Burnout and Workaholism: An Adlerian and Transdiagnostic Trait Perspective

A Literature Review

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Abstract

Work is an essential activity that all individuals must negotiate in life. According to Adler, it is one of three tasks of life, along with the social and love tasks. It is how individuals contribute and belong to the human community. Given its salience, it is not surprising that it is also a major source of stress. For some individuals, work stress contributes to syndromes of distress and dysfunction such as workaholism and burnout. Each of these disorders is associated with negative outcomes in multiple areas, including mental and physical health, occupation, and relationships. Many environmental and individual factors contribute to the development of these behavioral health problems. The diathesis-stress model may explain why some individuals develop distress in circumstances where others do not. Individuals with a diathesis, or predisposition, may be more vulnerable to the development of distress in the face of certain life stressors. Neuroticism is a personality trait that has been proposed to represent a diathesis, or vulnerability, associated with the development of multiple mental disorders. In a parallel model, Adler proposed that a neurotic lifestyle predisposes a person to the development of mental disorders. A review of the research revealed support for an association between neuroticism and both workaholism and burnout. Therefore, workaholism and burnout may be understood as arising from the predisposing vulnerability of neuroticism interacting with stressors in the work environment. Both external and intrapersonal factors are significant in this process. However, by using interventions that target individual vulnerability, counselors can empower individuals to become more resilient in their response to stress in a range of environments. Further, a transdiagnostic approach targeting neuroticism and the neurotic lifestyle may be applied in the prevention and treatment of multiple problems, including workaholism and burnout.

Keywords: burnout, workaholism, work addiction, diathesis-stress, neuroticism
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Burnout and Workaholism: An Adlerian and Transdiagnostic Trait Perspective

According to Adler, life is a continual process of adapting to external demands related to the three tasks of life: social, work, and love (as cited in Ansbacher & Ansbacher, 1956). Through work, individuals find self-worth, a sense of belonging, and meaning. Adler also pointed out that, by nature and necessity, human beings are reliant on the community of others; therefore, these challenges of life must be solved with cooperation (as cited in Ansbacher & Ansbacher, 1956). Given its significance and requirements, work is a major source of stress. Occupational stress in today’s world is reflected by increased work hours and responsibility, continuous adjustment, and decreased work-life boundaries and job security (Ahola, 2007; Tziner, Shkoler, Rabenu, & Oren, 2018). Work is not only a means of survival. In Adler’s view, individuals who address the work task with a sense of cooperation and concern for others derive a sense of “feeling-at-home” in the world (as cited in Ansbacher & Ansbacher, 1956, p. 155).

Individuals may develop mental health symptoms related to their work. Two examples are burnout and workaholism. Primary features of burnout include emotional exhaustion, cynicism, and diminished sense of accomplishment (Taris, van Beek, & Schaufeli, 2010). Workaholism is characterized by working excessively and compulsively to the extent that it interferes with other aspects of life (Clark, Michel, Zhdanova, Pui, & Baltes, 2016). Both burnout and workaholism are associated with a negative impact on mental and physical health, job performance, and relationships (Clark et al., 2016; Simionato & Simpson, 2018; Swider & Zimmerman, 2010). Research also shows that workaholism correlates with burnout (Quinones & Griffiths, 2015). Why some individuals develop workaholism and-or burnout is not completely understood; however, a combination of environmental and individual factors is believed to play a role (Atroszko, Demetrovics, & Griffiths, 2019; Maslach & Jackson, 1981).
The diathesis-stress model is a way of explaining why some individuals develop disorders in certain circumstances while others do not (Klein, Kotov, & Bufferd, 2011; Slavik & Croake, 2006). The diathesis-stress model is one type of vulnerability model in which a predisposition, or diathesis, interacts with stressors to give rise to symptoms (Klein et al., 2011). The trait vulnerability model for mental disorders such as depression, anxiety, and addiction suggests that the personality trait of neuroticism is a common predisposing factor in their development (Klein et al., 2011; Ormel et al., 2013). Results of a literature review support personality traits, particularly perfectionism and neuroticism, as associated with both burnout and workaholism (Quinones & Griffiths, 2015; Taris et al., 2010). Perfectionism is a lower order trait associated with neuroticism (Smith et al., 2019). Overall, the research supports a diathesis-stress model of understanding burnout and workaholism with neuroticism representing a vulnerability that, acting in concert with work stressors, predisposes individuals to develop symptoms of work-related distress and dysfunction.

In a parallel model, Individual Psychology proposes that a neurotic personality, or lifestyle, predisposes individuals to develop mental illness (Griffith & Powers, 2007). A transdiagnostic approach to distress and dysfunction suggests that multiple mental disorders arise from common underlying processes (Garland & Howard, 2014). As will be discussed, there are many similarities in the features of neuroticism and the neurotic lifestyle that may contribute to a vulnerability to mental disorders. Transdiagnostic interventions have been developed that target the common processes related to neuroticism thought to contribute to the development and maintenance of mental disorders (Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014b). In a similar manner, Adlerian therapy aims to revise the faulty neurotic lifestyle (Griffith & Powers, 2007). These complementary approaches offer the potential for enduring and comprehensive
change through empowering individuals with more resilience in response to stress in the
workplace and in general.

**Overview of Burnout**

*Burnout* was first described clinically in the 1970s by Freudenberger, a psychoanalyst
(Kraft, 2006). He brought attention to a syndrome of emotional and physical exhaustion
combined with a cynical attitude that he noticed developed in himself and his colleagues in
response to working with patients (Kraft, 2006). His description closely resembles burnout as it
continues to be recognized today. Burnout is a syndrome that develops gradually over time in
response to work and is classically defined by the three components of exhaustion,
depersonalization, and loss of a sense of personal accomplishment (Ahola et al., 2006; Maslach,
Schaufeli, & Leiter, 2001). Burnout was first recognized in human services professionals;
however, in the 1990s, it became recognized as relevant for occupations in general (Maslach et
al., 2001).

**Features of Burnout**

Exhaustion is considered the most fundamental feature of burnout, and it is the dimension
most widely studied and reported (Maslach et al., 2001; van Wijhe, Peeters, & Schaufeli, 2014).
Exhaustion refers to a combination of mental and physical symptoms, described as feeling
drained, fatigued, used up, strained, frustrated, and at the limits of one’s ability to cope (Maslach
& Jackson, 1981). Depersonalization, the second key dimension of burnout, represents a
dehumanizing, callous, or indifferent attitude toward clients (Maslach & Jackson, 1981). This
attitude is adopted to create distance between the helper and care recipients in order to cope with
feeling overwhelmed by exhaustion (Maslach et al., 2001). In occupations without an
interpersonal component, this dimension is represented by a cynical or disengaged attitude
toward work (Ahola et al., 2006; Maslach et al., 2001). The third dimension of burnout is a diminished sense of accomplishment or efficacy; individuals have a negative evaluation and associated feelings about themselves as workers and about their work (Maslach & Jackson, 1981). It is unclear whether inefficacy develops simultaneously or in response to the other two dimensions of burnout (Maslach et al., 2001). This dimension is considered burnout’s least defining characteristic (van Beek, Hu, Schaufeli, Taris, & Schreurs, 2012).

There is a significant overlap between burnout and depression including shared symptoms and cognitive patterns (Bianchi & Schonfeld, 2016). Research supports an association between increasing severity of burnout and increasing risk for depression (Simionato & Simpson, 2018). A large majority of those with significant burnout also meet criteria for depression (Schonfeld & Bianchi, 2016). There is also research support for burnout as a mediating variable in the association between depression and work strain (Ahola, 2007). Given this considerable overlap, some scholars propose there is no clinically meaningful difference between depression and burnout (Bianchi, Schonfeld, & Laurent, 2015). Other experts emphasize burnout’s distinct qualities of cynicism and loss of work-related meaning and argue that research supports the two as closely linked yet distinct (Maslach & Leiter, 2016). At present, burnout is not included in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association [APA], 2013). Regardless of the outcome of this scientific debate, it is clear that depression is a diagnostic consideration for individuals with apparent burnout. The research also provides some support for conceptualizing burnout as akin to depression.
Measures of Burnout

The Maslach Burnout Inventory (MBI) was developed to measure burnout (Maslach & Jackson, 1981). Although there are other scales, it remains the most widely used burnout assessment instrument (Young, 2015). The MBI consists of 22 questions pertaining to how often and how strongly individuals experience symptoms in three dimensions: emotional exhaustion, depersonalization, and decreased personal accomplishment (Maslach & Jackson, 1981). As described by the originators of the instrument, emotional exhaustion refers to “feelings of being emotionally overextended and exhausted by one’s work,” depersonalization describes “an unfeeling and impersonal response towards recipients of one’s care or service,” and personal accomplishment captures “feelings of competence and successful achievement in one’s work with people” (Maslach & Jackson, 1981, p. 101). The original MBI is geared for work related to the human services. There is a more general version that can be used for occupations that do not focus on working with people (Maslach et al., 2001). On the MBI, higher scores on the exhaustion and depersonalization/cynicism dimensions and a lower score on the personal accomplishment/professional efficacy dimension indicate burnout (Young, 2015).

Prevalence and Demographics of Burnout

It is difficult to get an accurate sense of the prevalence of burnout in different populations and settings because there are very few population-based studies, and researchers vary on how they report results of the MBI (Ahola, 2007). For example, the prevalence of burnout experienced at least weekly in the working U.S. population has been reported to be 28.4% (Shanafelt et al., 2015, Table 3, p. 1610); whereas, the prevalence of severe burnout in Scandinavian workers has been reported as 6-7% (Ahola, 2007, p. 15). Human services professionals are thought to be particularly at risk for burnout due to the intense, interpersonal
nature of the work, the complex nature of the problems, and the occupational culture of self-sacrifice (Maslach & Jackson, 1981; Maslach & Leiter, 2016). Burnout in U.S. physicians has been increasing rapidly, with burnout recently reported in more than half of physicians (Jha et al., 2019; Rothenberger, 2017). Reviews of the literature have reported the prevalence of burnout in psychotherapists to be 54.54% (Simionato & Simpson, 2018, p. 1435) and in psychologists to range from 39.9% to 56% (McCormack, MacIntyre, O’Shea, Herring, & Campbell, 2018, p. 11). The prevalence of burnout in nurses has been reported as 43% (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002, p. 1990). Burnout prevalence rates of 18.5%-25% have been reported in substance abuse clinical staff (Young, 2015, p. 675). Rural counselors, in particular, have high rates of burnout (Oser, Biebel, Pullen, & Harp, 2013).

Several demographic factors have been found to be associated with burnout. For example, in the helping professions, younger age, less work experience (Simionato & Simpson, 2018), and being a professional in training (Dyrbye et al., 2014) have been associated with higher rates of burnout. These findings may be due to idealistic expectations or less effective coping in younger professionals; however, this data is also confounded by the possibility that those who have burned out may have left their jobs (Simionato & Simpson, 2018). After age 30, increasing age is associated with a small increase in the rate of burnout across a variety of occupations (Ahola et al., 2006). Gender has not been consistently shown to be a significant predictor of burnout (Simionato & Simpson, 2018; Young, 2015). Although research is limited, race as a factor does not appear to be significantly associated with burnout (Lent & Schwartz, 2012). Higher burnout rates have been reported in individuals with higher levels of education; however, this could be a result of other confounding variables such as occupation, status, degree
of responsibility, and job expectations (Young, 2015). Being married or cohabitating is a protective factor for burnout in men (Ahola et al., 2006).

**Etiology of Burnout**

*Work and organizational factors.* Factors related to the work environment are considered by some researchers to have the strongest research support for an association with burnout (Ahola et al., 2006; Maslach et al., 2001). Work factors such as a lack of control, feedback, and social support, and the presence of time pressure and role conflict have been associated with burnout (Ahola et al., 2006; Maslach et al., 2001). Tziner et al. (2018) found work load was positively associated with burnout, and person-organization fit and work recognition were negatively correlated with burnout. Further, longitudinal research has been reported to provide support for increased job demands and decreased job resources as predictive of burnout (Bianchi, Mayor, Schonfeld, & Laurent, 2018). For physicians, the use of electronic health records and computerized physician order entry is associated with increased risk of burnout (Shanafelt et al., 2016). Some researchers have found mixed results regarding work variables and burnout. For example, Prins et al. (2019) studied over a thousand medical residents and found that medical specialty, overtime work hours, decreased autonomy, and decreased quality of learning environment were associated with burnout; however, hours worked and clinical setting were not associated with burnout.

Work variables have also been studied in the mental health field. Increased time spent on activities other than counseling, such as paperwork or case management, contributes to increased burnout in counselors (Ducharme, Knudsen, & Roman, 2008). Research is mixed for whether severity of client problems is a risk for burnout (Rosenberg & Pace, 2006). Practice setting is a factor with those in private practice being at lower risk for burnout, and those in community
agencies are at higher risk, possibly related to higher job demands and lower control (Rosenberg & Pace, 2006). According to Martin and Schinke, compared to working with individuals, working with families and-or children has been associated with increased risk for burnout among mental health workers (as cited in Rosenberg & Pace, 2006). Hours worked per week has been associated with increased burnout; however, it has also been reported that client contact hours positively correlates with personal accomplishment (Rosenberg & Pace, 2006). Specific emotion-related factors, such as requirements for empathy or emotion suppression, contribute to burnout supporting the theory that occupations with intense interpersonal work are at increased risk for burnout (Maslach et al., 2001).

**Individual factors.** Results of a prospective study completed by Vaillant, Sobowale, and McArthur (1972) spoke powerfully about the impact of individual factors in determining distress and dysfunction. Their seminal study demonstrated that a discouraging childhood and lower psychological health as a college student increased the risk of poor marriage, abuse of drugs or alcohol, and-or use of psychotherapy in physicians 30 years later (Vaillant et al., 1972). This early research set the stage for subsequent research that supports the theory that it is not only the particularly stressful nature of occupations that contributes to burnout; individual factors also play a role. Descriptions of burnout by early pioneers in the field also emphasized the role of individual cognitive and behavioral responses to the situation rather than external job demands as driving the downward spiral of burnout (Freudenberger & North, as cited in Kraft, 2006).

Research studies have shown many individual characteristics are associated with higher levels of burnout. These include personality characteristics such as neuroticism, Type A personality, rigid style of thinking, conscientiousness, perfectionism, overinvolvement, and low agreeableness and extraversion traits (Simionato & Simpson, 2018; Young, 2015). Research by Hallsten, Voss,
Stark, Vingard, and Josephson showed that performance-based self-esteem, basing one’s value and worth on achievement, is associated with burnout (as cited in van Wijhe et al., 2014). Passive coping strategies, including avoidant- and emotion-focused coping, have been associated with burnout (Simionato & Simpson, 2018; Young, 2015). General self-esteem, general self-efficacy, internal locus of control, positive affectivity, optimism, proactive personality, and hardiness have all been shown to inversely correlate with burnout (Alarcon, Eschleman, & Bowling, 2009). Although the research is mixed, there is some support for negative life events impacting burnout (Hakanen & Bakker, 2017).

**Perfectionism.** Perfectionism is characterized by unrealistically high-performance standards and concern with meeting those standards (Falco et al., 2017). Research supports an association between perfectionism and burnout; however, the relationship is dependent on the specific features of perfectionism (Hill & Curran, 2016; Moate, Gnilka, West, & Bruns, 2016). Perfectionism has multiple dimensions that can be grouped into two categories: perfectionistic strivings and perfectionistic concerns (Hill & Curran, 2016). Perfectionistic strivings are achievement-oriented and include self-oriented perfectionism and the pursuit of self-prescribed high standards (Smith, Saklofske, Yan, & Sherry, 2017). Perfectionistic concerns are more evaluation-oriented and include socially-prescribed perfectionism, the perception that others expect perfection, concern over mistakes, worry about level of performance and not meeting expectations, and being overly self-critical about performance (Falco et al., 2017; Smith et al., 2017). The combination of high personal standards without the tendency to be excessively self-critical is considered adaptive perfectionism and is associated with hopefulness and positive outcomes such as greater life satisfaction (Moate et al., 2016). On the other hand, maladaptive perfectionism is characterized by a combination of high personal standards and high self-
criticism, and it is associated with ineffective behaviors and negative outcomes such as increased depression (Moate et al., 2016).

Hill and Curran (2016) performed a meta-analysis of the association between perfectionism dimensions and burnout. The meta-analysis demonstrated a significant association between perfectionistic concerns and overall burnout as well as with each of the burnout dimensions individually. Perfectionistic strivings showed a smaller association and only with the emotional exhaustion component of work-related burnout (Hill & Curran, 2016). In a longitudinal study, Childs and Stoeber (2012) found that socially-prescribed perfectionism was not only associated with increased levels of burnout at baseline, it predicted increased burnout over time. Moate et al. (2016) studied counselor educators and found that those with maladaptive perfectionism reported significantly higher levels of burnout than either adaptive perfectionists or nonperfectionists. In another contemporary study, school counselors who were maladaptive perfectionists had the highest score for the exhaustion subscale of burnout compared to adaptive perfectionists or nonperfectionists. They also perceived more stress and were more likely to use avoidant coping compared to the other two groups (Fye, Gnilka, & McLaulin, 2018).

**Neuroticism.** There are multiple cross-sectional studies demonstrating an association between personality traits and burnout. Based on a meta-analysis of 121 empirical studies of personality and burnout, Alarcon et al. (2009) reported that the personality trait of emotional stability (low neuroticism) and the related trait of negative affectivity showed the strongest associations with burnout out of 14 personality variables studied. Emotional stability was inversely, and negative affectivity was positively, associated with burnout (Alarcon et al., 2009). Swider and Zimmerman (2010) performed a meta-analysis of 115 empirical studies of higher
order personality traits and burnout and found that neuroticism had a moderate to strong association with burnout.

Results of several more contemporary studies also support the association between burnout and neuroticism. Prins et al. (2019), in a study of over 1200 medical residents, found that neuroticism and burnout were strongly correlated, and the association remained significant after controlling for work-related variables such as overtime and autonomy. A study of 587 nurses showed a strong association between neuroticism and burnout (Geuens, Van Bogaert, & Franck, 2017). Neuroticism was shown to correlate with burnout in a study of 340 professional counselors (Lent & Schwartz, 2012). Extraversion, agreeableness, and conscientiousness have been shown to inversely correlate with burnout, and the strength of the association is weaker than between neuroticism and burnout (Geuens et al., 2017; Lent & Schwartz, 2012; Swider & Zimmerman, 2010).

In correlational studies, information related to cause and effect cannot be ascertained from associations; however, there have been several longitudinal studies of the relationship between personality traits and burnout in health professionals including physicians, nurses, and therapists, and these studies support personality factors as antecedents of burnout (Fornes-Vives, Garcia-Banda, Frias-Navarro, & Pascual-Soler, 2019; McCranie & Brandsma, 1988; Piedmont, 1993; McManus, Keeling, & Paice, 2004). Personality factors, as measured by the Minnesota Multiphasic Personality Inventory (MMPI), present just prior to medical school were shown to predict burnout in physicians 25 years later (McCranie & Brandsma, 1988). Specifically, neuroticism and inadequacy were positively predictive of burnout while the trait of intellectual interests was protective against burnout. In the same study, characteristics of the work environment, such as physician specialty, hours worked, practice setting, and proportion of work
spent on direct patient care, were not associated with the development of burnout at follow-up (McCranie & Brandsma, 1988). A longitudinal study of occupational therapists showed that neuroticism positively predicted, and agreeableness negatively predicted, burnout seven months later (Piedmont, 1993). A prospective study of physicians in training showed that higher neuroticism and lower extraversion predicted burnout five to six years later when they were practicing physicians (McManus et al., 2004). In addition, perception of heavy workload and having to manage alone, and feelings of overwhelm and doubt in the face of work tasks, were also predictive of burnout over time (McManus et al., 2004). Neuroticism in nursing students has been shown to predict burnout six years later (Fornes-Vives et al., 2019).

**Relative impact of work and individual factors.** Researchers in the field of burnout have long recognized that both work environment and individual factors play a role in its development (Maslach & Jackson, 1981); however, the prevailing thought has been to emphasize the importance of work-related environmental factors as the more significant contributor to burnout and to highlight the research base supporting this theory (Bianchi, 2018; Brigham et al., 2018; Maslach et al., 2001; Prins et al., 2019; Swider & Zimmerman, 2010). Part of this perception may have arisen because research studies have more commonly studied job-related and individual factors separately rather than simultaneously to determine their relative importance (Bianchi et al., 2018). An exception is the research study by Piedmont (1993), a longitudinal study of both the big-five personality factors and work environment factors, including job demands and resources, that demonstrated personality factors were more impactful in predicting burnout than features of the work environment.

More recent studies have examined the impact of work versus individual factors, and these also provide support for the relative importance of individual factors (Bianchi, 2018;
Two studies showed that neuroticism was more strongly associated with burnout than *effort-reward imbalance*, a measure of the ratio between factors representing several types of work-related efforts and rewards (Bianchi, 2018; Bianchi et al., 2018). Prins et al. (2019) found neuroticism in medical residents to be significantly associated with burnout even after controlling for work environmental factors including overtime and autonomy. This research does not diminish the importance of work environmental factors in the development of burnout and as a target for prevention and intervention. Research and high contemporary burnout rates support the importance of job factors (Rothenberger, 2017). As noted by Piedmont (1993), at some point, circumstances may be so stressful that they outweigh any individual differences in vulnerability. The research supporting the importance of individual factors highlights their validity as a relevant focus for individual counseling. Perfectionism and neuroticism, in particular, stand out as significant.

**Common theories.** Several models have been applied to understand the development of burnout. One of the most prominent is the job strain model represented by the Job Demand-Control Model and the related Job Demands-Resources Model (Ahola, 2007; Maslach & Leiter, 2016; Young, 2015). These occupational stress models conceptualize job strain as a result of an imbalance between work-related stressors and resources (Maslach & Leiter, 2016). Job demands, or stressors, include all the aspects of a job that require effort, whether mental or physical (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). Resources are all the factors that are health-protecting such as aiding work accomplishment, offsetting job stressors, or promoting professional growth (Brigham et al., 2018; Demerouti et al., 2001). Resources may be work-related, such as support, feedback, control, and rewards (Demerouti et al., 2001), as well as personal such as resiliency and recovery strategies (McCormack et al., 2018). When there is
chronic job strain as a result of an imbalance between demands and resources, burnout can result (McCormack et al., 2018). There is research to support these models for burnout (Maslach & Leiter, 2016; Young, 2015).

Individual factors may be incorporated into the job strain model through considering how they affect individual appraisal of job demands and their resources (Tashman, Tenenbaum, & Eklund, 2010). In support of this, research shows a correlation between burnout and perception of job stress (McCranie & Brandsma, 1988). Neuroticism impacts psychological strain partly as a result of the perception of increased job demands (Bakker et al., 2010). Individuals higher on the scale of neuroticism have been shown to have a perception of greater workload, less autonomy, and less support from their peers (Prins et al., 2019). This supports the influence of neuroticism on the Job Demand-Control Model of occupational stress and burnout.

Other models emphasize the relationship of the individual with work. The Areas of Worklife model proposes that job stress and burnout are the result of mismatches between individuals and their work in six areas: workload, reward, control, fairness, community, and values (Maslach & Leiter, 2016). An example of a mismatch in values contributing to burnout may be seen in physicians. Modern structural and regulatory changes in the delivery of healthcare are thought to be the major cause of the increase in burnout in physicians (Jha et al., 2019; Rothenberger, 2017). The increased clerical burden and other demands associated with these changes interfere with the values that led them to choose the healing profession (Jha et al., 2019). An existential approach to burnout, described by Pines (1993), also emphasized the meaning of work for individuals. According to this perspective, individuals who seek personal significance through their work approach it with high motivation and involvement and undergo a “gradual process of disillusionment” when they experience themselves as failing to achieve that
significance (p. 40). In this theory, job factors contribute to the process of burnout by hindering work accomplishment and diminishing worker significance, which in turn promotes a sense of insignificance in individuals who derive their life meaning from their work (Pines, 1993).

**Implications of Burnout**

Many negative correlates of burnout have been described. Professional and organizational associations with burnout include diminished client care, lost work days, staff turnover, diminished morale, career change, interpersonal conflict at work, diminished productivity, lower job satisfaction, decreased organizational commitment, and decreased job performance (Maslach & Jackson, 1981; Maslach et al., 2001; Simionato & Simpson, 2018; Swider & Zimmerman, 2010). On an individual level, burnout has been associated with increased substance abuse, mental distress, anxiety, depression, a wide variety of somatic symptoms, and lower quality of life (Maslach et al., 2001; Oser et al., 2013; Simionato & Simpson, 2018). Burnout is also associated with marital and life dissatisfaction (McCranie & Brandsma, 1988). Burnout is an independent risk factor for musculoskeletal disorders in women and an independent risk factor for cardiovascular disease in men (Ahola, 2007).

**Current Treatment of Burnout**

Many approaches to the prevention and treatment of burnout have been suggested, although research on effectiveness is limited (Hakanen & Bakker, 2017; Maslach & Leiter, 2016). For example, interventions targeting the dimensions of burnout have been proposed, such as decreased workload and increased self-care strategies to treat exhaustion, fostering community and value congruency in the workplace to mitigate cynicism, and increased recognition and job control to increase professional efficacy (Maslach & Leiter, 2016). Other suggestions have included training to promote self-awareness of person-job fit, mindfulness to combat
maladaptive perfectionistic cognitions, and appropriate boundary setting (Rosenberg & Pace, 2006; Simionato & Simpson, 2018). A meta-analysis of interventions for the prevention and reduction of burnout in physicians demonstrated support for the effectiveness of both organizational and individual interventions (West, Dyrbye, Erwin, & Shanafelt, 2016). Workplace structural interventions in the meta-analysis included changes directed toward decreasing workload. Individual-focused treatments included mindfulness-based approaches, group therapy, and training in stress-management, self-care, and assertiveness (West et al., 2016). Results of small studies suggest that increasing the sense of belonging and fostering close social connections may decrease burnout (Reyes Ortega, Kuczynski, Kanter, Arango de Montis, & Santos, 2019; Salles, Nandagopal, & Walton, 2013). There is limited research on recovery from burnout (Hakanen & Bakker, 2017). Anecdotal evidence suggests one outcome is an increased sensitivity to the possibility of burnout (Hakanen & Bakker, 2017) and that relapse is common (Rothenberger, 2017). Based on the available research, the question of how to most effectively treat burnout remains to be answered.

**Overview of Workaholism**

Workaholism has many different definitions, but most revolve around the central feature of “an unreasonable investment in work” (Schaufeli, Shimazu, & Taris, 2009b, p. 321). *Work addiction* and *workaholism* are terms typically used interchangeably to refer to individuals who work excessively, beyond what is expected or required, and with obsessive-compulsive features (Andreassen, 2014). Another common feature is experiencing negative emotions such as guilt or anxiety when not working (Clark et al., 2016). Work is a required activity for most, and in some cultures, excessive work is socially sanctioned (Griffiths, Demetrovics, & Atroszko, 2018). This prosocial perception of work involvement has hindered work addiction from being recognized as
a problematic behavior (Atroszko et al., 2019). In addition, the definition of workaholism has historically varied substantially resulting in confusion about the concept and even over whether it is a desirable or problematic behavior (Clark et al., 2016); however, the association of work addiction with chronic stress, depression, and burnout, and the costs of these on a global scale, support the importance of work addiction as a clinical and research focus (Atroszko et al., 2019).

Definitions of Workaholism

Over the years, workaholism has been operationally defined and measured in multiple ways reflecting different definitions and conceptualizations. An early definition was simply working more than 50 hours a week, which is not sufficient in today’s workplace where this is the norm for many individuals (Andreassen, 2014). Contemporary scholars do not consider working excessively as sufficient for characterizing work addiction (Quinones & Griffiths, 2015). Engaging either transiently or reluctantly in excessive work in response to external pressures or job demands is also distinguished from work addiction (Clark et al., 2016; Griffiths et al., 2018); whether work addiction could evolve over time from other types of excessive work behavior is unknown (Clark et al., 2016; Griffiths et al., 2018). Although it is acknowledged that individuals may experience some positive consequences as a result of workaholism (Sussman, 2013), it has been increasingly distinguished from other forms of work engagement by its association with long term negative life, job, and health-related outcomes (Clark et al., 2016; Griffiths et al., 2018).

Measures of Workaholism

The most widely used assessment tool for workaholism has been the Workaholism Battery (WorkBat) which measures three dimensions: *Work Involvement*, *Drive*, and *Work Enjoyment* (Quinones & Griffiths, 2015). This contributed to some of the confusion around
workaholism because the inclusion of work enjoyment gave rise to a category of workaholics characterized by positive emotions such as happiness and enthusiasm, and which was associated with positive individual and job performance outcomes (Griffiths et al., 2018; Ng, Sorensen, & Feldman, 2007; Sussman, 2013). This category of engaged workers is now distinguished from the construct of work addiction (Griffiths et al., 2018). In fact, there is an emerging consensus that work addiction should be distinguished from all positive forms of work involvement that have been described under the term workaholism (Clark et al., 2016; Griffiths et al., 2018; Sussman, 2013). In spite of their names, two other common assessments, the Work Addiction Risk Test (WART) and the Dutch Work Addiction Scale (DUWAS) are based on an obsessive-compulsive conceptualization of workaholism (Clark et al., 2016; Quinones & Griffiths, 2015). The Bergen Work Addiction Scale (BWAS) is based on workaholism framed in terms of the key components of addiction (Quinones & Griffiths, 2015). Researchers in the field recognize that there is still a need for a more consistent definition for the clinically significant problematic form of workaholism whether that is ultimately called workaholism or work addiction (Atroszko et al., 2019).

**Workaholism as a Behavioral Addiction**

The idea of an addiction to work was first described by Oates (1968), a minister who used the term workaholism to describe his own work-related behavior in which he saw parallels to alcoholism. Many, if not most, researchers today view workaholism through the framework of a behavioral addiction (Atroszko et al., 2019; Clark et al., 2016). Behavioral addictions, such as gambling, are recognized as having much in common with substance use disorders, including clinical features, genetic vulnerabilities, involvement of the brain’s reward circuitry, and co-morbidity with other addictions (Quinones & Griffiths, 2015). Workaholism shares key features
with addiction such as salience and loss of control, as evidenced by working compulsively and with difficulty disengaging from work as a result of an inner drive, working beyond what is necessary or reasonable, obsessing about work when not working, and persisting in these behaviors in spite of negative consequences (Clark et al., 2016). It has been theorized that workaholic behavior serves to relieve negative feelings associated with not working as well as to gain self-esteem from the work realm when other life areas are not as successful (Ng et al., 2007). These motivations are argued as similar to the appetitive goals that are a feature of addiction (Atroszko et al., 2019). Other features characteristic of substance addiction such as withdrawal and tolerance are more controversial for behavioral addictions (Kardefelt-Winther et al., 2017); however, withdrawal-like symptoms of feeling ill or stressed when not allowed to work have been reported in workaholism (Atroszko et al., 2019). Work addiction, like food, shopping, and exercise addictions, has been reported to be driven by self-nurturing rather than hedonistic motives (Sussman, 2013). There may be different types of workaholics based on varying motivations that underlie the behavior (Andreassen, 2014). Some have advised caution in labelling problematic excessive behaviors as behavioral addictions without a theoretical basis because potentially critical, unique distinctions may be overlooked that could hinder appropriate interventions (Billieux, Schimmenti, Khazaal, Maurage, & Heeren, 2015).

**Workaholism as an Obsessive-Compulsive Pattern**

Other researchers maintain that there is research support for workaholism as having features of obsessive-compulsive personality disorder and obsessive-compulsive disorder (Loscalzo & Giannini, 2017). Even among those who espouse the behavioral addiction framework, there is recognition of symptom overlap with an obsessive-compulsive framework (Atroszko et al., 2019). Furthermore, despite the growing opinion that workaholism is a
behavioral addiction, neither workaholism nor work addiction are included in the *DSM-5* (APA, 2013). In fact, symptoms of work addiction are included as one of the *DSM-5* criteria for obsessive-compulsive personality disorder: “excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)” (APA, 2013, p. 678). Loscalzo and Giannini (2017) have proposed *DSM*-like criteria for workaholism based on a combined addiction and obsessive-compulsive framework, requiring work-related obsessions and compulsions, perfectionism symptoms (work-related high standards or insecurity), and low work engagement (lack of pleasure or energy), together with two of eight addiction symptoms as they relate to work (Loscalzo & Giannini, 2017). Regardless of which model is favored, it is important that research on workaholism continues from the standpoint of multiple conceptualizations rather than settling prematurely on one framework in order to fully capture its unique characteristics and ensure effective treatment (Kardefelt-Winther et al., 2017).

**Prevalence and Demographics of Workaholism**

Prevalence statistics for workaholism depend on how it is measured and reported. For example, self-reporting based on lay perceptions of workaholism resulted in rates as high as one-third of the Canadian working population (Quinones & Griffiths, 2015, p. 53). On the other hand, when workaholism is assessed as a work addiction measured with the Bergen Work Addiction Scale, a nationally representative study in Norway reported an 8.3% prevalence (Andreassen et al., 2014, p. 3). The prevalence of workaholism in the U.S. population has been estimated at 10% with reported rates ranging from 5% to 25% (Sussman, 2013, p. 5). The higher rates reflect certain professional groups such as doctors, lawyers, and psychologists (Sussman, 2013). A meta-analysis of studies showed that demographic variables, including age, educational level, gender, marital status, number of children, and parental status, were not
associated with workaholism (Clark et al., 2016). With respect to gender, it has been shown that the correlation between work addiction and job-related negative affect is stronger for women than for men; however, there is no gender difference in the association between workaholism and the development of mental distress, as measured by the General Health Questionnaire (Balducci, Avanzi, & Fraccaroli, 2018). Increased clinical level symptoms of several mental disorders have been reported in association with work addiction including attention deficit/hyperactivity disorder, obsessive-compulsive disorder, anxiety, and depression (Andreassen, Griffiths, Sinha, Hetland, & Pallesen, 2016b).

**Etiology of Workaholism**

There is general consensus that the antecedents of workaholism include both individual and environmental factors (Atroszko et al., 2019). The psychological literature has focused on individual factors. The field of organizational research has investigated work environmental factors as part of work stress models; however, investigation of macro-level factors, such as cultural-specific factors, is lacking (Atroszko et al., 2019).

**Work and organizational factors.** Job demands have been consistently associated with workaholism (Andreassen, Pallesen, & Torsheim, 2018; Molino, Bakker, & Ghislieri, 2016; Schaufeli, Bakker, van der Heijden, & Prins, 2009a; Ng & Feldman, 2008). This relationship was further investigated by a longitudinal study that showed greater job demands positively predicted workaholism rather than workaholism predicting more job demands (Balducci et al., 2018); however, alternative hypotheses include workaholics gravitating toward jobs with high demands or attributing their behavior to high job demands (Clark et al., 2016). In the meta-analysis by Clark et al. (2016), work-related overload and conflicting roles at work were positively associated with workaholism. Results of studies examining the relationship between
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job control and workaholism have been mixed (Andreassen et al., 2018). This may be due to complex relationships among variables. For example, the association between workaholism was shown to more strongly correlate with job demands when workers also had high job control (Andreassen et al., 2018). A lack of resources, such as job control and supervisory support, has been associated with workaholism (Schaufeli, Taris, & van Rhenen, 2008). Research on a connection between workaholism and coworker support has also shown mixed results, with support for both protecting against and fostering workaholism (Andreassen et al., 2018).

Exposure to bullying-type behaviors at work has been shown to be associated with workaholism, and the authors of that study proposed the behavior might be used to cope (Andreassen, Nielsen, Pallesen, & Gjerstad, 2019). Workaholism has been associated with higher effort-reward ratios, meaning individuals with workaholism report putting in greater efforts compared to expected or received rewards (Andreassen et al., 2018). Career variables, such as career insecurity and extrinsic career goals, have been found to be associated with workaholism after controlling for personality factors (Spurk, Hirschi, & Kauffeld, 2016). Given that most of this research is cross-sectional, it is unclear whether the correlates identified contribute to the development of workaholism, are a consequence of workaholism, or simply reflect workaholism.

**Individual factors.** Several authors have proposed that personality traits underlie workaholism (Andreassen, Hetland, & Pallesen, 2010). Consistent with this, workaholism is understood to be a fairly stable characteristic (Griffiths et al., 2018), although a few studies have shown some fluctuation over time such as in response to job change (Balducci et al., 2018; Loscalzo & Giannini, 2017). Many personality attributes have been identified as potentially contributing to workaholism including obsessive and compulsive traits, perfectionism, narcissism, neuroticism, conscientiousness, achievement orientation, and overcontrol (Quinones
Research also supports a relationship between work addiction and study addiction, a possible precursor to work addiction, with study addiction linked to the personality traits of conscientiousness and agreeableness (Griffiths et al., 2018). Other individual factors that have been associated with workaholism include nondelegation and Type A personality, an achievement-oriented trait (Clark et al., 2016). Low self-esteem has been associated with addictions in general (Ng et al., 2007); however, studies of workaholism and self-esteem have been mixed. The meta-analysis by Clark et al. (2016) did not show an association with self-esteem. On the other hand, a longitudinal study demonstrated that performance-based self-esteem was associated with the development of the working compulsively dimension of workaholism (van Wijhe et al., 2014). Depression and anxiety have been reported to be risk factors for workaholism (Waghorn & Chant, as cited in Loscalzo & Giannini, 2017). The centrality of work to an individual’s identity has been shown to be associated with hours worked (Ng & Feldman, 2008).

**Perfectionism.** In the meta-analysis of workaholism and its correlates by Clark et al. (2016), workaholism was more strongly correlated with perfectionism than with multiple other personality variables. Studies that have looked specifically at the relationship between workaholism and dimensions of perfectionism have shown a more consistent association with perfectionistic strivings than with perfectionistic concerns (Falco et al., 2017). Both self-oriented and socially-prescribed perfectionism have been found to be indirectly associated with workaholism with the association mediated by irrational beliefs about performance and failure (Falco et al., 2017). In the same study, only self-oriented perfectionism had a direct association with workaholism (Falco et al., 2017). Stoebber, Davis, and Townley (2013) also found a positive association between workaholism and self-oriented perfectionism but not socially-prescribed
perfectionism. On the other hand, perfectionistic concern over mistakes, more related to socially-prescribed perfectionism, has been associated with overcommitment to work (Philp, Egan, & Kane, 2012), a construct similar to workaholism.

**Neuroticism.** Neuroticism, the tendency to experience negative emotions, has been associated with several behavioral addictions (Andreassen et al., 2016a), and multiple studies have shown an association between neuroticism and workaholism (Andreassen et al., 2016a; Balducci et al., 2018; Schaufeli, 2016; Spurk et al., 2016; Winburn, Reysen, Suddeath, & Perryman, 2017). These studies represent individuals from several countries and in a wide range of occupations. In the meta-analysis by Clark et al. (2016), neuroticism was not found to be associated with workaholism; however, that study did show the top dispositional variable associated with workaholism was perfectionism (Clark et al., 2016), a lower order trait associated with neuroticism (Enns, Cox, & Clara, 2005). It also showed an association between workaholism and trait negative affect (Clark et al., 2016), a construct closely related to neuroticism (Kotov, Gamez, Schmidt, & Watson, 2010). A longitudinal study of workaholism and personality traits showed that neuroticism predicted a small increase in workaholism over time (Andreassen et al., 2016a). Research on the connection between other higher order personality traits and workaholism is less convincing with either mixed results or weak associations. Further, in studies where more than one personality trait was associated with workaholism, neuroticism showed the strongest association (Andreassen et al., 2010; Burke, Matthiesen, & Pallesen, 2006; Schaufeli, 2016).

**Relative impact of work and individual factors.** In terms of the comparative impact of personality and work factors, the meta-analysis by Clark et al. (2016) showed the relationships of workaholism with job demands and with perfectionism were about equally strong; whereas, the
relationship between workaholism with job resources was much weaker. On the other hand, an organizational climate that promotes overwork was found to be associated with workaholism, even after controlling for personality factors (Schaufeli, 2016). Further complicating the picture, environmental and individual factors may interact in contributing to workaholism (Loscalzo & Giannini, 2017). For example, self-efficacy and conscientiousness were found in a study by Mazzetti, Schaufeli, and Guglielmi to be associated with workaholism only in a climate in which overwork was expected (as cited in Loscalzo & Giannini, 2017). Overall, it is generally accepted that both individual and environmental factors play a role in the development of workaholism (Quinones & Griffiths, 2015). For counselors, the research supporting associations between workaholism and the personality factors of neuroticism and perfectionism is particularly relevant.

**Current theories.** Workaholism is commonly conceptualized within the addiction or obsessive-compulsive frameworks; however, other theories have also been proposed. For example, learning theory suggests that workaholic behavior is a result of external reinforcement (Quinones & Griffiths, 2015). Workaholics may receive rewards for their behavior, or they may avoid unpleasant aspects of their lives through their work behavior. Sociocultural influences on reinforcements may come from professions, organizations, society, and families. Another theory is that individuals are motivated to become workaholics in an attempt to meet external standards of acceptance and approval that they have internalized through a process of introjected regulation (Quinones & Griffiths, 2015). *Introjected regulation* is a form of motivation in which individuals feel compelled to follow externally-derived standards even though they may conflict with their own values (Quinones & Griffiths, 2015). Research has shown that workaholism is associated with introjected regulation (van Beek et al., 2012). This theory suggests that
workaholism is motivated by an attempt to preserve self-esteem by gaining the approval of others for their work behavior. In this way, introjected regulation is similar to socially-prescribed perfectionism, and research supports this association (van Beek et al., 2012).

There are other cognitive and behavioral explanations proposed for workaholism. A cognitive theory put forth by Chen suggests irrational cognitions are the underlying cause of work addiction (as cited in van Wijhe, Peeters, & Schaufeli, 2013). Research provides support for this theory by showing an association between irrational cognitions regarding work-related performance, such as having to be the best and not allowing for mistakes, and workaholism (van Wijhe et al., 2013). These irrational cognitions are also characteristic of perfectionism (Falco et al., 2017). Another irrational cognition, needing to work until there is a felt sense of having “done enough,” predicted workaholism behaviors in a longitudinal study (van Wijhe et al., 2014, p. 162). Workaholism has also been proposed to be a maladaptive coping strategy in response to high work demands based on the prospective study in which high work demands predicted workaholism (Balducci et al., 2018). Alternatively, workaholism may be an escape coping strategy for managing the negative emotions associated with neuroticism (Andreassen et al., 2010).

Implications of Workaholism

Many negative correlates of workaholism have been reported in cross-sectional studies (Quinones & Griffiths, 2015). Reviews of workaholism have reported associations between workaholism and depression, anxiety, career dissatisfaction, relationship conflict, sleep problems, work absences, and co-occurring addictions (Griffiths et al., 2018; Loscalzo & Giannini, 2017; Quinones & Griffiths, 2015). In a meta-analysis, workaholism was associated with diminished physical health, mental health, and life satisfaction (Clark et al., 2016).
Workaholism is associated with elevated blood pressure (Balducci et al., 2018). It is associated with the development of mental distress, even after controlling for workload. Workaholism is associated with job-related negative affect, such as anger, distrust, and pessimism, even after controlling for neuroticism and extraversion (Balducci et al., 2018). Workaholism is associated with family and marital dysfunction, work-life conflict, and with social dysfunction in general (Andreassen et al., 2018; Clark et al., 2016). Workaholism is associated with job stress (Clark et al., 2016), decreased job satisfaction and performance, and increased intention to change jobs (van Beek, Taris, Schaufeli, & Brenninkmeijer, 2014). Workaholism may lead to negative health outcomes through a perpetuating cycle of loss of resources in which the lack of recovery associated with workaholism as a consequence of both lack of recovery time and inability to mentally disengage adds to the effort required to meet the job demands of the next day resulting in additional resource loss and so on (Balducci et al., 2018).

**Current Treatment of Workaholism**

There are not yet any empirically-supported treatments for workaholism (Balducci et al., 2018; Loscalzo & Giannini, 2017). Suggested therapeutic approaches have included cognitive behavioral therapy, rational emotive behavioral therapy, motivational interviewing, positive psychology, self-help groups such as Workaholics Anonymous, training in relaxation, mindfulness, stress management, and assertiveness, and holistic components such as diet, exercise, sleep, and attention to spirituality or existential issues (Andreassen, 2014; Loscalzo & Giannini, 2017; Sussman, 2013). Preventative organizational strategies have also been suggested, such as promoting healthy work climates that emphasize time management, work-life balance, and active use of leisure time (Loscalzo & Giannini, 2017). Leadership development of
management toward recognizing and helping workers meet their psychological needs has also been suggested (Andreassen, 2014).

**Burnout and Workaholism Connection**

**Research**

Research supports workaholism and burnout as distinct constructs as well as a positive correlation between them (Schaufeli et al., 2008). A connection between workaholism and burnout was evident in early descriptions of the burnout process (Freudenberger & North, as cited in Kraft, 2006). Freudenberger and North described excessive and compulsive working in an effort to meet high standards to the exclusion of other life-sustaining activities, core components of workaholism, as part of the process of burnout (as cited in Kraft, 2006).

Scholars recognize that the association between workaholism and burnout is supported by the results of multiple studies (De Carlo et al., 2014; Quinones & Griffiths, 2015). In their meta-analysis, Clark et al. (2016) found workaholism to be positively correlated with burnout, including overall burnout and with the individual burnout dimensions of emotional exhaustion, depersonalization, and cynicism, but not with decreased professional efficacy. In fact, Tziner et al. (2018) found that the working compulsively component of workaholism was associated with increased personal efficacy. In a longitudinal study the working compulsively component, but not the working excessively component, was significant in predicting burnout as measured by the MBI exhaustion subscale (van Wijhe et al., 2014).

Workaholism has also been shown to mediate the association between other factors and burnout. For example, De Carlo et al. (2014) studied two patterns of self-regulation referred to as *assessment*, characterized by careful evaluation prior to movement, and *locomotion*, characterized by continual forward movement toward a goal without hesitation. The research
showed that assessment, the more cautious style of movement, was positively correlated with burnout. It also showed workaholism mediated the effect of assessment on burnout (De Carlo et al., 2014). Workaholism has also been shown to mediate the association between perfectionistic concern for mistakes and burnout (Taris et al., 2010). This is further supported by a study by Philp et al. (2012) who found that overcommitment to work, a construct similar to working compulsively, mediated the association between perfectionistic concern over mistakes and burnout. Finally, workaholism has been shown to both mediate the relationship between job demands and burnout (Andreassen et al., 2018; Molino et al., 2016) and to be a risk factor for burnout independent of job demands (Schaufeli et al., 2009a).

**Theories**

Cognitive theory suggests that workaholics with negative core beliefs about an inability to ultimately be successful together with the irrational belief that they must work hard drives them to continue to work compulsively in a negatively perpetuating cycle of resource loss that leads to burnout (van Wijhe et al., 2014). Longitudinal research demonstrated that performance-based self-esteem predicted working compulsively which, in turn, predicted burnout-related exhaustion (van Wijhe et al., 2014). Further, that study showed that working compulsively predicted exhaustion and that exhaustion predicted both working compulsively and excessively (van Wijhe et al., 2014). This supports the theory that workaholism and burnout are part of a negative cycle in which workaholism contributes to exhaustion which, in turn, increases workaholic behavior (Andreassen et al., 2018).

The workaholism dimension of working excessively did not predict the burnout dimension of exhaustion in the longitudinal study by van Wijhe et al. (2014), suggesting that it may not be enough in isolation to cause burnout. Another study that examined the components
of workaholism found that the combination of high drive together with low enjoyment of work was positively associated with burnout and job stress (Andreassen, Ursin, & Eriksen, 2007). In contrast, the group with high drive but also high enjoyment of work showed a negative association with burnout and job stress. Andreassen et al. (2007) discussed how the results can be explained by the Cognitive Activation Theory of Stress in which stress and its negative impact on health only occur when, in the face of a stressor, the individual does not expect to be able to successfully meet the challenge based on their resources. It could be that those who experience high work enjoyment together with drive do so because they expect positive outcomes and as a result, experience less stress and burnout (Andreassen et al., 2007).

**Transdiagnostic Trait Model of Common Mental Disorders**

It has been argued that the classification of mental disorders in the *DSM-5* is limited due to its descriptive rather than etiologic basis for categorizing disorders, resulting in multiple disorders with overlapping features, high rates of comorbidity, and questionable reliability and validity (Garland & Howard, 2014). In response to these limitations, there is growing interest in a transdiagnostic conceptualization of mental health problems based on common underlying processes (Garland & Howard, 2014). Research support for a transdiagnostic approach to anxiety and mood disorders includes their high comorbidity, shared neurobiological correlates, and evidence that symptoms of comorbid disorders respond to treatment of the primary disorder (Barlow et al., 2014b). One transdiagnostic approach to emotional disorders is to conceptualize them as different manifestations of a single underlying construct of neuroticism (Barlow et al., 2014b). In their review of the research, Barlow et al. (2014b) concluded that neuroticism is a higher order dimension at the core of internalizing disorders, including depression and obsessive-
compulsive disorder, which are pertinent to this discussion of burnout and work addiction, respectively.

**Personality Theory**

Individual disposition has been recognized as more important than environmental features in predicting mental distress and subjective well-being (Piedmont, 1993). Personality, or temperament, is an enduring style of emotionality that has been recognized since the ancient Greeks described it in terms of the four humors: blood, black bile, yellow bile, and phlegm (Barlow, Ellard, Sauer-Zavala, Bullis, & Carl., 2014a). Black bile, referencing a tendency toward gloominess or melancholia, presaged the concept of neuroticism as a personality trait that was described in the 1940s (Eysensck, as cited in Barlow et al., 2014b). Neurosis, a related term, was used in an early version of the *DSM* to describe the category of anxiety, depressive, and related disorders (Barlow et al., 2014b). Each of these usages of the concept are descriptive. In contrast, Adler and Freud both used the term *neurotic* to refer to psychodynamic processes that explain behavior, albeit in quite different ways (Ansbacher & Ansbacher, 1956; Lahey, 2009). As will be discussed, there are similarities between neuroticism as a personality trait and Adler’s neurotic disposition as well as parallels between how each represents a vulnerability for the development of emotional disorders.

Personality impacts the way individuals interpret, experience, react, and respond to their environment (Swider & Zimmerman, 2010). The traits that make up diverse personalities are thought to derive in a hierarchical manner from a handful of higher order personality factors (Kotov et al., 2010). The five-factor model (FFM) of personality is a well-established model for the structure of personality based on five dimensions: neuroticism, extraversion, conscientiousness, agreeableness, and openness (Swider & Zimmerman, 2010). Extraversion is
a disposition that tends toward social interaction, activity, excitement, and assertiveness, and positive emotions such as cheerfulness and optimism (Bakker, Van Der Zee, Lewig, & Dollard, 2006; Zellars, Perrewe, & Hochwarter, 2000). Neuroticism, also called *emotional instability*, is characterized by a tendency toward negative emotions such as fear, irritability, guilt, frustration, depression, and anxiety, as well as low self-esteem and self-consciousness (Alarcon et al., 2009; Bakker et al., 2006; Zellars et al., 2000). Conscientiousness is associated with being dutiful, dependable, self-disciplined, achievement-oriented, hardworking, efficient, and competent (Bakker et al., 2006; Zellars et al., 2000). Agreeableness is described as altruistic, cooperative, tolerant, and nurturing (Bakker et al., 2006; Zellars et al., 2000). The fifth trait, openness, refers to intellectual curiosity, imagination, and a tendency to seek change and variety (Alarcon et al., 2009; Bakker et al., 2006). Research has shown that these dispositional traits are robust constructs across age, rating method, and culture, and that they remain stable over time (Kotov et al., 2010).

**Neuroticism**

Neuroticism as a personality trait or temperament is the tendency toward negative affectivity in the face of stress (Barlow et al., 2014a). Stress comes from many sources and takes many forms, including “threat, frustration, or loss” (Lahey, 2009, p. 241). Neuroticism is also characterized by “the pervasive perception that the world is a dangerous and threatening place, along with beliefs about one’s inability to manage or cope with challenging events” which gives rise to a sense of lack of control (Barlow et al., 2014a, p. 481). Individuals higher on the neuroticism trait spectrum more frequently experience intense negative emotions out of proportion to the challenge (Lahey, 2009). Features that overlap with perfectionism, such as feelings of inadequacy, sensitivity to criticism, and self-criticism are also associated with
neuroticism (Lahey, 2009). The degree of neuroticism in an individual tends to decline after peaking in late adolescence (Lahey, 2009). Neuroticism overlaps considerably with other constructs in the literature, including negative emotionality, trait anxiety, harm avoidance, and behavioral inhibition (Barlow et al., 2014b).

Research shows robust support for an association between neuroticism and multiple mental disorders, including strong associations with mood, anxiety, somatoform, and eating disorders as well as schizophrenia, and moderate associations with several personality disorders (Lahey, 2009). Research also supports an association between neuroticism and comorbidity of mental disorders. Neuroticism has also been associated with a wide range of physical health problems, higher mortality rates, and lower quality of life (Lahey, 2009). There is a strong association between neuroticism and depression (Kotov et al., 2010), which is pertinent to burnout given its significant overlap with depression. With regards to frameworks applicable to work addiction, both obsessive-compulsive disorder and addiction are strongly associated with neuroticism (Kotov et al., 2010).

Although in general, neuroticism becomes apparent in childhood and is relatively stable thereafter (Barlow et al., 2014a), levels of neuroticism are impacted by significant life stressors in adolescence and adulthood, such as positively by satisfying relationships and negatively by poor quality relationships and chronic unemployment (Ormel et al., 2013). The ability of both positive and negative environmental factors to impact neuroticism is congruent with studies that suggest neuroticism is associated with heightened conditioning response to both reward and punishment (Barlow et al., 2014a).
Perfectionism as Related to Neuroticism

Personality theory suggests that higher order traits are diversely expressed in a multitude of lower order traits, and that these lower order traits may develop as a result of the interactions between the FFM traits and the childhood environment (Smith et al., 2019). According to this view, perfectionism may be a lower order trait related to one of the FFM personality factors. As discussed by Smith et al. (2019), many great psychological theorists, including Alfred Adler, Karen Horney, and Albert Ellis, have referred to perfectionism in relation to neuroticism. According to a meta-analysis of perfectionism and the FFM personality factors by Smith et al. (2019), perfectionism is significantly associated with neuroticism. Due to the different dimensions of perfectionism, however, the relationship between perfectionism and FFM traits is complex. For example, in the study by Smith et al. (2019), the size of the effect for the association with neuroticism was strong for the dimension of perfectionistic concerns and small for perfectionistic strivings. Conscientiousness is also associated with perfectionism, with a strong positive association with perfectionistic strivings and a smaller, negative association with perfectionistic concerns (Smith et al., 2019).

Some researchers argue that, although perfectionism may overlap significantly with neuroticism, perfectionism has dimensions distinct from neuroticism (Smith et al., 2019). They point to research that shows the perfectionistic concerns dimension contributes to explaining the association with depression, anxiety, and stress even after controlling for neuroticism (Smith et al., 2017); however, other research did not show a predictive value of perfectionism for depression over neuroticism (Enns et al., 2005). Even researchers whose results do support a degree of uniqueness for perfectionism have concluded that clinical traits such as perfectionism “are akin to facets of… neuroticism” (Mahaffey, Watson, Clark, & Kotov, 2016, p. 764).
Models of Neuroticism and Mental Health

The association of “common mental disorders” (CMDs), including anxiety, mood, and substance use disorders with neuroticism, may be explained according to several theories (Ormel et al., 2013, p. 686). In the vulnerability model, neuroticism contributes directly or indirectly to the development of CMDs. In this model, processes and behaviors associated with neuroticism such as maladaptive coping and negative attentional bias, may lead to CMDs (Ormel et al., 2013). Research shows high neuroticism is associated with use of escape-avoidance coping strategies in the face of stress (Lahey, 2009). Negative attentional bias is a maladaptive process by which the normal brain function of attentional bias used to direct attention to motivationally salient information is biased toward negative stimuli congruent with negative affect (Garland & Howard, 2014). For example, an individual with anxiety is hyperaware of potential threats. This negative attentional bias perpetuates anxiety (Garland & Howard, 2014). Alternatively, the vulnerability associated with neuroticism may relate to its association with increased life stressors, which, in turn, are associated with increased risk for CMDs (Barlow et al., 2014a). The prospective association between neuroticism and CMDs is a strong argument in favor of the vulnerability model (Ormel et al., 2013). The diathesis-stress model, an extension of the vulnerability model, predicts that neuroticism interacts with life stressors, amplifying their detrimental impact, leading to CMDs. There is research demonstrating the risk of CMDs following life stressors is greater in those who also have neuroticism, providing support for the diathesis-stress model (Ormel et al., 2013).

Ormel et al. (2013) discussed four additional models for the association between neuroticism and CMDs as well as the research that supports them. In the common cause model, neuroticism and CMDs are not causally related but are associated as a result of shared underlying
root causes. Research on genetic factors and environmental risk factors provides support for the common cause model (Ormel et al., 2013). The spectrum model posits that features of neuroticism and CMDs are qualitatively the same, and that CMDs represent higher levels of expressed neuroticism. This model is supported by the substantial overlap in features of neuroticism and symptoms of CMDs, particularly for anxiety disorders. In the scar and state models, the occurrence of a mental disorder episode increases neuroticism rather than neuroticism contributing to the development of CMDs. The increase in neuroticism is either transient, as in the state model, or permanent, as in the scar model, as a result of an episode of CMD. The scar and state models have the least empirical support; whereas, the vulnerability, common cause, and spectrum models have the most research support (Ormel et al., 2013).

**Vulnerability Model of Neuroticism**

Barlow et al. (2014a) have proposed the triple vulnerability theory to describe the etiology of neuroticism and its relationship to emotional disorders. According to this theory, a general biological vulnerability interacts with a general psychological vulnerability to give rise to neuroticism, which may then interact with a specific psychological vulnerability to give rise to a specific emotional disorder (Barlow et al., 2014a). The genetic contribution to neuroticism is estimated to be 40-60% with the remainder due to environmental influence (Barlow et al., 2014a, p. 483). The biological vulnerability in neuroticism is thought to relate to genetic differences that influence the neurobiology of emotions and the stress response, resulting in more intense emotional reactions to stress and a less efficient return to baseline when the stress is removed (Barlow et al., 2014a). Environmental experiences also shape the stress response. In animal studies, adverse experiences that involve unpredictable stress and that promote a sense of lack of control over meeting fundamental needs contribute to an anxious temperament, increased
intensity of negative emotions in response to stress, inhibited behavior in the face of novel stimuli, and altered biological stress response. In humans, early environmental experiences that involve unpredictable and uncontrollable stress disrupt the neurobiology of the stress response (Barlow et al., 2014a).

The core of the general psychological vulnerability is a sense of lack of control over stressors (Barlow et al., 2014a). Early childhood experiences that hinder the development of self-efficacy and adaptive coping contribute to the general psychological vulnerability (Wilamowska et al., 2010). For example, parental behaviors characterized by low responsiveness, intrusiveness, and overcontrol contribute to a child’s decreased sense of control (Barlow et al., 2014a). Adverse childhood experiences such as abuse and neglect, and family dysfunction in the form of cold parental or family emotional tone, are associated with neuroticism (Barlow et al., 2014a; Kendler & Gardner, 2011). According to the model, this association may be a result of these risk factors contributing to the general psychological vulnerability (Barlow et al., 2014a). The biological and psychological vulnerability constructs are also theorized to interact. A genetically more reactive stress response system may increase an individual’s vulnerability to the impact of environmental stressors. Conversely, repetitive or chronic environmental stress impacts neurobiology, potentiating the reactivity of the stress response system. In the model, neuroticism is the phenotype that arises from the general biological and psychological vulnerabilities (Barlow et al., 2014a).

According to Barlow et al. (2014a), neuroticism in its more extreme form may be expressed as clinical anxiety or depression; however, other emotional disorders may develop from a background of neuroticism through exposure to an additional specific psychological vulnerability. In this case, the symptomatology of a specific disorder may result from a learned
association between a particular focus of distress with fear, reward, or punishment. For example, formative learning experiences with sickness or harsh disapproval could represent specific psychological vulnerabilities that interact with neuroticism to become somatic symptom disorder or social anxiety disorder, respectively (Barlow et al., 2014a).

In line with a transdiagnostic approach, there are a number of processes that are thought to link neuroticism to emotional disorders (Barlow et al., 2014b). These processes consist of cognitive and behavioral responses that individuals with neuroticism employ with the aim of decreasing the likelihood of triggering negative emotions and for managing negative emotions. Examples include negative attentional bias, intolerance of uncertainty, and avoidance coping strategies. The latter include situational avoidance as well as cognitive avoidance through rumination or suppression of emotions (Barlow et al., 2014b). The pattern of using strategies to escape from unwanted inner experiences, whether thoughts, feelings, or sensations, is referred to as experiential avoidance (Barlow et al., 2014b). These strategies paradoxically result in greater negative emotions, perpetuating maladaptive behaviors. The tendency to experience distress and to perceive distress as “uncontrollable and intolerable” together with these maladaptive responses to distress are thought to explain how neuroticism may lead to emotional disorders (Barlow et al., 2014b, p. 349).

**Transdiagnostic Trait Model Applied to Workaholism and Burnout**

There is an association between workaholism and burnout (Clark et al., 2016; Quinones & Griffiths, 2015). Neuroticism is associated with each of these disorders (Alarcon et al., 2009; Schaufeli, 2016). The association between burnout and workaholism could be attributed in part to a common cause model, with neuroticism representing a shared root factor in the development of each disorder; however, this would not explain the bidirectional predictive relationship
between workaholism and burnout demonstrated by van Wijhe et al. (2014) in their longitudinal research. Instead, workaholism seems to represent a risk factor for burnout and vice versa (van Wijhe et al., 2014).

To explain the association between neuroticism and burnout and between neuroticism and workaholism, the vulnerability model may apply. Burnout is closely related to depression, and workaholism is usually conceptualized within the obsessive-compulsive or addiction frameworks (Loscalzo & Giannini, 2017; Schonfeld & Bianchi, 2016). Just as the vulnerability model has been proposed to explain the association between neuroticism and these mental disorders (Lahey, 2009; Ormel et al., 2013), neuroticism may also represent a vulnerability predisposing an individual to burnout and workaholism. In the French literature, Hartmann and Mathieu (2017) have proposed the idea of neuroticism as a vulnerability factor in the development of both burnout and workaholism. Furthermore, application of the diathesis-stress model would suggest that neuroticism potentiates the effect of work environmental stressors, increasing the risk for workaholism and-or burnout.

There is research that lends support for neuroticism as a vulnerability factor that interacts with occupational stress to contribute to the development of burnout. Research has shown that increased job demands and decreased job resources are predictive of burnout (Bianchi et al., 2018). It also shows that individuals with higher neuroticism have a perception of greater workload, less autonomy, and less support from their peers, supporting the adverse impact of neuroticism on the work factors that are associated with burnout (Prins et al., 2019). Research also showed that a positive association between neuroticism and burnout was demonstrated only in the presence of higher numbers of negative experiences, providing further support for the diathesis-stress model (Bakker et al., 2006). Additional support comes from research on
maladaptive perfectionism, which is related to neuroticism (Falco et al., 2017). Maladaptive perfectionism is associated with avoidance coping, threat appraisal, and perceived stress, as well as burnout (Moate et al., 2016). This research lends plausibility to the theory that neuroticism represents a vulnerability that may be expressed through cognitive and behavioral processes such as increased perceived stress and avoidance coping in the face of work stress that contribute to burnout (Bakker et al., 2006; McCranie & Brandsma, 1988; Prins et al., 2019).

The diathesis-stress model can also be applied to neuroticism and workaholism. A personality trait-based diathesis-stress model for workaholism has been discussed by McMillan, O’Driscoll, Marsh, and Brady (2001). Burke et al. (2006) discussed the possibility that this model may explain how neuroticism and workplace stressors give rise to workaholism. A more specific explanation is suggested by van Beek et al. (2014) who described how the presence of work strain, the imbalance between job demands and resources, could interact with neuroticism to prompt workaholic behavior in an attempt to promote safety and prevent negative outcomes. In fact, research has shown that workaholics are more strongly motivated by security than by the opportunity for growth and development (van Beek et al., 2014). Research has also shown that workaholism is associated with a tendency to catastrophize failure, and workaholic behavior may be an attempt to avoid feared consequences (van Wijhe et al., 2013). This research is also congruent with the diathesis-stress model, with neuroticism as a psychologic vulnerability and work as a stressor interacting to prompt workaholic behavior.

**Transdiagnostic Trait Approach to Treatment**

A transdiagnostic approach to diagnosis has beneficial implications for treatment. Rather than many specific interventions for many specific disorders, a transdiagnostic approach offers the potential for effectively and efficiently treating symptoms that cut across multiple diagnoses.
This approach carries the potential for simultaneously treating co-occurring disorders for which empirically-supported treatments are lacking (Egan, Wade, & Shafran, 2011) as well as for treating symptoms that fall short of diagnosis (Barlow et al., 2014b). Targeting the processes associated with neuroticism is an example of a transdiagnostic treatment for emotional disorders (Barlow et al., 2014b). Although neuroticism is generally considered a relatively stable trait, there is some evidence that it is malleable in response to treatment (Sauer-Zavala, Wilner, & Barlow, 2017).

Interventions targeting neuroticism show promise in terms of decreasing both levels of neuroticism and symptoms of emotional disorders (Sauer-Zavala et al., 2017). Mindfulness-based cognitive therapy and the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP) are two examples of interventions targeting neuroticism that have shown preliminary success (Sauer-Zavala et al., 2017). The UP is a cognitive behavioral therapy-based treatment intervention developed to treat a range of emotional disorders thought to be underpinned by neuroticism. It has shown efficacy in early research studies (Sauer-Zavala et al., 2017). The theory of this approach is that targeting the aversive response to intense emotions lessens the need for avoidance coping strategies that serve to both perpetuate and increase negative emotions. As a result of this intervention, negative emotions decrease in frequency and intensity (Sauer-Zavala et al., 2017). The UP includes eight modules that cover motivation enhancement, psychoeducation and treatment rationale, emotion awareness training, cognitive reappraisal, emotion driven behaviors and emotional avoidance, awareness and tolerance of physical sensations, interoceptive and situational exposure, and relapse prevention (Wilamowska et al., 2010). Key components of the modules include increased knowledge of the nature and function of emotions, development of mindfulness-based awareness of emotional experiences,
increase flexible thinking through developing awareness of appraisal and practicing reappraisal, identifying avoidant and other maladaptive responses to emotions, and exposure therapy to increase tolerance of the range of emotional experiences (Wilamowska et al., 2010).

Acceptance and commitment therapy (ACT) is an intervention that also emphasizes the role of experiential avoidance in contributing to the development and maintenance of mental disorders (Lloyd, Bond, & Flaxman, 2013). As discussed previously, it is one of the key processes linking neuroticism and emotional disorders (Barlow et al., 2014b). The theory of ACT also posits that when individuals expend their psychological resources attempting to avoid or control their unpleasant internal states, they limit their awareness of, and effectiveness in responding to, current environmental realities (Lloyd et al., 2013). Like the Universal Protocol, ACT targets the aversive reactions to emotions rather than symptoms directly (Harris, 2009). The goal of ACT is to change an individual’s relationship with, and response to, symptoms (Harris, 2009). Techniques of ACT overlap with the UP, including mindfulness for developing awareness of automatic avoidance responses, mindful acceptance as a tool to manage emotional states more adaptively, and a commitment to values-driven action, which is a manner of exposure therapy (Lloyd et al., 2013).

Based on the previously mentioned rationale for applying the transdiagnostic model for neuroticism and mental disorders to burnout and workaholism, it seems likely that a transdiagnostic approach targeting the maladaptive processes of neuroticism through interventions such as the UP and ACT could be effective in the treatment of burnout and workaholism. There is some precedence for this in the literature. As previously discussed, mindfulness-based approaches have been suggested or studied for both burnout and workaholism (Loscalzo & Giannini, 2017; West et al., 2016). For example, acceptance and commitment
therapy has been shown to decrease burnout compared to a waitlist control group (Lloyd et al., 2013).

**Individual Psychology**

Adlerian psychology, also called Individual Psychology, is the psychological theory founded on the principles of Alfred Adler, a contemporary of Sigmund Freud, and further developed and disseminated by his followers, particularly Rudolph Dreikurs (Mosak & Maniaci, 1999). Individual Psychology posits several key concepts. Unlike Freudian psychoanalytic theory that includes separate parts of self, such as the ego and the id, potentially in conflict with each other, Adlerian theory is holistic, with all features of an individual congruent with the unity of their whole (Griffith & Powers, 2007). Adler also highlighted how individuals are evolutionarily socially-embedded and cannot be understood apart from the social context (as cited in Ansbacher & Ansbacher, 1956). All challenges in life, therefore, require solutions that align with the good of the community, which necessarily requires cooperation and contribution (Ansbacher & Ansbacher, 1956). The sense of belonging to the community of humankind, together with acceptance of responsibility for the community, compose Adler’s concept of *community feeling*, also commonly referred to as *social interest* (as cited in Griffith & Powers, 2007).

Individuals are unique and express varying levels of mental health reflected by the degree to which they express social interest in solving life’s problems (Griffith & Powers, 2007). Adler discussed how *feelings of inferiority* are universal because of our inherent animal weaknesses and our dependency on others and the community for survival (as cited in Ansbacher & Ansbacher, 1956). According to Adler, these inferiority feelings motivate individuals to *strive toward superiority*, to move from a *felt minus* to a *felt plus* (as cited in Griffith & Powers, 2007).
An individual’s behavior, what Adler referred to as movement, is directed toward a fictional goal which, for the individual, represents a state of overcoming inferiority; i.e., a felt plus (as cited in Griffith & Powers, 2007).

In Adlerian psychology, the lifestyle is akin to personality (Griffith & Powers, 2007). It is the characteristic movement, or manner of adapting to life, that aligns with the fictional goal. All movement, including thoughts, feelings, and behaviors, is understood in Adlerian psychology to be purposeful, in line with the fictional goal. In an environment conducive to the development of social interest, an individual is likely to choose and strive toward a guiding fiction that reflects social interest (Griffith & Powers, 2007). Individuals who have well-developed social interest solve the challenges of life in harmony with their community and, in doing so, experience mental health (Ansbacher & Ansbacher, 1956).

According to Adler, human beings have a natural capacity for social interest, but it needs to be nurtured through encouragement and education in childhood (as cited in Ansbacher & Ansbacher, 1956). Individual Psychology views each individual as having forged a unique way of being, one’s lifestyle, founded on core convictions that were concluded from early childhood experiences (Griffith & Powers, 2007). Their beliefs about themselves, others, and the world are influenced by their family constellation, who is in their family, how it is organized, and by their psychological birth-order position, or role, within it. Impressions of the world and their place in it are also influenced by their family atmosphere, whether it is warm and inviting or cold and hostile, and by family values. A child who experiences an encouraging family atmosphere develops the courage to solve life’s challenges with social interest on the useful side of life (Griffith & Powers, 2007). Adler emphasized that under adverse circumstances, such as child neglect, abuse, overprotection, and organ inferiority, children are likely to feel discouraged (as
cited in Ansbacher & Ansbacher, 1956). In response, they develop exaggerated feelings of inferiority that form the basis for mistaken convictions referred to as *basic mistakes*, or *interfering ideas* (Griffith & Powers, 2007). For example, a child may conclude that they are inadequate, that others are indifferent, and that the world is unsafe. In response to excessive inferiority feelings, the child strives toward a self-protective goal of personal superiority. A goal of superiority over others reflects the self on a *vertical plane* with others rather than as an equal amongst others as on a *horizontal plane* (Griffith & Powers, 2007).

A *neurotic disposition* occurs when an individual recognizes the logic of getting along with the community yet due to their discouragement holds the conviction that they are not capable of succeeding on the useful side of life (Sperry, 2015). As a result, they move toward a mistaken goal of personal superiority such as perfection (Sperry, 2015). To support their mission, the individual makes use of *private logic* (logic that makes sense only within their personal meaning-making system), and *safeguarding* (behaviors that preserve self-esteem in the face of lack of courage to meet the life tasks (Griffith & Powers, 2007). Adler described depreciating others or circumstances, hesitating, and retreating as examples of safeguarding (as cited in Ansbacher & Ansbacher, 1956). When safeguarding behaviors become symptomatic, such as when an individual with a neurotic disposition faces a particular challenge, or *exogenous factor*, then neuroses, i.e. clinical disorders, such as anxiety and depression, may develop (Ansbacher & Ansbacher, 1956). Key features of an individual’s lifestyles are reflected in their *early recollections*, memories recalled from early childhood that serve as reminders for their core convictions about themselves, others, and the world (Griffith & Powers, 2007). What Adler referred to as a *unitary theory of mental illness*, in which the variety of mental disorders arise from the common underlying processes of inferiority feelings, discouragement, underdeveloped
social interest, and maladaptive safeguarding behavior (as cited in Griffith & Powers, 2007), is essentially a transdiagnostic approach. Adlerian scholars have noted this distinction between the Adlerian approach to diagnosis and the DSM-5 (Sperry, 2015).

**Individual Psychology and Stress**

Adler has been considered a personality theorist (Christopher & Bickhard, 1994); therefore, it is not surprising that Individual Psychology emphasizes personality, or lifestyle, in theories of stress and burnout (Caldwell, 1984). Adlerian theorists find theoretical support for the significance of the individual’s unique response to stress from the renowned stress researcher, Hans Selye, who highlighted the importance of perception of external events on the experience of stress (as cited in Caldwell, 1984). Furthermore, there is research to support the Adlerian lifestyle as integral to the impact of stress on an individual. Herrington, Matheny, Curlette, McCarthy, and Penick (2005) studied the impact of individual variables, including Adlerian lifestyle themes as measured by the BASIS-A Inventory, and the environment on emotional distress. The researchers found that lifestyle and coping resources were both more important than negative life events in predicting distress (Herrington et al., 2005).

Individuals learn to interpret and respond to stress in early childhood (Caldwell, 1984). According to Adlerian theory, maladaptive behavior in response to stress reflects an attempt to meet environmental demands without social interest, a learned adaptation to compensate for exaggerated inferiority feelings as a child (Caldwell, 1984). Ideas and behaviors that made sense in the eyes of the child become embedded in their early recollections and carried forward as part of their guiding fictions. As adults, these methods may be ineffective or inappropriate and lead to distress such as burnout when they are employed to manage stress (Caldwell, 1984). Research provides support for the connection between Adlerian lifestyle and coping effectiveness. Kern,
Gfroerer, Summers, Curlette, and Matheny (1996) studied the relationship between lifestyle themes (*belonging-social interest, going along, taking charge, wanting recognition, and being cautious* as measured by the BASIS-A Inventory) and *coping resources effectiveness* based on an inventory of coping resources ranging from social support to physical fitness. The lifestyle of being cautious was found to correlate with lower coping resources effectiveness overall and especially with diminished social support as a resource. The opposite pattern was found for the lifestyle of belonging-social interest, which is characterized by a sense of belonging and associated likelihood of cooperation. The belonging-social interest lifestyle was associated with the highest levels of overall coping resources effectiveness as well as the highest level of social support as a specific resource. The lifestyle of being cautious on the BASIS-A was described as likely arising from a painful or unpredictable early childhood and characterized by sensitivity to the environment and to affect resulting in a cautious attitude toward life (Kern et al., 1996). These features of the being cautious lifestyle are similar to the oversensitivity and hesitating attitude that Adler described as characteristic of the neurotic lifestyle (as cited in Ansbacher & Ansbacher, 1956).

Slavik and Croake (2006) applied the stress-diathesis model to Individual Psychology to describe how the personality, or lifestyle, mediates the relationship between stress and mental disorders. In their discussion, Slavik and Croake (2006) described two variations of the stress-diathesis model. In Beck’s cognitive stress-diathesis model, negative beliefs about self, the world, and the future are the vulnerability integral to development of depression (as cited in Slavik & Croake, 2006). In the interactive stress-diathesis model, ineffective behaviors related to coping and social skills create the vulnerability through increasing the frequency and impact of stress and decreasing social support and positive experiences. Slavik and Croake (2006)
discussed how in both of these models, early childhood experiences contribute to the
vulnerability to stress. An additional stressor then interacts with the vulnerability to create
distress. According to the stress-diathesis model, a less intense stressor is needed to create
distress in an individual with greater vulnerability (Slavik & Croake, 2006). As discussed by
Slavik and Croake (2006), Individual Psychology aligns with a stress-diathesis model having
both cognitive and interactive components. Mistaken beliefs are the cognitive component, and
coping behaviors that lack social interest act as the interactive component. Both are part of a
lifestyle that form a vulnerability that interacts dynamically with life stressors to contribute to the
development and maintenance of psychopathology (Slavik & Croake, 2006).

**Adlerian Theory Applied to Workaholism and Burnout**

Workaholism and burnout can be understood, according to Adlerian theory, as two types
of purposeful behavior that reflect discouragement in the face of the work challenge. This
conceptualization can be further illuminated in light of Adlerian theory applied to the more
common obsessive-compulsive, addictive, and depressive symptoms. Adler viewed all three as
safeguarding behaviors used by a discouraged individual to create distance from, or avoid, the
tasks of life (as cited in Ansbacher & Ansbacher, 1956). For example, Adler viewed compulsive
behavior as a form of hesitating, of moving back and forth, to avoid potentially falling short of
unrealistically high personal goals and to safeguard self-esteem (as cited in Ansbacher &
Ansbacher, 1956). Adlerian scholars view workaholism as a common feature of obsessive-
compulsive personality disorder which, in turn, reflects perfectionism, an expression of a
neurotic lifestyle (Sperry, 2015). Depression can be understood as withdrawal in line with a
lifestyle characterized by the safeguarding tendency to isolate and retreat (Sperry, 2015). Like
compulsive patterns and depression, the behaviors characterizing workaholism and burnout
reflect discouragement and underdeveloped social interest in the face of life challenges, and in particular, the challenge of work stressors.

Maladaptive behaviors in Adlerian psychology may also be viewed as reflecting *mistaken goals of the discouraged child*, a concept contributed by Dreikurs (as cited in Griffith & Powers, 2007). According to Dreikurs, when children do not believe they can succeed in socially acceptable ways, they direct their behavior toward the mistaken goals of attention, power, revenge, and a display of inadequacy (as cited in Griffith & Powers, 2007). Shifron and Reysen (2011) conceptualized workaholism from the perspective of these mistaken goals, suggesting workaholics may work hard to obtain recognition and status from their occupational role or spend their time working as a way to punish family members.

In Adlerian theory, emotions also represent purposeful behavior (Rasmussen & Dover, 2006). Human beings universally strive for the feeling of a felt plus, and emotions provide motivation, feedback, and communication to facilitate moving toward this goal. In the face of stress, emotions facilitate a line of movement, such as whether to give up or fight. In their discussion of this, Rasmussen and Dover (2006) provided the example of how anxiety motivates a defensive response to ambiguous threats, including hypervigilance for threats, avoidance of threats, and enlisting others to assist. In this way, anxiety keeps the individual engaged in servicing the goal of safety. This anxiety may drive compulsive behavior, such as workaholism; however, if the battle toward the goal continues without resolution, whether because expectations are excessive or there is lack of sufficient preparation for overcoming obstacles, an individual may give up and retreat. Rasmussen and Dover (2006) further explained how the pain of giving up a goal believed to be necessary to self-worth or of potential repeated failure to reach the goal are both judged greater than the pain of depression. Depression, in this instance, represents a
relative felt plus. On the contrary, if the individual would change the goal to something more realistic, depression would not be adaptive (Rasmussen & Dover, 2006). This conceptualization of depression could potentially apply to burnout.

**Adlerian Approach to Therapy**

An Adlerian approach to therapy is based on the assumption that, with encouragement and insight, individuals have the capacity to change (Caldwell, 1984). Key components of Adlerian therapy include the therapeutic relationship, collaborating with an individual to develop self-understanding through the *lifestyle assessment*, and redirecting the lifestyle toward more adaptive goals (Griffith & Powers, 2007). The life-style assessment explores the family constellation and atmosphere, psychological birth order, and early recollections. It facilitates understanding of the mistaken convictions and fictional goals that underlie the individual’s symptoms (Griffith & Powers, 2007). With this understanding, faulty beliefs and goals are modified to reflect social interest, which is more conducive to well-being (Sperry, 2017). This process is similar to cognitive restructuring in cognitive behavioral therapy (CBT), the origins of which were influenced by Alfred Adler (Sperry, 2017).

The basic beliefs that support the lifestyle serve a protective function at the highest level of the self, having arisen in response to a sense of primal fear experienced in early childhood (Christopher & Bickhard, 1994); therefore, in addition to insight, a crucial component of successful therapy is to address the function of the belief by helping the client “work through the underlying sense of terror” (Christopher & Bickhard, 1994, p. 231). The therapist must facilitate courage through the experience of the therapeutic relationship (Yang, Milliren, & Blagen, 2010). “The courage facilitator’s being, active listening, and modeling create the conditions of social feeling that communicates patience, selflessness, acceptance, hope, and positive regard” (Yang et
al., 2010, p. 135). With encouragement and the sense of community feeling, an individual may then be able to transform insight into change (Yang et al., 2010).

Treatment approaches to work stress, burnout, and workaholism based on these foundational Adlerian principles have been described (Caldwell, 1984; Dreikurs Ferguson, 2014; Shifron & Reysen, 2011). For example, modifying mistaken goals of superiority that reflect unrealistic standards of achievement will likely modify the perception that work stress is a threat to self-esteem (Caldwell, 1984). Directing change efforts toward individual factors that impact the perception and response to stress rather than the external source of stress has the potential for effective long-term stress management (Caldwell, 1984). Redirecting the definition of success from personal achievement to community contribution may also help alleviate discouragement felt in the face of work stress (Dreikurs Ferguson, 2014). Feeling more encouraged generally leads to improved functioning and well-being (Dreikurs Ferguson, 2014). Encouragement and the development of social interest are key to an Adlerian treatment approach for both workaholism and burnout (Caldwell, 1984; Shifron & Reysen, 2011).

Transdiagnostic Trait Model and Adlerian Theory

The transdiagnostic trait model and Adlerian theory are similar in their conceptualization of a vulnerability related to personality and in how that vulnerability interacts with an additional stressor in the development of clinical symptoms according to a diathesis-stress interaction. The features of the personality trait of neuroticism discussed earlier, such as feelings of inadequacy, perceiving the world as threatening, and being sensitive to criticism (Barlow et al., 2014a; Lahey, 2009), are similar to features of the Adlerian neurotic disposition, including exaggerated inferiority feelings, a lack of social interest, and a lack of courage (Ansbacher & Ansbacher, 1956). Scholars have highlighted that a difference between the five-factor trait of neuroticism
and the Adlerian neurotic disposition is how the opposite of neuroticism is emotional stability; whereas, the opposite of the neurotic disposition more closely aligns with social interest (Stasio & Capron, 1998). Like the transdiagnostic model of neuroticism predisposing an individual to emotional disorders through a repeating cycle of stress triggering negative affectivity and avoidance coping (Barlow, 2014b), an individual with a neurotic lifestyle is predisposed to symptoms based on their likelihood of reacting to life’s challenges with discouragement and safeguarding behaviors (Ansbacher & Ansbacher, 1956). In this way, Adlerian theory, in which the neurotic lifestyle represents a predisposition for the development of clinical symptoms, parallels the transdiagnostic trait model, in which neuroticism represents a vulnerability predisposing an individual to develop a variety of mental disorders.

**Discussion**

Workaholism and burnout are two behavioral health problems related to the occupational realm. Both are associated with significant negative mental, physical, and social consequences (Clark et al., 2016; Simionato & Simpson, 2018; Swider & Zimmerman, 2010). Research supports a relationship between these two disorders (Quinones & Griffiths, 2015). Although work environmental factors are significant, research also shows that individual factors are important in the conceptualization of both burnout and workaholism (Bianchi, 2018; Clark et al., 2016). In particular, there is a strong research base demonstrating an association between perfectionism and neuroticism with each of these disorders (Alarcon et al., 2009; Clark et al., 2016; Hill & Curran, 2016; Schaufeli, 2016). There is also evidence that perfectionism is substantially related to neuroticism (Smith et al., 2019); therefore, neuroticism stands out as a significant candidate vulnerability factor for workaholism and burnout as well as a common factor between them.
There is research to support a transdiagnostic, diathesis-stress model for common mental disorders in which neuroticism represents an individual vulnerability that interacts with environmental stressors to contribute to the development of mental disorders (Ormel et al., 2013). Neuroticism itself is proposed to arise from an interaction of biological and psychological vulnerabilities (Barlow et al., 2014b). Research supports the vulnerability model for explaining the association of neuroticism with depression, obsessive-compulsive disorder, and addiction (Ormel et al., 2013; Wilamowska et al., 2010). Burnout is closely related to depression (Schonfeld & Bianchi, 2016), and workaholism is conceptualized as either an addiction or obsessive-compulsive pattern (Loscalzo & Giannini, 2017); therefore, the vulnerability model of neuroticism and mental disorders likely also applies to burnout and workaholism, with neuroticism interacting with occupational stress via the diathesis-stress phenomenon.

The Adlerian theory of the neurotic lifestyle as a predisposition for neuroses through its interaction with the challenges of life parallels the diathesis-stress model of neuroticism interacting with life stressors to increase the risk of mental disorders. In both Adlerian theory and the personality trait model, the neurotic lifestyle and neuroticism are characterized by cognitive beliefs and maladaptive coping behaviors that negatively affect the experience, perception, and impact of stress (Barlow et al., 2014b; Caldwell, 1984; Lahey, 2009; Sperry, 2015). This creates a vulnerability to distress and dysfunction in the face of stress, whether expressed as workaholism, burnout, or other mental disorders. Both the trait vulnerability model and Adlerian psychology are transdiagnostic approaches in that they explain a range of mental disorders through common underlying processes related to neuroticism and the neurotic disposition, respectively.
Implications for Practice

Considering the multifactorial nature of workaholism and burnout, counselors can help clients discern whether the constellation of factors that contribute to the client’s unique case includes individual factors, work environmental factors, and-or person-occupational fit. This would direct the counseling approach toward therapy, advocacy, and-or career counseling. For some clients, neuroticism may play a role. In this case, it may be helpful to utilize interventions such as the Universal Protocol and Acceptance and Commitment Therapy that emphasize mindfulness, cognitive flexibility, and exposure techniques targeting the maladaptive processes associated with neuroticism (Lloyd et al., 2013; Wilamowska et al., 2010). Adlerian therapy would complement these approaches by using the lifestyle assessment to increase self-understanding and the therapeutic relationship to foster social interest and the courage to change (Yang et al., 2010). Through interventions targeting an individual vulnerability, counselors can empower clients to respond to stress in a wide range of environments with more resilience.

Recommendations for Future Research

Many questions remain to be answered. Additional research would be helpful in further delineating the relationship between burnout and depression, potentially leading to information about burnout that could be included in the DSM. Further research is also needed regarding the theoretical basis of workaholism, particularly with respect to whether it is better conceptualized as a behavioral addiction, an obsessive-compulsive pattern, or other type of disorder, because of the implications for treatment. Investigation of the impact of multicultural factors on workaholism and burnout could provide relevant information to their prevention and treatment in diverse clients. Additional cross-cultural research is also needed to explore the impact of culture on these disorders. More research is needed to clarify the relationship between perfectionism
and neuroticism to potentially identify unique implications of perfectionism for treatment.

Research is needed to determine effective treatments for both workaholism and burnout. Finally, further research investigating the etiology of neuroticism and how it contributes to behavioral health disorders could have a significant impact on our understanding and treatment of disorders.

**Conclusion**

Work is a significant source of both meaning and stress; therefore, it is not surprising that clients may present with significant behavioral health problems related to work such as workaholism and burnout. Research supports both workaholism and burnout are associated with the personality trait of neuroticism. Both problems can be conceptualized according to the diathesis-stress model in which neuroticism represents a predisposing vulnerability that interacts with work stressors to contribute to the development of workaholism and burnout. In a parallel model, both syndromes may be understood according to Adlerian psychology as symptoms arising from a predisposing neurotic lifestyle in the face of an exogenous stressor. Transdiagnostic therapeutic approaches such as the Universal Protocol and Adlerian therapy that target the vulnerability of neuroticism and the neurotic lifestyle hold the promise of transformative individual change and promoting resilience in the face of stress.
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