Understanding and Treating Workaholism: Setting the Stage for Successful Interventions

Corine I. van Wijhe, Wilmar B. Schaufeli, and Maria C. W. Peeters

Introduction

Many people invest a great amount of time and effort in their work. For instance, in the US, 25 percent of men and 11 percent of woman work more than 50 hours per week (Jacobs and Gerson, 2004). It seems that European workers work somewhat less hard—20 percent of men and 7 percent of women work more than 48 hours per week (European Foundation, 2007)—whereas Japanese work even harder—28 percent of the Japanese workforce works more than 50 hours per week and 12 percent even more than 60 hours (Iwasaki, Takahashi, and Nakata, 2006). Some people who work extremely long hours might do this just for the fun of it. Such engaged employees work with passion and take great pleasure in their work, and consequently work longer hours than prescribed (Schaufeli, Taris, and Van Rhenen, 2008). However, working excessive hours may also be a sign of work addiction: an uncontrollable tendency to work excessively.

Although at first glance work-addicted employees may seem to be an asset for the organization in terms of their commitment and effort, they typically make their work more complicated than necessary (Machlowitz, 1980). For instance, they refuse to delegate work and they have problematic relationships with their co-workers (Kanai and Wakabayashi, 2001; Spence and Robbins, 1992). In addition, workaholics are characterized by orderliness, rigidity, and a high need for achievement (Mudrack, 2004), as well as by inflexibility and perfectionism.
(Killinger, 2006). Taken together, this description does not fit with that of an efficient and productive employee. In fact, workaholic tendencies constitute a high potential for stress among co-workers, considering that workaholics perceive their co-workers as being of lesser value than themselves and their co-workers’ work as being of a lower quality than their own (Porter, 2001). But it is not only the organization that might suffer from workaholic tendencies; the workaholic himself1 might also experience adverse consequences, such as psychological distress, poor emotional well-being, and psychosomatic complaints (Burke, 1999b, 2008; Schaufeli, Taris, and Van Rhenen, 2008). Moreover, because workaholics work extremely long hours, their families also suffer (Bakker, Demerouti, and Burke, 2009) and their social life outside work atrophies (Bonebright, Clay, and Ankenmann, 2000).

Because of the adverse effects on the organization, the workaholic himself, his family and his social life, there seems to be a great need to prevent or treat work addiction. Despite the fact that workaholism is increasingly acknowledged as a problem, to date there are no evidence-based interventions available to prevent or cure work addiction. However, ever since the term “workaholism” was coined by Oates (1968), many suggestions—which are often based on common sense—have been made on how to combat it.

The aim of this chapter is twofold: first, to review explanations for workaholism that might be useful for developing interventions (“How to Explain Workaholism?”); second, to present an overview of possible strategies to prevent (“How to Prevent Workaholism?”) or treat workaholism (“How to Treat Workaholism?”). Before embarking on this endeavor, we will first elaborate on the difficulties related to preventing or treating workaholism (“Why Is It Difficult to Combat Workaholism?”) as well as on the assessment of workaholism (“How to Assess Workaholism?”). The chapter closes with some conclusions that may guide the quest for effective and efficient strategies to reduce workaholism (Outlook).

**Why is it Difficult to Combat Workaholism?**

There are at least four reasons that make it difficult to prevent or treat workaholism. First, in contrast to many other addictions, work addiction does not refer to a particular substance abuse (e.g., illicit drugs, alcohol) but to a particular behavior (i.e., work). Whereas complete abstinence is a rather obvious solution in the case of substance addiction, evidently stopping work

---

1 Of course, where “himself”, “his” or “he” and so on is used in the text, “herself”, “her” or “she” can be read as well.
entirely is not an option for work addicts (Robinson, 2001). This means that it is difficult to conceive what “abstinence” should look like for workaholics.

Second, it has been claimed that workaholism is a well-dressed addiction (Robinson, 2001). That is, workaholism is “just” an excess of something (i.e., work) that is considered to be a key virtue in most societies and, unlike alcoholism, drug abuse, or gambling, it is not related to criminal behavior (McMillan et al., 2001). This means that the social pressure to be treated for workaholism is less strong than for substance-related addictions.

Third, Porter (1996) has suggested that workaholics are largely in denial of their problem and that this constitutes the main obstacle for identifying and treating them. Tellingly, Porter and Herring (2006) observe that workaholics are referred to counseling not for their excessive work behavior as such, but for its consequences (e.g., impaired social functioning or difficulties with delegating). Alternatively, Ishiyama and Kitayama (1994) posit that workaholic clients are likely to be recruited for counseling through medical services, since workaholics are probably more willing to seek help for health-related complaints than for their disturbed work patterns. Seeking medical assistance would be experienced as less threatening by work addicts than seeking psychological support. This might indicate that an indirect approach that focuses on the negative consequences of work addiction would be more feasible, but probably not more effective in the long run, compared to a direct approach that focuses on the work addiction itself.

A final obstacle in the treatment of workaholics is rather obvious: because of the very nature of work addiction, workaholics do not have time for counseling or treatment; they are always working. This means that strategies for reducing workaholism should not be time-consuming.

Taken together, these four difficulties suggest that successful strategies for preventing or treating workaholism should:

- focus on setting realistic and attainable goals,
- enhance the workaholic’s awareness that he has a problem and should do something about it,
- directly focus on the excessive work behavior as well as focusing indirectly on the consequences of work addiction, and
- not be too time-consuming.

How to Assess Workaholism?

The most obvious characteristic of workaholics is that they work far beyond what is required. Consequently, they devote an excessive amount of time and
energy to their work, thereby neglecting other spheres of life (Mudrack and Naughton, 2001). However, conceiving workaholism exclusively in terms of the number of working hours would be incomplete because it would neglect its addictive nature. After all, people may work long hours for all kinds of reasons without being addicted to work. Rather than being motivated by external factors such as financial problems, a poor marriage, social pressure or career advancement, a typical work addict is motivated by an obsessive internal drive that (s)he cannot resist. Hence, we define workaholism as an irresistible inner drive to work excessively hard (Schaufeli, Taris, and Bakker, 2008). So in our view, workaholism includes two elements: (1) a strong inner drive to work; and (2) working excessively hard.

This two-dimensional conceptualization of workaholism corresponds with the original meaning of the term as it was used by Oates, who described workaholism as “... the compulsion or the uncontrollable need to work incessantly” (1971, p. 11). In addition, various overviews confirm that both dimensions appear in most definitions of workaholism. For instance, Scott, Moore, and Miceli (1997) observed that virtually all definitions assume that workaholics:

- spend a great deal of time on work activities when given the discretion to do so—they are excessively hard workers,
- are reluctant to disengage from work and persistently and frequently think about work when they are not at work—they are obsessed workers, and
- work beyond what is reasonably expected from them to meet organizational or economic requirements.

The latter is in fact a specification of the first and second characteristics, because it deals with the motivation to spend an excessive amount of time working. Hence, Scott’s, Moore’s and Miceli’s (1997) conceptual analyses revealed that workaholics work harder than is required out of an obsessive inner drive, and not because of external factors. In a similar vein, in seven of the nine workaholism definitions listed by McMillan and O’Driscoll (2006), working excessively hard and being propelled by an obsessive inner drive are mentioned as core characteristics. Finally, in a recent analysis of scholarly definitions, Ng, Sorensen, and Feldman (2007) conclude that hard work at the expense of other important life roles and an obsessive internal drive to work are the two core aspects of workaholism.

Taken together, there seems to be agreement about the two core elements of workaholism whereby working excessively hard represents the behavioral component that indicates that workaholics tend to allocate an exceptional
amount of their time and energy to work and that they work beyond what is reasonably expected to meet organizational or economic requirements. Working compulsively represents the cognitive component of workaholism, and indicates that workaholics are obsessed with their work and persistently and frequently think about work, even when not at work.

Based on this definition of workaholism we developed the Dutch WorkAholism Scale (DUWAS) that consists of two subscales: working excessively and working compulsively (Schaufeli, Shimazu, and Taris, 2009). Research with the DUWAS confirmed its two-dimensional structure (Schaufeli, Taris and Bakker, 2006, 2008), as well as its reliability and validity (Schaufeli, Taris, and Bakker, 2006, 2008; Schaufeli, Shimazu, and Taris, 2009). For instance, as expected, the DUWAS-scale that taps working excessively correlates positively with overwork, taking work home, and working at weekends (Schaufeli, Taris, and Bakker, 2006), whereas the scale that taps working compulsively correlates positively with psychological distress and psychosomatic complaints (Schaufeli, Taris, and Bakker, 2008). Most importantly, a recent study among junior doctors showed that compared to hard workers (who scored high on working excessively), compulsive workers (who scored high on working compulsively), and non-workaholic junior doctors (who scored low on both scale), workaholics (who scored high on both subscales) had the most unfavorable scores on virtually all study variables, including overwork, work-home conflict, burn-out, and happiness (Schaufeli, Taris, and Bakker, 2008).

How to Explain Workaholism?

McMillan, O’Driscoll, and Burke (2003) distinguish five traditional perspectives on workaholism. First, derived from the common view that workaholism is an addiction to one’s work (Porter, 1996), an addiction framework is differentiated. This general framework can be subdivided into a psychological perspective and a medical (or biological) perspective. The former posits that workaholics are psychologically dependent on their work because it comprises a benefit (Eysenck, 1997), whereas the latter hypothesizes that workaholics have become physically dependent on adrenaline (Fassel, 1992). However, so far, neither psychological dependency nor chemical dependency has been demonstrated.

Second, McMillan, O’Driscoll, and Burke (2003) state that workaholism could be viewed from an operant learning perspective as a learned behavior that originates from continuous reinforcement: the learning theory paradigm. That is, working excessively is considered "desired" behavior, so that reinforcement is maximized. Reinforcements can take the form of praising the workaholic's work
ethic and commitment, but also of more tangible rewards such as promotions, bonuses, fringe benefits, or salary increases. In a somewhat similar vein, the social learning paradigm assumes that workaholism results from role modeling: workaholism stems from imitating influential others—for instance one's father, superiors, or colleagues. Although the learning theory paradigm and role modeling are quite popular in explaining workaholism, so far no research has been carried out to verify their assumptions.

Third, trait theory can be subdivided into a trait-specific and a more broad personality approach. The former equates workaholism with specific trait-like behavioral manifestations, such as perfectionism, need for achievement, obstinacy, orderliness, compulsiveness, and rigidity (Mudrack, 2004). The latter consists of generic explanations of human behavior—for instance, higher-order personality traits like conscientiousness (Clark et al., 1996) and neuroticism (Burke, Matthiesen, and Pallesen, 2006). Because traits are, by definition, rather stable across time and situations, this approach does not lend itself to interventions. Perhaps preliminary screening of employees' personality traits could be useful in preventing workaholism. However, more research is needed to establish the relationship between workaholism and (specific or general) personality traits.

Fourth, cognitive theory assumes that people use cognitive structures (schemata) that manifest themselves in verbal self-statements (Beck, 1995). For instance, Burke (1999a) found that workaholism is related to cognitions concerning competing against others and demonstrating one's abilities. This might point to some deeply-rooted core beliefs that workaholics hold about themselves, such as “I am worthless.” Nonetheless, the study of workaholics' core beliefs is still in its infancy.

A final perspective on workaholism stems from family systems theory. According to this approach, workaholism is considered a family problem, in which the family’s rules, beliefs, and behavior patterns are crucial to the understanding of workaholism. Basically, this perspective views workaholic behavior as a reaction to a maladaptive family functioning (Robinson, 1998b).

The previous theoretical perspectives of McMillan, O'Driscoll, and Burke, (2003) are useful for organizing our knowledge of workaholism and thus for identifying principles for preventing and treating workaholism. However, none of these perspectives deals with the crucial question of when and why workaholics actually stop or continue working. This is quite remarkable because the answer to this question seems to be critical for designing interventions to combat workaholism. Therefore, we introduce a fresh, alternative perspective on workaholism that originates from clinical psychology and explains why people stop or continue with particular compulsive behaviors.
The Mood as Input (MAI) model (Martin et al., 1993) has successfully been applied in clinical psychology to explain repetitive cognitions and behaviors such as compulsive checking (MacDonald and Davey, 2005). A basic tenet of the MAI model is that individuals use so-called “stop rules” to determine when and why to quit with an open-ended task. In order to evaluate their progress toward a work goal, employees may ask themselves “Have I done enough?” (the “enough” stop rule), or likewise they might evaluate their enjoyment of performing the work task by asking themselves “Am I still enjoying the task?” (the “enjoyment” stop rule). The essential question is: on what grounds do people answer questions like “Have I done enough?” or “Am I still enjoying the task?” As the name of the model suggests, people use their current mood as an information source (or input) for answering these questions. That is, when an employee asks himself the question “Have I done enough?”, a positive mood signals that he is satisfied with his progress toward the goal, whereas a negative mood signals that he is not satisfied with his progress, and in the latter case he is thus likely to persist. When an employee asks himself “Am I still enjoying the task?,” a negative mood signals that is no longer enjoying the task, whereas a positive mood signals that he is actually taking pleasure from the task, and in the latter case he will therefore continue.

Typically, in evaluating progress toward their work goals, workaholics rely heavily on how much they have done (“Have I done enough?”) rather than on how much fun they are experiencing from doing their work tasks (“Am I still enjoying the task?”). And what is more, work addicts have never done enough; they tend to have unrealistic and endless lists of things to do. In other words, “... they are faced with trying to meet a performance goal that is a moving target” (Porter, 1996, p. 77). This ties in with the observation that workaholics are preoccupied with what they “ought” to do, which Mudrack (2004) labeled in terms of a strong superego.

In further support of the MAI model, mood seems to play an important role in workaholic behavior patterns. For instance, compulsive workers seem to use their work in order to avoid negative mood states (Porter, 1996). Also, workaholics report, on average, high levels of negative affect (Burke and Matthiesen, 2004), which accords with the prediction of the MAI model that a combination of a negative mood and using the “enough” stop rule would foster work persistence.

Results of a study of van Wijhe, Peeters, and Schaufeli (2010) showed that both aspects of workaholism—working compulsively and working excessively—were indeed positively related to using the “enough” stop rule. In other words, consistent with the predictions from the MAI model, workaholics continue working when they feel that they have not done enough. Furthermore,
it was found that working compulsively was related to negative affect, thus corroborating the findings of Burke and Matthiesen (2004). Hence it seems that an irresistible drive to work is indeed accompanied by undesirable feelings. The findings from our preliminary study are encouraging because they are largely in line with the MAI model. This means that the MAI model potentially opens a new perspective not only for understanding workaholism, but also for treating it.

CONCLUSION

To what extent do the various theoretical notions discussed above provide useful ingredients for successfully preventing or treating workaholism? It is important to note that most theoretical perspectives still await empirical testing, so that the recommendations below are preliminary and should be treated with caution.

- **Interventions should address reinforcing behavior.** Learning theory views workaholism as the product of rewarded behavior. Hence, interventions to prevent or to treat workaholism should target rewarding, appropriate behaviors rather than inappropriate, excessive work behavior.

- **Interventions should focus on maladaptive beliefs.** Cognitive theory assumes that workaholism is rooted in flawed thinking; thus, treatment needs to focus on changing workaholics' maladaptive thought patterns.

- **Interventions should not only focus on the workaholic himself, but also on the environment.** From a learning theory perspective, the maladaptive behaviors of workaholics are reinforced by the work environment, whereas from the family theory paradigm workaholism is a response to maladaptive family functioning. Therefore, treatment of workaholism should also focus on rearranging the workaholic's work- and family environment.

- **Intervention strategies should tackle both the behavioral and the compulsive component of workaholism.** The MAI model may offer the possibility of designing comprehensive interventions which address the persistent work behavior of workaholics by focusing on the compulsive aspect that is caused by cognitions (stop rules) in combination with emotions (mood).
How to Prevent Workaholism?

We use the traditional distinction between primary, secondary, and tertiary prevention (Murphy, 1988) to categorize the occasional suggestions that have been made in the literature about the prevention of workaholism. The aim of primary prevention is to reduce the risk of workaholism among healthy, non-workaholic employees; the aim of secondary prevention is to train a group that is at risk of workaholism to deal with possible triggers that may cause work addition; and, finally, the aim of tertiary prevention is to minimize the negative effects of workaholism as much as possible. Because the difference between tertiary prevention and treatment is often blurred, we will discuss tertiary preventive measures in greater detail in the next section about treatment. Although various ideas on how to prevent workaholism exist (Poppelreuter, 2006), there is virtually no research on this topic, so we cannot draw upon any empirical evidence of the effectiveness of preventive measures.

PRIMARY PREVENTION

Despite the fact that workaholics work hard out of an inner compulsion, their work environment may play an important role in stimulating their work addiction as well. Burke (1999c) found, for instance, that, in comparison to non-workaholics, workaholics worked in organizations that were less supportive of maintaining a healthy work-life balance. It cannot be ruled out, though, that workaholics may be attracted to organizations that favor hard work over a healthy work-life balance. Typically, the excessive amount of effort and energy that workaholics put into their work is usually viewed positively by the organization and its representatives, especially executives, managers, and supervisors. In other words; workaholics are acknowledged and rewarded for their excessive work behavior, which is line with the learning paradigm that was discussed above. The obtained rewards—in terms of praise, career promotion, bonuses, salary increase, or positive attention—confirm the perception of workaholics of being a “special” person who is greatly needed by the organization. It also strengthens the workaholic’s association between working excessively hard and their level of self-worth in such a way that their self-worth becomes dependent on their extreme working patterns.

Conversely, organizations may also contribute to the prevention of workaholism—for instance, by changing the organizational culture. Instead of cultivating the “heroism” of working hard, no matter the costs, organizations may emphasize the importance of a sound work-life balance by setting clear boundaries between work and leisure. For instance, employees can be
discouraged from working at home in the evenings and at weekends by closing access to e-mail accounts, or by emphasizing—and communicating—that the work can and should be done within normal working hours. Moreover, studies show that a so-called supportive work-family culture—that is, the extent to which the organization, direct supervisors, and colleagues are perceived to be supportive of the integration of employees' work and private lives and the utilization of work-home arrangements (Dikkers et al., 2004)—is related to less burn-out and more work engagement (cf. Peeters et al., 2009). Alternatively, employee reward systems may be redesigned in such a way that working smart, rather than working hard, is rewarded. Furthermore, instead of rewarding their employees particularly for extra-role behaviors, organizations might want to reward them more for their in-role performance.

A change of culture as described above is only effective, however, when management practices what it preaches, because the behavior of leaders has a decisive impact on the behaviors of their employees (Podsakoff, MacKenzie and Bommer, 1996). Executives, managers, and superiors must therefore set a good example and serve as role models if they want their employees to work in a healthy, non-addictive way (Fry and Cohen, 2009). This is not an easy thing to accomplish because many of them suffer from workaholism themselves (Brett and Stroh, 2003). Moreover, various managers may have been promoted into their current jobs because they work so frantically.

Finally, the accessibility and confidentiality of counseling services at work are important for the prevention of workaholism (Ishiyama and Kitayama, 1994). These services should not only focus on work-related matters, but should also cover family issues and problems that are related to employee health and well-being. The reason for this is simple: employees are rarely motivated to seek help for their excessive work behavior, but may contact counseling services for health (Ishiyama and Kitayama, 1994) or family problems (Porter and Herring, 2006) that are related to their work addiction.

SECONDARY PREVENTION

From a trait theory perspective, workaholism can be viewed as a set of rather stable personal characteristics that are dispositional in nature. Consequently, by their very nature these characteristics are fairly resistant to change. In addition, workaholic tendencies may be fostered by particular work situations such as highly competitive work environments or unclear role expectations. In such kinds of environments, employees with a certain predisposition for workaholism are encouraged to work excessively hard in order fulfill the high performance standards or the unclear expectations. To prevent a person-organization
mismatch, potential workaholics could—in principle—be identified on the basis of relevant personality factors (e.g., conscientiousness, perfectionism, need for achievement, obstinacy, orderliness, compulsiveness, and rigidity). However, including such traits in a personnel selection procedure might be somewhat preliminary because more research is needed to establish the relation between these traits and workaholic behavioral patterns. To complicate matters even more, some of these traits (such as conscientiousness and need for achievement) are also positively associated with job performance (Judge and Ilies, 2002), and organizations would be reluctant to exclude those job candidates who score highly on these performance-related traits. This is yet another illustration of the ambivalence of organizations vis-à-vis workaholism.

A further example of secondary prevention is to provide specific skills training programs to employees and their managers. Employees at risk of workaholism take on more work than they can handle and accept new tasks before completing previous ones. Training programs which focus on time management and stress management skills might be helpful here. Such programs help employees set realistic goals and prioritize them properly so that they can better cope with high workloads. In addition, employees at risk of workaholism can be trained in personal effectiveness and assertiveness in order to deal adequately with the social demands in their work environment by using such strategies as saying “no” to clients, colleagues or superiors, or holding to their own priorities (Schabracq, 2005). By means of conflict management programs, employees can be taught to deal effectively with interpersonal conflicts at work. Finally, social skills training programs may help employees at risk of developing workaholism to perceive and respond adequately to interpersonal and social cues at work. According to Fligstein (2001, p. 112), social skills are “the ability to induce cooperation among others,” a competency that workaholic-prone employees often lack. In other words, training alcoholics to use social skills, such as making “small talk” or giving compliments, facilitates a smooth and unproblematic interaction with colleagues which may increase the workaholic’s self-esteem and increase the probability that others will respond approvingly.

Furthermore, to prevent workaholism, employees should be encouraged to detach and recover from a hard day’s work. A demanding work situation increases the need for recovery because it draws on an individual’s resources (Zijlstra, 1996). Successive depletion of resources will result in negative effects, such as fatigue and, eventually, when no recovery occurs, in exhaustion. Distraction may help employees detach and recover from their work As workaholics are prone to burn-out (Taris et al., 2008), they should learn to slow
down by building in relaxation time such as taking a break, meditating or reading a book (Robinson, 1997).

CONCLUSION

Primary prevention of workaholism—that is, the reduction of the risk of workaholism among healthy, non-workaholic employees—boils down to changing organizational culture. In essence, the culture in which employees who work 60-plus hours per week are the “heroes” who are displayed as role models should be replaced by a culture which stimulates working smart rather than working hard and which values a healthy work-life balance. This is not an easy thing to accomplish, though, because those who are in charge of that culture change are often work addicts themselves.

In terms of secondary prevention—which focuses on those who are at risk of workaholism—basically two kinds of strategies may be followed. First, in personnel selection procedures, job candidates may be screened on personality characteristics that make them vulnerable for workaholism, such as conscientiousness, perfectionism, need for achievement, obstinacy, orderliness, compulsiveness, and rigidity. However, for the time being, we would advise against such screening of employees because—apart from the ethical issues involved—more research is needed to establish the links between workaholism and personality factors. This leaves us with the second, more feasible and realistic option: increasing the resilience of those who work in jobs that might foster workaholism by training time-management skills and social skills such as assertiveness and conflict management.

How to Treat Workaholism?

Although various forms of individual counseling and treatment of workaholics have been lively debated in the literature (Burwell and Chen, 2002; Ishiyama and Kitayama, 1994; Robinson, 1997, 1998a; Vaughn, 1992), few practical initiatives have been taken, let alone been tested for their effectiveness. Therefore, in this section we will also draw upon studies that deal with other behavioral addictions such as compulsive gambling and buying. Because the motivation to change addictive behavior is an important prerequisite for treating workaholism, we will consider this issue first. Next, we discuss a self-help initiative (Workaholics Anonymous) and a systems approach (family counseling), and then we move to interventions that focus on the behavioral and cognitive aspects of workaholism.
MOTIVATIONAL INTERVIEWING

It is well documented that motivation is a prerequisite for changing health-related behaviors. More specifically, Miller and Rollnick (1991, p. 19) view motivation as "the probability that a person will enter into, continue, and adhere to a specific change strategy." A model for understanding how motivation for change can be improved is the Trans Theoretical Model of Change (Prochaska and DiClemente, 1983). This model predicts that individuals progress through different stages of change. These stages are precontemplation (being unaware of a problem), contemplation (being aware of a problem), preparation (intention to take action), action (change behavior to resolve the problem), maintenance (continued changed behavior) and relapse (reoccurrence of the problem behavior), respectively (DiClemente and Prochaska, 1998). In each stage, individuals have to deal with different issues and tasks—for instance, addressing the ambivalence of changing the behavior.

Workaholics are likely to experience some motivational ambivalence because they simultaneously see reasons to change and not to change their excessive work behaviors. In order to involve workaholics successfully in the treatment process, it is crucial to reduce this ambivalence. Motivational interviewing is a client-centered therapeutic style that helps individuals examine and overcome their ambivalence about behavior change. By expressing empathy, developing discrepancy between values and behaviors, sidestepping resistance and supporting self-efficacy, the counselor helps the individual develop greater problem awareness, which may lead to an improved motivation to change (Miller and Rollnick, 1991). So far, brief motivational interventions have been applied to substance-related addictions, such as alcoholism (Brown and Miller, 1993), and substance-unrelated addictions, such as gambling (Wulfert et al., 2006). Research findings show that motivational interviewing produces the desired behavioral change. For that reason we expect motivational interviewing to be beneficial for workaholics as well, particularly because workaholics often lack the problem awareness that is necessary if they are to change their behavior.

WORKAHOLICS ANONYMOUS

The best known and probably most widely used treatment program for workaholism is offered by Workaholics Anonymous (WA), which is based on the Twelve Steps and Twelve Traditions of Alcoholics Anonymous (Alcoholics Anonymous, 2002). WA has offered its services for more than 30 years and currently has more than 80 so-called meetings in the US and in Europe (see www.workaholics-anonymous.org). When entering the WA program the
workaholic progresses through the Twelve Step program (e.g., admitting that one's life became unmanageable), practices the Twelve Traditions (e.g., by declaring that personal recovery depends on the common welfare of the WA group), and is advised to use the 15 "Tools for Recovery", consisting of listening and prioritizing, among other things (Workaholics Anonymous, 2006). These tools are regarded as crucial to practicing abstinence. In the WA meetings or with the help of a so-called sponsor (a WA member who is already recovered from working compulsively) abstinence plans are made, including a plan for maintaining personal bottom lines (e.g., "I do not work more than 45 hours per week") and top lines (e.g., "I will sleep at least eight hours every night"). The meetings provide support in case of relapse. Despite its eminence, the WA treatment program has no clear theoretical foundation; neither has evidence been published on its efficacy for reducing workaholism. Nevertheless, the popular practice of Alcoholics Anonymous suggests that this type of treatment program is effective in reducing addictive behaviors (Krentzman, 2008). Testing the effectiveness of such programs remains a difficult endeavor since, among other things, self-selection could be responsible for the possible treatment effect. In other words, it is to be expected that those who are most motivated to combat their work addiction will volunteer to participate in WA.

FAMILY COUNSELING

Family counseling has received considerable attention, mainly because of the writings of Robinson (e.g., 1998a, 2000b), and other authors (Ishiyama and Kitayama 1994; Seybold and Salomone 1994), who regard changing the family system as the main focus of treating workaholism. Before implementing an intervention, Robinson (2001) recommends mapping out the workaholic family system. Once this screening has been done, the counselor should address the communication patterns of family members that maintain the addictive behavior of the workaholic. Next, the counselor can assist the family in setting healthy boundaries regarding the time and attention devoted to work. Robinson further suggests that attention must be given to "effective family roles, greater affective responses, more affective involvement, and higher general functioning—all of which characterize the workaholic family system" (2001, p. 133). Unfortunately, except for an occasional case illustration (cf. Robinson, 1998b, 2000a), no empirical research has been carried out on the effectiveness of family or couples' counseling.
BEHAVIORAL INTERVENTION STRATEGIES

According to the behavioral perspective (McMillan, O’Driscoll, and Burke, 2003), workaholism refers to an acquired dysfunctional behavior that, consequently, can be altered through behavioral intervention drawn from learning theories. Behavioral treatments commonly include techniques such as imaginary desensitization (a guided imagery technique founded on the principle that systematic desensitization enables individuals to manage their urges), relaxation training (muscle relaxation techniques to reduce tension associated with the compulsion), and behavioral monitoring (giving feedback about the individual’s behavior). Other elements that we have already discussed as secondary prevention strategies are social skills training, assertiveness training, and problem-solving. Chen (2006) notes that, especially in the earlier stages of treating workaholics, so-called cue response techniques—such as imaginary desensitization—may be useful. For workaholics this means that they visualize situations in which they usually work long hours or think about work. Using muscle relaxation techniques simultaneously with visualization, clients are gradually directed through these visualized situations by the counselor. In fact, the counselor helps the workaholic deal with the induced triggers (i.e., the visualized situations) and concomitant feelings of restlessness. Muscle relaxation is incompatible with the muscle tension that is caused by the induced triggers and feelings of restlessness, and therefore has the potential to override these and thus undo their negative effects.

Although such behavioral interventions have not been evaluated empirically for workaholism, they have been successfully applied to other addictive behaviors, such as gambling (McConaghy, Blaszczynski, and Frankova, 1991). For instance, McConaghy and his colleagues found that 78 percent of the participants, who were treated with imaginary desensitization, quitted gambling or were able to control their gambling compared with 53 percent who were treated with different methods such as aversion therapy (i.e., administering electric shocks to the gambler paired with reading about their gambling behavior in order to eliminate that behavior) and in vivo exposure (i.e., observing others playing at a gambling house without gambling oneself).

An alternative behavioral approach to treating workaholism is to use contingency or reinforcement management. This means systematically rewarding workaholics for desired behaviors, such as, among other things, working fewer hours. We posit that for workaholics effective reinforcement of appropriate work behaviors can be fostered by rediscovering hobbies and redeveloping interests (Oates, 1971). Workaholics must seek alternative ways to enhance their low self-esteem—for instance, by learning to find purpose and
meaning in other things than work (Kiechel, 1989). The rationale is simple: being engaged in a hobby or following other interests outside work is incompatible with work; time that is spent on leisure activities cannot be spent at work. Hence, leisure activities by definition reduce workaholism.

COGNITIVE INTERVENTION STRATEGIES

The compulsive thought patterns and distorted core beliefs of workaholics can be addressed by cognitive therapy (CT) which aims to alter these patterns in order to decrease working excessively and compulsively. Cognitive therapy should not be confused with cognitive behavioral therapy (CBT). CBT will be addressed in the next section and assumes that cognitions and behaviors are mutually dependent so that both components should be addressed simultaneously (Walker, 2005).

Circumstantial evidence for the potential effectiveness of cognitive strategies in reducing workaholism can be found in the treatment of other behavioral addictions. For instance, Ladouceur et al. (2001) carried out a randomized controlled study among pathological gamblers to test the effectiveness of a cognitive intervention. The effect of the treatment was compared to the levels of pathological gambling of a waitlist control group. The treatment focused on changing erroneous perceptions about the randomness of winning a bet in gambling—that is, changing gamblers' false belief that they can predict the outcome of a play. The results showed that at the end of the three-month treatment period participants in the treatment met fewer diagnostic criteria of pathological gambling according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994), and reported less desire to gamble than the participants in the waitlist control group. At one-year follow-up, 86 percent of the participants who completed cognitive treatment recovered from their pathological gambling according to the diagnostic criteria of the DSM-IV. Unfortunately, no comparison against the waitlist control group could be made, because this group was offered treatment nine months earlier, after the post-treatment test.

COGNITIVE-BEHAVIORAL STRATEGIES

Whereas cognitive intervention strategies focus solely on changing the cognitions in order to change mood and behavior, cognitive-behavioral interventions focus on changing both the cognitive and behavioral components of addiction at the same time. Such interventions combine cognitive strategies (e.g., identifying distressing thoughts) and behavioral intervention strategies (e.g., skills
training). Chen (2006) describes how to apply the principles of rational emotive behavioral therapy (REBT)—see Ellis (1993, 2000)—to workaholism. He argues that workaholism can be treated as a form of cognitive irrational disturbance and proposes several cognitive strategies to decrease workaholism—for instance, to debate irrational beliefs. This is a therapeutic technique that is used to challenge dysfunctional beliefs. Typically, workaholics may hold irrational beliefs, such as “I am the only person in the department who can do this job” or “When I do not finish my work on time a disaster will happen.” Chen (2006) argues that such irrational beliefs are the root cause of the workaholic’s preoccupation with work. The counselor teaches the workaholic to challenge his own misconceptions by asking himself questions like “Who did this job before I came to the department?” or “What will be the consequence when I miss that particular deadline?” As the workaholic gains insight into his own irrational thinking, the counselor helps him to view the situation from a different perspective. The counselor then teaches the workaholic to replace his old, wrong, “irrational” thoughts by novel, more “realistic” thoughts and beliefs. This way of dealing with cognitive distortions is called cognitive restructuring (Burwell and Chen, 2002). So, instead of holding the irrational belief that they are the only ones who can do the job or that missing a deadline is an absolute disaster, workaholics might now reason that finishing a particular job is the supervisor’s responsibility and missing a deadline doesn’t cause chaos, but just a small delay in the process.

In addition, Chen (2006) points out that, instead of using words like “ought” and “must”, a workaholic could learn to use rational statements. For instance, instead of saying “I must meet that deadline at all costs,” they could say “I will try to keep the deadline and, if I cannot, I will communicate this in time.” Mastering this kind of self-talk is important for workaholics because it creates awareness that there are alternative, more realistic ways to perceive and interpret what is going on in the work situation. In other words, it helps the workaholic free himself from the burden of compulsive thought patterns that focus exclusively on work-related matters.

Burwell and Chen (2002) argue that rational-emotive imagery, another element of REBT, could be an effective intervention strategy for workaholics as well. This strategy consists of learning to feel new pleasant emotions, instead of unpleasant emotions in particular situations. Using rational-emotive imagery, workaholics imagine themselves to be in a worst-case scenario, such as not being able to work long hours for whatever reason. Subsequently, they are asked to intensely experience the feelings associated with working fewer hours, such as feeling like a failure in the eyes of their colleagues. Finally, they are instructed to change the negative emotional experiences into appropriate feelings that are in line with rational thinking. More particularly, they are trained to signify that
they may feel and behave alternatively—for instance, by deciding to not be preoccupied with what colleagues think about them. As a result, workaholics will be less bothered by negative feelings.

Finally, difficult situations could be rehearsed by means of role-playing. Role-playing provides workaholics with the opportunity to examine in a simulated real-life setting the irrational thoughts that have led them to feel inappropriate emotions. An example is rehearsing a conversation with one’s superior who is not satisfied about one’s performance. During the conversation the counselor can tackle associated irrational thoughts like “When my superior is not satisfied, my career is terminated and everyone thinks I am a loser.”

Findings from studies that applied CBT to other behavioral addictions are positive. For example, Müller et al. (2008) conducted a randomized controlled study among compulsive shoppers. Half the participants received a group treatment based on cognitive-behavioral principles, whereas the remaining participants were assigned to the waitlist control group. The participants in the treatment group took part in one session per week over a period of 12 weeks. At follow-up, after the intervention, symptoms associated with compulsive shopping (e.g., buying things when one could not afford them) had decreased significantly, and also in comparison to the control group. Specifically targeting gambling-related beliefs and cognitions, Breen, Kruedelbach, and Walker (2001) found that a 28-day in-patient CBT program affected the targeted gambling beliefs and attitudes significantly and in the desired direction. Unfortunately, no control group was included in this study.

As argued previously, the MAI model provides a rationale for a cognitive-behavioral treatment of workaholics in terms of changing mood and stop rules. The MAI model implies that when negative mood is reduced through intervention, the persistent behavior of the workaholic will decline. That is because workaholics no longer feel discontented or guilty about their achievements and therefore no longer feel that they have to work so frantically to undo or avoid these negative feelings. Such negative emotions of workaholics can be altered through, for instance, shame-attacking exercises (Chen, 2006). This exposure exercise directly targets emotional disturbances by instructing the individual to deliberately do something that is shameful in his own eyes and evokes the disapproval of others (Ellis, 1969). A workaholic might, for instance, leave the office earlier than his colleagues do (without compensating for it the next day). While doing this, the workaholic tries to cancel out his shameful feelings that arise from leaving earlier. Through such exercises, the workaholic learns that he should not be so concerned about others’ opinions. He might also discover that the reactions of his colleagues are more supportive than expected.
Eventually, by means of these shame-attacking exercises, workaholics may learn to accept themselves unconditionally instead of relying on outside approval.

Another approach based on the MAI model is stop rule management. First, workaholics should be made aware of what specific stop rule drives their persistence and why they use it. Second, the irrational thought of not having done enough may be challenged through cognitive techniques. With the help of a counselor the workaholic should gain control over his—often implicit—stop rule. Ultimately, his maladaptive cognition of having to continue until he has done enough is to be replaced by a more rational stop rule, such as continuing until he no longer takes pleasure from working. We anticipate that learning to manage stop rules will help workaholics resist their compulsive drive to work excessively hard. To illustrate, Watkins and Mason (2002) found that ruminators usually have a default “enough” stop rule, leading to high persistence in producing ruminative thoughts. The authors discovered that instructionally modifying ruminators’ stop rules that they used for the interpretation of mood affected the persistence in rumination. Their results showed that when instructing ruminators to use an “enjoyment” stop rule, rumination decreased to the intensity found in low ruminators. From this it appears that people may adopt the stop rule that they are instructed to use, at least for the short run. Sustained adoption of stop rules, however, is not an extrinsic, but rather an intrinsic, process. Workaholics should not just temporarily use a different stop rule because the counselor has instructed them to do so, but instead they must internalize their new stop rule of continuing as long as they enjoy working. Little is known yet about how to set this adoption process in motion.

CONCLUSION

Although self-help groups (Workaholics Anonymous) and family systems counseling are intuitively appealing, it seems that—from an evidence-based perspective—the most promising way to treat workaholism is by applying the principles of cognitive and behavioral therapy. This is not very surprising because workaholism has both a cognitive (working compulsively) and a behavioral (working excessively) component. However, because workaholics are notoriously unmotivated for treatment, motivational interviewing might be a useful tool for positively influencing their readiness to change, and thus to seek professional help.

Several techniques focusing on one of the two components of workaholism or on both simultaneously have been discussed. Most of these techniques may be used in more comprehensive treatment programs such as rational emotive behavioral therapy (REBT), role-playing, or cognitive behavioral therapy (CBT).
Un fortunately, so far, no studies on the effectiveness of these treatment programs have been conducted among workaholics, but studies among other behavioral addictions, such as excessive buying or gambling, show encouraging results.

A new opportunity for the treatment of workaholism may lie in the application of the principles of the MAI model. Although we need to know more about the exact role that mood and stop rules play in the development and maintenance of workaholism, changing moods and stop rules seems a promising avenue for an effective and theory-based intervention. A MAI-based intervention would, however, be a double-edged sword. On the one hand, it improves the impaired mood of workaholics and enhances their general well-being. On the other hand, changing the maladaptive compulsive stop rule into a more favorable one reduces excessive work behavior so that more time can be spent on pleasurable non-work activities.

GUIDELINES FOR THE DESIGN AND IMPLEMENTATION OF WORKAHOLISM INTERVENTION PROGRAMS

So far, we have discussed the content of intervention programs to prevent or treat workaholism. But what about the process? The steps that should be followed in order to develop and implement an intervention program successfully are no less important. For that reason we would like to introduce intervention mapping, a systematic method for designing and implementing evidence-based interventions (Bartholomew et al., 2006). Intervention mapping uses the following six steps:

1. **Needs assessment.** The nature and prevalence of workaholism is assessed and its determinants in high-risk groups identified—for instance, by using employee surveys or and focus groups consisting of workaholics.

2. **Identification of objectives and determinants of change.** Based on our two-dimensional conceptualization of workaholism performance, objectives would be to reduce excessive work behaviors as well as accompanying compulsive cognitions. Because workaholic behaviour is displayed in different contexts (at work and at home) intervention objectives should be specified for each context separately.

3. **Selecting methods and strategies.** Theory-based intervention methods and practical strategies to prevent or treat workaholism are reviewed and evaluated—by using the current chapter, for instance.
4. *Developing the program.* The selected methods and strategies are combined into a comprehensive intervention program, and intervention materials such as protocols are developed. The intervention program is piloted.

5. *Implementing the program.* The intervention program is tailored to the target group, and objectives are specified for implementation. In other words, Steps 2 and 3 are repeated, but now for facilitating the implementation of the intervention program.

6. *Evaluation.* Finally, an evaluation plan is developed that assesses the extent to which the desired changes have been achieved. That is, have levels of workaholism indeed been reduced?

We encourage the use of this framework because of its systematic approach, because of its focus on evidence-based interventions, and—last but not least—because it leads to quality improvement for workaholism interventions. For more details about intervention mapping we refer to Bartholomew, Parcel, and Kok (1998), and Bartholomew et al. (2006).

**Outlook**

We defined workaholism as an irresistible inner drive to work excessively hard (Schaufeli, Taris, and Bakker, 2008). Although there is not complete agreement about the nature of workaholism, most definitions concur that working excessively hard (the behavioral component) and working compulsively (the cognitive component) constitute its core elements. On the basis of this two-dimensional view of workaholism, a valid and reliable self-report questionnaire has been developed that can be used for identifying employees who suffer from work addiction (Schaufeli, Taris, and Bakker, 2006, 2008; Schaufeli, Shimazu, and Taris, 2009). This so-called Dutch WorkAholism Scale (DUWAS) can be employed in prevention programs to detect specific groups that are at risk of workaholism as well as in treatment programs to assess the extent to which workaholism has been reduced.

Our overview of theoretical approaches revealed that these are useful for organizing our knowledge of workaholism, but that their usefulness as a basis for interventions is rather limited. Alternatively, some intervention practices emerged (e.g., Workaholics Anonymous) that lack clear theoretical underpinnings. Nevertheless, based on our overview of prevention and treatment of workaholism, we may formulate three major principles for combating workaholism.
First, workaholism is an ambivalent phenomenon; it is neither entirely good, nor entirely bad. Some stakeholders (organizations) have a vested interest in employees working very hard, whereas others (partners of workaholics) have opposite interests. The workaholics themselves are caught in between: their behavior is approved of, as well as disapproved of. This means that it is inherently difficult to combat workaholism and that considerable effort is needed to raise the workaholic's awareness that his excessive work behavior constitutes a problem that needs to be dealt with. A technique like motivational interviewing might be helpful here.

Second, interventions should not exclusively focus on the target person, but also on the organizational and family environments. For instance, preventive measures should aim at changing an organizational culture that promotes workaholism into a more healthy culture. Moreover, family members should also be included in prevention and treatment programs because they are not only victims of workaholism, but also play a role in maintaining it.

Third, the treatment of workaholism should aim at changing its behavioral component (working excessively hard) as well as its cognitive component (working compulsively). It seems that treatment programs based on principles that are used in cognitive and behavioral therapy are the most promising when it comes to reducing workaholism. That is, circumstantial evidence from the treatment of other behavioral addictions suggests that a cognitive-behavioral approach is likely to be successful for workaholism as well.

A Final Note

This chapter pulled together our current knowledge on preventing and treating workaholism. Over the years, many suggestions have been made to combat workaholism, but no evidence-based intervention protocols are available yet. So the future challenge is to transform these suggestions into successful interventions. We hope that this chapter will help both scholars and practitioners to meet that challenge.

References


