Workaholism

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Abstract

This entry provides an overview of the key contributions and debates concerning 'workaholism' and work addiction research. More specifically, it summarises the variety of conceptualization and measurement instruments ranging from multidimensional, trait-based perspectives to current clinically-validated measures. It is argued that the historical lack of consensus and concept confusion is largely the result of a lack of integration between the organizational and clinical psychology literatures. Key explanatory factors at the individual and structural level are summarised, alongside the methodological and conceptual limitations in the field. Moreover, a summary of the interventions at primary, secondary and tertiary levels are provided, focusing on interventions at the organizational level. Finally, the entry critically discusses and calls for (i) further integration of the clinical and organizational psychology literatures to advance the study of work addiction; and (ii) critical perspectives that widen the focus from individual and organisational interventions to challenge societal expectations about the way individuals work.

Keywords: workaholism, work addiction, addictions, intervention, critical perspectives

History of workaholism and work addiction

In his seminal 1971 book *Confessions of a Workaholic*, Wayne Oates discussed his observations that some individuals exhibit similar cognitive and behavioural responses in relation to their work, that alcoholics display in relation to alcohol. Oates coined the term "workaholic":

> *"…a person whose need for work has become so excessive that it creates noticeable disturbance or interference with his (sic) bodily health, personal happiness, and interpersonal relations, and with his (sic) smooth social functioning".*

This clear conceptualization viewed the study of workaholism from an addiction-based perspective. The concept of 'behavioral addiction' is not new and views such addictions as being behaviors that are both problematic and excessive in which individuals engage in to the neglect of everything else in their lives. These ideas run in parallel to the multidimensional, mainly trait-based approaches of problematic work-based behavior within the organizational psychology literature.

The term 'workaholism' has been used interchangeably with 'work addiction' both in the work and clinical psychology literature. However, some scholars argue that these overlapping constructs are different particularly because some workaholics have few negative detrimental consequences (Griffiths et al., 2018). 'Workaholism' appears to be the most widely used term in the organizational psychology literature because it removes the clinical connotations. Using different terms to differentiate between related literatures, contributes to the conceptual confusion and lack of integration that prevent field development (Quinones & Griffiths, 2020). In this entry, the terms are used interchangeably.

One of the first, and most rudimentary ways to determine workaholism was based on the number of hours worked, classifying workaholics as those that work more than 50 hours per week. Scholars soon realized that number of hours worked was a simplistic and unreliable indicator, particularly because overwork became an ingrained part of working culture within capitalist societies.

The search for key dimensions of workaholism that followed in the organizational psychology literature focused on identifying the core attitudes and underlying traits that

predispose individuals to approach work in that particular way. This gradually led to a departure from Oates' original addiction view. The inclusion of positive elements as workaholism components and classifying individuals as "happy workaholics" "achievement-oriented workaholics" or "work enthusiasts" (e.g., Spence & Robbins, 1992) contributed to the conceptual confusion that followed.

This view has been extensively challenged as scholars agree that workaholism from an addiction perspective is inherently damaging for individuals' health (e.g., high blood pressure, sleeping difficulties, heart problems), relationships, and even business productivity (Clark et al., 2020). There is also an agreement that workaholism is motivated by a compulsion and involves loss of control, akin to other addictions. The work of Schaufeli et al. (2006) distinguishing between work engagement and workaholism was a key landmark within the organizational psychology literature, as were Griffiths et al. (2018) in the clinical psychology field.

Definition, conceptualization, and assessment of work addiction in organizational psychology

Broadly speaking, multidimensional conceptualizations are mostly aligned with a trait-based perspective of workaholism, which prioritizes the explanatory value of dispositional variables over contextual ones, because the dispositional variables are relatively stable across contexts and situations. Workaholism is viewed as an interaction between an underlying trait (e.g., obsessive-compulsive) and the environment. A common limitation to the assessment instruments that follow are that these have been mostly driven empirically rather than theoretically.

Work Addiction Risk Test

Robinson (1999) developed the first instrument assessing work addiction – the Work Addiction Risk Test (WART). Robinson defined workaholism as an *"overindulgence in and preoccupation with work, often to the exclusion and detriment of the workaholic's health, intimate relationships, and participation in child rearing…workaholics are frequently perfectionists and obtain their self-worth from their jobs".* The 25-item scale has five subscales comprising compulsive tendencies to work, (lack of) control, impaired communication/self-absorption, inability to delegate and self-worth.

Further studies found that inability to delegate and self-worth did not differentiate between a sample of workaholics and the control group, which led to dropping these from further investigations and reducing the scale to 15 items and three dimensions. It was also found that of the three dimensions, 'compulsive tendencies' was the strongest discriminatory factor between workaholics and non-workaholics. This scale has been criticized because it reflects the measurement of Type A personality and anxiety rather than contemporary workaholism conceptualizations.

Workaholism Battery

Spence and Robbins (1992) developed one the most widely used instruments to assess workaholism in organizations – the Workaholism Battery (WorkBat). This three-dimensional scale reflects the authors' conceptualization of workaholism as a three-dimensional construct comprising strong drive to work, high work involvement, and low enjoyment of work. The developers argued that those who scored high on all three dimensions including enjoyment could be classified as "enthusiastic workaholics".

The psychometric properties of WorkBat, particularly the original 'work involvement' subscale, were problematic which led to the revision of the scale and the narrowing it to inner drive and enjoyment. A more critical issue is the conceptualization of enjoyment as a key dimension of work addiction (Clark et al., 2020). Firstly, accumulated evidence suggests that high work involvement and enjoyment are core elements of the work engagement construct and that this is independent from workaholism which are related to markedly different outcomes (Hakanen & Peeters, 2015). Secondly, there is strong evidence showing that the negative consequences of work addiction align best with an addiction perspective where enjoyment has no relevance compared to critical discriminatory elements like lack of control and conflict. In short, work enjoyment is a key dimension of work engagement but not a defining feature of workaholism.

Dutch Work Addiction Scale

Schaufeli et al. (2009) developed the Dutch Work Addiction Scale (DUWAS). The lack of clear conceptualization and measurement in the field motivated the DUWAS developers to go back to Oates' original ideas and remove any positive connotations by distinguishing between (unhealthy) workaholism and (healthy) work engagement. The authors conceptualized workaholism as an obsessive-compulsive construct comprising

working excessively (working too hard) and working compulsively (inner drive to work incessantly). The authors adopted specific subscales from WorkBat and WART aligned with their conceptualization. They used the Compulsive Tendencies subscale from WART which they labelled 'Working Excessively' because the original labelling did not represent what it was assessing (i.e., working hard without including motivation, inability to relax, and feeling guilty). Additionally, they adopted the 'Drive' subscale of Work-Bat which they labelled 'Working Compulsively'. Their validation study showed that items concerning guilt and inability to relax from the 'Working Excessively' subscale loaded on the 'Working Compulsively' dimension which made theoretical sense.

The DUWAS has been used widely in the organizational psychology literature. From a clinical perspective, there are some challenges as to whether it can be used reliably based on the high scores on both dimensions working excessively and compulsively. The emphasis on working excessively as a defining factor is challenging because although this is positively associated with addiction, current addiction thinking does not considers it to be a key indicator (Quinones & Griffiths, 2020). Furthermore, working excessively does not appear to be related to controlled motivation, which is a defining factor of a behavioral addiction.

Multidimensional Workaholism Scale

Clarke et al. (2020) recently developed a new scale aiming to align the consensus regarding the main dimensions of workaholism in the field and differentiate it from related constructs such as health or well-being impairments. Moreover, they departed from the trait-based perspective concerning existing evidence regarding situational influences, and from the clinically-based addiction language. They defined workaholism as comprising four dimensions: motivation (inner pressure or compulsion to work), cognitive (persistent uncontrollable thoughts about work), emotion (feeling negative emotions when not working or when prevented from working), and behavior (excessive work going beyond what is required and expected).

The psychometric properties of the scale are promising (showing discriminant validity from the WorkBat, DUWAS, and WART). The dimensions identified show a great overlap with those identified in the addiction-based literature. However, the authors failed to examine convergent and discriminant validity with a clinically validated work addiction instrument (Bergen Work Addiction Scale). Therefore, their aim to separate workaholism from clinical aspects of work addiction remains untested.

Definition, conceptualization, and assessment of work addiction in clinical psychology

There is currently broad agreement about the addiction-like nature of workaholism. This understanding is due to the accumulated evidence concerning similar biological, behavioral, cognitive, and vulnerability factors (Quinones & Griffiths, 2020). The component model of addictions (Griffiths, 2005) asserts there are six core elements to any addiction:

- *Cognitive and/or behavioral salience*: the activity dominates individuals' thoughts and/or behavior.
- *Mood modification*: the behavior is used as a way to modify mood.
- *Tolerance:* increasing amounts of time (or other resources such as money or substance) are required to obtain the same mood modifying experiences with the activity.
- *Withdrawal symptoms:* feeling negative psychological and/or physiological consequences when the activity is stopped or diminished.
- *Relapse and reinstatement:* returning to the activity after a period of cessation.
- C*onflict:* the behavior conflicts with everything else in the person's life and may result in a subjective loss of control.

The model has been extensively validated across a number of substance and behavioral addictions including addictions to gaming, exercise, sex, internet use, and social media use (Quinones & Griffiths, 2020). Drawing on this conceptualization Andreassen et al. (2012) developed the Bergen Work Addiction Scale (BWAS). This is a seven-item where each item taps into the aforementioned components. Individuals need to endorse four or more of the seven items ('often' or 'always') to classify as being at risk of work addiction. The scale showed good internal consistency in the original validation study with nearly 12,000 individuals (Andreassen et al., 2012). The BWAS also showed good convergent validity with existing workaholism scales. The scale has been further psychometrically validated in several longitudinal and cross-sectional studies. Given the strong theoretical foundation, the brevity (favoring use in prevalence studies or for screening in various work and/or clinical settings), its clinical validation and cut off-

scores, the BWAS is a promising psychometric instrument in advancing the understanding of workaholism across both the work and clinical psychology literature.

Why do individuals become addicted to work?

There is a broad consensus that any addiction emerges as a result of a complex biopsychosocial interactions that predispose the individual to interact with a particular object of addiction and no other (Quinones & Griffiths, 2020). In assessing the understanding of the specific vulnerability factors for work addiction, it must be noted that (i) there is a lack of integration in the definition and measurement of workaholism, and (ii) most studies are cross-sectional (which means that although associations can be strong, causality between study variables cannot be determined).

Individual and family factors

The study of vulnerability factors has mainly focused on personality traits such as perfectionism, conscientiousness, self-esteem, and Type A personality. A recent meta-analysis (Kun et al., 2021) found that perfectionism was one of the most relevant personality risk factors along with performance-based self-esteem and negative affect. Although the authors also found associations with extraversion, conscientiousness and intellect, these were weak. The authors concluded that personality only explained a small amount of variance in work addiction.

Psychopathological factors such as anxiety and ADHD have been found strongly related to workaholism in some studies, whereas demographic factors such as gender, age, parental status, and marital status re less clear (Quinones & Griffiths, 2020). Motives and values have also been proposed as a critical vulnerability factor. Workaholism can be the means to escape from psychological pain. More specifically, engaging in compulsive work will initially be a strategy to evade pain (e.g., feelings of loneliness, need for achievement). With regards to the individual factors related to the upbringing, workaholism has been conceptualized as a symptom of dysfunctional family dynamics characterized by “over-responsibility” and workaholic’s children seem to show greater levels of “parentification” than those of non-workaholic parents (Quinones & Griffiths, 2020).

Work and societal factors

Workaholism is maintained via deeply ingrained societal values such as presenteeism (even if this means being virtually present by engaging in sending emails when working off-site) and a system of unhealthy work practices. Unsurprisingly, workaholics tend to work in jobsites that are less supportive regarding employees' work-life balance. This is likely the combination of both self-selection and organizational rewards. For instance, some organizational cultures nurture long working hours applied to workers that do not switch off by providing rewards such as promotions or pay raises, or indirectly, by using them as role models and mentors for new employees (Quinones & Griffths, 2020). Hakaken and Peters (2015) warn against the reinforcement of workaholic role models in organizations, as they label them 'unhealthy heroism'. Similarly, professional cultures of excellence and high competition like those within the high technology industry tend to be associated with long hours and intense working patterns. Professional grouping also seems to be an important variable to consider. For instance, workaholism seems to be less prevalent amongst blue collar employees and more prevalent in high responsibility or managerial positions (Taris et al., 2012).

At a higher level, the socio-economic context characterized by job insecurity and uncertainty may also contribute to the increasing trend concerning maladaptive work behavior that could trigger workaholism among vulnerable individuals. For instance, Kanai and Mitsuru's (2004) study of Japanese workers during the times of economic downturn showed how work overload increased as enjoyment decreased, and that the 'drive to work' component of workaholism remained high. Workaholism also seems to be associated with broader societal values because work investment appears to be higher in societies that emphasize economic security than in those which emphasize subjective wellbeing and quality of life. Arguably, it also fits within a wider capitalist system which tends to favor instrumental gains over relationships.

Prevalence of work addiction

The lack of conceptual consensus, the use of ad-hoc cut off scores, and limited clinical validation of the instruments have prevented scholars from reaching a clear epidemiological picture regarding the prevalence of work addiction. Initial attempts estimated prevalence around 10% and higher among American samples. Although there is greater agreement today about its addiction-based conceptualization, there are very few

addiction-based prevalence studies with the exception of a Norwegian study that reported 7.3%-8.3% prevalence using the BWAS, and a study conducted in Hungary using WART where they reported an 8.2% prevalence.

While these figures show a an arguably high prevalence compared to other addictions, the glorification of work and consumerism in capitalist societies along with work intensification can lead to greater individuals at risk of working in unhealthy ways. In line with this, Piotrowski and Vodanovich's (2008, cited in Quinones & Griffiths, 2020) two-stage model of work addiction differentiates between stage 1 (at-risk individuals) and stage 2 (full-on workaholism). Stage 1 individuals go through a phase of working compulsively and show some interference with their social and/or family life owing to a combination of specific vulnerability (such as high perfectionism traits), and experiencing particular economic or personal circumstances. When these temporary behaviors increase in intensity and frequency and become a default learned mechanism to deal with the demands resulting from the combination of personal and work-related stressors, individuals enter stage 2 and full-on workaholism. While most individuals never get to stage 2, attention needs to be paid to what happens in these preliminary stages, as individuals' wellbeing starts to suffer from these unhealthy working patterns. The next section looks at the key intervention strategies that have been proposed at these different stages.

Tackling work addiction

The work addiction literature has been more prolific and creative in the conceptualization and measurement of work addiction than in the prevention and treatment domain. This section summarizes the main intervention strategies following the classic intervention typology: (i) primary intervention, educating healthy populations to reduce any risk of work addiction by promoting healthy habits; (ii) secondary intervention, supporting individuals to develop adaptive coping mechanisms against triggers to those who are at risk of work addiction, and (iii) tertiary intervention, minimizing the consequences of work addiction. Table 1 summarizes the intervention strategies according to the stakeholder involved in the intervention, and the level of intervention required.

Table 1. Level of intervention in work addiction by stakeholder type (adapted from Quinones and Griffiths, 2020)

Level of intervention	**Stakeholder involvement**		
	Individual/ self-assessment	*Psychologists (practitioner and scholars)*	*Organizations (managers, executives, HR professionals)*
Prevention: primary intervention	- Monitor time spent at work vs. objectives met - Engage in off-work fun, un-related learning activities and/or exercise	- Raise awareness about the impact and risks on the intensification of work, the importance of psychological recovery -Disseminate through all meaningful channels (e.g., social media, knowledge exchange activities, organizational consultancy and training)	- Organizational diagnosis of workaholic-friendly culture. For instance, is over-work being implicitly incentivized? (e.g., promotions, or status); do we have an 'always-on 'culture'? (e.g., weekends or outside of office hours -Promote evidence-based healthy working patterns and norms for recovery outside work and "switching-off" (e.g., workshops showing examples of techniques to switch off and manage email overload) -Develop organizational culture that values and rewards healthy role models (e.g., reject workaholic heroes)
Reducing early signs: secondary intervention	Practice a relaxation strategy. For instance, 10 minute of mindfulness meditation has been found to reduce early symptoms	- Disseminate evidence-based adaptive coping strategies including switching-off, work-home boundary setting, practicing relaxation and or mindfulness techniques - Challenge organization with unhealthy working patterns	-As above
Treatment: tertiary intervention	- Seek professional help	- Diagnose with a clinically validated measures and treat accordingly with evidence-based techniques. These include motivation interviewing, CBT, mindfulness-based techniques and positive psychology approaches	- Employee Assistance Program (EAP) - Support for external counselling/therapy

Critical reflection

Although the concept of workaholism is more than five decades old and its study has spanned over three decades, the understanding has been stalled by the lack of conceptual clarification about its core dimensions, its association with socially desirable

aspects like passion or commitment, and the lack of agreement about the ways in which workaholism can be clearly discriminated from related constructs. Multidimensional-trait based approaches have mostly been driven by empirical rather than theoretical processes. Moreover, there has been little empirical support regarding the number and type of dimensions suggested by these approaches, or show poor psychometric qualities.

Furthermore, there have been limited efforts to examine convergent and discriminant validity between these measures which challenges the ability to integrate findings concerning workaholism across work, health, and clinical psychology to reliably assess its impact and inform effective interventions. Thankfully, there is a much broader consensus today and general agreement on the addiction-based conceptualization of workaholism or work addiction, owing to the differentiation between work addiction and work engagement, as well as the greater understanding of the generic manifestations of addictions (impulsivity, conflict, loss of control), and the availability of clinically validated instruments.

While these developments have contributed to our understanding regarding components, triggers, and interventions of work addiction at the individual level, workaholism involves multiple layers that arguably produce and maintain the problematic behavior (individual, familial, sociocultural) which need to be addressed. Critical psychologists have long argued that the excessive emphasis on the individual aspects removes the social, cultural, and political triggers from the etiology and maintenance of the problem. Without this broader level of analysis and intervention, efforts on individual prevention and treatment are likely to be futile.

From this level of analysis, the function that work addiction plays in culture can be examined. Generally, addictions are perceived as negative and initiated by "pleasure seeking" motives (e.g., sex addiction or gambling). In contrast, the motives underlying work addiction are socially valued because work is associated with the fulfilment of the social expectations concerning adulthood and the achievement of financial resources in culture. In this sense, work is considered a "nurturance addiction" (Sussman, 2012). Second, given the centrality of work in a capitalist society, being overly involved in work, even when this causes family conflict, is more socially accepted than leaving the family to go gambling or take drugs. In fact, these behaviors are not only not penalized, but often socially and financially rewarded.

Arguably, the alignment between cultural expectations of work and an individual problematic behavior could lead to downplaying the difficulties experienced by

individuals who are genuinely addicted to work. Also, while fewer individuals develop full-on addiction, the strong work intensification and normalization of unhealthy working patterns, means that many individuals will work excessively and compulsively even during a specific period of time. This can equally harm interpersonal relationships and health even in the short-term, and contribute to validate neoliberal expectations about the viability of work intensification. If these contributing factors are ignored, intervention strategies will be biased. The social conditions that reinforce the behavior at a macro-level will not be addressed and generic addiction treatments are more likely to be applied that may temporarily fix the problem while leaving the underlying dysfunctional psychological processes untouched. Integrating critical perspectives with work and clinical understandings of work addiction may inform more ambitious prevention strategies. This may include challenging and developing different ways of organizing work in a more balanced and sustainable way.

Future avenues

These key challenges ahead for the development of the workaholism literature include:

- *Greater integration of the clinical and organizational psychology literatures.*

Working with the common aim of knowledge development and from a parsimonious approach, it seems crucial that efforts to integrate findings are continued. Moreover, if new instruments are developed, the developers must demonstrate its added contribution and discriminant validity over existing adequate measures

- *Widening the focus to structural and societal factors.*

Following from critical analysis, there is a need to go beyond immediate organizational vulnerability factors to challenge the economic and societal factors that shape the establishment of unhealthy working habits. Therefore, it is critical that both practitioners and scholars engage with the public, as well as disseminate and advocate changes to working habits. This may involve engaging discussions around the implicit assumptions about the nature of work in society. If these assumptions are not articulated, they cannot be challenged, and individuals are more likely to end up needing secondary and tertiary interventions. Scholars and practitioners may raise awareness through the means at their disposal such as social media, and consultancy activities for organizations.

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