity and participation impairments, criteria D, E, G) of the anxiety must be understood as the central point to define the disorder.

**Table 1. Suggestion for diagnostic criteria of Workplace Phobia, adopted and modified from the diagnostic criteria of Specific Phobia (300.29) catalogued in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA 1994).**

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A.	Marked and persistent excessive fear, cued by either being confronted with or thinking of the workplace or workplace-related stimuli (e.g. colleagues, superiors, situations, work duties).
B.	Exposure to the workplace or thinking of it intensively almost invariably provokes an immediate anxiety response with physiological arousal which may take the form of a panic attack.
C.	The patient can but must not perceive the fear as excessive or unreasonable. The person often feels realistically endangered by situations, duties, or persons at work.
D.	The workplace is avoided or else is endured with intense anxiety or distress. This avoidance often leads to long term sick leave and endangers work ability.
E.	The avoidance, anxious anticipation, or distress concerning the workplace interferes significantly with the person's normal working routine, occupational functioning, or work-related social activities or relationships, or there is marked distress about having the phobia.
F.	Workplace phobia can occur in adult people who are in the working age, that is between 18-65 years of age.
G.	The anxiety, panic attacks, or phobic avoidance associated with the workplace can have developed beside a primary conventional mental disorder, such as Obsessive-Compulsive Disorder, Post-traumatic Stress Disorder, Separation Anxiety, Social Phobia, Panic Disorder with Agoraphobia, or Agoraphobia without history of Panic Disorder. Workplace phobia shall be diagnosed when it leads to a specific state of impairment which cannot be explained through the primary or comorbid conventional (mental) disorder.
H.	In persons who are out of work, a workplace phobia may be related to a past workplace or, in generalised form, it may be related to any possible future workplace (generalized workplace phobia).

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## Differential diagnosis

Until now, it has been found in three studies (Linden & Muschalla, 2007; Muschalla, 2008; Linden, Muschalla, Markova, Dirks, Herm, 2008) that workplace-related anxiety and workplace phobia can be distinguished from conventional anxiety disorders: There are patients with both – conventional anxiety and workplace-related anxiety – but also those patients who do have a conventional anxiety disorder but *no* workplace-related anxiety, and also those who do only suffer from workplace-related anxiety, but no other conventional anxiety disorder.

In order to illustrate the differential diagnostic aspect, three examples shall be given concerning differential diagnostic in workplace phobia and conventional (i.e. not workplace-related) social phobia:

1. A patient with workplace phobia following a primary manifested specific social anxiety towards a specific superior, resulting from a mobbing experience, did not at the same time feel anxious towards people outside the workplace or even to other colleagues. This person did not fulfil the criteria of a conventional social phobia.
2. In another case, a person with a conventional social phobia reacted anxious in new interaction situations, but was free of anxiety when interacting with well-known people, like the family or good colleagues at work whom he had been working together with for a long time. This person had a specific social phobia in new interaction situations, but not a workplace phobia.
3. A third case is an example of comorbidity of social phobia and workplace phobia. A young generally anxious person who obtained his first job reacted anxious in interaction and achievement situations at work and started to avoid team meetings and presentations. He got into trouble with the superior, because of lacks in achievements and failure, and finally lost his job after having been on a long period of sick leave. He was afraid of searching any new job because of anticipation of a similar development at a new workplace. In this case, workplace phobia occurred as a secondary disorder and thus a complication of a primary conventional social phobia.

## Avoidance and work participation

Workplace phobia is not only defined by a special conglomerate or quality of anxiety symptoms, but by work-related participation disorders resulting from workplace phobic avoidance behaviour. Avoidance is an important diagnostic criterion (DSM-IV, Specific Phobia) of phobic anxiety disorders and functions as a classical coping strategy in those patients. In terms of learning theory, avoidance means negative reinforcement (Skinner, 1969) and reduces anxiety for a certain time.

Avoidance within the context of workplace phobia is often to be seen in long-time sick leave, it may end in quitting the workplace or early retirement. Therefore avoidance gets a specific significance as it has in a special way negative effects for the person's further professional course. This is not true for most other specific phobias (Greenberg et al., 1999).

The direct association of workplace phobia with work participation disorders, which can be described with the sick leave duration and work ability status as objective criteria, can be seen as a specific characteristic of workplace phobia. Empirical findings (Muschalla, 2008) show that the longer the sick leave duration, the higher is the probability to suffer from workplace phobia. Patients with conventional anxiety disorders only were not associated with sick leave in the same way as workplace phobics. This can be explained due

to the fact that avoidance through sick leave does only make sense in case the anxiety-provoking stimulus is the workplace. Interestingly, in the case of “common mental disorders in the workforce” within an epidemiological study (Sanderson & Andrews, 2006) it was found that depression and anxiety were consistently associated with presenteeism.

It has also been found that different diagnostic groups of psychiatric patients require different strategies for certifying sick leave (Tritt et al., 2005). Thereby it was found that there were patients with anxiety disorders and longer sick leave who had a deterioration in symptoms over time, in contrast to a group of anxiety patients with shorter or no prior sick leave. Hereby workplace-related anxiety or workplace phobia could play a major role as a moderating factor.

There are mainly two plausible theoretical explanations concerning the narrow relationship between sick leave and workplace phobia: On the one hand, the longer the duration of sick leave due to any (not directly work-related) health injury, the more a perception of workplace-related anxiety may increase. This would mean workplace-related anxiety develops as a result from enduring sick leave, because of rising cognitions of uncertainty, worries, speculative anticipation of possible changes or uncontrolled events happening at work while the person is staying away, or even the anticipation and fear to be “mobbed” by other colleagues after return to work, because they had to do all the work of the colleague who was missing a long time.

On the other hand, anxiety can have manifested at the workplace first, for example in response to an awful frightening experience there, and sick leave occurs in the following as an avoidance behaviour, leads to immediate anxiety reduction but in mean time maintains workplace-related anxiety so that it eventually increases and ends in a workplace phobia. These developments should be investigated in longitudinal studies in future research.

The aspect of malingering symptoms in order to get on early retirement is relevant in all mental and somatic disorders, it does not seem specific for workplace phobia. From clinical experience, patients with a desire for early retirement more often focus on somatic disorders and general activity impairment due to a general low state of health. This could be due to the better acceptance of somatic disorders in comparison to mental (often perceived as not objectively observable) disorders.

## **Therapeutical implications of workplace phobia**

In all behavioural therapeutic treatments of phobias, exposition is an important method (Hand & Wittchen, 1988; Linden & Hautzinger, 2005). The special problem about the therapy of workplace phobia is that in vivo expositions with anonymous graded approaching are difficult or even impossible to be realised. Furthermore, the external conditions at the workplace cannot be controlled by the therapist so that a planned and therapeutically dosed exposition is not possible. Under such insecure conditions there is even the risk of strengthening the phobia.

Generally utile therapy techniques are descriptions and analysis of situations and behaviour, the development of coping strategies, the revision of self-imposed demands, principles of reframing and anxiety management, clearing of conflicts or exposition in sensu (Linden & Hautzinger, 2005).

A specific instrument may be a therapeutically supervised “therapeutic working trial” (Beutel et al., 1998; Hillert et al., 2001). The idea is to send patients on a hospitation in chosen co-operating firms or workplaces similar to the professional setting in which the patient’s problems were originally occurring. This therapeutic working trial seems to be useful especially in case a workplace phobia that has exceeded one specific workplace and has generalized to any other possible new workplace.

In cases of underlying real deficits in competency or coping strategies and thereby developed workplace-related anxiety, like technology fears in older employees, specific training programs can be useful (Beutel et al., 2004; Heitzmann et al., 2008).

In future research, controlled clinical therapy studies focusing specific workplace-related anxieties are necessary. In the context of psychosomatic rehabilitation, it was found exploratively that patients with workplace-related anxiety were more often treated with additional work-directed group therapies like conflict management, time management, job application training in comparison to patients without any workplace-related anxieties (Muschalla, 2008). These group therapies are one possibility to realise in sensu exposition and competency (soft skills) training at the same time. The aim of such work-directed therapies is that in the end of the treatment the patient shows motivation for a return to work or start or search for a new workplace.

There are until now no findings concerning pharmacological treatment of workplace phobia. This is a future research perspective as well.

## **The diagnostic setting – implications for the practice: Can “workplace phobia” be used as a proper diagnosis?**

Workplace phobia can be associated with a very complex stimulus and therefore appears not only as a specific, but even as a “complex” specific phobia. Workplace phobia has far-reaching consequences for work participation and thus can mean existential endangerment for the affected person. As specific phobias are usually not going along with comparable severe work participation problems (Greenberg et al., 1999), they are not expected to provoke existential fears in the same degree. Therefore also existential threat appears as a specific consequence of workplace phobia.

Another point which makes workplace phobia appear different from the conventional specific phobia is the treatment aspect. Expositions can only be made in a therapeutically supervised working trials or in sensu. Treatment often does not focus on anxiety (symptom) management only, but on the improvement of social skills and competencies.

Due to empirical findings and their practical implications which have been discussed, it seems to be necessary to describe the phenomenon of workplace phobia with an extra diagnosis instead of subsuming it under a conventional anxiety disorder like “agoraphobia”. It makes a difference whether a person avoids leaving the own flat because of the fear to come into situations where help is not possible (agoraphobia), or whether a person avoids going out because of a possible confrontation with colleagues or superiors from the feared workplace (workplace phobia). In both cases the avoidance reactions look like the same, and implicate the diagnosis of agoraphobia, but the psychological mechanisms lying behind are different.

To give the diagnosis of workplace phobia by naming it “workplace phobia”, additionally to a comorbid or behind lying primary conventional mental disorder therefore has good practical reasons.

In primary medical, psychotherapeutic and socio-medical practice, workplace phobia should be named as a proper diagnosis. Primary care physicians should be aware of workplace phobia in patients who are on long-term sick leave. This seems especially relevant as the majority of patients with mental disorders initially seek help in primary care (Kroenke et al., 2000).

It can be suggested to diagnose “workplace phobia” explicitly with the ICD-10 number F 40.8 (other phobic disorders).

## Conclusion and prospect

Workplace phobia is not primarily defined by its symptoms' quality, but by the quality of the stimulus, the severity of the subjectively perceived domain-specific work-anxiety symptom load, as well as the resulting work participation disorders often occurring as long-term sick leave. Workplace phobia therefore requires special diagnostic and therapeutic attention, and a specific symptom and competency-focusing treatment instead of purely “sick leave” certification.

Further research should consider the development and evaluation of work-directed therapy approaches and their role for durable professional reintegration. Furthermore, workplace-related anxiety and workplace phobia should be investigated in other clinical populations. Finally, different professional settings and the working population should be investigated for epidemiologic findings.

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## References

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Washington, DC: American Psychiatric Association 1994
- Bakker A., van Emmerik H., van Riet P. How job demands, resources and burnout predict objective performance: A constructive replication. *Anxiety, Stress & Coping* 2008; 21: 309-324
- Beutel M.E, Kyser E, Vorndran A., Farley A, Bleichner F. Die integrierte berufliche Belastungserprobung in der medizinischen Rehabilitation – Erfahrungen und Perspektiven am Beispiel der psychosomatischen Rehabilitation. *Die Rehabilitation* 1998; 37: 85-92
- Beutel ME, Gerhard C, Wagner S, Bittner HR, Bleicher F, Schattenburg L, Knickenberg R, Freiling T, Kreher S, Martin H. Reduction of technology fears in psychosomatic rehabilitation – concepts and results based on a computer training for older employees. *Zeitschrift für Gerontologie und Geriatrie* 2004; 37: 221-230
- Bilgel N, Aytac S, Bayram N. Bullying in Turkish white collar workers. *Occupational Medicine* 2006; 56: 226-231
- Campbell R, Pepper L. Downsizing and social cohesion: the case of downsizing survivors. *New Solutions* 2006; 16: 373-393
- Chevalier A, Bonenfant S, Picot MC, Chastang JF, Luce D. Occupational factors of anxiety and depressive disorders in the French National Electricity and Gas Company. The Anxiety-Depression-Group. *Journal of Occupational Environmental Medicine* 1996; 38: 1098-1107
- Cramer C, Davidhizar R. The health care employee with an “attitude”. *Hospital Materiel Management Quarterly* 2000; 22: 27-33
- Eriksen W, Tambs K, Knardahl S. Work factors and psychological distress in nurses' aides: a prospective cohort study. *BMC Public Health* 2006; 28: 290
- Fehm L, Schmidt K. Performance anxiety in gifted adolescent musicians. *Journal of Anxiety Disorders* 2006; 20: 98-109
- Girardi P, Monaco E, Prestigiacomo C, Talamo A., Ruberto A., Tatarelli R. Personality and psychopathological profiles in individuals exposed to mobbing. *Violence and Victims* 2007; 22: 172-188
- Greenberg PE, Sisitsky T, Kessler RC, Finkelstein SN, Berndt ER, Davidson JR. The economic burden of anxiety disorders in the 1990s. *Journal of Clinical Psychiatry* 1999; 60: 427-435
- Griffin JM, Fuhrer R, Stansfeld SA, Marmot M. The importance of low control at work and home on depression and anxiety: do these effects vary by gender and class? *Social Science and Medicine* 2002; 54: 783-798
- Haines J, Williams CL, Carson JM. Workplace Phobia: Psychological and psychophysiological Mechanisms. *International Journal of Stress Management* 2002; 9: 129-145
- Hand I, Wittchen HU (Eds). *Panic and Phobias*. Berlin: Springer 1986

- Hansen AM, Hogh A, Perrson R, Karlson B, Garde AH, Orbaek P. Bullying at work, health outcomes, and physiological stress response. *Journal of Psychosomatic Research* 2006; 60: 63-72
- Haslam C, Atkinson S, Brown SS, Haslam RA. Anxiety and depression in the workplace: Effects on the individual and organisation (a focus group investigation). *Journal of Affective Disorders* 2005a; 88: 209-215
- Haslam C, Atkinson S, Brown SS, Haslam RA. Perceptions of the impact of depression and anxiety and the medication for these conditions on safety in the workplace. *Occupational Environmental Medicine* 2005b; 62: 538-545
- Heitzmann B, Helfert S, Schaarschmidt U. Fit für den Beruf. AVEM-gestütztes Patientenschulungsprogramm zur beruflichen Orientierung in der Rehabilitation. Bern: Verlag Hans Huber 2008
- Helge D. Turning workplace anger and anxiety into peak performance. Strategies for enhancing employee health and productivity. *American Association of Occupational Health Nurses Journal* 2001; 49: 399-406
- Hillert A, Lehr D, Pecho L. Berufsgruppen bezogene Therapieansätze? Zur Relativität therapeutischer Perspektiven am Beispiel psychosomatisch erkrankter Lehrer / innen. In M. Bassler (Ed), *Störungsspezifische Ansätze in der stationären Psychotherapie* (pp. 74-87). Giessen: Psychosozial-Verlag 2001
- Hobson J, Beach JR. An investigation of the relationship between psychological health and workload among managers. *Occupational Medicine* 2000; 50: 518-522
- Kawakami N, Iwata N, Tanigawa T, Oga H, Araki S, Fujihara S, Kitamura T. Prevalence of mood and anxiety disorders in a working population in Japan. *Journal of Occupational and Environmental Medicine* 1996; 38: 899-905
- Kessler RC, Frank RG. The impact of psychiatric disorders on work loss days. *Psychological Medicine* 1997; 27: 861-873
- Kolassa IT, Buchmann A, Lauche R, Kolassa S, Partchev I, Miltner WH, Musial F. Spider phobics more easily see a spider in morphed schematic pictures. *Behavioral and Brain Functions* 2007; 3: 59
- Kroenke K, Taylor-Vaisey A, Dietrich AJ, Oxman TE. Interventions to improve provider diagnosis and treatment of mental disorders in primary care. A critical review of the literature. *Psychosomatics* 2000; 41: 39-52
- Laposa JM, Alden LE, Fullerton LM. Work stress and post-traumatic stress disorder in ED nurses/personnel. *Journal of Emergency Nursing* 2003; 29: 23-28
- Lindblom KM, Linton SJ, Fedeli C, Bryngelsson IL. Burnout in the working population: relations to psychosocial work factors. *International Journal of Behaviour Medicine* 2006; 13: 51-59
- Linden M, Dirks S, Glatz J. Die „Pathologische Realangst“ am Beispiel kardiovaskulärer Erkrankungen. *Zeitschrift für Psychosomatik und Konsiliarpsychiatrie* 2008; 2: 248-254
- Linden M, Hautzinger M (Eds). *Verhaltenstherapiemanual*. Heidelberg: Springer Verlag 2005
- Linden M, Muschalla B. Anxiety disorders and workplace-related anxieties. *Journal of Anxiety Disorders* 2007; 21: 467-474
- Linden M, Muschalla B, Markova M, Dirks S, Herm K. Anxieties in cardiac rehabilitation inpatients, 2009, in preparation.
- Linden M. Arbeitsplatzängste und -phobien. In W Müller-Fahrnow, T, Hansmeier, M. Karoff (Eds), *Wissenschaftliche Grundlagen der medizinisch-beruflich orientierten Rehabilitation* (pp. 181-192). Berlin: Pabst Science Publishers 2007
- Lissek S, Biggs AL, Rabin SJ, Cornwell BR, Alvarez RP, Pine DS, Grillon C. Generalization of conditioned fear-potentiated startle in humans: experimental validation and clinical relevance. *Behavior Research and Therapy* 2008; 46: 678-687
- MacDonald HA, Colota V, Flamer S, Karlinsky H. Post-traumatic stress disorder (PTSD) in the workplace: a descriptive study of workers experiencing PTSD resulting from work injury. *Journal of Occupational Rehabilitation* 2003; 13: 63-77
- Maslach C, Jackson SE. The measurement of Experienced Burnout. *Journal of Occupational Behaviour* 1981; 2: 99-113
- McLaughlin TJ, Aupont O, Bambauer KZ, Stone P, Mullan, MG, Colagiovanni J, Polishuk E, Johnstone M, Locke SE. Improving psychologic adjustment to chronic illness in cardiac patients. The role of depression and anxiety. *Journal of General Internal Medicine* 2005; 20: 1084-1090
- Melchior M, Caspi A, Milne BJ, Danese A, Poulton R, Moffitt TE. Work stress precipitates depression and anxiety in young working women and men. *Psychological Medicine* 2007; 37: 1119-1129
- Mezerai M, Dahane A, Tachon JP. Dépression dans le milieu du travail. *Presse Med* 2006; 35: 823-830
- Moore RS, Light JM, Ames GM, Saltz RF. General and job-related alcohol use and correlates in a municipal workforce. *American Journal of Drug and Alcohol Abuse* 2001; 27: 543-560
- Munir F, Yarker J, Haslam C, Long H, Leka S, Griffiths A, Cox S. Work factors related to psychological and health-related distress among employees with chronic illnesses. *Journal of Occupational Rehabilitation* 2007; 17: 259-277
- Muschalla B. *Workplace-related Anxieties and Workplace Phobia: A Concept of Domain-specific Mental Disorders*. Online published doctoral dissertation, University of Potsdam, Germany 2008
- Nagata S. Stress management in the workplace in the era of industrial and economic change. *Sangyo Eisaigaku Zasshi* 2000; 42: 215-220
- Nakazawa H, Ikeda H, Yamashita T, Hara I, Kumai Y, Endo G, Endo Y. A case of sick building syndrome in a Japanese office worker. *Industrial Health* 2005; 43: 341-345
- Nicholson PJ, Vincenti GE. A case of phobic anxiety related to the inability to smell cyanide. *Occupational Medicine* 1994; 44: 107-108
- Nieuwenhuijsen K, Verbeek JH, de Boer AG, Blonk RW, van Dijk FJ. Predicting the duration of sickness absence for patients with common mental disorders in

- occupational health care. *Scandinavian Journal of Work, Environment and Health* 2006; 32: 67-74
- Nishikitani M, Nakao M, Karita K, Nomura K, Yano E. Influence of overtime work, sleep duration, and perceived job characteristics on the physical and mental status of software engineers. *Industrial Health* 2005; 43: 623-629
- O'Brien A, Terry D, Jimmieson N. Negative affectivity and responses to work-stressors: An experimental study. *Anxiety, Stress & Coping* 2008; 21: 55-83
- Price JL, Monson CM, Callahan K, Rodriguez BF. The role of emotional functioning in military-related PTSD and its treatment. *Journal of Anxiety Disorders* 2006; 20: 661-674
- Ryan CM, Morrow LA. Dysfunctional buildings or dysfunctional people: an examination of the sick building syndrome and allied disorders. *Journal of Consulting and Clinical Psychology* 1992; 60: 220-224
- Sakai Y, Akiyama T, Miyake Y, Kawamura Y, Tsuda H, Kurabayashi L, Tominaga M, Noda T, Akiskal K, Akiskal H. Temperament and job stress in Japanese company employees. *Journal of Affective Disorders* 2005; 85: 101-112
- Sanderson K, Andrews G. Common mental disorders in the workforce: recent findings from descriptive and social epidemiology. *Canadian Journal of Psychiatry* 2006; 51: 61-62
- Sanderson K, Tilse E, Nicholson J, Oldenburg B, Graves N. Which presenteeism measures are more sensitive to depression and anxiety? *Journal of Affective Disorder* 2006; 23: 377-387
- Sanford K. Attributions and anger in early marriage: wives are event-dependent and husbands are schematic. *Journal of Family Psychology* 2005; 19: 180-188
- Schaarschmidt U, Fischer AW. *Bewältigungsmuster im Beruf*. Göttingen: Vandenhoeck & Ruprecht 2001
- Sheehan D, Janavs J, Baker R, Knapp E, Sheehan KH, Sheehan M. *MINI. Mini-International Neuropsychiatric Interview*. Tampa: University of South Florida 1994
- Skinner BF. *Contingencies of Reinforcement: A theoretical Analysis*. New York: Appleton Century-Crofts 1969
- Strazdins L, D'Souza RM, Lim LL, Broom DH, Rodgers B. Job strain, job insecurity, and health: rethinking the relationship. *Journal of Occupational Health Psychology* 2004; 9: 296-305
- Thomas M, Hynes C. The darker side of groups. *Journal of Nursing Management* 2007; 15: 375-385
- Tritt K, Schneider H, Bidmon RK, Nickel M, Leiberich P, Joraschky P, Loew TH. Do patients with different psychiatric diagnosis require different strategies for certifying sick leave? – First indications from a prospective study. *Croatian Medical Journal* 2005; 46: 308-314
- Turnipseed DL. Anxiety and burnout in the health care work environment. *Psychological Reports* 1998; 82: 627-642
- Uehata T. Long working hours and occupational stress-related cardiovascular attacks among middle-aged workers in Japan. *Journal of Human Ergology* 1991; 20: 147-153
- Wieclaw J. Risk of affective and stress related disorders among employees in human service professions. *Occupational and Environmental Medicine* 2006; 63: 314-319
- World Health Organization. *International Statistical Classification of Diseases and Related Health Problems, 10<sup>th</sup> revision*. Geneva: World Health Organization 1992
- Yıldırım A., Yıldırım D. Mobbing in the workplace by peers and managers: mobbing experienced by nurses working in healthcare facilities in Turkey and its effects on nurses. *Journal of Clinical Nursing* 2007;16: 1444-1453