CE

Professional Case Management
Vol. 16, No. 2, 55–59


# Dealing With Anxiety Disorders in the Workplace

## *Importance of Early Intervention When Anxiety Leads to Absence From Work*

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**ABSTRACT**

**Purpose:** A report from the Partnership on Workplace Mental Health, a program of the American Psychiatric Foundation, supports the widely held view that intervening early in a psychiatric disability absence will result in earlier return to work and reduce the likelihood of permanent disability. Studies unfortunately reveal that patients with psychiatric illness do not receive a level of care consistent with evidence-based best practice. This article highlights the importance of early interventions that utilize best practices for anxiety disorders that impair an employee's occupational functioning.

**Primary practice setting:** Behavioral Health Consulting Firm.

**Findings/conclusions:** Studies on occupational disability conclude that collaborative communication between clinicians, disability case managers, and the employer is important to facilitate a successful and timely return to work for employees with temporary psychiatric disability. Avoidance of preexisting workplace conflicts can undermine return to work. Undertreatment and ineffective treatment are common causes of delayed recovery from acute anxiety conditions. In addition, lack of urgency among clinicians regarding the crisis nature of absence from work due to psychiatric illness can contribute to lengthy and unnecessary absence from work.

**Implications for case management practice:** A basic understanding of the acute aspects of anxiety disorders can assist disability case managers working in collaboration with treating clinicians and employees in a successful and timely return to work when an anxiety condition leads to absence from work.

**Key words:** *anxiety disorders, disability case management, occupational disability, psychiatric disability*

Compared to other diseases, mental illness is the second leading cause of disability in the United States (Social Security Administration, 2009). According to prevalence rates published by the National Institute of Mental Health (2008), 40 million American adults in a given year have an anxiety disorder, compared with an estimated 20.9 million Americans with a mood disorder, making anxiety the most common mental illness among American adults. Absence from workplace because of mental illness is a growing crisis and needs to be addressed with a sense of urgency by employers, disability case managers, and treatment providers. Anxiety disorders, which have the propensity to increase fear and avoidance of stress associated with the workplace, create an even more complicated picture for case managers facilitating return to work.

Anxiety and fear are natural and universal human emotions. Fear and apprehension warn us of danger and potential threats and serve a biological purpose of securing safety and survival. In other words, we are biologically programmed to avoid what we learn to be dangerous and a threat for our safety. We also have the psychological capacity to take on a challenge to preserve our physical or personal integrity. We have all felt anxious in anticipation of an event, where we will be judged, such as a job interview or performance review. You may have felt more intense anxiety, with racing heart, even brief panic if a deer ran out in front of your car. Anxiety is a combination of emotional and biological processes. Our heart pumps faster to get blood to the muscles and lungs. Our breathing increases to get the oxygen we may need for a physical response. These physiological reactions are referred to

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as the "fight or flight response." However, the problem for some people with anxiety disorders is that the ability to distinguish between real threats versus an emotional threat becomes blurred. These individuals may begin to fear common situations that they now associate with anxiety and panic. The belief that the common situation is unsafe can trigger a panic attack, which is really the fight or flight response that has gone a bit haywire. When the anxiety feelings and the subsequent response, fleeing the scene, escalates to an uncontrollable level it may interfere with an individual's ability to effectively function, at least temporarily, in a social or work environment.

## Case Example

Ross is a 49-year-old maintenance supervisor. Shortly after Ross was promoted to a supervisory position that involved more responsibility including managing other employees, he became increasingly nervous about how to manage a poor performing employee. In addition, he was feeling pressure from his supervisor regarding the performance of his department. He would lay awake at night worrying about events at work. He felt increasingly nervous on the drive to work. One day while at work, Ross experienced intense chest pain and had difficulty catching his breath. He became panicked, believing that he was having a heart attack. He left work. When the sensations of chest pains continued, he went to the emergency department. At the emergency department, he was told he had a panic attack and was referred to his family doctor who told him to avoid stress. His doctor recommended short-term disability while receiving treatment. Ross was prescribed alprazolam (Xanax), a mild sedative, to take up to three times a day if feeling anxious. He also began seeing a counselor. However, this counselor was not trained in specific treatment for panic attacks and instead wanted to delve into his childhood experiences. Two months later, Ross was still off work and reported experiencing panic attacks on a weekly basis with increased depression. He had grown increasing fearful of his worksite, believing it was too stressful.

## What Went Wrong With This Case?

Managing a case such as this requires an understanding of mental health issues and the importance of effective treatment focused on return to work. It was unfortunate that this employee was not referred for a psychiatric consultation during the early weeks when he was away from work. Instead, the early psychiatric treatment was by the family doctor who was unfamiliar in the treatment of panic disorder.

There was no improvement in this employee's condition after months and no plan for return to work in sight. After specialized case management was assigned, the psychiatric case manager advocated for a referral to a psychiatrist. His medications were changed and he started seeing a psychologist trained in treating anxiety disorders. The employee demonstrated improvement and returned to work within 8 weeks of referrals for a more effective treatment plan—a great outcome! Consultation with clinicians who have expertise in the assessment and treatment of specific psychiatric conditions can be an effective intervention for cases in which expected progress is not occurring.

## Best Practices in Treatment of Anxiety Disorders

Review of the literature indicates that less than 50% of people with an identified psychological disorder receive treatment from a mental health professional. A thorough and objective evaluation by a psychologist or psychiatrist is needed to establish an accurate diagnosis and identify functional impairments to formulate an effective treatment plan. A physical examination with primary care is recommended to rule out the presence of an organic cause of symptoms. The combination of psychotherapy and medications is considered the best practice in treatment of anxiety disorders. The cognitive–behavioral therapies, particularly, *Exposure Therapy* and *Cognitive Restructuring*, are the best empirically supported psychotherapies for the treatment of posttraumatic stress disorder (Arehart-Treichel, 2001). *Exposure Therapy* assists the individual to confront the memory and anxiety response of the psychological trauma and come to terms with it. *Cognitive Restructuring* helps identify negative and irrational beliefs associated with the trauma and develop more accurate and adaptive thoughts and beliefs. Cognitive–behavioral therapy is

a goal-directed therapy that addresses both the behavioral and thought processes involved with panic disorder and is a common treatment of panic disorder.

Medication consultation with a psychiatrist is the recommended treatment for anxiety, especially if symptoms are severe enough to cause absence from work. In remote areas, access to a psychiatrist can be limited, and medications will be managed by a family physician. Selective serotonin reuptake inhibitors are Food and Drug Administration-approved medications for the treatment of most anxiety disorders. Benzodiazepines, a class of mild sedatives, can be taken for an effective short-term treatment for severe panic attacks.

The Partnership for Mental Health (2009) formed a task force, which has evaluated current practices in the field of psychiatric disability. An initial study concluded that psychiatric disability should be treated as a crisis. Collaboration between treatment providers, employers, case managers, and employees is recommended to ensure that treatment is focused on restored functioning and timely return to work. The task force has developed a set of assessment tools and recommendations, which are currently being pilot tested with a large employer in the Pacific Northwest.

## Intermittent Anxiousness Compared to Anxiety Disorders That May Lead to Absence From Work

One episode of a panic attack does not make for a panic disorder. There must be recurring panic attacks with other associated symptoms. Nightmares or fears of a boss who is perceived to be mean, rude, and overly demanding does not meet criteria for posttraumatic stress disorder (PTSD). Many people who experience an actual life threatening traumatic event do not develop PTSD. Some people live most of their adult lives with general worry and anxiety that is distressing but does not limit their daily activities or work capacity. So, what separates common and expected anxiety feelings from an actual psychiatric condition? According to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised* (*DSM-IV-TR*) (2000), an individual must experience a cluster of specific symptoms that occur with a level of frequency and duration, which causes significant distress or impairment in a basic area of functioning. According to the *DSM-IV-TR*, the lifetime prevalence for panic disorder in the general population is estimated at 3.5%. However, the prevalence increases to 10%–30% in vestibular, respiratory, and neurology clinics, and as high as 60% in cardiac clinics. We do know that some anxiety disorders, namely, panic disorder, agoraphobia, acute stress reaction, and PTSD can involve acute and debilitating symptoms that have the potential to limit daily function and work capacity. Other less severe conditions including adjustment disorder with anxiety and generalized anxiety are typically not considered severe psychiatric conditions.

The definition of a panic attack includes experiencing four or more of the following symptoms within 10 min:

- palpitations or pounding heart,
- shortness of breath,
- dizziness,
- sweating,
- trembling,
- chest pain,
- choking,
- nausea,
- feeling detached,
- fear of losing control,
- fear of dying, and
- chills/hot flashes.

As you can imagine, these symptoms can be quite unpleasant, physically and emotionally. Some of the symptoms are quite similar and difficult to distinguish from a cardiac event or stroke and often lead people to the emergency department or their doctor's office; hence, the high prevalence rate of patients with panic disorders is seen initially in cardiac clinics.

## Indicators of a Serious Anxiety Disorder Necessitating Treatment Intervention to Reduce Potential for Absence from Work

Frequent and intense panic or PTSD symptoms can interfere with daily living and work capacity. An individual may begin to flee any situation when they notice the first signs of intense anxiety and emotional discomfort. Avoidance of the situation or place that is perceived to be the source of stress causing one's symptoms is a common aspect of panic disorder and PTSD. Multiple trips to the emergency department because of the severe physiological sensations associated with a panic attack can be a sign that acute and persistent anxiety has reached a severity to interfere with functioning. In addition, the preoccupation and fear of another panic attack or heart attack can interfere with concentration. The intrusive thoughts or flashbacks of a traumatic event, an aspect of PTSD, can cause agitation and reduced concentration.

Should a patient avoid work if it causes stress? Generally not. Avoidant behavior associated with anxiety can be a factor contributing to extended absence from work. This can also occur when an individual develops anxiety secondary to a medical condition. You may have worked with employees who

recover from a physical injury, but subsequently develop acute anxiety or panic with loss of confidence that prevents them from returning to work. Anxiety motivates avoidance of the perceived threat or fear. Note that the key here is "perceived threat." Avoidant behavior of an irrational or learned threat becomes maladaptive and has the potential to reduce functioning.

An example is the employee who believes that the stress from work will trigger a panic attack, heart attack, or flashback. They begin to avoid work altogether. Providers can unknowingly reinforce helplessness and maladaptive avoidant behavior with extended and unnecessary work restrictions. Systematic desensitization is a specific cognitive–behavioral method that systematically teaches the individual to confront the situations, feelings, and thoughts that trigger their anxiety. An example of desensitization is to have the employee drive by the workplace until the anxiety feels manageable. The next step is to drive and sit in the parking lot until anxiety subsides. Another step is to walk inside and increase the time near the work or at the work environment. Once back at work, a plan is put in place to reduce the potential of fleeing work if feeling nervous or panicky.

What situations would require avoidance of the work site? Traumatic and life threatening events that occur to an employee while at work often contribute to avoidance of the worksite. Examples of traumatic events that occur at work could include physical or sexual assault, robbery with threatened or real assault, or serious physical injury caused by an occupational accident. These cases are particularly difficult and may require a clinician that is specially trained in trauma recovery who is collaborating with the case manager and employer to develop a return to work plan. Also, an accommodation such as a transfer to another department, office, or business location may assist in quicker and successful return to work.

## Potential Barriers for Successful Return to Work for Anxiety and Mental Health Disability

A workplace conflict that is emotionally distressing can get incorrectly labeled as PSTD. Being unfairly reprimanded at work, imagined or real, or perceiving a boss as overdemanding or demeaning does not qualify as a life-threatening trauma, a primary criteria in the diagnosis of PTSD (*DSM-IV-TR*, 2000). If an individual displays significant psychological symptoms in response to a stressful but common life event, they might receive a diagnosis of adjustment disorder. If the employee is functioning normally outside of work and only feels nervous and upset when thinking about being at work, it is a workplace issue to be addressed by the employer. Mislabeling someone with PTSD or another psychological disorder, while advocating for the patient against the employer, can increase feelings of victimization and helplessness that will make return to work quite difficult.

Poor and insufficient treatment can delay recovery and reduce motivation needed for successful return to work. As previously mentioned, the combination of psychotherapy and medication is the recommended best practice in the treatment of anxiety disorders. However, many people with an anxiety disorder do not receive the recommended level of treatment. A study by Stein et al. (2004) demonstrated that, of individuals identified with an anxiety disorder at outpatient clinics in the western United States, less than one third received either psychotherapy or medication treatment that met a criterion for quality care. Even when the appropriate therapy was used, the duration of treatment was often too short.

Imagine Sue, an employee who complains to her family doctor that work has been too stressful. She reports chest pains, anxiousness, and trouble sleeping. The treatment is a prescription of a benzodiazepine, which is a mild sedative, and a restriction from work for 3–6 months to rest. Follow-up in 3 months to reevaluate is recommended. Unfortunately, this scenario is far too common. In my clinical experience, once an individual is accustomed to the quick, though temporary, relief they feel by taking a pill, they become reluctant to tolerate the emotional discomfort of cognitive–behavioral therapy. Multiple studies on treatment outcome indicate that long-term use of benzodiazepine for panic disorder and PTSD may reduce the effectiveness of psychotherapy (Westra et al., 2004). The prevalence rates of anxiety disorders are comparable to depressive disorders. However, outcome research on best practices for anxiety lags behind studies on treatment for depression—a study conducted by Peter Roy-Byrne, MD, of the University of Washington Seattle, and colleagues (2010). Conclusions supported a positive outcome using a flexible collaborative treatment model for anxiety disorders designed by the researchers. The model the researchers designed is called coordinated anxiety learning and management (CALM). The model included a treatment manager who coordinated treatment. Treatment included the option of cognitive–behavioral therapy with or without medication, or medication alone. Results of the study indicated participants in the CALM group showed significantly greater symptom improvement and remission rates than those receiving usual care. Usual care involved medication and brief counseling from a physician.

## Successful Management of Absence from Work Due to Anxiety

Working with employees to set goals focused on recovery and return to work is the challenge for all case managers. Recovery from anxiety disorders is complicated by the negative impact that loss of work function has on identity and self worth. Key factors identified in successful management of anxiety conditions include the following:

- Early and regular contact with employees when they are off work is encouraged to address motivation to engage in treatment consistent with best practice for an anxiety disorder.
- Early assessment and appropriate treatment is recommended for comorbid anxiety with a physical injury or illness to prevent prolonged absence once physical function is restored.
- Addressing workplace conflicts that precipitated a medical leave is important when managing absence from work due to anxiety condition.
- Prolonged absence can reinforce anxiety and avoidant behavior. Having a return to work plan that includes specific dates and accommodations can help the employee successfully transition back to work and be productive sooner rather than later.

Anxiety, even when severe, does not have to be debilitating nor result in prolonged absence from work. Though uncomfortable, most anxiety conditions are not disabling. If symptoms become acute and interfere with daily activities including work, early and effective intervention strategies can often result for a quick and full recovery. Disability case managers serve an important role in helping employees navigate their way through absence from work. Isolation and loss of routine can be unintended consequences of a medical leave, which can exacerbate many mental health conditions. Ongoing contact with employees while on psychiatric disability can improve motivation and treatment compliance. Overall, maintaining an empathic manner, while holding an employee accountable for his or her own involvement in treatment and recovery, is a helpful, balanced approach to managing psychiatric disability.

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