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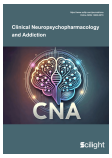

Article

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Occupational stress, Glossophobia, and Impostor Cognitions: An Integrative Clinical Case Study of Anxiety and Maladaptive Psychotropic Coping

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Abstract: The contemporary world is marked by the rise of social networks and increased professional demands, generating considerable pressure on individuals. Among the most common psychological disorders are glossophobia, impostor syndrome, and anxiety, which significantly influence personal and professional life. This clinical case study explores these disorders in depth by analyzing the psychological and behavioral manifestations in a patient confronted with a stressful professional environment. Clinical assessment included semi-structured interviews and validated psychometric instruments, including the Hamilton Anxiety Rating Scale, Rosenberg Self-Esteem Scale, Cungi Stress Reaction Scale, 16PF, DSM-5 criteria, and MINI assessment. The findings highlight the interconnection between occupational stress, professional expectations, personality, and the manifestation of psychological disorders. This analysis underscores the need for a multidimensional approach to help individuals overcome these challenges.

Keywords: glossophobia; impostor syndrome; personality; coping; psychic dynamics

1. Introduction

In contemporary professional environments, individuals are increasingly exposed to heightened performance demands, continuous evaluation, and social comparison, factors that contribute to significant psychological pressure and vulnerability to mental health difficulties [1]. Such environments, characterized by competitiveness and performance accountability, may exacerbate stress-related disorders and negatively affect both wellbeing and occupational functioning.

Among the psychological difficulties emerging in these contexts, glossophobia (fear of public speaking) and impostor syndrome have received growing attention due to their high impact on anxiety, occupational functioning, and self-esteem [2,3]. Glossophobia is characterized by intense fear, physiological arousal, and avoidance of speaking situations [4,5]. Impostor syndrome, initially described by Clance and Imes [6], refers to persistent self-doubt and difficulties internalizing success despite objective competence. Although these phenomena have been widely studied independently, their interaction remains insufficiently explored in clinical settings. Emerging evidence suggests that impostor-related cognitions may intensify anticipatory anxiety and fear of negative evaluation in performance situations, thereby reinforcing avoidance behaviors and psychological distress [7].

From a theoretical perspective, this interaction may be understood through cognitive behavioral models emphasizing maladaptive beliefs, cognitive distortions, and avoidance processes [8,9], as well as stress and coping theories highlighting the role of cognitive appraisal and adaptive resources [10].

Rather than proposing a formal explanatory model, the present case suggests a reciprocal interaction between occupational stress, maladaptive coping strategies, impostor-related cognitions, and anxiety symptoms. These

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processes appeared to reinforce each other progressively over time. Understanding these interactions may contribute to improved clinical assessment and prevention strategies in occupational mental health settings.

This study is presented as an exploratory clinical case study aiming to analyze the interaction between occupational stress, impostor syndrome, glossophobia, and maladaptive psychotropic use in a professional context. The objective is not to establish causal relationships but to provide an in-depth clinical understanding of the psychological and behavioral mechanisms associated with chronic occupational stress and self-medication practices.

Although glossophobia, impostor syndrome, and occupational stress have each been extensively studied, their combined interaction in clinical settings remains insufficiently explored. In particular, few studies have examined how chronic workplace stress may intensify performance anxiety, impostor-related cognitions, and maladaptive psychotropic coping strategies within the same clinical trajectory.

Clinical assessment included semi-structured interviews and validated psychometric instruments, including the Hamilton Anxiety Rating Scale [11], Rosenberg Self-Esteem Scale [12], Cungi Stress Reaction Scale [13], 16PF, DSM-5 criteria, and MINI assessment.

2. Theoretical Framework

2.1. Glossophobia

Glossophobia refers to an intense and persistent fear of public speaking and is commonly conceptualized as a specific manifestation of social anxiety disorder [1,5]. It is characterized by significant physiological arousal, including excessive sweating, tremors, tachycardia, dry mouth, and gastrointestinal discomfort, reflecting activation of the autonomic nervous system in response to perceived social threat.

Beyond its physiological expression, glossophobia involves complex cognitive and emotional processes. Individuals experiencing this condition typically report anticipatory anxiety, which may range from mild nervousness to overwhelming fear prior to speaking situations [2]. This anticipatory phase is often dominated by maladaptive cognitions such as catastrophizing (e.g., “I will fail publicly”), overgeneralization, and heightened self-focused attention [9].

These cognitive distortions contribute to intense psychological distress, including feelings of inferiority, shame, and guilt associated with perceived failure to meet social or professional expectations. Moreover, a lack of self-confidence and an exaggerated fear of negative evaluation play a central role in maintaining the disorder [7]. As a result, individuals tend to engage in avoidance behaviors or rely on safety strategies, which, although temporarily reducing anxiety, ultimately reinforce the fear over time.

Consequently, glossophobia may significantly impair academic and professional functioning by limiting participation, reducing performance quality, and restricting opportunities for personal and career development.

2.2. Impostor Syndrome

Introduced in 1978 by Pauline Rose Clance and Suzanne Imes, impostor syndrome is characterized by chronic doubt about one’s own abilities and a persistent fear of being exposed as an “impostor”. Despite tangible evidence of competence or success, affected individuals attribute their achievements to external factors such as luck or overestimation of their abilities.

Individuals experiencing this phenomenon tend to attribute their achievements to external or unstable factors such as luck, effort, or misjudgment by others, rather than to their own abilities [14]. This cognitive distortion reflects deeply rooted maladaptive schemas related to self-worth, perfectionism, and conditional self-esteem.

Impostor syndrome is particularly prevalent among high-achieving individuals and has been associated with a wide range of negative psychological outcomes, including anxiety, depressive symptoms, emotional exhaustion, and burnout [3]. It manifests through several characteristic cognitive and behavioral patterns:

- Excessive overwork as a compensatory strategy
- Emotional masking due to fear of negative judgment
- Constant need for external validation
- Low self-confidence and avoidance of self-assertion
- Heightened sensitivity to criticism and evaluation

Individuals with impostor syndrome maintain negative thought patterns such as: “If I succeed, it’s due to luck, not my skills”; “Any recognition of my work is undeserved”; “To be legitimate, I must master everything before acting”.

These beliefs contribute to a fragile sense of identity and reinforce a cycle of self-doubt and psychological distress.

2.3. Conceptual Link between Glossophobia and Impostor Syndrome

While glossophobia primarily concerns the fear of public speaking and social evaluation, impostor syndrome relates to a deeper sense of illegitimacy and internalized self-doubt. However, both constructs share common cognitive and emotional vulnerabilities, including fear of negative evaluation, low perceived self-efficacy, and maladaptive core beliefs.

From a cognitive behavioral perspective, impostor beliefs may amplify anticipatory anxiety in performance situations, thereby increasing vulnerability to glossophobia. Conversely, repeated experiences of anxiety or perceived failure in public speaking contexts may reinforce impostor cognitions, creating a self-perpetuating cycle of avoidance, distress, and reduced self-efficacy.

This interaction highlights the importance of adopting an integrative perspective to better understand the underlying psychological mechanisms and their implications for mental health.

3. Clinical Case Presentation

3.1. Biographical Data

Ms. A., 37-year-old single woman with a degree in economics, has been working for 11 years in a wiring company. She comes from a large family of seven children and reports a successful academic trajectory with no significant difficulties. She describes herself as sociable and well-regarded by her teachers. Presented with chronic stress, anxiety, and reduced self-confidence.

3.2. History of the Problem

Ms. A., a 37-years-old women employed in a wiring company for 11 years, reported progressive psychological distress associated with a highly stressful professional environment characterized by interpersonal conflict, perceived discrimination, and workplace tension.

Over time, occupational stress was associated with somatic symptoms including headaches, gastrointestinal disturbances, eczema, tachycardia, chronic fatigue, and persistent sleep difficulties. Emotional manifestations included anxiety, reduced self-confidence, demotivation, concentration difficulties, and anticipatory fear in evaluative situations.

In response to worsening anxiety and insomnia, she consulted a general practitioner who prescribed short-term anxiolytic treatment (Stresam 50 mg/day) and hypnotic medication (Stilnox 10 mg at bedtime), in addition to supplementation for anemia and vitamin D deficiency. The use of anxiolytic and hypnotic medications appeared to function as a maladaptive coping strategy aimed at reducing hyperarousal, anticipatory anxiety, and sleep disturbances.

Although these medications may provide temporary symptomatic relief through modulation of GABAergic neurotransmission, prolonged or irregular use may reinforce avoidance behaviors and psychological reliance on medication. After nearly two years of sleep disturbances, the patient reported partial symptomatic relief but progressively developed irregular self-medication behaviors, occasionally increasing doses following particularly stressful workdays.

The patient also reported intense fear of evaluation, avoidance of public speaking situations, and recurrent self-doubt consistent with impostor-related cognitions.

3.3. Clinical Findings

The patient described a professional environment marked by chronic stress, interpersonal conflict, perceived workplace hostility, and emotional exhaustion. Clinical manifestations included persistent anxiety, sleep disturbances, somatic complaints, reduced motivation, low self-esteem, and avoidance behaviors.

3.4. Psychometric Evaluation

Psychometric assessment revealed a clinically significant pattern of psychological distress. The patient exhibited very high levels of perceived stress as measured by the Cungi Stress Reaction Scale, with a score of 48 exceeding the clinical threshold (>45). The Hamilton Anxiety Rating Scale indicated moderate to severe anxiety symptoms (score = 29), consistent with clinically relevant anxiety manifestations. Self-esteem evaluation using the Rosenberg Self-Esteem Scale showed a low level of self-worth (score = 29), suggesting negative self-evaluation and diminished self-concept (Table 1).

In contrast, the assessment of substance use did not indicate any addictive disorder. Both DSM-5 criteria and the MINI neuropsychiatric interview confirmed the absence of psychotropic abuse or dependence, with no positive responses on addiction-related items.

Table 1. Psychometric assessment results.

Instrument	Score Obtained	Clinical interpretation
Cungi Stress Reaction Scale (1997)	48	Very high stress level (clinical threshold > 45)
Hamilton Anxiety Rating Scale	29	Moderate to severe anxiety (score > 25 indicates clinically significant anxiety)
Rosenberg Self-Esteem Scale (1965)	29	Low self-esteem
Psychotropic consumption assessment (DSM-5 + MINI)	0 (abuse), 2 (dependence)	No evidence of substance abuse or dependence; MINI interview negative for addiction

3.5. Clinical Cognitive and Personality Profile

The patient additionally reported maladaptive cognitive schemas characterized by fear of negative evaluation, excessive self-criticism, perfectionistic tendencies, and persistent doubts regarding professional competence, suggesting vulnerability to performance-related anxiety and impostor-like cognitions.

Personality assessment using the 16 Personality Factor Questionnaire (16PF, Cattell, 5th edition) revealed a heterogeneous profile combining adaptive interpersonal openness with emotional instability (Table 2).

Table 2. 16PF personality profile (Cattell, 5th edition).

A	*Affectothymia*: open, warm, easygoing, cooperative
B	Bright mind, high intellectual level
C	Emotional consciousness: emotional, tormented, versatile, ego weakness
H	*Parmia*: bold, spontaneous, sociable
L	*Alaxia*: trusting, accommodating
N	Direct, unpretentious, sincere but socially awkward, naive
O	Hight Anxiety, guilty feelings, worried, tormented, self-blaming tendency

3.6. Diagnosis

From a diagnostic perspective, the clinical presentation was characterized primarily by chronic occupational stress associated with anxiety symptoms, avoidance behaviors, sleep disturbances, and impaired self-esteem. Although certain manifestations overlapped with burnout syndrome and adjustment-related difficulties, the symptom profile did not fully meet criteria for major depressive disorder, substance dependence, or severe burnout syndrome. Emotional exhaustion was clinically significant; however, depersonalization and profound professional disengagement remained limited.

The clinical picture was therefore more consistent with adjustment disorder with anxiety associated with performance anxiety (glossophobia) and impostor-related cognitions. Psychotropic use remained irregular and non-dependent. Nevertheless, anxiolytic and hypnotic consumption appeared to participate in a negative reinforcement process through temporary reduction of anxiety and emotional discomfort.

Symptomatology also resembles vertical mobbing (hierarchy: ignoring presence, discrimination, lack of organizational justice) and horizontal mobbing (colleagues: contemptuous attitudes, permanent humiliation, mockery, disengagement). Although bullying generates post-traumatic stress states [15], insufficient data on frequency and intensity preclude definitive classification.

These clinical pictures contribute to diagnostic ambiguity, as stress, burnout, and bullying are complex, interacting processes that evolve insidiously toward serious pathologies.

3.7. Deployed Coping Strategies

Ms. A. was exposed to occupational stressors, requiring adaptation. However, stress exceeded her resources and triggered physiological, emotional, cognitive, and behavioral manifestations.

The work sphere was marked by unpleasant factors: workload, long hours, lack of support, tense atmosphere, high demands and control (active work), lack of control over pace, methods, and environment, deficient communication, and inappropriate treatment by colleagues.

Initially, she did not perceive or appraise her professional situation as stressful. She minimized and underestimated the negative effects of stress on her mental and physical health, preventing effective coping.

Instead, she adopted avoidance behaviors, avoiding stressful situations, people, and frustrating experiences. Although avoidance temporarily reduced stress, it did not resolve underlying problems.

Her attitude may have encouraged further pressure from her professional environment. She believes she was the target of hostile acts and mistreatment from her supervisor (vertical mobbing) and colleagues (horizontal mobbing).

This professional reality harmed her professional identity, health, and career prospects.

Psychological suffering, stress, deterioration, and loss of meaning at work were among the experienced psychological afflictions. She adopted various attitudes and strategies, including confrontation, problem-solving, self-control, and excessive work engagement. Over time, these strategies proved ineffective, leading to denial, indifference, and avoidance as defense mechanisms.

Avoidance, as a form of protection or survival [16], involved avoiding confrontation with colleagues and hierarchy to preserve well-being. This consciously deployed avoidance may appear beneficial in the short term, allowing management, reduction, or tolerance of internal or external pressures that endangered or exceeded her resources [17]. However, these mechanisms demanded high energetic costs.

Repressing and suppressing emotions, maintaining a facade of well-being, likely contributed to long-term psychological suffering. According to her statements: "I was able to resist for a while by ignoring my colleagues' humiliations, gossip, and mistreatment. But at some point, I lost it; I became irritable, angry, nervous, and sometimes remained silent and cataleptic, as a colleague said, 'I adopted the Mona Lisa attitude', especially during long work meetings. In other words, I adopted Austria's attitude toward people who emotionally exhausting interpersonal interactions, waiting for the slightest mistake to take revenge. At first, I thought I was the observer, but in reality, I was the observed".

Unresolved stress, avoidance, repression, and suppression of emotions gradually accumulated, worsening her vulnerability. Minor frustrations became unbearable, and she realized she could no longer manage this unpleasant professional reality. This awareness of growing vulnerability to stress developed over the years.

Faced with persistent stressors, she ultimately resorted to psychotropic substances, irregularly using sleeping pills and anxiolytics to self-medicate, relax, and sleep. These medications likely provided temporary relief from anxiety and sleep disorders, reinforcing their use as defensive and coping mechanisms aimed at reducing internal psychic tension, aggressive charge, and finding comfort. However, these mechanisms quickly proved insufficient.

3.8. Cognitive Appraisal Process

Dysfunctional cognitive schemas and early maladaptive schemas identified include:

- Thoughts about self:

I am emotional, I struggle to assert myself, I am not a good communicator, others do better than me, I don't know if I am up to standard, I lack experience, I always expect the worst, my personal satisfaction depends on others' satisfaction, I cannot tolerate frustration, I manage my time and money poorly, I am sensitive and rigid.

- Thoughts about others and the future:

I will not be up to standard, I am convinced that supervisors will not be satisfied with my skills, they will bombard me with work, one day I will suffer a blow from a supervisor or colleague, people will notice that I am anxious (mind reading). With a feeling of lack of future vision, creating a sense of horizon without perspective.

There is a negative self-focus linked to a pessimistic view of professional future. It is reasonable to assume that stress is triggered and maintained by cognitive dissonances or logical errors that render the individual more vulnerable before facing a stressful situation.

3.9. Cognitive-Behavioral Model of Consumption

Based on [8] cognitive-behavioral model of addictive behaviors, dysfunctional cognitive schemas underlying consumption maintenance were identified. As Ms. A. does not present dependence on psychoactive substances, the craving criterion was omitted.

Figure 1 illustrates the cognitive-behavioral mechanisms potentially involved in the maintenance of psychotropic use in response to occupational stress.

According to Beck et al.'s cognitive approach, dysfunctional cognitive schemas may contribute to SPA use maintenance. However, no abusive or dependent SPA consumption was observed in this case.

Quantifying associated automatic thoughts is essential to understanding their impact on consumption or addiction behaviors.

Drawing on Prochaska and DiClemente's model of addiction [18], Ms. A.'s stress-related phase corresponds to precontemplation: she did not recognize her condition as stress, denied and trivialized stress, was unaware of or

disregarded long-term consequences, and minimized clinical stress symptoms (irritability, asthenia, insomnia, anxiety, etc.).

Figure 2 summarizes the patient's progression through a prolonged precontemplation phase characterized by minimization of stress-related symptoms.

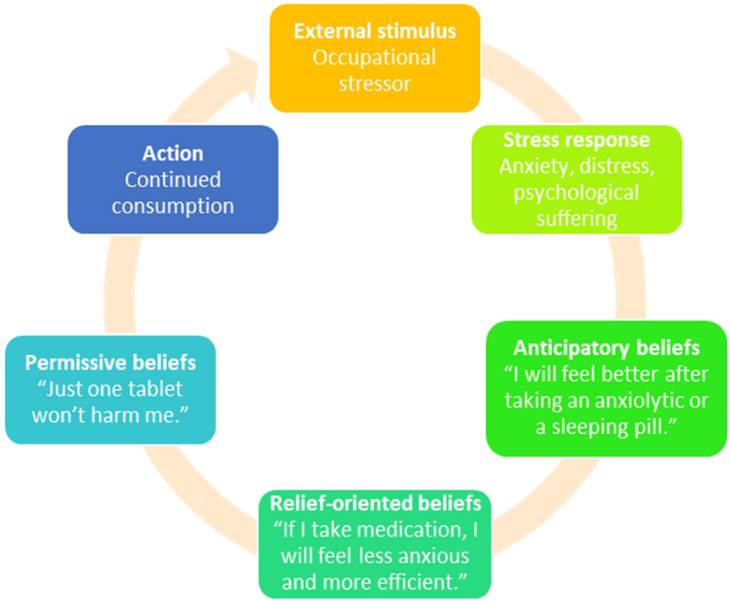

Figure 1. Cognitive-behavioral model of the maintenance of psychotropic use (adapted from [8]).

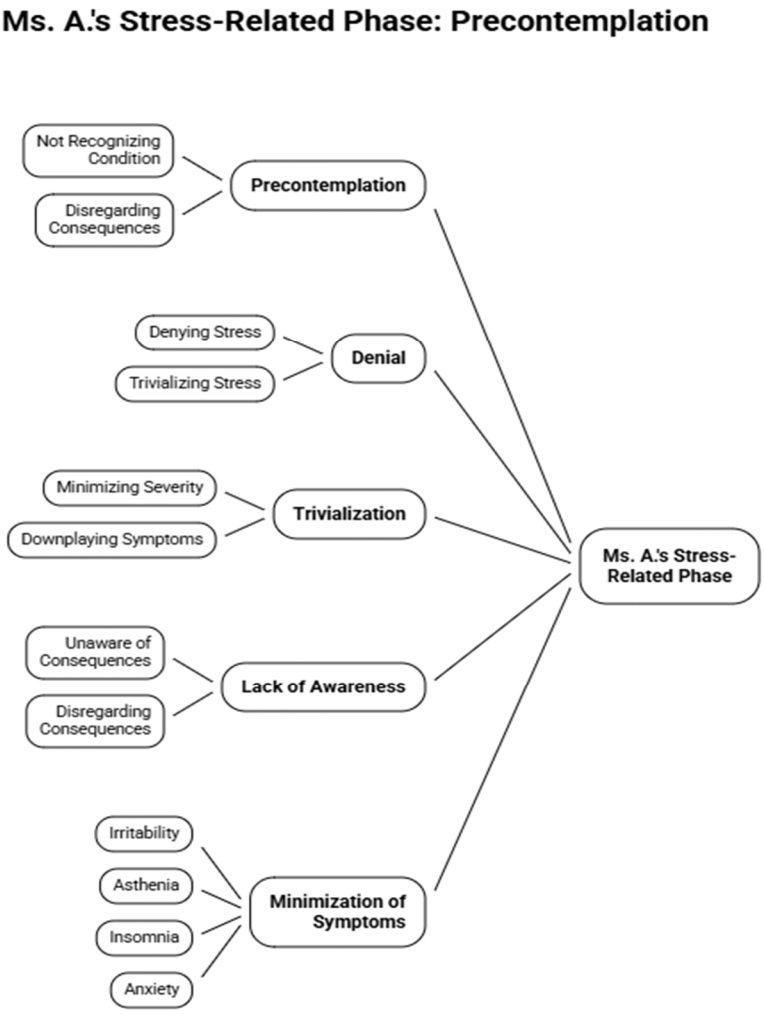

Figure 2. Precontemplation stage of stress, adapted from the Prochaska and DiClemente model of change in addiction.

She resisted stress, repressed angry affects and painful emotions, fled stressful situations and frustrating experiences. However, not thinking about, repressing, and suppressing anxieties demanded high energetic costs and made this strategy responsible for her suffering.

After this long precontemplation phase (three years), Ms. A. became aware of her extreme vulnerability and fragility, even to minimal frustrations. Nevertheless, she continued to delude herself that she could manage this unpleasant professional reality. This mental distancing, serving as a defense to palliate and swallow an overly frustrating reality, was only temporary because painful events and challenges were integral to her daily life.

4. Psychopathological Discussion

Ms. A. comes from a middle socioeconomic background. Her mother is a housewife, illiterate, gentle, and responsible. Her father is a merchant who travels frequently, relatively absent, literate, described as emotionally rigid. The mother maintained family equilibrium.

She describes herself from a young age as calm, respectful, obedient, loved by everyone. In adolescence, she was charming, gentle, and academically brilliant.

As an adult, she is independent, values freedom, was dedicated to her studies, refused romantic commitment, yet cannot tolerate emotional emptiness.

At age 26, she entered the workforce and decided to live alone, away from family supervision.

When asked to retrospectively describe her subjective work experiences after ten years in a private wiring company, we noted that she experienced occupational stress that became persistent and chronic after several years, with massive and lasting physical and psychological repercussions. Her descriptions were colored by negative affectivity.

She believes she was the target and victim of hostile acts and mistreatment (mobbing), citing frequent contemptuous attitudes from colleagues, discrimination (supervisor addressing others while ignoring her), permanent humiliation and mockery from a colleague even in the supervisor's presence, tense work climate, conflictual environment, disengagement, lack of organizational justice. She describes certain individuals as emotionally draining interpersonal relationships, dominant, perpetually dissatisfied with her work, emotionally exhausting interpersonal interactions. She perceived herself as exposed to persistent interpersonal hostility and workplace exclusion. This professional reality harmed her professional identity, health, and career prospects.

Stress, psychological suffering, deterioration, and loss of meaning at work were among her experienced psychological afflictions. She adopted several attitudes, including confrontation, problem-solving, excessive work engagement. These proved ineffective, leading to denial, indifference, and avoidance.

She endured until exhaustion. Initially, the patient attempted to cope with occupational stress through emotional suppression, excessive work engagement, and avoidance of interpersonal confrontation. Although these strategies temporarily reduced emotional distress, they progressively contributed to psychological exhaustion, persistent anxiety, and reduced coping flexibility. Humor and emotional inhibition appeared to function as defensive mechanisms aimed at limiting emotional discomfort associated with workplace stressors.

However, this had high energetic costs: "it is the things that should be forgotten that are remembered best, and if forgetting is the remedy, it is the remedy that is forgotten" [17]. Forgetting is an intentional act, a form of conscious repression "to avoid painful awareness" [17], to avoid being consumed by misfortune and depression, and to not slide into severe emotional distress. Added to these defensive mechanisms was "humor" directed at herself to oppress the painful professional reality: "the defensive aspect of this mechanism consists of sparing the person in difficulty from painful affects" [17].

Indeed, based on the principle "Know thyself," she attempted self-analysis, introspection, or self-observation to restore psychological stability, save what remained of herself, correct errors, and return to her normal or premorbid state. However, normality, according to Dejours and Molinier [19], "represents an unstable equilibrium that the subject seeks to maintain despite constraints". Normality is defined as "suffering normality" since it results from an unstable compromise between suffering and defenses developed to bear that suffering [20].

The subject shows a tendency to intensify work effort to focus exclusively on professional tasks and avoid unpleasant thoughts. This increased work investment may be attributed to specific professional demands but also involves restricting subjective expression.

Due to her passionate work engagement at the expense of personal life, this engagement appears to be a support and narcissistic reassurance compensating for internal deficiencies. However, loss of meaning at work represented a loss of support that collapsed this narcissistic reassurance, threatening the reappearance of internal deficiencies. She exhausted her resources, reached her peak, and found herself at the zenith of her suffering. Notably, her success in tasks also generated conflicts with colleagues, contributing to creating enemies.

Thus, the mismatch between ideal and actual work leads to dissatisfaction, work hardship, and insecurity. Such dissonance causes loss of meaning at work and thereby damages self-esteem.

Following this, she is inhabited by a locked-down feeling of misfortune she sought to stifle with all her strength, preoccupied with worries: fear of losing her job, income, sense of usefulness, professional identity, and self. Loss is a small word with great significance; for Freud, "loss of the object" is the paradigm of psychic pain. Absence of professional identity reflects insecurity, and the fantasy "if I lose all this, I lose myself" symbolizes a threat to self-cohesion and narcissistic stability.

She suffered in silence for over four years, living in a vicious circle (work/home) and incarcerated within it. She sporadically exercised. All her psychic investments during this period were focused on work, to the detriment of personal interests, family, and herself, leading to a very limited social life. She was immersed in a dilemma: "I must perfect myself and fulfill my functions properly, even at the expense of my health. And not finding the dynamism and energy to work". Drinking several cups of coffee throughout the day and taking vitamins every morning were new habits adopted, despite persistent sleep problems exacerbated by these poor habits.

She suffered from powerlessness manifesting as low self-esteem, linked to "the judgment a person makes about themselves, including their physical appearance, personal and professional skills, intellectual abilities, and aptitude to be appreciated by others" [20].

Stress weakened internal resources and eroded self-esteem and self-confidence: "a person with low self-esteem is more likely to feel stress in challenging professional conditions" [21]. "Self-doubt is the conscious expression of investment conflicts that mobilize the entire intrapsychic dynamic" [22]. "Self-esteem is a fragile and changing value that increases when we live in accordance with our own values and decreases whenever our behavior is inconsistent with them" [20].

5. Clinical Mechanisms

This case illustrates the interaction between chronic occupational stress, maladaptive cognitive schemas, performance anxiety, and avoidance behaviors. Persistent exposure to workplace stressors appeared to progressively weaken psychological resources and contribute to emotional exhaustion, anticipatory anxiety, and impaired self-esteem. From a cognitive-behavioral perspective, maladaptive beliefs regarding competence, fear of negative evaluation, and perfectionistic expectations may have amplified glossophobia and impostor-related cognitions. Avoidance behaviors and emotional suppression likely maintained anxiety symptoms by preventing adaptive emotional processing. Although psychodynamic mechanisms related to identity vulnerability and self-esteem regulation may provide additional interpretative perspectives, these interpretations remain hypothetical and should not be generalized beyond the present clinical case. Psychotropic Use and Maladaptive Coping Psychotropic medications appeared to function primarily as emotion-focused coping strategies aimed at reducing anxiety, insomnia, and psychological distress. The temporary anxiolytic effects of hypnotic and anxiolytic medications may have reinforced their repeated use through negative reinforcement mechanisms. While no substance dependence was identified according to DSM-5 criteria, irregular self-medication behaviors contributed to maintenance of avoidance processes and reduced emotional coping capacities. This observation highlights the importance of monitoring psychotropic use in individuals exposed to chronic occupational stress, particularly when medications are used outside structured psychiatric follow-up.

Psychotropics (anxiolytics and sleeping pills) served as a temporary escape from psychological difficulties, a flight from stressful situations and frustrating experiences, a means to palliate and swallow a frustrating reality. The subject was prey to a locked-down feeling of misfortune she sought to stifle, preoccupied with fears of losing her job, income, sense of usefulness, professional identity, and self. "Loss of the object," for Freud, is the paradigm of psychic pain. Absence of professional identity reflects insecurity, and the fantasy "if I lose all this, I lose myself" symbolizes a threat of engulfment and "narcissistic hemorrhage".

However, not thinking about it, circumscribing fear, repressing anxieties, and suppressing frustrations through a substitute object (psychotropics) can be interpreted as an attempt to avoid being consumed by misfortune, emotional distress, and depression, and to not sink into severe emotional distress. Furthermore, this provides a sense of relief and comfort, thus acting as a "normopathic" defense.

The inescapable conclusion of this clinical case is that stress makes a person emotionally, cognitively, and relationally fragile; self-esteem and self-confidence erode drop by drop.

Despite changing jobs, she retains psychological sequelae and scars. Freud used the metaphor of a crystal to illustrate how the psyche can break, like a fractured crystal, due to persistent trauma and frustration, leaving deep traces and scars in the psyche, acting like fractures in a fragile crystal. This recalls the persistence of emotional wounds and the fragility of the human psyche.

We conclude that the psychological suffering experienced by this case is both a stimulus and trigger for SPA use, as well as a response to that suffering, allowing pain to be plugged by reducing emotional discomfort while maintaining control over consumption.

6. Clinical Implications

This case underlines the importance of integrative clinical assessment in patients presenting with occupational stress, performance anxiety, and maladaptive coping behaviors.

Clinical management should include cognitive-behavioral interventions targeting maladaptive beliefs and avoidance behaviors, stress-management strategies, psychoeducation regarding psychotropic medication use, monitoring of self-medication behaviors, and workplace interventions aimed at reducing psychosocial stressors.

7. Limitations

This study presents several limitations inherent to single-case designs, including limited generalizability, absence of longitudinal assessment, and reliance on subjective self-reported experiences.

Furthermore, psychotropic use was evaluated clinically without biological verification. Consequently, interpretations should remain cautious and exploratory.

Nevertheless, this case provides clinically relevant insights into the interaction between occupational stress, maladaptive coping strategies, impostor-related cognitions, and psychotropic use.

8. Conclusions

This clinical case illustrates how chronic occupational stress may contribute to anxiety symptoms, impaired self-esteem, glossophobia, and maladaptive coping behaviors, including irregular psychotropic use.

The interaction between impostor-related cognitions, fear of evaluation, emotional exhaustion, and avoidance behaviors appeared to progressively reinforce psychological distress over time.

Although psychotropic medications provided temporary symptomatic relief, their irregular use contributed to the maintenance of avoidance mechanisms rather than resolution of underlying difficulties.

This case highlights the importance of comprehensive clinical assessment integrating occupational stress, cognitive vulnerabilities, coping strategies, and psychotropic medication use in order to improve prevention and therapeutic management in stressful professional contexts.

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Institutional Review Board Statement

Ethical review and approval were waived for this study because it is based on a single anonymized clinical case report, and no identifiable personal information is disclosed. Written informed consent was obtained from the participant for the publication of this case study.

Informed Consent Statement

Informed consent was obtained from the subject involved in the study.

Data Availability Statement

The data presented in this study are not publicly available due to privacy and ethical considerations. Public sharing of the clinical data could compromise participant confidentiality.

Conflicts of Interest

The author declares no conflict of interest.

Use of AI and AI-Assisted Technologies

During the preparation of this work, the author used ChatGPT (OpenAI) to assist with language editing, translation, text organization, and manuscript refinement. After using this tool, the author critically reviewed, revised, and validated all content and takes full responsibility for the content of the published article.

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