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A GUIDE FOR PEOPLE LEADERS

Supporting Employees with Anxiety Disorders

Understanding the most common mental health conditions on your team: what anxiety disorders are, how they show up at work, the conditions that travel with them, and the practical strategies and accommodations that help people do their best work.

INSIDE Anxiety 101 • Signs & symptoms • Co-occurring conditions • Strategies • Accommodations • Scripts & panic response • Quick reference

June 2026 • Companion to "Supporting Employees with ADHD" • For educational purposes — not medical or legal advice.

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1. Why This Guide Matters

Anxiety disorders are the **most common mental health conditions in the world**. Nearly **1 in 5 adults** meets criteria in any given year, and roughly **1 in 3 will at some point in their lives** — women at about twice the rate of men. On any team of meaningful size, someone is managing an anxiety disorder right now. Most of them you would never suspect: anxiety hides well behind diligence.

The business stakes are larger than most leaders realize. The World Health Organization estimates that depression and anxiety cost the global economy **12 billion working days and roughly US$1 trillion in lost productivity every year** — and that only about **1 in 4 people with an anxiety disorder ever receives treatment**. The rest are at work, compensating, often at high personal cost.

Here is the leadership insight that makes this guide practical: **anxiety feeds on ambiguity**. Vague expectations, unexplained meeting invites, silence after a deliverable, shifting priorities — these are background noise to some employees and threat signals to an anxious brain. The reverse is also true: clarity, predictability, and specific feedback are among the most powerful anti-anxiety tools that exist, and they are entirely within your control. They also happen to be the habits of excellent management in general.

> **You don't need a diagnosis to manage well**
>
> Everything in this guide is simply good management: clear expectations, advance notice, specific feedback, realistic workloads, psychological safety. These practices help everyone and single out no one. Never wait for — or ask about — a diagnosis before making work more navigable. Manage the barriers you can see, not the label you can't.

This guide pairs with **Supporting Employees with ADHD**: the two conditions co-occur frequently (around half of adults with ADHD also have an anxiety disorder), and the management approaches reinforce each other. As before, this guide will help you understand, support, and lead — it will **not** equip you to diagnose anyone, and Section 5 explains why you shouldn't try.

2. Anxiety 101: What It Is — and What It Isn't

A threat-detection system stuck on high

Anxiety itself is not a malfunction — it is the brain's **threat-detection and preparation system**, built around the amygdala and the body's fight-or-flight machinery. In the right dose it is useful: it's why people prepare for presentations and double-check contracts. An **anxiety disorder** is what happens when that system becomes stuck on high — firing persistently, out of proportion to any real threat, and interfering with life and work. The alarm is real even when the danger is not: heart racing, muscles braced, thoughts looping, sleep broken.

Anxiety disorders arise from a mix of genetics (moderate heritability, roughly 30–40%), temperament, life experience, and stress load. They typically begin **early in life** — childhood or adolescence is the most common onset — which means many adults have spent decades building elaborate coping and concealment skills before they ever reach your team.

The single most important clinical fact for a manager: anxiety disorders are among the most treatable conditions in psychiatry. Cognitive-behavioral therapy and modern medications produce strong response rates. The tragedy is the treatment gap — most affected people never seek help, often because of stigma or fear of being seen as weak. A workplace where mental health support is normalized materially changes that calculus.

Normal stress vs. an anxiety disorder

Everyone experiences stress and situational worry. Three markers distinguish a disorder: it is persistent (months, not days), excessive (out of proportion to the trigger, or present without one), and impairing (it measurably interferes with work, relationships, sleep, or health). Stress fades when the stressor passes; an anxiety disorder hums along regardless — and often spikes hardest when everything looks fine on paper.

The major anxiety disorders

Disorder	Core picture	How it often surfaces at work
Generalized anxiety disorder (GAD)	Chronic, hard-to-control worry across many domains for 6+ months, with restlessness, fatigue, muscle tension, irritability, poor concentration, and disrupted sleep. ~3% of adults per year.	Catastrophizing project risks; over-checking; difficulty tolerating uncertainty or ambiguous direction; tension and exhaustion that have no obvious cause.
Social anxiety disorder	Intense fear of being judged, embarrassed, or negatively evaluated. ~7% of adults per year — the most common after phobias.	Dread of presentations and meetings; avoids speaking up despite having the best idea in the room; skips networking, visibility, even promotions.

Disorder	Core picture	How it often surfaces at work
Panic disorder	Recurrent, unexpected panic attacks — sudden surges of intense fear with pounding heart, chest tightness, dizziness, breathlessness — plus persistent worry about the next one. ~2–3% per year.	May leave meetings abruptly; avoids situations associated with past attacks (commutes, elevators, crowded rooms); occasional ER visits for what feels like a heart problem.
Specific phobias & agoraphobia	Intense fear of particular situations or objects (flying, heights, enclosed spaces; or of being somewhere escape feels hard).	Often invisible until the role collides with the fear — a promotion that requires air travel, a move to a high-rise office.

Two related conditions — **obsessive-compulsive disorder (OCD)** and **post-traumatic stress disorder (PTSD)** — are classified separately in the DSM-5-TR but share anxiety's machinery and frequently co-occur with it. The management principles in this guide apply to them as well.

Myths vs. facts

Myth	Fact
"Anxiety is just stress — everyone has it."	Stress is situational and fades with the stressor. An anxiety disorder is persistent, excessive, and impairing — a difference of degree so large it becomes a difference of kind.
"Anxious people are fragile and can't handle pressure."	Many of the most reliable, highest-performing people on any team have anxiety disorders — often because of relentless over-preparation. The cost is hidden, not the competence.
"They could calm down if they really wanted to."	Telling an activated threat system to relax doesn't reach it — it adds shame on top of fear. Regulation comes from safety, structure, and treatment, not willpower.
"It's all in their head."	Anxiety is profoundly physical: muscle tension, GI distress, headaches, racing heart, fatigue, insomnia. Many people see doctors for years before anyone names the cause.
"Avoiding a task means they're lazy or uncommitted."	Avoidance is the signature behavior of anxiety — it soothes in the moment and grows the fear long-term. Address the barrier, not the character.
"Therapy and medication are crutches."	Anxiety disorders are among the most treatable conditions in psychiatry. Treatment choices are private medical decisions — never a manager's business to suggest or question.

3. Signs and Symptoms at Work

Anxiety at work rarely announces itself. It usually wears a disguise — and the most common disguise is **excellence**. Below are the patterns to recognize. The same cautions as always: everyone shows some of these sometimes; what matters is persistence, intensity, and cost. And this list exists to build empathy and better systems, **never to diagnose colleagues**.

Pattern	How it can show up at work
Worry & rumination	Replays conversations for days; catastrophizes small signals ("my boss said 'fine' — what did that mean?"); imagines worst-case outcomes of routine decisions; struggles to let resolved issues stay resolved.
Perfectionism & over-checking	Triple-checks work that was right the first time; polishes past the point of value; misses deadlines not from doing too little but from being unable to call it done; drafts and redrafts simple emails.
Avoidance	Procrastinates anxiety-provoking tasks — difficult calls, conflict, asking for help; dodges presentations and big meetings; delays opening feedback emails; takes the long way around a feared situation.
Reassurance-seeking	Frequent "just checking this is okay?" messages; difficulty acting without sign-off; asks the same question in different forms; needs explicit confirmation that silence doesn't mean trouble.
Physical symptoms	Tension headaches, stomach and GI trouble, fatigue from broken sleep, racing heart, jaw and shoulder tension; sick days that cluster around high-pressure moments.
Concentration problems	Worry consumes working memory — rereads the same paragraph, loses the thread mid-meeting, agonizes over small decisions. Can look identical to ADHD inattention (see Section 4).
Irritability	Snappish or brittle when stretched; reads neutral messages as criticism; apologizes excessively afterward.
Overcommitment	Says yes to everything for fear of disappointing; volunteers, then quietly drowns; works early and late as a safety behavior rather than a workload necessity.
Presenteeism	Always online, always responsive — while actual output quietly declines. Visibility becomes armor: being seen working feels safer than working.

“High-functioning anxiety” is still anxiety

The employee you should think about may be your best one: early to every meeting, immaculate work, never says no. Hyper-reliability can be the disorder — performance powered by fear of failure rather than by sustainable motivation. It works until it doesn’t; the crash arrives as burnout, sudden resignation, or health collapse, and it blindsides every manager who mistook the coping for thriving. If someone’s diligence looks effortful and joyless, get curious before you get another quarter of output from it.

Panic attacks: what they are and what to do

A panic attack is a sudden surge of intense fear that peaks within minutes: pounding heart, chest tightness, shortness of breath, dizziness, trembling, sweating, a feeling of unreality or of losing control. It is **not dangerous, but it feels like dying** — many people’s first attack ends in an emergency room with a suspected heart attack. Attacks pass, usually within 10–20 minutes. If a team member has one at work:

1. **Stay calm and stay with them.** Your steadiness is the intervention. Speak slowly, in short sentences.
2. **Offer a quieter space** — “Want to step out with me?” — but don’t force movement or crowd them.
3. **Don’t flood them with questions.** “You’re safe. This will pass. I’m right here” beats interrogation. Ask once: “What helps?”
4. **Let them lead the recovery.** Water, fresh air, a few minutes alone — follow their cues.
5. **Afterward, no spotlight.** A brief private “glad you’re okay — anything you need from me?” and back to normal. Don’t announce it, don’t hover for days.
6. **New, severe chest pain is a medical event** until proven otherwise. If the person has no panic history, is unsure, or asks for help — treat it as medical and get help. Never diagnose “just a panic attack” yourself.

4. Common Co-Occurring Conditions

Like ADHD, anxiety rarely travels alone — and the combinations shape what you actually see at work. Figures below are approximate ranges from large studies; individuals vary.

Depression — the most frequent companion

Anxiety and depression are deeply intertwined: **roughly half or more of people with an anxiety disorder will also experience depression**, and chronic anxiety is one of the strongest predictors of a later depressive episode. The combination — sometimes called anxious depression — tends to look like exhausted worry: the dread is still running, but the energy and hope that fueled over-preparation are gone.

Watch for the shift from baseline: an anxious-but-driven employee who goes flat. Output drops across the board, enthusiasm disappears, they stop fighting for quality they used to over-deliver on, they withdraw from people. That pattern change — not any single bad week — is the signal that warrants a caring check-in and a pointer to support (EAP, benefits).

> **If someone signals real distress**
>
> If an employee mentions hopelessness, feeling like a burden, or thoughts of self-harm — take it seriously, every time. You don't need the perfect words: listen without judgment, thank them for telling you, and connect them with professional support (your EAP, their doctor; in the U.S., the 988 Suicide & Crisis Lifeline; emergency services if there is immediate danger). Then loop in HR for guidance. Your job is connection and a warm handoff — never assessment, counseling, or secrecy promises you can't keep.

ADHD

Around **half of adults with ADHD also have an anxiety disorder**, and the overlap runs both ways — chronic anxiety also impairs concentration and working memory, so the two can mimic and mask each other. The combined picture: someone who over-prepares yet still misses deadlines, is perfectionistic yet disorganized, and runs on worry as a substitute for executive function. Pressure tips this person into paralysis; structure plus reassurance unlocks them. (See the companion guide, **Supporting Employees with ADHD**, for the full picture.)

Sleep problems

Insomnia and anxiety form a tight loop: worry delays sleep, short sleep amplifies next-day anxiety, repeat. A majority of people with anxiety disorders report significant sleep disturbance. The practical workplace translation: morning fog, afternoon recovery, and a strong return on flexible scheduling and on not scheduling high-stakes confrontations at 8:00 a.m.

Substance use

Roughly **1 in 5 people with an anxiety disorder** also has a substance use problem at some point — most commonly alcohol, used as self-medication for social situations or sleep. It works briefly and worsens everything after. Handle concerns as you would for any employee: privately, without assumptions, through HR and EAP channels.

Physical health conditions

Anxiety has real physiological weight: elevated rates of irritable bowel syndrome, migraine, chronic pain, and cardiovascular strain. Two implications for managers. First, recurring physical complaints and medical appointments may all be one condition, not flakiness. Second, never play diagnostician in either direction — just make flexibility for healthcare normal and unremarkable.

Burnout

Burnout is an occupational phenomenon rather than a clinical diagnosis, but anxiety accelerates it dramatically: the anxious employee runs hotter at the same workload — over-preparing, over-checking, never truly off. The loop is predictable: **anxiety drives overwork → overwork erodes recovery → exhaustion amplifies anxiety**. Workload design, real vacations that aren't punished, and explicit "good enough" standards are anti-burnout infrastructure for your whole team and life support for your anxious high performers.

5. Your Role — and Its Limits

You manage performance, not diagnoses

Exactly as with ADHD: your job is expectations, barriers, feedback, and support — **never** identifying, suggesting, or probing for a medical condition. “You seem really anxious lately — have you talked to anyone?” feels kind and lands as exposure. Address work and wellbeing; leave labels alone.

Never do the following

- Suggest an employee has anxiety or any condition, or recommend therapy or medication.
- Ask whether someone has a diagnosis, takes medication, or is in treatment.
- Share a disclosure with anyone beyond HR partners who need to know.
- Treat a disclosure as fragility — quietly removing opportunities, visibility, or stretch assignments “to protect them.” That is discrimination wearing kindness as a costume.
- Force exposure as amateur therapy (“I cold-call him in meetings to build his confidence”). Graduated challenge works only with consent and support.

If an employee discloses an anxiety disorder

1. **Thank them.** “Thank you for trusting me with that — I know it’s not easy to say.”
2. **Keep it confidential,** and say so explicitly: “This stays between us and HR if you choose to involve them.”
3. **Ask, don’t assume.** “What tends to help? What about how we work makes things harder?” Anxiety is heterogeneous — one person needs advance notice, another needs fewer check-ins, not more.
4. **Make immediate adjustments** within your authority — meeting formats, scheduling context, written expectations.
5. **Offer the formal route** through HR for accommodations, without pushing.
6. **Keep expectations intact.** Flex the path, not the standard. Continued trust in their competence is itself therapeutic; lowered expectations confirm their worst fears.

The legal landscape (in brief)

In the U.S., anxiety disorders can qualify as disabilities under the **Americans with Disabilities Act** when they substantially limit major life activities (concentrating, sleeping, interacting with others). For covered employers (15+ employees) the same framework applies as in the ADHD guide: **reasonable accommodations** absent undue hardship, a good-faith **interactive process**, strict **confidentiality** of medical information, and **no retaliation**. An employee doesn’t need legal vocabulary to trigger the process — “my anxiety is making the open office

unworkable” can be enough. Loop in HR early; similar protections exist in other jurisdictions (UK Equality Act 2010, Canadian human rights codes).

> **Disclaimer**
> This section is a general orientation, not legal advice. Laws vary by jurisdiction and facts matter. Always involve your HR partner or employment counsel on specific situations.

6. Day-to-Day Management Strategies

One principle organizes everything in this section: **ambiguity is fuel for anxiety, and clarity is kindness**. Each practice below removes a source of uncertainty. As with the ADHD strategies, this is universal design — these habits make work better for everyone and single out no one.

Kill ambiguity at the source

- **Give context when you schedule.** "Got 15 minutes tomorrow?" detonates in an anxious brain. "Got 15 minutes tomorrow to plan the Q3 timeline? Nothing's wrong" costs you four seconds and saves them a sleepless night.
- **Define "done" and "good enough."** Perfectionism expands to fill undefined quality bars. "B+ and shipped Friday beats A+ and late" is management, not lowered standards.
- **Make priorities explicit and singular.** "Everything is urgent" forces anxious triage-by-dread.
- **Never go silent after a deliverable.** To an anxious brain, silence is data — and the data says "bad." A two-word "Got it, looks good" closes the loop.

Feedback that calms instead of spikes

- **Specific, behavioral, prompt, private** — the same formula as the ADHD guide, for overlapping reasons: vagueness gets filled with catastrophe.
- **Lead with the headline.** "This is solid; two fixes before it ships" — state the overall verdict first so they aren't scanning for doom while you talk.
- **Make positive feedback concrete and routine.** Anxious employees discount praise as politeness. "Your risk analysis caught what the client missed" is evidence; "great job!" is noise.
- **React calmly to mistakes.** Your response to one person's error is watched by every anxious brain on the team and sets the price of honesty.

Meetings and visibility

- **Agendas in advance, always.** Over-preparers will over-prepare regardless; an agenda lets them do it efficiently and sleep the night before.
- **Retire the surprise cold-call.** "Let's go around the room" and "Sarah, thoughts?" without warning are social-anxiety landmines. Instead, flag contributions ahead: "I'd love your take on X tomorrow."
- **Create async lanes.** Written input after the meeting, shared docs, chat threads — some of your best thinking is currently trapped behind a fear of speaking up.
- **Build visibility gradually and consensually.** Small-room wins before big-stage moments; co-presenting before solo; always agreed, never sprung.

Workload and the overcommitment trap

- **Watch your volunteers.** The person who never says no may be the one least able to. Periodically audit actual load, not accepted load.
- **Make "my plate is full" a safe sentence.** Praise it publicly the first time someone says it.
- **Timebox polish.** Give perfectionists explicit stop signals: "Two review passes, then ship."
- **Set milestone check-ins** so course-correction happens early and calmly rather than at the deadline cliff.

Change and uncertainty

- **Give the most advance notice you can** about reorgs, role changes, new tools, office moves.
- **Say what you know, what you don't, and when you'll know more.** A confident "no update until Friday" beats drip-fed fragments that feed rumination.
- **Keep routines stable where you can.** Predictable 1:1 cadence, consistent formats. Canceling a 1:1 without a word reads as threat; "bumping us to Thursday — nothing's wrong" doesn't.

Model what you want to normalize

- **Take real breaks and vacations, visibly.** Your team treats your behavior as the real policy.
- **Speak about therapy and EAP neutrally,** the way you'd mention a dentist appointment, so using support carries no tax.
- **Admit your own mistakes plainly.** Every unpunished imperfection lowers the ambient threat level.

7. Reasonable Accommodations

As with ADHD, most anxiety accommodations are inexpensive — in JAN employer surveys, **about half of all accommodations cost nothing**. The pattern differs, though: ADHD accommodations mostly add structure; anxiety accommodations mostly **reduce uncertainty and threat**. Many employees need both.

Challenge	Accommodations that help
Uncertainty & worry	Expectations and assignments in writing; advance notice of changes; scheduled (not surprise) check-ins; explicit evaluation criteria; context given with meeting invites.
Meetings & visibility	Agendas in advance; advance warning before being asked to present or speak; async contribution options; gradual, agreed build-up to high-visibility tasks; camera flexibility on video calls.
Treatment & recovery	Flexible scheduling for therapy appointments (often weekly, same slot); time off for treatment; gradual return-to-work after leave; check-in adjustments during medication changes.
Environment & overstimulation	Quiet or low-traffic workspace; noise-cancelling headphones; remote days; access to a private space for grounding or panic recovery.
Acute episodes	Brief breaks without interrogation; private recovery space; a discreet signal the employee can use to step out of meetings; patience with occasional rough mornings after sleepless nights.
Workload & pacing	Milestone deadlines; a single prioritized task list; periodic workload reviews; explicit “good enough” definitions; protected lunch and end-of-day boundaries.

Process tip: same as ADHD — openness and speed, not adjudication. Try adjustments, iterate, involve HR for anything formal. The accommodation conversation itself, handled warmly, reduces the anxiety it is about.

8. Conversation Scripts

Anxious brains parse every word for threat, so wording matters even more than usual. Adapt these to your voice.

Checking in on someone who seems to be struggling

> *"You've seemed stretched lately, and I wanted to check in — no agenda, and nothing's wrong with your work. You don't have to share anything personal. I just want to make sure the job is set up to support you. What's weighing on you most right now, and is there anything I can take off your plate or make clearer?"*
>
> Why it works: rules out the feared interpretations up front ("nothing's wrong with your work"), makes sharing optional, and offers concrete help without requiring any disclosure.

Responding to a disclosure

> *"Thank you for trusting me with that — seriously. It stays between us, and HR only if you want their help. Can you tell me what tends to help you do your best work, and what about how we operate makes things harder? Some things I can change this week. And nothing about how I see your work changes — you've been excellent, and that's still true."*
>
> Why it works: gratitude, explicit confidentiality, the employee as expert — plus the reassurance an anxious discloser is silently desperate for: that disclosure didn't just cost them your respect.

During a panic attack

> *"I'm right here. You're safe — this will pass. Want to step somewhere quieter with me? Take all the time you need; I've got the room covered. What usually helps?"*
>
> Short sentences, slow voice, one question. Afterward, privately: "Glad you're okay. Anything you need from me?" — then back to normal, no spotlight. New or unexplained chest pain: treat as medical.

Phrases to retire

Instead of…	Try…
“Relax / calm down / don’t worry so much.”	“What would make this feel more doable?”
“We need to talk.” (no context)	“Quick sync tomorrow on the Q3 plan? Nothing’s wrong — just scheduling.”
“You’re overthinking it.”	“Here’s exactly what done looks like: X, Y, Z. That’s the whole bar.”
“Why are you so quiet in meetings?”	(Privately) “Your read on X is sharp — want me to flag it on tomorrow’s agenda so you can bring it?”
“Everyone gets stressed.”	“That sounds heavy. What would help — and what can I take off your plate?”
“Are you seeing someone for this?” / “Have you tried meditation?”	(Nothing. Never appropriate.) “Our EAP is there for everyone, no questions asked — I use the benefits portal myself.”

9. Quick Reference: Do & Don’t

A one-page summary to keep handy.

Do	Don’t
Give context whenever you schedule time with someone.	Send “we need to talk” and let them marinate overnight.
Put expectations, priorities, and quality bars in writing.	Leave “good enough” undefined for a perfectionist.
Close every loop — acknowledge deliverables, even with two words.	Go silent and let silence be interpreted.
Share agendas and flag asks before meetings.	Cold-call people or spring presentations on them.
Give advance notice of changes; say when you’ll know more.	Drip-feed alarming fragments of news.
Lead feedback with the headline verdict, then specifics.	Bury the verdict while they scan for doom.
Watch real workloads — especially your volunteers’.	Reward never-saying-no until the person breaks.
Keep disclosures confidential; involve HR for formal accommodations.	Diagnose, suggest therapy, or ask about medication.
Keep standards and opportunities intact; flex the path.	“Protect” people out of visibility, stretch roles, or promotion.
Stay calm in the storm — your steadiness is contagious.	Match their urgency with your own.

10. Resources & References

For managers and HR

- **Job Accommodation Network (JAN) — askjan.org.** Free expert guidance on accommodations for anxiety and other conditions.
- **EEOC — eeoc.gov.** U.S. guidance on the ADA, reasonable accommodation, and mental health conditions at work.
- **ADAA — adaa.org.** Anxiety and Depression Association of America: evidence-based education and workplace resources.
- **NIMH — nimh.nih.gov.** National Institute of Mental Health: authoritative statistics and plain-language condition guides.
- **NAMI — nami.org.** National Alliance on Mental Illness: education, helpline, and workplace mental health programs.
- **988 Suicide & Crisis Lifeline (U.S.) — call or text 988.** For any employee in acute distress; know it exists before you need it.
- **Your EAP and benefits team.** Know the offerings well enough to signpost them naturally and without prying.

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> **About this guide**
>
> This guide is for general educational purposes. It is not medical, psychiatric, or legal advice, and it is not a tool for identifying anxiety disorders in yourself or others. Diagnosis and treatment belong to qualified clinicians; accommodation decisions belong with HR and counsel. If an employee appears to be in significant distress, your role is human connection and a warm handoff to professional support — your EAP, their doctor, the 988 Lifeline (U.S.), or emergency services if there is immediate danger.