

Work Addiction: When Our Profession Becomes an Addiction

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The Well-Dressed Addiction

In the domain of pathological addictions, work addiction is one of the more topical and dangerous forms of addiction which do not involve substance abuse, but rather an activity which is part of everyday life (Harpaz & Snir, 2003). It is known also as workaholism, a term which was coined in the United States (Oates, 1971) and which comes from the close analogy that this pathology shows with alcoholism; the behavior manifested by workaholics is, in fact, very similar to that of alcoholics (Mentzel, 1979). Robinson (1998) calls work addiction the *well-dressed addiction* because it constitutes a pervasive phenomenon which is not sufficiently recognized by society. According to the Robinson, it is an obsessive-compulsive disorder which manifests itself through demands made on the self and an exaggerated devotion to work, to the point of neglecting other daily activities. The specific feature of work addiction, in relation to other addictions which do not contemplate substance abuse, is that it does not involve an object which is habitually associated with instant and direct gratification, but rather an activity which demands an effort in order to obtain a product or a service, in exchange for which financial remuneration or another type of gratification is granted (Alonso-Fernández, 1996). Work becomes a state of mind, an escape route which frees the subject from any emotions, responsibilities and intimacy s/he may feel in relating to other people (Lavanco & Milio, 2006).

Workaholism appears to affect males more than females, although the number of women who suffer from this addiction is constantly increasing (Guerreschi, 2009).

Three distinct phases are identifiable in the development of the pathology (Fassel, 1990; Guerreschi, 2005):

- *an initial phase* (use - pleasure - abuse). Work addiction initially presents itself as a tendency in the subject to devote excess hours to working, and change his/her lifestyle to accommodate for new and increased work rates. The subject is slowly and gradually absorbed by his/her profession, which distances him/her emotionally from the family and social context. Neglect of his/her family and other interests gives rise to feelings of guilt which the individual does not accept ("I work very hard so my family and I can have everything we want and be happy": an illusion which the work addict needs to believe). This can lead to physical disorders (such as headaches, stomach pains, circulatory and cardiac disorders) and mental ones (concentration disorders, mild depression and psychogenic anxieties), which subjects often disregard by increasing the time they spend at work;
- *a critical phase* (abuse – evasive behaviour - addiction). Subjects accumulate work-related tasks and feel useless if they are not under constant pressure. They distance themselves from emotional relationships and their social lives; they begin to exhaust themselves physically and experience bouts of amnesia and develop sleep disorders. They try to find justifications for their excessive devotion to their profession. The admiration and sympathy which other people show for the subject's increased workload strengthens his/her self-esteem and reduces feelings of guilt. The subject builds up feelings of aggressiveness and impatience towards his/her colleagues. There

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may also be a worsening of the subject's clinical presentation, to the point of developing serious or chronic illnesses;

- *a chronic phase* (addiction – dependence). This phase brings a further increase in the amount of time spent at work, and a hardening in attitude towards those colleagues who do not share a similar working style. The subject often begins to rely on stimulants or tranquillizers. Organic illnesses and serious mental disorders can ensue.

In Japan, studies have been carried out on *karoshi*, a phenomenon which has been linked to work-related stress. *Karoshi* is the tendency shown by many workers, who work excessive hours or in harmful conditions, to develop severe cerebrovascular or cardiac pathologies. A number of these workers have died unexpectedly due to heart attacks and ischaemic problems (Hamajima, 1992). Indicators of work addiction can be (Guerreschi, 2009):

- a compulsion to work manifested by persistent and repeated work abuse, with the subject habitually spending more than twelve hours a day working, or working during holidays;
- constant thoughts and fantasies regarding new ways of resolving work-related problems or achieving professional success;
- withdrawal symptoms, with feelings of emptiness, anxiety or irritation when the subject is kept away from work, such as during holidays;
- a tendency to never miss work, even if the subject is ill;
- recurrent concerns linked to work-related issues;
- manifestations or experiences of fear of losing one's job;
- an inability to knock off and take a break from work, a reduction of time set aside for leisure activities and hobbies and a tendency to occupy weekends and free time with professional updating or work-relating readings and training. Often this attitude comes with feelings of contempt in watching others have fun and engage in normal leisure activities;

Work addiction is typified by (Guerreschi, 2009):

- an accentuated compulsion to work, with crises of working late into the night or working for days without interruption;
- problems in family life caused by lack of communication, authoritarian attitudes, with the subject failing to heed his/her family's constant requests to participate more in family life. After years of work addiction, these problems may also lead to separations and divorces;
- social isolation;
- chronic relational problems with colleagues, superiors or employees;
- job stress syndrome which can degenerate into more serious psychological and physical disorders (such as depression, anxiety, alcoholism and cardiac disorders);
- burnout or emotional exhaustion syndrome¹;
- multiple addictions, with the subject relying on stimulants - such as excessive amounts of coffee to reduce the time spent sleeping and maximize time which can be devoted to working – alcohol, or other often illegal substances.

Portrait of the Work Addict

The workaholic generally presents a personality structure characterized by rigidity and perfectionism. Anxiety, inadequate management of time and work, and low self-esteem are also consistent traits. The subject's entire life is focused on his/her profession, and this consequently leads to a drastic reduction in free time which can be dedicated to other things. Eventually, all the subject's free time is absorbed by work and s/he no longer stops to take a break or pursue leisure activities, emotional attachments or interests. The workaholic always seeks tangible evidence that

¹ Burnout is a form of distress which commonly also has other origins. In this case, it is manifested as conflict which occurs in the workplace. Burnout arises as a consequence of the reactivation of painful experiences suffered, for instance, in childhood in the family environment and which are actualized within the subject's work environment. Such conflicts may be experienced in relation to colleagues and superiors who remind the subject of distressing authority figures.

attests his/her work, and sees his/her personal value as given by the sum of all the things s/he accomplishes. Workaholics concentrate most of their attention on the results which they aim to obtain so that everyone, themselves included, can clearly see how much they are worth (Porter, 1996). They are very often hard on themselves if they make even a minimum error. Any positive feedback which they receive from people who recognize their merits is in conflict with their perception of themselves, and must therefore be adjusted to fit their beliefs. They therefore ignore or disregard any situation which disproves their firm conviction of their inadequacies, and these episodes are not subsumed into personal experience. Positive comments are turned into negative ones (Killinger, 1991). The subject's compulsive behaviour appears to be motivated by a deep sense of insecurity regarding their abilities in different fields of their profession and by feelings of inadequacy in measuring up to other people's expectations. Working thus provides a refuge in which the addict can take control of the situation and feel efficient (Guerreschi, 2009).

Workaholics feel a strong need to devote all their life and free time to their profession at the expense of their emotional, personal and family relationships, which are reduced or entirely eliminated. They live for their profession and feel desolate, empty, anxious or irritable when they are off work, such as during public holidays and weekends. They think about their work day and night, strive to find solutions to work-related problems - be they real or imaginary - and have nightmares about the errors they suspect they have made at work.

In general, the first negative effects of workaholism are felt in the family environment. The subject tends to behave in an authoritarian manner within the family and sees his/her partner as a stranger or an accessory. This leads to a serious deterioration of the subject's emotional life which promotes coldness, apathy, cynicism and indifference between partners. Working has an anesthetizing effect both on the subject's emotional life, making him/her detached and indifferent, and on sexual activity, which is reduced or nullified (Doerfler & Kammer, 1986; Robinson, 1999). The workaholic's family is seldom able to understand his/her behaviour and provide the necessary support. The suffering experienced by family members arises from feelings of neglect, loneliness and abandonment; the workaholic perceives any protests they might voice as signs of rejection and ingratitude. While the workaholic's partner can choose to separate or divorce, his/her children are compelled to live with the difficulties of a workaholic parent until they are old enough to leave home. As a damaging result of this, the workaholic's children become co-dependent, which can lead to the following situations: (a) the child does not realize the parent has a disorder and assumes it is the norm; (b) the child notices the disorder from childhood and shows adaptive behaviour of a varied nature. In this case, contact with a workaholic parent forces the child to dynamically readapt his/her investment in the parent, with regard to time, money and emotional demands, and generally take on greater individual responsibilities. The child gradually freezes his/her feelings so as to survive in the medium to long-term (Burke, 2006).

The workaholic's inability to judge his/her own abilities, rigid thought and sense of direction, and obsessive behaviour are all manifested in the workplace. The subject's relationship with his/her subordinates and colleagues becomes tyrannical and irascible. Being unaware of his/her feelings, the work addict is unable to feel empathy and behaves insensitively towards others, undermining his/her chances of establishing intimate relationships. The need to be in control of oneself and others leads the subject to assume a dominant position in relationships, thus losing the ability of be open with others (Lavanco & Milio, 2006). Workaholics also experience sudden mood swings, going from states of deep depression to maximum euphoria (bipolar disorder).

Addicts lose control of the space and time coordinates of their work in a way which is all-encompassing: there are no more rules and the subject has serious difficulty in recognizing that the addiction has taken over and governs him/her. Workaholics always think they should be doing more than what they are doing, because it is imperative that everything gets done. They explicitly deny their problem by making statements which reflect a strong ethical attachment to their profession. When justifying their dedication, workaholics most frequently cite their sense of duty and the pleasure they feel when working.

In order to affirm his/her identity, and simply to keep going, the workaholic must work constantly and fill all free time with work-related activity. Perennially tied down with commitments and engagements, the workaholic seeks safety in his/her career and success; however, some of his/her personality traits can seriously compromise the validity of his/her work: subjects often have

difficulty relating within a work team with other colleagues and suffer from perfectionism². This can lead to a reduction of professional efficiency and poor time management, with subjects paying too much attention to detail in performing their work. The subject overvalues him/herself, is hypercritical of colleagues, rigidly adheres to the job, never delegates any tasks to others, is ever present in the workplace and is hypervigilant and control oriented.

A very unique characteristic of work addiction is that it develops from secondary rewards, i.e. from the indirect pleasure provided by working repeatedly and for lengthy periods of time, something which can help us to comprehend how subjects can develop an addiction to an activity which rarely also gives primary or direct reward. Not all workaholics are masochists, and manifesting self-punitive trends in this way appears to be quite rare.

The second implication of this unique characteristic of work addiction is that it can appear in those subjects who have developed the so-called secondary process, i.e. the capacity to renounce an immediate pleasure to wait for a future reward. This aspect leads us to believe that workaholics show a certain psychological maturity in dealing with their needs and goals, something which is often lacking or entirely missing in other types of addiction.

The workaholic does, however, experience a degree of direct and immediate pleasure, a factor which consolidates the addict's complete dedication to his/her profession. This pleasure frequently manifests itself when the subject develops a passion for the activity in itself, or a particular field or area of interest pertaining to his profession. This is the case with those professionals who devote all their free time to activities related to their jobs, such as in-depth readings and professional updating.

Work, for the workaholic, plays an exclusive role in everyday life and, to an even greater extent, in mental life. The subject represents him/herself entirely by the compulsion to work. Work addicts often lack the desire and purpose to make plans and carry them out, something which they justify and rationalise by telling themselves that these plans are unfeasible due to work engagements.

Workaholics are psychologically distinguished by a lack of motivation in seeking moments of diversion; they do not show signs of suffering over the work-related sacrifices they undergo, consequently adopting an ethos of living for their work rather than working for a living, and thus neglecting other activities (Heide, 2003; McMillan, O'Driscoll, Marsh & Brady, 2001; Machlowitz, 1980; Pani & Sagliaschi, 2008; Poppelreuter, 1997; Robinson, 1989; Rohrlich, 1981).

Sufferers often have a family history of work addiction. They have often, for example, been raised by caregivers who were very devoted to their profession, reluctant to take care of their family and distracted from their children's problems - parents who have hindered emotional and affective exchange within the family and who have passed their anxiety and stress onto their children (Guerreschi, 2005).

Prevention and intervention techniques

We believe that schools could be an effective tool of education and prevention, admonishing young people about the dangers involved in certain socially accepted behaviours, such as work. Awareness should also be raised within the household environment in order to inform family members on the nature of work addiction and how to recognize its symptoms, and stress the serious consequences that it can have on a person's life (Schaeff & Fassel, 1989).

We think that work addiction today is an underestimated phenomenon, and one which still lacks recognition in the context of psychological disorders. As a result of this, it is diagnosed only when associated with other psychological or physical problems, thus prevalently permitting diagnosis at an advanced stage, after a heart attack or other serious diseases for which absolute rest is prescribed. Even when workaholics are at home or on holiday, they feel the pull of their profession and find it very difficult to admit they have a problem which needs to be seriously addressed in order to put their relationship with their work back in perspective.

² Perfectionism is, however, tantamount to an abstraction and becomes an unattainable obsessive need to satisfy the internal interlocutors which persecute the addict, and urge him to achieve the impossible. This striving for the impossible keeps the workaholic in a vicious circle.

Early diagnosis could occur in family or couples treatment, as it is often family members who are the first to detect the workaholic's malaise and the negative effects of his/her addiction (Robinson, Flowers & Ng, 2006; Robinson & Post, 1995). Most addicts reach clinical observation when their abuse behaviour has already been developing for several years and has seriously affected different areas of their lives. At present, psychodiagnostic assessment of addict behaviour relies on observation, interview, anamnestic collection and implementation of measuring instruments such as Robinson's (1989) *Work Addiction Risk Test (WART)*, Spence and Robbins' (1992) *Workaholism Battery (WORK-BAT)*, and Clark's (1993) *Schedule for Nonadaptive Personality Workaholism Scale (SNAP-WORK)* which are specific to addictive behaviour.

Given the complex nature of the problem, there is no standardised or specialist treatment for workaholism. We believe an integrated multimodal intervention can be useful. It is essential, when treating a work addict therapeutically, to work on: cognitive restructuring; building motivation to change; reclaiming feelings and the ability to communicate emotions; fighting self-destructive tendencies, reinforcing self-esteem and the subject's emotional relationships, both with the partner and in the family context.

Psychotherapeutic treatment of the workaholic should involve (Pani & Sagliaschi, 2010):

- often a pharmacological treatment with a mood modulator to manage the compulsive nature of the addiction and the obsessive pursuit of work;
- cognitive-behavioural psychotherapy, individual psychodynamic psychotherapy and group psychotherapy (e.g. psychoanalytic psychodrama) which focus on helping the patient gain experience of him/herself dealing with specific communication abilities such as empathy; encourage self-analysis and emotional openness; stimulate his/her ability to identify, recognize and then express emotions; help the subject mentalise and regulate his/her feelings and use them appropriately in the context of personal relationships, in the hope of helping him/her reach a greater internal autonomy and not only an apparent independence. Furthermore, these treatments should aim to overcome the patient's linear and monothematic structure, in order to help him/her form a circular and polythematic way of thinking which permits him/her to fill the emptiness which s/he attempts to cover up with addiction;
- family and couples therapy which can be useful in re-establishing communication, restoring trust between the subjects and encouraging intimacy through emotional sharing;
- self-help groups which allow the workaholic to feel a sense of belonging, witness the importance of interpersonal relations and experience other people as interested in helping him/her to establish genuine relationships.

In our opinion, psychotherapeutic interventions should aim to:

- encourage self-revelation in the subject;
- increase introspection in the subject (by *working through*, i.e. initiating a process of elaboration which enables connections to be made, within the self, between planes and situational contexts guided by a sense which is still unknown and unused, to make the subject feel autonomous and in harmony with him/herself);
- stimulate the elaboration and integration of traumatic experiences; in doing so, it is fundamental that the psychotherapist represents a secure base (Bowlby, 1988) to allow the subject to develop a sense of trust with regard to the experience of treatment;
- help the workaholic achieve a sense of stability within him/herself allowing him/her to renounce the coercive compulsion to repeat, navigate the experiential world with confidence and become aware of the reasons which have led to the addiction;
- promote the ability to handle daily events and problems;
- develop the subject's ability to be intimate with him/herself and others, his/her openness towards others and social and communicational skills;
- encourage comparison and relativity to moderate the omnipotent sense of absolutism with which the workaholic assesses reality;
- interpret his/her own subjectivity;
- prevent relapses by identifying activating stimuli and symptoms, while developing strategies to avoid relapses;
- understand and be aware of the process of addiction;

- structure self-esteem, train and strengthen the subject's true self with its meanings, and encourage him/her to take responsibility for his/her actions;

- develop a vision of the group as a unit of the self (*the group as a whole*), realizing that, despite their inherent differences, other people share many of our dynamics, even if not always of a conscious nature. For this reason, psychoanalytical psychodrama has proven very useful and suited to the treatment of compulsive pathology. In groups of eight to ten, the psychoanalyst encourages, and attempts to work towards, the elements listed above. Improvement can occur in promoting an interpsychic and intrapsychic process. The play which is enacted portrays a theme which the whole group shares, and thus encourages group members to find indirect answers and listen to their feelings, allowing them to become protagonists rather than merely passive onlookers (the infantile position of the spectator). The body, which represents the self, and being seen, expresses itself and finds pleasure in collecting alternatives to its sense of impotence, and attempts to free itself from its enslavement to the compulsion to repeat, typical of compulsivity and obsession (Pani, 2007).

*Clinical Example*³

Giorgio, 42 years old, begins a twice-weekly psychotherapy, in the hope that it will help him recover genuine feelings, and free him from what he calls an "imprisonment to his job". Giorgio is a chartered accountant who monitors business tax returns. During sessions, all he can talk about is his job, his concerns for his clients. He never relaxes and seems tense, keeping a close watch on my every expression. He skips most of our sessions, telling me he is tied up with meetings which prevent him from being available for our work together. I feel that Giorgio is not genuinely interested in emerging from his imprisonment, despite realising that his marriage is on the verge of collapse. His wife is beginning to hate him because he never keeps his word, making it impossible for them to plan a trip or a holiday. His sons can also stand him no longer, unable as he is to keep his word or his promises.

I decide to invite Giorgio to a psychoanalytic psychodrama group which I run. In a role-play which he enacts at my request, Giorgio finds himself talking to a client who tells him that he is feeling calm as everything is running smoothly in a certain tax-related issue. The other participants, who are providing a voiceover, point out how absurd it is that a customer should be reassuring him; it should be the professional who is reassuring the client. In the role reversal (reverse playing), Giorgio, playing the role of the client, feels nervous and would like to receive reassurance from the group member who is now playing his role. In this way, Giorgio is able to fully experience how the exchange should take place. Giorgio, facing his insecurity, feels like a child who is asking his father to give him the strength which he has always felt he lacked. In a soliloquy, Giorgio understands that he must leave the uncertain family environment in which he grew up as a child and accept the adult life which he would ultimately like to live. After a few months, the patient's autonomy had already improved.

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³ The case presented is from Roberto Pani's clinical work.

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