Workaholism and its symptoms in individuals manifesting mental disorders: a clinical analysis based on a case study

Małgorzata Dobrowolska

Silesian University of Technology in Gliwice, Poland , University College of Social Sciences and Philologies

Bernadetta Izydorczyk

Jagiellonian University in Krakow, Poland, Faculty of Management and Social Communication, Institute of Applied Psychology

Abstract

Workaholism is an exceptionally complex psychological phenomenon that has been widely described in the literature from numerous theoretical perspectives. The common assumption in describing psychological profiles of individuals characterised by the so-called workaholic attitude to work and life pertains to the presence of many various mental disorders manifested by a given person. These include depressive disorders, anxiety disorders, psychosomatic disorders and personality disorders. Persons who manifest different stages of inner compulsion are characterised by the absence of control and distance to increased professional activity. Over time, psychopathological symptoms become displayed in the psychological functioning of such individuals, which requires treatment. Moreover, a workaholic patient needs also medical, psychological or psychotherapeutic assistance. The aim of this article is to determine the significance of differential diagnoses of workaholics' psychological profiles by means of examining clinical case reports to provide a broader and a more in-depth view on treatment and directions to be taken in psychological assistance. By presenting the theoretical grounds of workaholism, the authors focused primarily on presenting clinical aspects of an individual's negative functioning (detrimental to his or her development and health) in the organisation and structure of a given work situation. Clinical cases reports pertaining to patients suffering from workaholism are not common in the literature. For this reason, the article aimed primarily at describing three psychological profiles of individuals who manifested workaholism with comorbid mental disorders.

Keywords: workaholism, case study, mental disorders

Introduction

The considerations on experiencing workaholism made so far in the literature find it to be a specific psycho-social process that causes in the life of an individual who experiences it the risk factor of developing psychopathological symptoms and mental disorders defined in psychology as neuroses and in medical classifications as mixed anxiety and depressive disorders and obsessive-compulsive disorders (Porter, 1996; Hornowska, Paluchowski, 2007) and personality disorders (Golińska, 2008, Wciórka, 2008, Wojdyło, 2006, 2010). Another trait commonly observed in workaholics pertains to addiction in a broad sense (Oates, 1968, 1971, Spence, Robbins, 1992, McMillan, O'Driscoll, Marsh, Brandy, 2001).

Professional activity of patients diagnosed with traits of workaholism is varied, though as indicated by psychologists' clinical practice, it results in or strengthens the formation and/or continuance of different most often chronic mental disorders (neuroses and personality disorders) in this group of people.

Regardless of the typologies of workaholics provided in the literature, the model of psychological functioning of a workaholic in the mentioned typologies is said to commonly share the element of a noticeable compulsion that is pursued by a given person and which determines his or her engagement in work that is excessive in terms of the dedicated time and remains beyond his or her control, as well as a compulsion to structure and implement all life activities accordingly and exclusively to occupational tasks. Work situation becomes the main object that determines and motivates the direction of daily activities.

1. Clinical analysis based on case studies of workaholics

In order to illustrate the hypotheses provided in the article that state that workaholic traits and behaviour act as predictors in generating symptoms of mental disorders, clinical case reports of three individuals with workaholic tendencies and comorbid medically diagnosed neuroses were provided below. Oftentimes, prevailing neurotic symptoms in workaholics include those associated with anxiety and depression.

Individuals with this group of psychopathological symptoms (all the more those displaying workaholic symptoms) require psychological help. Participation in psychotherapy allows one to work on his or her mental issues, particularly negative thinking and anxiety thinking. Psychological assistance promotes restoration of mental balance by means of changing fallacies and problem solving.

The below-described three psychological profiles of individuals diagnosed by psychologists with workaholism were constructed based on three random life stories of people who sought medical and psychological assistance at facilities due to various chronic neurotic symptoms they experienced. The source data come from psychological and medical records collected during clinical studies conducted by the authors of the article.

The medical records provided data that confirmed firstly the medical diagnoses of a given person's type of disorder, as well as recommendations regarding necessary pharmacological and psychological treatment. An analysis of the medical records allowed data on the psychological diagnosis of emotional, cognitive and behavioural functioning in the context of the reported symptoms to be obtained for each of the presented individuals.

A verification by means of a clinical method (clinical interview and psychological conversations during treatment at a medical facility) allowed the authors to determine a profile of prevailing psychological traits that either support or reject the hypothesis about the existence of factors that would confirm the presence of traits typical of workaholism in a given patient who was medically diagnosed with a specific disorder. In the course of preparing this article, clinical data were collected in accordance with the rules of professional secrecy and personal data protection (the so-called sensitive data). Each of the individuals consented to having his or her data used for experimental purposes. Due to data protection, the authors used only the personal information essential to outline the psychological type of a person addicted to occupational activity who also manifested a mental disorder.

The below-presented group of individuals, further referred to as 'workaholics', who manifested various chronic mental disorders comprised, as follows: a person medically diagnosed with mixed anxiety and depressive disorders (ICD-10 F41.2), a person medically diagnosed with obsessive-compulsive disorders (ICD 10 F42) and a person medically diagnosed with somatoform disorders (ICD 10 F45).

1.1. Psychological profile of a workaholic experiencing obsessive-compulsive disorders (a case study)

Mr M., 32 years old, college degree in Management, long-term inhabitant of a metropolitan area, married for 12 years, no children. Mr M. runs his own business rendering legal services to numerous companies for a large law firm and is considered – as he described himself – a very respected person who is highly perfectionistic in his work. Mr M. sought help at a medical centre due to obsessive-compulsive symptoms (consistent with anxiety obsessions, particularly fear of social evaluation and contact with other people; especially in work-related situations). After being examined by a psychiatrist, Mr M. was medically diagnosed with obsessive-compulsive disorders (ICD-10 F42). Obsessive thoughts pertained mostly to receiving a negative evaluation of his performance, a growing concern of not fulfilling occupational tasks without any actual grounds for such thoughts and concerns). As a result of obsessive negative thoughts on failing to fulfil occupational tasks that awaited him, anxiety-inducing thoughts about getting fired due to his performance at work receiving a negative evaluation from his superiors, Mr M. reacted with avoiding behaviours, e.g., increasingly more frequent holiday leaves (including a short-term leave on request), seeking doctor's visits and increasingly more frequent sick leaves due to various progressive symptoms (from common cold to mental disorders). Mr M. most commonly reported symptoms of anxiety obsession and depressive symptoms (mood swings with prevailing tendency for negative thinking about oneself and the future). Apart from fear about his work and not fulfilling occupational tasks, Mr M.'s anxiety obsessions also pertained to fear about his house and family, his own and his loved ones' health. Anxiety obsessions and compulsive behaviour associated with, for

instance, checking in various daily routines (e.g., checking door and window locks, checking for other personal belongings he carried with him) appeared 4 years earlier and with time caused his psychophysical wellbeing to deteriorate, resulting in difficulties in fulfilling his occupational tasks and social alienation. With increasing emotional and social difficulties in his family and social life, and, primarily, in fulfilling his occupational duties, Mr M. sought medical and psychological help. At the time when he reported to the centre, he lacked the awareness to relate the emotional disorders he was manifesting with the significant role of his addiction to work. Mr M. was subjected to pharmacological treatment and psychotherapy. Owing to treatment (including long-term psychotherapy) Mr M. has gained an insight into the psychological mechanisms of anxiety disorders and gained awareness about the role of his own workaholic attitude to his job in the process of mental disorders and obsessive-compulsive symptoms he has developed. The description of Mr M.'s psychological functioning provided in the records confirmed the controller type of a workaholic. A model based primarily on the need to perform all tasks and behaviours formed in his personal, social and occupational activities and dominated all his activities for many years. When explaining the workaholic model of Mr M.'s attitude towards his work situation that formed at the very beginning of his professional career and the obsessive-compulsive symptoms that was progressing for several years one ought to note also the context of Mr M.'s family background and workaholic attitude promoted by one of his parents. In Mr M.'s model of functioning in life situations (be it family- or work-related situations involving his co-workers, superiors, employers) attention should be put on the formed pattern and establishing relationships based on, as follows: excessive control over undertaken actions, behaviour and social relations; cognitive rigidity and focus on unimportant details; as well as dissatisfaction with performed actions combined with a permanent feeling of frustration and criticism of his own actions. The above pattern of Mr M.'s reaction in social situations he found himself in was associated with the following traits identified in his self-description (inadequate to the needs, the possibility to receive gratification and satisfaction with performed tasks): excessive independence and ambition, extremely high motivation, high impulsivity and impatience (displaying buoyant energy despite comorbid symptoms), low need for sleep (frequent insomnia), high endurance and capability to perform without the need for rest. With regard to his own professional activities and social relations, Mr M. noted that from the very beginning of his career he has been engaging in a pattern of experiencing work as "a time-killing activity that fills the void". The absence of awareness of the need for having his own free time and 'escaping' into work have become an adaptive mechanism Mr M. has been systematically employing in his life.

In professional relations and contacts with his employers, Mr M. has always adopted a directive attitude that allowed him to control decisions taken in companies he cooperated with. Due to the nature of his profession (lawyer) he had a decisive or a significant impact on the decisions taken by management boards. From the very beginning of his career, especially after getting married, Mr M. has been systematically working longer hours, extending his daily working hours from 8.00 am to 8.00/9.00 pm with no breaks and without acknowledging or reporting the need for rest or leaving for home over only a few years. Mr M. motivates his behaviour in the following words, "I had a mortgage to pay off, I had to work a lot, keep records in order, run cases before courts, always busy because there was always much to do from morning to evening". Mr M. was unaware of the destructive nature of his own actions, as he would frequently resort to the psychological mechanism of rationalisation and denial of the actual situation. As emotional difficulties accumulated and anxiety symptoms (depressive symptoms, anxiety obsessions) progressed over the years, Mr M. continued to employ the workaholic attitude despite having paid off the mortgage and improved his family's living conditions. When describing his experiences, he noted that his ambitions and the need to constantly prove himself in the professional field increasingly more often signalled his progressively decreasing self-esteem. In the course of his psychological therapy, Mr M. referred to this condition as "killing the emotion, depression and void with working". What is more, Mr M. noted that work has become the only source of satisfaction understood as goal achievement, the need for social validation (to be the best), total control over emotions, which increased his experience of a compulsion to constantly remain in work situation. Work served as the source of control over negative emotional states he was experiencing, i.e., depression and anxiety. Owing to psychotherapy Mr M. has gained an insight into the psychopathological mechanisms of mental disorders, including those related to his workaholic attitude towards occupational activities, which were to great extent characterised by excessive control of his own thoughts and actions, as well as progressing obsessive-compulsive disorders.

In reference to the literature it ought to be stated that the description of Mr M.'s psychological profile is consistent with research reports that confirm the presence of similar dysfunctions regarding a workaholic's emotional and cognitive functioning, which is referred to in the literature. Apart from the obsessive-compulsive symptomatology, the described workaholic individual's emotional functioning was also characterised by depressive and anxiety states (fear of negative evaluation, fear of failure, fear of social rejection) (Killinger, 2007), inability to relax, impatience, nervousness, becoming

quickly bored with tasks (Szpitalak, 2012, p. 56). In terms of psychological mechanisms related to emotional regulation, Mr M.'s profile was dominated by excessive control and denial (inability to confront problems, striving to become the best and to achieve a high status within the group) (Szpilak, 2012).

Whereas Mr M.'s cognitive functioning was dominated by a lack of concentration, dichotomous thinking (black-and-white thinking), telescopic thinking based on exaggeration, pessimistic thinking, feeling of helplessness, undertaking a victim's perspective, wishful thinking, blurry boundaries, experiencing ongoing struggle (Kalinowski et al., 2005, Frąszczak, 2002). Mr M. has been implementing the following dysfunctional belief in his family teachings, "only hard work ensures happiness, hard work is what society expects" (Robinson, 1998).

In the social context, as a consequence of obsessive thoughts related to a negative evaluation of his work situation and the fear of social evaluation, Mr M. experienced disordered relations in his workplace understood as social alienation and 'escaping' into illness, which resulted in sick leaves and a growing social alienation.

1.2. Psychological profile of a workaholic experiencing mixed anxiety and depressive disorders (a case study)

Ms K., aged 44, a higher-educated city resident, married for 23 years with two children aged 11 and 6 whom she is raising with her husband. Ms K. sought help at a medical facility due to anxiety symptoms (fear of death, disease, being fired, social evaluation, contact with other people, particularly in work-related situations). Ms K. reported lack of satisfaction with her life (including work), a depressive mood and negative thinking about herself. Her ailments have been slowly developing for years with depressive symptoms progressing in work situation (sadness, anxiety, dissatisfaction, a feeling of loneliness and helplessness, pessimistic thoughts). Moreover, Ms K. also complained on a difficulty to focus and memorisation problems. Subjected to an examination by a psychiatrist, Ms K. was medically diagnosed with mixed anxiety and depressive disorder (ICD-10 F41.2).

Ms K. has been professionally active for 23 years as an administrative clerk in an educational establishment. When describing her professional activities, Ms K. expressed her admiration for diligence and an urge to work with a temptation to spend many hours at the office to prove herself and "remain in the organisation" (Killinger, 2007).

From the very beginning of her professional work, Ms K. has been fulfilling duties related to "being submissive and overly dependent". The social and psychological functioning of Ms K. can be described as typical of an excessively submissive and dependent person (Robinson, 1989). Nevertheless, Ms K. was fond of her job and experienced more benefits than costs at work, and noted that despite being overly submissive to others she was content and satisfied with her occupational activity. When she was unable to perform at work due to illness and had to resort to sick leaves, she displayed increased anxiety and apathy, as well as mood swings, without being able to determine the cause. In the literature, such traits may indicate withdrawal symptoms typical of addiction related to an emotional dysregulation in a situation where Ms K. was unable to go to work and fulfil her occupational duties (Porter, 1996; Hornowska, Paluchowski, 2007). Ms K. often recalled a strong urge to be at work and fulfil her professional tasks, which might be identified as a compulsion pertaining to certain work-related behaviours (Shimazu, Schaufeli, 2009).

Moreover, the workaholic behaviour pattern that has developed in Ms K. may also stem from the fear of being fired. This type of fear was frequently mentioned by Ms K., though she did not report any objective situation of facing the risk of losing her position. The uncertainty of employment and the fear of being let go are indicated in the literature as significant factors that stimulate the development of the workaholic attitude (Fassel, 1990).

When examining Ms K.'s psychological profile, one ought to note that the psychological traits she displays in her intrapersonal relationships are characteristic of a pleaser-type workaholic (Killinger, 2007). In both mentioned types of workaholism the focus is put primarily on excessive submissiveness and pleasing others regardless of whether one's own needs are met. In her self-description Ms K. presented a belief that work has become for her the only source of satisfaction, e.g., allowing her to fulfil her ambitions and to gain social validation despite being aware that she had to seek acceptance by resorting to the role of a scapegoat (as she reported in many situations, e.g., from her school years). Ms K. reported a compulsion to be constantly in work situation that allowed her to implement a pattern based on dominance and excessive (inadequate to Ms K.'s needs) submissiveness to others in social relations. Ms K. described herself as an ambitious and outgoing person, though also noted that her relations with others are dominated by a pattern based on submissiveness and excessive dependence (addiction to the approval of others), a dislike for undertaking any risks, hypersensitivity to criticism, poor emotional control and a permanent sense of inferiority. In her depiction of her own behaviours and emotional-social

functioning from childhood to adulthood, Ms K. stressed the fact of serving as a scapegoat (quote: "I used to be a scapegoat at school and I continue to be one at work"). When describing her relations with other people from childhood to adulthood (including relations at work), Ms K. noted experiencing lack of faith in herself, difficulties in bonding emotionally and establishing relations with peers.

Ms K. was raised in her family of origin where the pattern of dominance and submissiveness was implemented in the upbringing model and parental attitudes. Based on the interview and her autobiographical data Ms K. was identified to have an internalised pattern of emotional reacting in social situations based on the characteristics of the aggressor-victim relationship (dominant-submissive pattern with complete submissiveness). The above pattern has been formed as a result of emotional-social experiences in childhood and adolescence that involved her caregivers. Ms K. sought psychological help due to progressive anxiety, depressive and somatic symptoms (fatigue, apathy, sleep and eating disorders). The onset of psychosomatic symptoms took place 4 years ago and pertained to eating disorders. Ms K. was subjected to pharmacological treatment and psychotherapy. In the past, Ms K. used to be treated also due to anorexia. When experiencing a relapse in her adulthood, Ms K. also reported bulimic symptoms and cycles of excessive engagement in work occurring at the very same time (despite her complaint of playing the role of a victim in the workplace), as well as a lack of interest in professional activities (fear of going to work and failing to fulfil tasks perfectly enough). Ms K. worked without controlling her own attitude to work and working time or avoided work by resorting to sick leaves and 'escaping' into illness due to the experienced symptoms, which often involved severe bulimic symptoms, increasingly more disordered social relations and severe somatic symptoms, while Ms K.'s performance standards were unrealistic, which compromised her performance at work and increased anxiety, dependence on others, excessive submissiveness and functioning in dominant-submissive relationships (as a scapegoat). As a result of long-term psychotherapy, Ms K. has gained a partial insight into psychological mechanisms of mental disorders and those related to her workaholic attitude towards occupational tasks. Ms K. identified in her behaviour pattern applied in work-related interpersonal relationships a type of workaholic reaction based on excessive submissiveness to others.

To sum up, the description of Ms K.'s psychological profile is consistent with research reports presented in the literature that confirm the impact of low self-esteem that has been developing since childhood in a person who experiences workaholism in adulthood. Individuals characterised by low self-esteem compensate it by engaging in excessive professional activity or other target-oriented activity (Porter, 1996).

The developing cognitive biases related to one's self-image prevent the said individual from performing accurate self-evaluation. Thus, he or she experiences permanent dissatisfaction due to his or her constantly growing expectations of him- or herself, resulting in the inability to evaluate his or her own achievements in the above-mentioned objective manner (Wojdyło, 2003).

Apart from the pattern of excessive submissiveness in interpersonal relations that the depicted workaholic has experienced since childhood, her emotional functioning profile is characterised by anxiety and depressive symptoms that have developed over the years and a specific style of professional activity based on a compulsion to retain her overly submissive role in the work environment (Wojdyło, 2004, p. 56). The pattern of occupational relationships based on strong submissiveness and compulsion may contribute to a development of a typical workaholic attitude.

The following elements are observed to develop gradually: progressive physical health detriment, numerous mental disorders, substantial and progressively deteriorating relationships with the environment and a loss of satisfaction with life (depression, anxious attitude towards life and work). The applied pattern of emotional reactions can be described as depressive and anxiety states (fear of negative evaluation, fear of failure, fear of social rejection (Killinger, 2007), inability to relax, impatience, nervousness, being quickly bored with tasks) (Szpitalak, 2012). Ms K.'s psychological mechanisms related to emotional regulation were dominated by excessive control and denial (inability to confront problems and submissive tendencies) (Szpilak, 2012).

Ms K.'s cognitive functioning was dominated by a lack of concentration, dichotomous thinking (black-and-white thinking), telescopic thinking based on exaggeration, pessimistic thinking, feeling of helplessness, undertaking a victim's perspective, wishful thinking, blurry boundaries, experiencing ongoing struggle (Kalinowski et al., 2005, Frączak, 2002). In the social context, as a consequence of her emotional and cognitive attitude, Ms K. reacted with an overly submissive behaviour and developed numerous symptoms, which resulted in sick leaves and increasing social alienation.

1.3. Psychological profile of a workaholic experiencing somatoform disorders (a case study)

Male aged 52, secondary education, resident of a small town, involved in a romantic relationship for 31 years, no children. Professionally active for 27 years. Executive positions from the beginning of his professional career. Mr W.'s social and psychological functioning can be described as typical of an individual displaying narcissistic traits. The issues Mr W. reported when seeking medical help were diagnosed as F48, 'Other nonpsychotic mental disorders'. The treatment and further medical and psychological diagnoses allowed Mr W. to be recognised with a narcissistic personality. Mr W. manifested low tolerance for frustration, boredom and stressed the need to experience stimulation and risk behaviour. Mr W. was considered in the environment as a creative person who undertake new challenges and does not fear to seek and engage in difficult or new tasks. Therefore, Mr W. was assigned by his superiors with more and more new tasks he completed successfully, thus developing a growing sense of omnipotence and a need to maintain it. Mr W. reported obsessive thoughts regarding work and a need to perfectly fulfil his assignments, as well as a significant role of ambition in implementing more and more new tasks. Since childhood (particularly adolescence and young adulthood), his social functioning in the familial, professional and personal context has been marked by an emerging need to be the most important person who fulfils special tasks, a need to be constantly praised and a strong frustration when he failed to receive a reward (praise). The model of his emotional functioning in relationships with other people was dominated by suppressed emotions and impulsivity in exploring frustration, little capacity for empathy and expressing positive feelings for others and a manipulative attitude towards the environment with the aim to pursue his own interests at the expense of the needs of other people engaged in a relationship with him. The work situation was dominated by a grandiose attitude, a need to be admired and to be the best, as well as demanding valuation from others. Over time, this aspect of Mr W.'s behaviour has given rise to troubles at work and increasingly more frequent changes of workplace. Conflicts at work (particularly with superiors, employers) and a superior attitude towards his subordinates resulted in a frequent change of workplace, though Mr W. dedicated all his time to work to fill the emptiness he felt within. In order to outperform others, achieve fulfilment, reach his goals and a sense of omnipotence, he spent more and more hours at work, giving up his family life. In his actions, he focused primarily on implementing tasks most perfectly to improve and be the best, he supervised standards of actions taken as part of occupational tasks fulfilled by individuals in his work environment regardless of the relationship (subordinates, co-workers). Mr W. displayed cognitive rigidity and focus on unimportant details, he was also constantly dissatisfied with the occupational tasks he performed. Oftentimes, Mr W. tended to be driven in the implementation of his professional tasks by a pursuit of power, leadership, high positions, high earnings, he was capable of handling duties despite occupational burden and conflicts at work.

When summarising Mr W.'s psychological profile, one should note that he has been implementing in his work experience a specific ethos of his own career characterised by a hunger for success and professional accomplishments. This specific 'life orientation' in which an individual perceives career as the primary goal in life contributes to an excessive occupational engagement, overworking that can evolve into a pathology (LaBier, 1989, p. 11). In Mr W.'s case, traits of an inner compulsion to fulfil occupational tasks manifested together with an exclusion, a 'repression' of the need to fulfil his own personal desires regarding his family and social life (Kalinowski, Czuma, Kuć, Kulik, 2005, after: Szpitalak, 2012, p. 10).

At the stage when the addiction to work is formed, Mr W. indicated solely the prevalence of advantages gained from his work situation and disregarding its negative consequences. Mr W. has a subjective compulsion to fulfil occupational tasks and to experience pleasure, contrasted with a feeling of frustration and discomfort when discontinuing his professional activities. Hence, Mr W. exhibited traits typical of workaholism, i.e., high commitment to work, a sense of inner compulsion to work and low satisfaction with work (Spence & Robbins, 1992), as well as emergence of symptoms (withdrawal symptoms) where working is not possible or not pursued (Porter, 1996; Hornowska, Paluchowski, 2007).

Mr W. can engage in sustaining his professional activity to improve his sense of self-worth (as already mentioned, he displayed narcissistic traits). In such case, Mr W. condemns himself due to his addiction to work to a frustration of needs related to family and other aspects of life, combined with a lack of control over the addiction to work and subjecting himself to damaging symptoms. Workaholism can be associated with a development of a disordered functioning of one's personality (Golińska, 2008; Wojdyło, 2006, 2010). Although Mr W. displayed narcissistic traits, he also indicated in the interview the need for resorting to psychoactive substances (alcohol) in a situation of frustration due to his emotional needs remaining unmet and an increasing depressive mood (Golińska, 2008). Among Mr W.'s traits one could also identify difficulties with establishing empathic relationships with others, a grandiose attitude in relationships with others, a sense of his own uniqueness and a need to be admired and praised – a need for winning acclaim for his achievements (Killinger, 2007). The

inaccuracy of Mr W.'s self-image and his dependency on success and performance, as well as the progressive psychosomatic symptoms can provide an explanation for his workaholic attitude.

Due to the fact that Mr W. is at the beginning of his psychotherapy, he has gained only a partial cognitive understanding and awareness of the type of workaholic reaction called a narcissistic controller that he has been unconsciously applying in his occupational and social life (particularly in work situation) in relationships with other people. Due to the specificity of his personality structure and dominant narcissistic traits, Mr W. requires further psychotherapy aimed at examining the psychological mechanisms of mental disorders that cover a dysfunctional area that goes beyond the workaholic attitude present in his life.

Summary -The consequence of workaholism.

Untreated workaholism may lead to the occupational burnout syndrome (Fassel, 1990; Mieścicka, 2002). Each time overworking may be related to exceeding one's adaptive capabilities, thus lead to exhaustion, which is one of the constituents of the burnout syndrome (Bańka, 2005). Apart from emotional and psycho-physical exhaustion, the said syndrome also involves depersonalisation and low satisfaction with occupational performance (Maslach, 1986).

Other difficulties that can be experienced pertain to interpersonal relationships, avoiding other people, low self-esteem, permanent stress and fatigue, low contentment and satisfaction with work (Sęk, 2000; Retowski, 2003).

The fundamental difference between workaholics and individuals suffering from the burnout syndrome lies in the fact that professions exercised by the latter involve human contact and helping others, which is uncommon for occupational activities performed by workaholics. However, the most significant difference is that in experiencing psycho-physical exhaustion by an individual suffering from the burnout syndrome, his or her activity decreases, whereas a workaholic's activity increases with his or her growing engagement in professional duties (Schultz, Schultz, 2002).

Here, it is worth to return to the subject of the Type A Behaviour Pattern recognised in a situation where a person seeks to gain and maintain control over the external environment (Glass, 1977, Wrześniewski, 1993). A considerably stressful situation takes place each time a subject cannot gain such control and is characterised in its initial stage by increased vigilance and excitability, whereas the next stage involves increased aggressiveness followed by a feeling of helplessness.

According to another approach, this disorder is associated with three fallacies: a person should constantly prove him- or herself to validate his or her social status; there is no moral principle that ensures well-deserved punishment and reward are given to the person who earned them; in order to mark one's presence and achieve self-fulfilment, one has to pursue ambitious goals. This model is called achievement-oriented workaholism (Price, 1982). Despite numerous similarities, these two disorders have different aetiology, since the Type A Behaviour Pattern is to some extent genetically conditioned or stems from environmental conditions, whereas addiction results from upbringing methods and socialisation (Robinson, 1996). Additionally, addicts vary from Type A individuals in terms of experienced obsessive-compulsive symptoms (Wojdyło, 2003).

Workaholism can be classified in DSM-IV-TR as an 'impulse-control disorder not otherwise specified' (312.30), while in ICD-10 it is classified in the category of 'impulse disorders'. The said category allows repetitive maladaptive behaviours to be diagnosed provided that they are not secondary to a recognised mental disorder and allow the behaviour to be discontinued by the patient with a period of tension experienced prior to the behaviour and a feeling of relief at the time when the said behaviour takes place (Szpitalak, 2012, p. 29). This category allows the diagnosis of repetitive and maladaptive behaviours that are not secondary to a recognised mental disorder.

Workaholism and one of its possible consequences, i.e., the occupational burnout syndrome are occupational issues that afflict people in present-day labour markets that force workers to face tasks that are beyond their capacity, which oftentimes exposes them to the risk of making inhuman effort and promotes excessive professional activity that requires tasks to be fulfilled most perfectly, resulting in exhaustion or even compromised health.

Reference

[1] Bańka, A. (2005). Psychologia pracy. W: J. Strelau (red.), *Psychologia. Podręcznik akademicki. Jednostka w społeczeństwie i element psychologii stosowanej* (s. 281 – 320). Gdańsk: Gdańskie Wydawnictwo Psychologiczne.

[2] Fassel, D. (1990). *Working ourselves to death: The high costs of workaholism and the rewards of recovery.* San Francisco, CA: Harper Collins.
[3] Frąszczak, A. (2002). Pracoholizm. W: M. Strykowska (red.), *Współczesne organizacje – wyzwania i zagrożenia* (s. 211-233). Poznań: Wydawnictwo Fundacji Humaniora.
[4] Glass, D. (1977). *Behaviour patterns, stress, and coronary disease.* Hillsdale, New Jersey: Erlbaum.
[5] Golińska, L. (2008). *Pracoholizm: uzależnienie czy pasja*. Centrum Doradztwa i Informacji Difin.
[6] Hornowska, E., Paluchowski, W.J. (2007). *Praca – skrywana obsesja. Wyniki badań nad zjawiskiem pracoholizmu.* Poznań: Bogucki Wydawnictwo Naukowe.
[7] Kalinowski, M., Czuma, I., Kuć, M., Kulik, A. (2005). *Praca.* Lublin: Wydawnictwo Gaudium.
[8] Killinger B. (2007): *Pracoholicy. Szkoła przetrwania.* Dom Wydawniczy REBIS, Poznań
[9] LaBier, 1989. LaBier D. (1987): *Modern madness: The hidden link between work and emotional conflict*. Addison-Wesley, Reading, MA
[10] Maslach, C. (1986). Stress, burnout and workaholism. W: R. Kilburg, P. Nathan, R. Thoreson (red.), *Professionals in Distress: Issues, Syndroms and Solutions in Psychology*. Washington, DC: American Psychological Association.
[11] McMillan, L., Brady. E.C., O'Driscoll. P., Marsh. N. (2002). A multifaceted validation study of Spence and Robbins (1992) Workaholim Battery. *Journal of Occupational and Organizational Psychology, 75*, 357-368.
[12] McMillan, L., O'Driscoll, M.P., Marsh, N.V., Brady E.C. (2001). Understanding workaholism: Data synthesis, theoretical critique, and future design strategies*. International Journal of Stress Management, 8*, 69-91.
[13] Mieścicka, L. (2002). *Pracoholizm.* Warszawa: Instytut Psychologii Zdrowia.
[14] Oates, W.E. (1968). On being a "Workaholic" (A Serious Jest). *Pastoral Psychology, 19*, 16-20.
[15] Oates, W.E. (1971). *Confessions of a Workaholic. The facts about work addiction.* Nashville: ABINGDON.
[16] Porter, M. E. (1996). What is strategy. *Published November*.
[17] Price, V.A. (1982). *Type a behaviour pattern: a model for research and practice.* New York: Academic Press.
[18] Retowski, S. (2003). Pracoholizm – próba teoretycznego zdefiniowania zjawiska. W: B. Wojcieszke, M. Plopa (red.), *Osobowość a procesy psychiczne i zachowanie* (s. 313-342). Kraków: Oficyna Wydawnicza Impuls.
[19] Robinson B.E. (1996). The psychosocial and familiar dimensions of work addiction: Preliminary perspectives and hypotheses. *Journal of Counseling and Development, 74*, 447-452.
[20] Robinson, B.E. (1989). *Work addiction.* Deerfield Beach, FL: Health Communications.
[21] Robinson, B.E. (1998). Spouses of workaholics: Clinical implications for psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 35*, 260-268.
[22] Schultz, D.P., Schultz, S.E. (2002). *Psychologia a wyzwania dzisiejszej pracy.* Warszawa: Wydawnictwo Naukowe PWN.
[23] Sęk, H. (2000). Uwarunkowania i mechanizmy wypalenia zawodowego. W: H. Sęk (red.), *Wypalenie zawodowe. Przyczyny i zapobiegania*. Warszawa: Wydawnictwo Naukowe PWN.
[24] Shimazu, A., Schaufeli, W.B. (2009). Is workaholism good or bad for employee well-being? The distinctiveness of workaholism and work engagement among Japanese employees. *Industrial Health, 47*, 495-502.
[25] Spence, J.T., Robbinson, A.S. (1992). Workaholism: Definition, Measurement, and Preliminary Results. *Journal of Personality Assessment, 58*, 160-178.
[26] Szpitalak, M. (2012). *Wielowymiarowy kwestionariusz oceny pracoholizmu*. Kraków: Wydawnictwo Naukowe Uniwersytetu Jagiellońskiego, 56.
[27] Wciórka, J. (2008). *Kryteria diagnostyczne według DSM –IV-TR.* Wrocław: Elsevier Urban & Partner.
[28] Wojdyło, K. (2003). Charakterystyka problem uzależnienia do pracy w świetle dotychczasowych badań. *Nowiny Psychologiczne, 3*, 33-50.
[29] Wojdyło, K. (2004). Pracoholizm – rozważania nad osobowościowymi wyznacznikami obsesji pracy. *Nowiny Psychologiczne, 2*, 55-75.
[30] Wojdyło, K. (2006). Osobowość pracoholiczna. Właściwości i mechanizmy regulujące. *Nowiny psychologiczne, 2*, 23-36.
[31] Wojdyło, K. (2010). *Pracoholizm. Perspektywa poznawcza.* Warszawa: Difin.
[32] Wrześniewski, K. (1993). *Styl życia a zdrowie. Wzór zachowania A.* Warszawa: Wydawnictwo Instytutu Psychologii Polskiej Akademii Nauk.