Chapter 21. Prevention and Treatment of Work Addiction

Abstract

This chapter provides an overview of the key areas of agreement and debate about workaholism, particularly its conceptualization, prevention, and treatment. The chapter integrates biomedical and health psychology perspectives with a view to challenging and advancing understanding on how to prevent people from developing a problematic relationship with work, and how best to support those experiencing the problem. The chapter begins by reviewing the conceptualization of workaholism, and then reviews the existing evidence concerning the main correlates and vulnerability factors. This then leads to an exploration into alternative ways that workaholism can be theorized, in particular, biopsychosocial models and critical theory of addiction. Building upon this combined theoretical perspective, the chapter ends by reviewing and speculating on different aspects of prevention and treatment according to the different stakeholders involved.

What Workaholism is (And is Not)

Oates (1971) was the first person to conceptualise workaholism as an addiction building on the observed cognitive-behavioral pattern that resembled that of alcohol addiction and defined it a workaholic as:

> *"...a person whose need for work has become so excessive that it creates noticeable disturbance or interference with his bodily health, personal happiness, and interpersonal relations, and with his smooth social functioning"* (Oates, 1971; p. 4).

This neat conceptualization became gradually blurred in the literature as researchers sought to identify the dimensions that made up this multifaceted construct, often by including variables that were correlated with such compulsive behavior rather than based on sound theoretical justifications (Andreassen, 2014; Ng et al., 2007). The present authors review some of these explanations and discuss why some of these personality traits, affective components, and attitudes are not 'workaholism'.

Criteria for Inclusion in This Review

The most comprehensive meta-analysis studies were examined, and searches were made between 2011-2018 in PsycINFO, MedLine, and the Google Scholar search engine with the terms 'workaholism', 'work addiction' and 'compulsive work'. The start date of 2011 was used to follow up from Sussman's (2012) meta-analysis that reviewed all studies up to 2011. Sussman's study was chosen not only for its relevance but also for the transparency in terms of how the searches were conducted. Sussman's review included definition, prevalence, etiology, measurement, prevention, and treatment. This chapter briefly examines how the conceptualization has changed since Sussman's review and includes a more recent conceptual review by the present authors (Quinones & Griffiths, 2015) but also expands on these by also examining prevention and treatment. Also building on the work by Clarke et al. (2016), the

chapter focuses on studies that conceptualize workaholism as addiction, not merely as working excessively (DeLibano et al 2012). Consequently, studies focusing on excessive work rather than addiction to work were omitted from the present review. Furthermore, although the chapter briefly examines cross-sectional studies identifying single personality factors (e.g., narcissism and workaholism; Andreassen et al. 2012), these were (on the whole) not reviewed as the aim of this chapter was to ascertain those factors that were present across a large number of studies and/or those showing stronger research designs (e.g., including more than one wave, not just a typical cross-sectional design).Workaholism is Not the ‘High Involvement-Low Enjoyment’ Combination

Spence and Robbins (1992) conceptualized workaholism as a trait-based multidimensional construct comprising enjoyment, drive, and work involvement and developed one of the most influential instruments to assess workaholism, namely the Workaholism Battery (WorkBat). The authors distinguished between real workaholics from the enjoyment workaholic type because although they shared high levels of involvement and drive, real workaholics reported low enjoyment from the work they did. Affective dimensions have since been included in subsequent work by others (Ng, Sorensen & Feldman, 2007). However, the enjoyment dimension as a key component of workaholism is problematic. First, the idea of being affectively attached to one’s work was never psychometrically nor theoretically strong (McMillan, Brady, O’Driscoll, & Marsh, 2002). In fact, accumulated evidence suggests that over-engagement with enjoyment (negatively or positively) is a separate construct from workaholism and is better represented by the construct of ‘work engagement’ (Van Beek et al., 2012; DeCarlo et al., 2014; Taris et al., 2010).

Unlike what was initially thought, workaholism and work engagement are in fact associated with very different outcomes. For instance, one of longest follow-up studies with a seven-year gap between measurements, confirmed that work engagement boosted positive

work to family interaction and decreased the negative side of this interference in the long-term, as opposed to workaholism which led to lower satisfaction and poorer health outcomes (Hakanen & Peeters, 2015). Furthermore, work engagement and workaholism appear to be only weakly related, with longitudinal studies reporting less than 7% shared variance (Shimazu et al 2012). In short, enjoyment of work is relevant when it comes to work engagement, but it is not a central feature of workaholism (Clarke et al., 2016; Mudrack, 2006; Schaufeli, Taris, & Bakker, 2006; Taris, Schaufeli & Shimazu, 2010).

Workaholism is Not a Stable Individual Characteristic

Workaholism has been conceptualized as a stable individual characteristic by a number of scholars, either because of the need to exhibit specific personality traits, or as a symptom of compulsive-obsessive personality disorder (American Psychiatric Association: APA, 2013). Within this compulsive-obsessive conceptualization, workaholism is characterized by *"perfectionism, inflexibility, and preoccupation with work, and by an excessive devotion to work and productivity to the exclusion of leisure activities and friendships"* (Molino et al., 2016; p.401).

The idea of a stable trait within the obsessive-compulsive realm has been operationalized by the work of Schaufeli and colleagues, who defined workaholism as a two-dimensional construct comprising of working excessively (i.e., working too hard) and working compulsively (i.e., the inner drive to work incessantly), and they developed an instrument to assess these sub-dimensions (Dutch Work Addiction Scale; Schaufeli, Bakker, van der Heijden, & Prins, 2009a; Schaufeli, Shimazu & Taris, 2009b). Current thinking in this field rejects the notion that excessive behavior is necessarily a key component of addiction, although strong correlations exist (Griffiths, 2011). Furthermore, studies examining the motivational dispositions of workaholism have found that working excessively is not related to controlled motivation, which is a commonly cited antecedent of the key compulsive element of

workaholism (Van den Broeck et al., 2011). In addition to the conceptual issues, the operationalization is also problematic because the excessive work sub-scale developed by Schaufeli et al (2009a, b) shows poor psychometric qualities (Sussman, Arpawong, Sun, Tsai, Rohrbach, Sprutjt-Metz, 2014).Robinson (1999) also conceptualized workaholism as the combination of compulsive tendencies and control along with other abilities and personality traits (e.g., impaired communication/self-absorption, inability to delegate, and self-worth). This multidimensional view was operationalized in the widely used diagnostic tool, the Work Addiction Risk Test (WART). However, factor analysis failed to confirm the five dimensions. This and the high correlations with general anxiety and Type A personality have either deterred researchers from using the WART model to assess workaholism or to only use the first two sub-scales (Andreassen, 2014).

In short, although the various multidimensional approaches (typically taking a trait view) have been useful in fostering discussion on what drives individuals to work excessively, there has not been strong empirical support concerning the number and type of dimensions proposed. As discussed earlier, enjoying work is a key dimension of work engagement which is a separate (although related) construct from workaholism. Similarly, excessive behavior does not qualify as a key dimension of addiction on its own (Griffiths, 2011). Additionally, many of the personality variables that were once thought to be defining dimensions have now been shown to be weakly related, with only two variables (i.e., 'compulsive tendencies' and 'control') showing consistent antecedent value across studies (Clarke et al., 2016). More specifically, the compulsive tendencies (i.e., the compelling need to work) and control dimensions (i.e., the experience of negative emotions such as anger and impatience as a result of not having full control over work) appear to discriminate between workaholics and non-workaholics (Flowers & Robinson, 2002). Recent meta-analysis and previous theoretical reviews have led many to agree that an addiction-based explanation of workaholism appears

the most sensible approach to understand this phenomenon (Clarke et al., 2016; Griffiths, 2011; Griffiths, Demetrovics & Atrosko, 2018; Schimazu et al., 2015).

The Biopsychosocial Perspective of Workaholism

A robust theoretically-driven conceptualization of workaholism is possible by building upon the strong body of knowledge concerning behavioral addictions more generally to conceptualize workaholism (Andreassen, Griffiths, Hetland, Kravina, Jensen, & Pallesen, 2014; Sussman, Lisha, & Griffiths, 2011). In this section, key theoretical contributions are drawn upon to examine (i) key dimensions of workaholism and the (ii) vulnerability factors.

Theorizing on the Dimensions of Workaholism: The Component Model of Addiction

The components model of addiction draws upon Brown's (1993) *hedonic management model* and has been largely inspired by the diagnostic classification of pathological gambling in the DSM-IV (APA, 2000). According to this framework, an addict displays symptoms that represent each of the following components: *cognitive and/or behavioral salience* (i.e., the activity dominates one's thoughts and/or behavior), *mood modification* (i.e., the behavior is used as a way to modify mood), *tolerance* (i.e., the increasing amount of time required to obtain the same experience with the activity), *withdrawal symptoms* (i.e., feeling negative emotions when the activity is stopped or diminished), *relapse and reinstatement/loss of control* (i.e., the need to return to the same level of use after trying to stop, and losing control over the use), and *conflict* (i.e., the behavior conflicts with everything in the person's life such as relationships, job, and/or education) (Brown, 1993; Griffiths, 2005).

This model has been validated in a variety of substance and non-substance based addictions and has been widely used to develop tools to understand and assess prevalence across a number of different addictions such as gaming addiction (e.g., Griffiths, 2002), exercise addiction (e.g., Allegre et al., 2006), internet addiction (Widyanto & Griffiths, 2006), and more recently social networking addiction (Andreassen, Tosheim, BrunBerg & Pallesen,

2012). Building on these findings, Andreassen, Griffiths, Hetland and Pallesen (2012) developed the Bergen Work Addiction Scale (BWAS). The scale comprises seven items tapping into each of the aforementioned components, and each item is scored on a Likert scale from 'never' to 'always'. Individuals are operationally classified as workaholics if they endorse four or more out of seven items (i.e., scoring 'often' or 'always'). Although still in relative infancy, it has already been validated in Norwegian samples of over 12,000 people with high Cronbach's alphas in the range of .80-.85. Convergent and discriminant validity analysis suggests that the BWAS converges well with existing workaholism scales tapping the compulsive element (r=.50-.84). Given the strong conceptual foundation, the brevity of the scale (favoring its use for prevalence studies or for screening within the workplace),and considering that its operationalization enables the integration of this behavior with potential co-occurring addictions, the BWAS is a promising tool in advancing the understanding of workaholism.

Examining Vulnerability Factors

The syndrome-based model of addiction has been most helpful in understanding antecedents and vulnerability in behavioral addictions and helps integrate current understanding of antecedents of workaholism. This model suggests that similar underlying mechanisms operate regardless of the object of addiction, and that manifestations of the syndrome are both generic and unique to the specific addiction (e.g., see Sussman & Pakdaman, 2019, Chapter 1 of this Handbook). Similar underlying vulnerabilities may be operating along with more unique psychosocial variables that predispose the individual to interact with a particular object of addiction and no other. Increasing research evidence in the field is supportive of such a model. For instance, self-report multi-addiction survey studies have found strong correlations among different behavioral and substance addictions (Villella et al., 2011). Furthermore, an increasing number of studies report both chemical and behavioral addictions

share similar course, history, and neurobiological correlates (Orford, 2001; Grant, Potenza, Weinstei & Gorelick, 2010; Griffiths, 2005). Perhaps the most compelling evidence comes from neurological studies, as these support the hypothesis that reward circuits in the brain are involved in both substance and non-substance based addictions, both share similar genetic vulnerability and clinical features, and that they develop following a similar pattern, which adheres to the components model of addiction (i.e., initial arousal before the act, pleasure/high relief linked to the act, lowered arousal afterwards along with guilt, withdrawal, and potential tolerance) (Villella et al., 2011; Grant et al, 2011). Many studies in this field have traditionally been cross-sectional, which interferes in the ability to distinguish between antecedents and simple correlates (Quinones & Griffiths, 2015; Quinones et al., 2016). Nonetheless, empirical evidence accumulated to date can be used to identify what appear to be the most salient individual, familial, and socio-cultural factors favor the development of workaholism (Griffiths & Karanika-Murray, 2012).

Individual Factors

Clarke et al.'s (2016) meta-analysis suggested that aside from mere correlations, it is only the achievement-oriented personality traits (perfectionism and Type A personality) that are strong antecedents of workaholism across empirical studies. In contrast, there is no (or at best weak) support with other personality traits (e.g., conscientiousness, self-esteem, positive affect). Equally, demographic factors such as gender, parental status, and marital status appear to have mixed relationships with workaholism. Consequently, these are not unequivocal antecedents of workaholism. With regards to psychopathological factors, a largescale study by Andreassen et al. (2016) showed that anxiety and ADHD were strong contributors to the variability of workaholism, more so than obsessive-compulsive symptoms, which is at odds with the compulsive-based conceptualizations of workaholism discussed earlier in this chapter.

Familial Factors

The family therapist and academic Robinson (2013; p.ix) – who called workaholism the *"best dressed problem of the twenty-first century"* (p. ix) – drew on his clinical practice to explain how specific family dynamics, such as over-responsibility, contribute to the development of workaholism in adulthood. Considering the strong association between managerial roles and high responsibility, and the complex dynamics between that and gender, it is unsurprising that Andreassen et al. (2016) found these participants most likely to be classified as workaholics. Over-responsibility is also more significantly found in children of workaholic parents. For instance, Carrol and Robinson's (2000) study found that adult children of workaholics show greater levels of parentification (i.e., role reversal whereby children act as parent to their own parent) than those of non-workaholic parents.

Socio-cultural Factors

Workaholic behaviors are often socially acceptable and even rewarded in society. Sussman, Arpawong, Sun et al. (2014) argued that workaholism is a 'nurturance-type' addiction. Consequently, although like other addictions it causes interpersonal conflict, the behaviors are also socially associated with the achievement of financial resources and in that way adheres to social expectations about adulthood. In contrast to this nurturance-type of addiction, other behaviors such as gambling, are viewed negatively because they are perceived to be pleasure-seeking driven, often to the detriment of nurturance because gambling addiction is associated with economic losses (Schwartz, 2010).

The socio-economic context characterized by job insecurity and uncertainty (Molino et al., 2016; Quinones, 2016) may also contribute to the increasing trend concerning maladaptive work behavior that could potentially 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. Studies suggest that workaholism also depends on work culture. At a broad level, work investment appears to be higher in societies that emphasize economic security than in those which emphasize subjective wellbeing and quality of life (Snir & Harpaz, 2011). Arguably, it also fits within a wider capitalist system which tends to favor instrumental gains over relationships (Clark et al., 2016). It is also shaped by organizational culture, in particular, those that favor role modelling workaholic behaviour, and spread what has been termed 'unhealthy heroism' (Hakaken & Peeters, 2014). Professional culture is also an important factor to consider, and workaholism is less likely in blue collar employees. Where the professional culture is one of excellence, and workers have freedom to work at their own pace, such as high-tech industry, there is a much higher tendency to work more hours. Although the externally imposed pressure to work harder cannot cause workaholism on its own, it can lead to maladaptive work habits which coupled with individual vulnerabilities may develop in workaholism Sharone (2004).

In short, considering the social acceptance, the reward of overwork in western societies, and the ability connect to work 24/7, strategies and tools are needed to help individuals engage with work in a more sustainably healthy way and prevent workaholism (Quinones, 2017). Before exploring prevention and treatment, the importance of broadening our understanding of addictions is discussed to further the understanding of what it means to be addicted to work.

Critical Perspectives on Addiction

The components model of addiction (Griffiths, 2005) is sometimes characterized as the "diagnostic" or "symptomatic" model. The model (and variations upon it) helps in understanding the extent to which specific behaviors (e.g., work) fit a pattern of addiction by stressing the importance of loss of control over the activity, impulsivity, and conflict (Van der Linden, 2015). The BWAS diagnostic tool (derived from such a model) was inspired by the DMS IV-TR criteria on pathological gambling justified by the fact that work addiction, like

other behavioral addictions, share phenomenological and neurobiological commonalities. The present authors believe the greater value of this model is for self-assessment and monitoring of behavior at the individual level, and also as one of the tools that clinicians will consider when examining the underlying psychological process behind those symptoms. Most research on workaholism tends to focus on the individual addiction aspects (and the implications this have for prevention and treatment). However, the problem (and its symptoms) have deeper psychological, socio-economic, and even historical and cultural roots. If these are ignored in favor of implementing addiction-based treatments, one is not only risking the social condition that reinforces the behavior at a macro-level, but also more likely to be applying generic addiction treatments that may temporarily fix the problem while leaving the underlying dysfunctional psychological processes untouched (Billieux et al., 2015).

Critical psychologists have longed argued for complementing the disease model of addiction with a thorough consideration of the social determinants of addiction (e.g., poverty, weak social support, exclusion, unemployment, hyper-individualism, etc.) (Reinarman & Granfield, 2015; Suissa, 2014). Critical psychologists argue that the excessive emphasis on the individual aspects removes the social, cultural, and political triggers from the etiology and maintenance of the problem, thereby eliminating key components in the prevention and treatment of addiction. Instead, the focus and responsibility are now on 'addicts' and their support networks (Van der Linden, 2015; Reinarman & Granfield, 2015). Any addiction, including substance-based addictions, benefit from this contextualization. As Reinarman and Granfield (2015) state, Andean peasants rarely become cocaine addicts regardless of their regular coca chewing because the habit is deeply integrated in that culture. Workaholism is a strong example of an addiction that could not be understood without the socio-economic context in which it emerges, and it is difficult to find a work addict in a non-capitalist society.

The acknowledgement of social factors is not new, and some authors have emphasized its importance. Sussman, Lisha and Griffiths (2011) argued that lifestyle and the type of social learning from the environment have as much explanatory value or more in workaholism than personal vulnerabilities. Nonetheless, a more varied multidisciplinary approach may help to actually examine ways in which these factors can be more seriously included in the academic debate particularly when talking about prevention and treatment. For example, the concept of 'loss of control' is central to disease theories of addiction (Reinerman & Granfield, 2015) and is one of the core symptoms in the components model of addiction (and related biological models). A historically contextualized approach to work addiction stresses the conflict inherent in a society that both pushes and punishes pleasure-seeking through consumption. Individuals are surrounded by easy access, fast, frequent (though often short-lived) sources of pleasure, and gratification enveloped in well-designed marketing strategies. Yet society also bombards individuals with the idea of taking responsibility for their pleasure-seeking and to exert self-control. This is worsened by the fact that western societies are becoming more individualistic in spite of the strong support for the health promotion effects of strong social ties. In short, widening the focus to the cultural and contextual factors enabling work addiction, will complement the brain disease approach to provide a more balanced understanding of the multiple factors contributing to these problem (Reinaman & Granfield, 2015, Van der Linden, 2015; Sussman, 2017; Sussman & Pakdaman, 2019, Chapter 1 in this Handbook).

An Integrative View on Prevention and Treatment

Although full-on workaholism only affects a minority of the population, working compulsively, even for a short period of time, or for a longer period but not to the point of work addiction, can still harm interpersonal relationships and health, and therefore prevention is important. It is important to bear in mind that the lack of conceptual clarity discussed earlier in

this chapter, and the limited power of many empirical studies that exist in the work addiction field, limit the extent to which interventions have been extensively validated (Andreassen, 2014). In this section, existing strategies from a multi-level interdisciplinary approach are discussed according to two main organizing principles: (i) the target population and the stage they are in relation to the problem, and (ii) the stakeholder involved in the intervention (this is, who is responsible for leading the intervention: individuals, clinicians, and/or organizations).

With regards to the target population, using the classic intervention typology, it needs to be determined whether the aim is (i) educating healthy populations to reduce any risk of work addiction by promoting healthy habits and preventing ill-health (i.e., *primary intervention*); (ii) supporting people to develop adaptive coping mechanisms against triggers to those who are at risk of work addiction (i.e., *secondary intervention*), or (iii) minimizing the consequences of work addiction (i.e., *tertiary intervention*). When examining secondary and tertiary interventions it is also important to identify the stage at which the individual is at because workaholism is at the extreme end of a continuum which develops over time. Piotrowski and Vodanovich's (2008) development process model is a useful framework to evaluate the stage at which the individual is at. The model comprises the: (i) *initial stage:* This is where individuals begin to exhibit patterns of compulsive work that result from the interaction between traits, family values/roles, and stressors. During this time, there is no significant interference with an individual's life or their meaningful others (primary and secondary prevention are relevant); and (ii) *full-on workaholism:* Here, the behaviors increase in intensity and frequency as a learned mechanism to deal with the demands resulting from the combination of personal and work-related stressors (tertiary prevention is relevant). These behaviors lead to problems both at work and outside of work and the experience of loss of control resembles the key components of a behavioral addiction (Griffiths, 2005). The vast majority of individuals will never cross to the second stage, and even if they do, they might

only stay there for a limited period of time owing to particular economic or personal circumstances. Building upon the two organizing principles discussed, what is known about prevention and treatment is reviewed in the following sub-sections in relation to the leading stakeholder involved, and examples are included in Table 1.

Table 1. Level of Intervention in Work Addiction by Type of Stakeholder

Level of intervention	**Stakeholder involvement**		
	Individual	*Clinician*	*Organization*
Prevention: primary intervention	- Monitor time spent at work vs. objectives met - Engage in off-work fun, learning and/or exercise	- Disseminate through all meaningful channels - Raise awareness	- Reward relevant role models - Support organizational culture that values psychological recovery outside work
Reducing early signs: secondary intervention	- Practice some relaxation strategy. For instance, 10 minute of mindfulness meditation has been found to reduce early symptoms (Quinones et al in press)	- Help develop adaptive coping strategies	- Training workshops, importance of switching off
Treatment: tertiary intervention	- Seek professional help	- Diagnose and treat accordingly	- Employee Assistance Program (EAP) - Support for external counselling/therapy

For Clinicians, Therapists and Scholars

According to Van Wijhe, Schaufeli and Peeters (2010), successful prevention and treatment strategies for this particular problem should address four inherent complexities, which set it apart from other behavioral and substance-based addictions:

1. Abstinence is not an option. Hence, interventions must set realistic goals.
2. Unlike with other addictions, workaholism is the extreme of an otherwise socially valued behavior. Thus, an effective intervention should enhance clients' awareness about the triggers and consequences that working in such a way has on them.

3. Derived from the previous two points, individuals are more likely to seek medical help for problems associated with workaholism (e.g. poor sleep, stress). Thus, effective interventions should tackle the compulsive behavior but also address the associated damage of work addiction.
4. Workaholics will, by definition, struggle to find time to do other things than work. Hence, feasible interventions should be designed bearing in mind, where possible, that briefness is crucial.

Points 1-3 are particularly relevant when it comes to primary and secondary interventions. Therapists, clinicians, and scholars in the field should use the different means at their disposal to communicate widely and clearly about the extent to which work addiction can become a problem for some individuals in contemporary society. This is likely to involve helping people to articulate implicit assumptions about the nature of work, and whether or not there is such a thing as an unhealthy work pattern. If these assumptions are not articulated, they cannot be challenged, and individuals are more likely to end up needing tertiary interventions rather than being more effectively supported through primary and secondary efforts. Also, building on the literature on healthy psychological recovery activities (e.g. Quinones, 2017; de Jonge et al., 2018), these professionals can help workers and students to develop healthy and adaptive habits of coping with stress, working on self-esteem, and developing interests and hobbies outside work.

Diagnosis to Inform Treatment

When it comes to secondary and tertiary interventions (i.e., clients at risk or already addicted to work), the first step is to ensure the problem is properly diagnosed. Clinicians should use specific addiction-related screening instruments coupled with a broader examination of the underlying psychological processes to be addressed. An assessment that is based only on the addiction symptoms may leave the underlying psychological dysfunctional

processes untouched. The danger of doing so is illustrated by Billieux et al. (2015) who reported the case of a client who was diagnosed with mobile phone addiction using a symptoms-based approach (i.e., adopting the DSM-IV-TR substance abuse criteria according to which symptoms must be present for at least 12 months). Then the authors followed a broader psychological processes approach to analyze the same client via the use of screening instruments and different clinical methods such functional analyses. This approach led them to identify irrational beliefs, dependent relationship maintenance, and low impulse control, targeted for treatment. The therapeutic strategy that followed would then be aimed at addressing the psychopathological processes, and problematic mobile phone use (here used as a maladaptive coping strategy) that would diminish as a function of the effectiveness of the treatment. In short, clinical treatment was tailored to the individual's needs depending upon the psychopathological processes involved and the extent to which the compulsive behavior is just a means to temporarily cope with events or a more fundamental and stable way of coping with pain or anxiety. This may be a good protocol to use when considering treatment of work addicts. Some of these specific techniques are now discussed.

Techniques

Mindfulness training and gradual muscle relaxation techniques. Both of these techniques have been proved effective in reducing the physiological arousal associated with the stress response which may otherwise trigger maladaptive coping strategies. Meditation is particularly effective in preventing individuals going into the automatic pilot reaction associated with behavioral addictions, even if it is practiced for a short period of time a day (Quinones, 2017; Shonin et al 2014). The *positive psychology approach* that focuses on supporting individuals to engage in healthy living includes developing a guiding meaningful vision, and then applying it to associated behaviors, thoughts about strengths, and self-care rather than focusing on problems *per se* (Andreassen et al., 2014). For instance, helping

individuals to reflect on and develop meaningful life goals, and learning to examine how work and other areas of life are contributing towards that goal, may facilitate a more positive life trajectory.

Cognitive-behavioral therapy (CBT) is a robust tool for therapists in many areas, including behavioral addictions. It helps tackle the irrational rigid beliefs that trigger workaholic behaviors (Andreassen et al 2016), One type of CBT, *emotive behavioral therapy* (Ellis, 1957; Chen, 2006 [cited in Pallesen et al., 2005]) is an example of approach that be helpful. Going from working compulsively to working more adaptively is a process that can be mapped onto different stages (from unawareness, to awareness to being treated and preventing relapse), which at the very least involves some level of ambivalence; strong reasons are needed to change the behavior (e.g., I cannot see my kids awake when I get home). However, other reasons for carrying on the behavior are likely to arise (e.g., 'I need the promotion', 'I might get fired if I don't work at the same level').

This Ellis approach involves confrontative statements. However, for many ambivalent and/or resistant patients, an approach to roll with resistance may be needed. In this type of case, CBT may be particularly effective if combined with *motivational interviewing.* This technique helps the client develop stronger awareness about their work behavior, and the discrepancy between values and behaviors, thereby increasing motivation for change. This addresses what Suissa (2014) believes to be central to developing addiction – the motives to work. More specifically, he argues that workaholism operates if individuals engage on this behavior as means to escape from psychological pain. That is, engaging in compulsive work will initially be a strategy to evade pain or psychological dysfunction (e.g., feelings of loneliness, rigid perfectionism, need for achievement). This lessens the negative emotions associated with such underlying problems and, in turn, becomes a more salient way of coping with these emotions

in the future. Motivational interviewing has been successfully applied to treat other substance and behavioral addictions (Sussman, 2017; Van Whije et al., 2010; Andreassen et al., 2016)

As this is a problem often associated with interpersonal consequences or triggers, *family therapy* has also been suggested as crucial (Robinson, 2001). Analyzing and developing better communication channels and more effective family dynamics in relation to work-life balance can be unpacked to help draw boundaries and achieve a better balance for all. Some therapists may find that self-help groups are useful for their clients. *Workaholics Anonymous* based on the 12-step and 12 tradition developed from Alcoholics Anonymous is by far the most established of its type (Sussman, 2012).

For Organizations: Line Managers, Executives, Human Resources Professionals

It is very important for employers to understand what work addiction is, and that although this is a problem that affects a minority, the consequences of compulsive working patterns, can be devastating for individuals' health and organizational objectives. While supporting employees through counselling is positive and welcomed, it only addresses one part of the problem. The problem involves multiple levels that produces and maintains the problematic behavior (individual, familial, socio-cultural) and these need to be addressed. Workaholism is maintained via a system of unhealthy work practices and more deeply ingrained societal values such as presenteeism (even if this mean being virtually present by engaging in sending emails when working off-site).

Unsurprisingly, workaholics tend to work in job sites that are less supportive about employees' work-life balance. This is likely the combination of both self-selection and organizational rewards (Van Whije et al., 2010). 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.

Diagnosis: How Workaholic-Friendly is The Culture?

This diagnosis can be done by undertaking an organizational culture analysis collecting data from different stakeholders. This may include asking questions such as:

- Are we incentivizing over-work through promotions, stronger status, etc.?
- Are we encouraging an 'always-on 'culture' explicitly or implicitly perhaps through the ways in which we send our emails during weekends or outside of office hours?

It is important to monitor implicit connectivity rules, particularly ways in which the more powerful members of organizations communicate with junior employees or members of minority groups. These may be setting unwritten rules of connectivity which may favor unnecessary rules of 'always-on' connectivity for the less advantageous group.

Prevention and Intervention Strategies

Employers need to offer support and develop policies that help individuals to work more healthily and to alleviate the pressure experienced by increased work intensification, working remotely, and/or achieving better work life balance which ultimately lead to a less 'workaholic-friendly' organizational culture. These include:

- Ensuring that workaholic behaviors are not incentivized (e.g., delayed promotions; Hamermesh and Slemrod, 2008) and instead, encouraging models of sustainable long-term productivity (Yaniv, 2011).
- Ensuring that promotions and status are not associated with a particular 'heroic' workaholic role model. This is particularly relevant for managers because studies show a higher prevalence of workaholics amongst managers (Hetland et al., 2012; Taris et al., 2012).
- Telling stories of individuals who achieve success through working smart rather than hard or all the time, celebrate families and employees' lives outside work, and promoting a reasonable work-to-life balance (Hakanen & Peeters, 2015)

- Hosting leadership development programs that address the aforementioned issues and encourage the development of boundaries (studies show that flexible working may increase excessive working (e.g., Kelliher and Anderson, 2010) and providing healthy role models.
- Hosting specific training programs on time management, assertiveness, and adaptive stress coping techniques. These are particularly important for people with early signs of work addiction as they struggle to say ‘no’ to work requests (Van Whije et al., 2010).
- Encouraging off-work recovery activities that seem to be most effective in helping people restore the psychological resources spent at work such as mindfulness meditation and gradual relaxation techniques (e.g., Quinones et al., 2017).

Finally, in those cases where employees seek direct support for their excessive work patterns, organizations should offer confidential employee wellbeing support, either directly or indirectly related to this issue. Both family and work lives are intertwined and impact on each other, and more often than not, employees may not seek support directly for the work addiction problem but for related issues.

For the Self

The increasing interest in healthy habits, along with the growing dissemination about the risks of excessive engagement with technology, and accessing ‘work on the go’ (to a great extent related to the rise of mobile technology), is planting the seeds for more conscious self-monitoring and self-care activities. Here, freely available tools could be used to monitor how an individual’s suspected over work may be problematic using the brief seven-item Bergen Work Addiction Scale (Andreassen et al, 2012). Alternatively, or in combination with this, individuals may monitor the way they work, their motivation to do so, and the impact this has on their lives and others over a period of one or two weeks in order to decide whether

any behavioral change in their work pattern is needed. Some of the strategies to regulate excessive behavior and preventing it from escalating were highlighted by Quinones (2017). If the individual feels either unable to change a behavior that they feel is problematic, or they feel they need further support from experts and peers, then they need to seek professional help.

Conclusion

In this chapter different conceptualizations of workaholism were explored and evaluated in relation to the existing empirical data accumulated over the past few decades with a view to establishing what workaholism is (and what it is not) – in other words, the key dimensions as opposed to just correlates. It was argued that the addiction-based explanations of workaholism appear the most sensible approach in understanding the manifestation of this problem particularly at the individual level. Additionally, it was argued that this needs to be complemented by a cultural, a historical, social, and cultural analysis of the circumstances that sustain the lifestyle enabling workaholism in a society that both pushes and punishes pleasure-seeking through consumption. Without this broader understanding, efforts and individual prevention and treatment are likely to be futile. To further a broader gage of workaholism causes and sustaining variables, as well as prevention and treatment possibilities, academics and practitioners from different disciplines including psychology, sociology, and anthropology should work collaboratively. This type of collaboration can occur in parallel to the different individual efforts by challenging the status quo and developing different ways of organizing work in a more balanced and sustainable way. Finally, existing prevention and treatment strategies were reviewed at different levels (i.e., primary, secondary and tertiary). Interventions need to set realistic goals, and not be too lengthy. There is also a crucial need to develop a strong awareness of the client about how and why work addiction has or will cause problems in different areas of individuals' lives.

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