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**Different workplace-related strains and different workplace-related anxieties  
in different professions**

Running title: workplace-related anxiety and profession

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## **Statement of Clinical Significance**

- Different professions pose different strains on employees.
- Diagnostic of workplace-related anxieties in dependence of different professional settings can be used for planning treatment and concretizing aims of mental health prevention at work.
- Knowing about workplace-related anxieties and their association with different professional fields is essential for occupational and company physicians.

## **Abstract**

**Objective:** Similar to the spectrum of the traditional anxiety disorders, there are also different types of workplace-related anxieties. The question is whether in different professional settings different facets of workplace-related anxieties are predominant.

**Methods:** A convenience sample of 224 inpatients (71% women) from a department of psychosomatic medicine was investigated. They were assessed with a structured diagnostic interview concerning anxiety disorders and specific workplace-related anxieties.

**Results:** Office workers suffer relatively most often from specific social anxiety, insufficiency, and workplace phobia. Service workers suffer predominantly from unspecific social anxiety. Health care workers are characterized by insufficiency, adjustment disorders, PTSD and workplace phobia. Persons in production and education are least often affected by workplace-related anxieties.

**Conclusions:** Different types of anxiety are seen in different professional domains, parallel to workplace characteristics.

## **Introduction**

The workplace is an area in life with many features which can provoke anxiety: There are social hierarchies and conflicts with colleagues or superiors, often described in terms of bullying<sup>1,2</sup>. There may be uncertainty about the professional future and job security<sup>3,4</sup>. There are always demands for achievements which may provoke perceptions of overtaxation or insufficiency and the possibility of failure<sup>5,6</sup>. There can be environmental factors, from aggressive clients to health hazards, which can lead to physical endangerments<sup>7,8</sup>. All this can lead to acute but as well persistent anxiety reactions and even anxiety disorders.

Similar to conventional anxiety disorders, workplace-related anxieties can appear in different psychopathological phenotypes<sup>9</sup>, i.e. panic, social anxiety, hypochondriac anxiety, insufficiency anxiety, generalized worrying, or phobic avoidance. Such different forms of anxiety have different meanings in different professional settings. In service jobs, with many contacts with clients, employees may especially need assertiveness and possibly will have problems if they suffer from social anxiety, while an industrial worker, who coordinates machines, can ignore social anxiety but will be affected especially if he is suffering from generalized worrying about what could go wrong.

Also, different professions are prone to provoke different forms of anxiety. Drivers are prone to experience accidents and develop posttraumatic stress disorders<sup>7</sup>. Employees who work together with others in the same office may experience social conflicts and develop social anxieties<sup>1</sup>. Managers have to fulfill specified expectations which can lead to worrying about their personal insufficiency and possible failure<sup>10</sup>. Persons who work in big institutions have to cope with ambiguous information and decision processes resulting in insecurity<sup>11</sup>.

The conclusion is that there should be differences in the spectrum and prevalence of workplace-related anxieties between professional settings, given the differences in anxiety-provoking stimuli and in the meaning of different anxieties in different contexts. The aim of this study is to investigate quality and pattern of workplace-related anxiety disorders in relation to the kind of profession. This is to our knowledge the first study of this kind. The results can give hints towards risk populations and concretizing directions for prevention.

## **Method**

### *Participants and clinical setting*

A convenience sample of 224 inpatients from a department of psychosomatic medicine was asked for their informed consent to participate in a study on work-related problems. This population was chosen because primary reasons for admission are psychological health problems at work and prolonged sickness absence from work. Therefore, work-related anxieties are overrepresented in this patient group, which allows to study the relation between job characteristics and type of work-related anxieties.

The inclusion rate was 94%. The average age was 46.9 years ( $SD = 9.0$ , range: 21 – 65 years). 71.3% were female.

### *Types of profession*

Professions were grouped in five classes:

- Administration and office jobs (“Office”): These employees work in big institutions, in offices, in contact with many colleagues, often sharing a big room.
- Services, trade, banks and insurances (“Service”): These employees carry out services, do often have contacts with clients and talk to third persons, though mostly only short time.

- Education and culture (“Education”): These employees are confronted with other persons they have to guide and take care of. They also have many social contacts, but rather in a continuous way. This group includes teachers in any type of school or social workers.
- Health care (“Health care”): These persons work in a medical setting, i.e. surgeries, hospitals, outpatient clinics, and have to deal with patients and illness.
- Production and technology (“Production”): These employees work in industrial or technical settings. They work with machines and in technical jobs.

In respect to this classification of jobs, 26.8% of the investigated patients worked in office, 32.6% in service, 9.8% in education, 14.7% in health care, and 16.1% in production.

90.9% of patients were white-collar-workers, 3% blue-collar-worker or unskilled, 3.5% had a leading position, and 2.5% were self-employed. At present, 24.3% of the patients were without a workplace and 3.5% got a disability pension. Patients without a job at present were also included in the study as they were under the perspective of work reintegration.

### *Instruments*

Patients were interviewed with the Mini International Neuropsychiatric Interview<sup>12</sup> MINI, a structured diagnostic assessment of mental disorders according to DSM-IV<sup>13</sup>.

Workplace-related anxiety disorders were assessed with the Work-Anxiety-Interview WAI<sup>9,14</sup> which covers workplace-related situational anxiety, specific social phobia (in relation to specific persons at work), unspecific social phobia, insufficiency anxiety, generalized anxiety, hypochondriac anxiety, adjustment disorder (related to some work problem), posttraumatic stress disorder, and workplace phobia. The criterion for workplace-related anxieties is that the patient sees an immediate relation between the workplace and feelings of anxiety and reacts correspondingly, when confronted with the workplace. This can be so because the patient is

suffering from some conventional anxiety which also affects the workplace, or because there is a special problem only in relation to the workplace.

The self-rating Short Job Analysis Questionnaire<sup>15</sup> was used to explore the characteristics of the work situation. The questionnaire contains 26 items which are grouped in eleven factors: Scope of action, variability, holistic job, social support, co-operation, qualitative stress at work, quantitative stress at work, interruptions while working, environmental stress, information and participation, and benefits.

Additionally, patients were asked for a rating on a scale from 0-100 whether they saw their workplace situation as a risk to their health status. This rating is a global indicator for perceived “workload” and the degree to which a person attributes health problems to the workplace.

Statistical analyses were done with SPSS. Descriptive data are reported.  $\chi^2$ -Tests were calculated for categorical variables (diagnosis of MINI and Work-Anxiety-Interview) and MANOVA for continuous variables (Short Job Analysis Questionnaire, duration of sick leave, perceived workload). Following statistical recommendations by Bortz<sup>16</sup>, a significance level of 10% is interpreted as trend, as this is an exploratory study in an innovative field of research.

## **Results**

In production and technology 69% were men, whereas in all other occupational areas there were mostly females (70-87%). Service workers are youngest, education workers oldest with

a difference of about ten years. There is no statistically significant difference in the average number of working hours per week between professions, although production workers report about five hours more than the others. The subjectively perceived workload is highest in health care. The duration of sick leave before admission is not significantly different across professions because of the large variation, in spite of a range from 5.18 weeks in education to 19.5 in office (Table 1).

[insert table 1 about here]

There are marked differences across professions in the perception of workplace characteristics according to the Short Job Analysis Questionnaire (Table 1). Self determination at work (e.g. decision on what the person does) is rated as worst in office jobs and best in education. Versatility of work (e.g. different and interesting tasks) is lowest in office and service, and highest in education. Social support (I can count on my colleagues) was lowest in office and best in service. Quantitative stress (there is much time pressure) was lowest in office and service and highest in health care and production. Interruptions at work (e.g. I am often interrupted by the telephone) were lowest in service and highest in health care. Environmental stress (e.g. noise) was lowest in office and highest in production. Information and participation (e.g. I am informed about what is going on) was highest in education and similarly low in all other groups. Holistic work (e.g. I have a task and bring it to an end), cooperation (I work together with others), qualitative stress (demands are too high), and development (e.g. I have the chance to be promoted) were similar across groups.

Table 2 gives an overview on the frequencies of conventional anxiety disorders and workplace-related anxieties separate for the five profession groups. In this clinical population about half of the patients fulfil criteria for some anxiety disorder according to the standardized



diagnostic interview, with no statistically significant difference between groups. In respect to single conventional anxiety diagnoses there is an increased rate of panic disorders in service and production workers and hypochondriasis in production.

The rate of workplace-related anxieties is highest in health care professionals (69.7%), office employees (66.7%), and production workers (61.1%), as compared to education (54.5%) and service (46.6%). There are also significant differences in the distribution of workplace-anxiety subtypes. Office workers suffer predominantly from work-related feelings of insufficiency (36.7%), specific social anxiety (30.0%), adjustment disorders (26.7%) and workplace phobia (21.7). Service workers suffer relatively most often from unspecific social anxiety (11.0%). Education workers complain mostly about situational anxieties (31.8%) and general worrying (31.8%). Health care workers are characterized by feelings of insufficiency (36.4%), adjustment disorders (30.3%), worrying (31.8%), situational anxiety (27.3%), PTSD (6.1%) and workplace phobia (21.2%). Production workers complain about worrying (30.6%) and situational anxiety (27.8%). Workplace-related worrying occurs frequently, but equally distributed across all groups.

[insert table 2 about here]

## **Discussion**

Patients report differences in respect to the demands and strains with which they have to cope depending on their profession. Our findings from the Short Job Analysis self-rating are in line with similar reports from the literature: Health care and social professions have been shown to be burdened mostly by social stress<sup>5,17-20</sup>. Further important problems are environmental demands, quantitative work stress, and interruptions<sup>15</sup>. Office employees predominantly

experience social stress, i.e. low scores in social support. This can be explained by the fact that in office jobs and big institutions group interactions play a major role including conflicts, rank fights and communication problems<sup>1</sup>. Similarly, social stress is not seen in professions with short time contacts like service, production/technology, or even education. Health care professionals, office employees and employees in technology/production alike seem to be affected from over all workload. Given this differences, the question is whether this is reflected in differences in the spectrum and or frequency of workplace-related anxiety.

Results from the diagnostic work anxiety interview (WAI) support that workplace-related anxieties are not evenly distributed across different professional groups. Office employees complain relatively often about social anxiety and feelings of insufficiency, as they work in social groups and hierarchies. This is obviously so burdensome, that they show relatively high rates of workplace phobia. Health care workers are another risk group suffering from feelings of insufficiency, adjustment disorders, traumatic anxieties<sup>5,17,19</sup>, to a degree which also results in workplace phobia. Service workers suffer predominantly from unspecific social anxiety, as they are not confronted with special other persons, but rather have to deal with changing social encounters.

These results support the assumption of an interrelation between job characteristics and anxiety profiles. This can be understood as different professions have different risks and as anxiety is to some degree dependent on anxiety-provoking stimuli. Specific social anxiety is activated in contexts with enduring social contacts with group interaction<sup>21</sup>, hierarchies and conflicts (office employees). For situational anxiety, like fear of a computer<sup>22</sup>, the person needs to be confronted with this special object or situation. Hypochondriac anxiety is provoked in a professional setting with environmental dangers, such as in

production/technology, services and education professions<sup>23,24</sup>, but not so much in office work.

An exception is worrying, for which no differences are found across professions. Worrying is a type of anxiety which is not so much triggered by external events (like social anxiety), but rather is a personality trait. These persons foresee problems in any minor daily hassle, they catastrophize little problems independent of their real threatening nature<sup>25</sup>.

This study has several limitations. It is a cross-sectional assessment. It does not give information on the development of workplace-related anxiety. The workplace can cause anxiety, but according to the person-environment-fit model, it could also be that persons with different types of anxiety preparedness choose different professions<sup>11,26,27</sup>. For example, persons who are in need of job security will try to work in an office as civil servants. But, if this thrift hypothesis would be true, there should be greater differences in regard to stimulus-independent worrying than in regard stimulus-dependent anxieties. In any case, there is a need for longitudinal research. The data come from a clinical sample. We have no information on the prevalence of respective anxieties in different professions in the general working population. Further studies in non-clinical samples are needed.

## **Conclusion**

Different professions pose different strains on employees. This seems to be paralleled by different qualities of workplace-related anxiety.

The analysis of anxiety-provoking characteristics of the workplace and the recognition of work-related anxieties in general and of special subtypes in particular is needed, as this type of mental disorder is closely related to work impairment. These disorders require preventive

measures in the workplace by superiors and occupational health management programmes.  
They are in need of special targeted treatment interventions<sup>28</sup>.

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**Table 1.** Perceived workplace characteristics according to the Short Job Analysis Questionnaire, working hours and duration of employment (N=224).

	<b>Office (n=60)</b>	<b>Service (n=73)</b>	<b>Edu- cation (n=22)</b>	<b>Health care (n=33)</b>	<b>Production (n=36)</b>	<b>Sig of difference <i>p</i></b>
<b>Females</b>	82%	77.6%	70%	87%	31%	$\chi^2$ .000
<b>Age</b>	48.9 (8.1)	44.4 (9.3)	52.5 (6.9)	46.9 (9.4)	45.3 (9.3)	<sup>a</sup> .031 <sup>b</sup> .002 <sup>c</sup> .031
<b>Working hours per week (incl. Overwork)</b>	39.29 (6.9)	39.41 (15.1)	40.62 (13.0)	39.31 (8.7)	45.3 (11.7)	
<b>Overwork hours per week</b>	3.33 (4.5)	5.51 (7.5)	4.05 (7.1)	6.67 (8.3)	7.16 (9.7)	<sup>e</sup> .087
<b>Duration of employment at present / last workplace</b>	14.89 (10.9)	9.7 (8.6)	16.84 (12.9)	11.44 (9.3)	11.49 (8.7)	<sup>b</sup> .068
<b>Perceived workload</b>	46.78 (35.2)	38.75 (33.1)	35.0 (34.5)	61.19 (25.8)	47.06 (35.1)	<sup>d</sup> .011 <sup>e</sup> .036
<b>Sick leave duration before admission in weeks</b>	19.5 (40.2)	9.45 (17.8)	5.18 (10.7)	16.64 (21.2)	16.22 (31.9)	
<b>Short Job Analysis Questionnaire</b>						
<b>Self determination</b> <i>0=bad, 4=good</i>	1.85 (1.2)	2.09 (1.3)	2.77 (0.7)	2.0 (1.14)	2.26 (1.2)	<sup>c</sup> .052
<b>Versatility</b> <i>0=bad, 4=good</i>	2.42 (1.13)	2.46 (1.0)	3.28 (0.6)	2.57 (1.16)	2.79 (0.8)	<sup>c</sup> .039 <sup>b</sup> .049
<b>Holistic Job</b> <i>0=bad, 4=good</i>	2.24 (1.27)	2.44 (1.19)	1.93 (1.0)	2.27 (1.23)	2.53 (1.2)	
<b>Social support</b> <i>0=bad, 4=good</i>	1.68 (1.08)	2.34 (1.19)	2.32 (1.0)	1.9 (1.25)	2.16 (1.0)	<sup>a</sup> .046
<b>Cooperation</b> <i>0=bad, 4=good</i>	1.98 (0.99)	2.32 (1.0)	2.43 (0.5)	2.19 (1.1)	2.4 (0.9)	
<b>Qualitative stress at work</b> <i>0= good, 4=bad</i>	1.63 (1.39)	1.27 (1.14)	1.75 (1.25)	1.61 (1.1)	1.97 (1.27)	
<b>Quantitative stress at work</b> <i>0= good, 4=bad</i>	2.4 (1.26)	2.45 (1.18)	2.85 (0.93)	3.37 (1.0)	3.04 (1.06)	<sup>e</sup> .094 <sup>f</sup> .006 <sup>h</sup> .002
<b>Interruptions while working</b> <i>0= good, 4=bad</i>	2.09 (1.12)	1.77 (1.11)	1.55 (1.2)	2.55 (1.28)	2.39 (1.24)	<sup>d</sup> .076 <sup>g</sup> .007 <sup>f</sup> .007 <sup>i</sup> .047
<b>Environmental stress</b>	1.21 (1.31)	1.74 (1.33)	1.63 (1.17)	2.01 (1.39)	2.36 (1.46)	<sup>e</sup> .002

<i>0= good, 4=bad</i>						
<b>Information &amp; participation</b>	1.6 (1.04)	1.78 (1.0)	2.53 (0.9)	1.86 (1.13)	1.77 (1.0)	<sup>i</sup> .059 <sup>b</sup> .029 <sup>c</sup> .003
<i>0=bad, 4=good</i>						
<b>Development</b>	1.28 (1.0)	1.17 (1.13)	1.65 (0.7)	1.18 (1.0)	1.43 (1.1)	
<i>0=bad, 4=good</i>						

Short Job Analysis Questionnaire: Means (SD) Rating from 0-4 no agreement – full agreement

<sup>a</sup> office vs service; <sup>b</sup> education vs service; <sup>c</sup> office vs education; <sup>d</sup> service vs production; <sup>e</sup> office vs production; <sup>f</sup> service vs health care; <sup>g</sup> education vs health care; <sup>h</sup> office vs health care;

<sup>i</sup> education vs production

<sup>o</sup>  $\chi^2$  overall significance of group difference

(MANOVA with post-hoc pairwise comparison and Bonferroni adjustment, controlled for age and sex. ANOVA for age,  $\chi^2$ -Test for sex).



**Table 2.** Anxiety disorders and workplace-related anxiety diagnosis in psychosomatic rehabilitation inpatients (N=224) according to the Mini International Neuropsychiatric Interview (MINI) and the Mini Work-Anxiety-Interview (WAI). *N* and relative frequencies in per cent for categorical variables and mean (standard deviation) for continuous variables

	Office (n=60)	Service (n=73)	Education (n=22)	Health care (n=33)	Production (n=36)	2-tailed sign. of difference X <sup>2</sup> -Test with <i>p</i> -value Bonferroni- adjusted
<b>Percentage of patients from the subgroup who have any conventional anxiety diagnosis (MINI)</b>	26 43.3%	40 54.8%	11 50.0%	16 48.5%	21 58.4%	.610
<b>Panic Disorder</b>	4 6.6%	16 21.9%	1 4.5%	2 6.1%	6 16.7	.033
<b>Agoraphobia</b>	10 16.7%	17 23.3%	2 9.1%	7 21.2%	8 22.2%	.608
<b>Social Phobia</b>	5 8.3%	7 9.6%	0 0%	2 6.1%	4 11.1%	.591
<b>Generalised Anxiety Disorder</b>	11 18.3%	13 17.8%	5 22.7%	6 18.2%	4 11.1%	.830
<b>Hypochondriasis</b>	3 5.0%	3 4.1%	1 4.5%	2 6.0%	7 19.4%	.042
<b>Anxiety and Depression mixed</b>	9 15.0%	7 9.6%	2 9.1%	1 3.0%	4 11.1%	.488
<b>PTSD</b>	0 0%	3 4.1%	2 9.0%	0 0%	1 2.8%	.158
<b>Obsessive Compulsive Disorder</b>	2 3.3%	4 5.5%	0 0.0%	4 12.1%	2 5.6%	.318
<b>Percentage of patients from the subgroup who have any workplace-related anxiety diagnosis (WAI)</b>	40 66.7%	34 46.6%	12 54.5%	23 69.7%	22 61.1%	.096
<b>Workplace-related situational anxiety</b>	7 11.7%	13 17.8%	7 31.8%	9 27.3%	10 27.8%	.135
<b>Workplace-related specific social anxiety</b>	18 30.0%	10 13.7%	3 13.6%	5 15.2%	2 5.6%	.023
<b>Workplace-related unspecific social anxiety</b>	2 3,3%	8 11,0%	0 0%	0 0%	2 5,6%	.087
<b>Workplace-related anxiety of insufficiency</b>	22 36.7%	15 20.5%	2 9.1%	12 36.4%	8 22.2%	.041
<b>Workplace-related</b>	21	19	7	11	11	.846

<b>generalised worrying</b>	35.0%	26.0%	31.8%	33.3%	30.6%	
<b>Workplace-related hypochondriac anxiety</b>	2 3.3%	9 12.3%	4 18.2%	2 6.1%	6 16.7%	.126
<b>Workplace-related adjustment disorder with anxiety</b>	16 26.7%	10 13.7%	4 18.2%	10 30.3%	3 8.3%	.062
<b>Workplace-related PTSD</b>	0 0%	0 0%	0 0%	2 6.1%	1 2.8%	.083
<b>Workplace phobia</b>	13 21.7%	12 16.4%	2 9.1%	7 21.2%	4 11.1%	.521