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WORKAHOLISM AND PSYCHOSOCIAL WELLBEING OF EMPLOYEES IN THE CORPORATE SECTOR

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Abstract
Workaholism was first defined by Oates as "an addiction to work, compulsion or the uncontrollable need to work incessantly". Psychosocial health can be affected by workaholism. It pertains to the influence of social factors on an individual's mind or behaviour and to the interrelation of behavioural and social factors (Martikainen, Bartley & Lahelma, 2002). Psychosocial health refers to mood, such as anxiety or depression, and could also include social adjustment. By understanding the effects on psychosocial health, the ways to cope with workaholism can be suggested. Using purposive sampling, the researcher collected data from 50 participants who were working in the corporate sector in Bangalore. The tools used for this study were Work Addiction Risk Test (Robinson, 1999) for the screening process and Beck's Depression Inventory (Aaron T. Beck, Robert A. Steer, and Gregory K. Brown) and I. P. A. T. Anxiety Scale (Raymond B. Cattell, 1957) to assess the psychosocial well-being. Of the 50 participants, 54% had mild workaholism (scoring within the range of 57 to 66) and 46% had high workaholism (scoring within the range of 67 to 100). It was found that workaholism was not significantly correlated with either depression or anxiety. It is important for social workers, mental health professionals and HR managers in organizations to recognize workaholic behaviour. Regular testing can be conducted to identify workaholics. Workaholism must be understood as an addiction to work. Workaholic behaviour is prominent in organizations and its negative consequences need to be prevented. By identifying workaholic behaviour, changes can be made in the individual which will reduce or completely prevent depression and anxiety from occurring.

Keywords: Workaholism, Psychosocial Wellbeing, Depression, Anxiety.

INTRODUCTION

1.1 Workaholism

Workaholism was first defined by Oates as "an addiction to work, compulsion or the uncontrollable need to work incessantly". The components involved in workaholism are compulsion and perfectionism, control, rigidity and identity issues (Burke, 2008). Workaholism can be seen as a regular occurrence especially due to the unstable market situation, which is displaying a fragile foundation, resulting in unsuitable working conditions. Long working hours, lowered pay and fear of layoffs all result in employees working harder but at the risk of their physical and mental health (Malinowska, 2013). Workaholism is often considered to be a positive habit and therefore, isn't considered to be a destructive compulsive behaviour. This self-labelling occurs as the employees work long hours every day at their place of employment. But, there are various other dimensions associated with workaholism, resulting in consequences affecting families and organizations (Malinowska, 2013).

Empirical research is weak in the field of workaholism, despite the concern for workaholics increasing at a rapid pace. The term has been used loosely for several years but its usage is being caught on by several organizations and their Human Resource departments. Workaholism is over-extending oneself at work and allowing the encroachment of work on important life activities, such as spending quality time with family members and time allocated for leisure and relaxation (Matuska, 2010). Intrinsic and extrinsic motivation is said to sustain workaholic behaviour. This is because it is often rewarded with high level of income, upward social mobility, employee empowerment and feeling personal control at their place of employment. This high reinforcement often leads to an addiction to work (Malinowska, 2013).

According to various studies conducted, people who scored high to moderate on a workaholism scale delegated work less, displayed higher perfectionistic behaviour, displayed stress behaviour, and complained more about health than individuals with lower workaholism scores. Those who displayed all the three features were more likely to identify themselves as workaholics and be labelled as workaholics by friends and colleagues.

Malinowska et al have looked at three approaches when it comes to workaholism:

1. Workaholism as an addiction.
2. Workaholism as a positive behaviour pattern.
3. Workaholism as a positive and a negative behaviour pattern, depending on type.

Workaholism as an addiction is characterized as a pathology, with aspects such as an inner compulsive drive, rigid patterns of behaviour, tolerance which has been built up due to long hours of work, health costs (especially anxiety and depression) and withdrawal symptoms. When viewed as a positive behaviour pattern, Cantarow states that workaholics seek passionate engrossment and fulfilment through their work. Machlowitz said that for workaholism to be a positive behaviour pattern, the family must accept that lifestyle. For positive and negative behaviour patterns, Spence and Robbins' classification has been empirically identified- workaholics and enthusiastic workaholics. Spence and Robbins (1992) research resulted in different conclusions. They diagnosed workaholism on the basis of three dimensions:

1. Drive to work,
2. Work engagement
3. Work enjoyment.

People who were classified as workaholics or enthusiastic workaholics declared a higher level of stress and more frequent health problems (Malinowska, 2013). In a study by Shimazu et al (2010), it was found that active coping leads to better health and performance and workaholism coincides with poor health.

There are a limited number of empirical studies which have been conducted in the area of workaholism, but they all point to similar results. Depression, anxiety, somatic symptoms, negative affect and disrupted family relations are just some of the results of workaholic behaviour. This is a phenomenon which occurs in all kinds of employees, ranging from academic researchers, industrial workers and nursing home workers.

1.2 Psychosocial Well-being

Psychosocial is an overarching term which have a variety of research studies carried out to understand the psychological and social pathways underlying health and illness.

The term 'psychosocial' represents the dynamic relationship between psychological and social processes and components (Psychosocial Well-being). It pertains to the influence of social factors on an individual's mind or behaviour and to the interrelation of behavioural and social factors (Martikainen, Bartley & Lahelma, 2002). Psychological components are internal. These include thoughts, feelings and emotions. Social procedures are external. They comprise of social networks and support, which includes the community, family and the immediate environment. These areas mutually affect each other. If there is a change in one then it will elicit a change in the other areas as well. The way an individual feels internally affects the way they relate to the environment around them. Similarly, traditions, communities, culture and environment affect the way individuals feel. The psychosocial aspects of well-being are importantly associated. (Psychosocial Well-being).

Psychosocial health refers to mood, such as anxiety or depression, and could also include social adjustment. Social networks, feeling control over work, the balance between effort and reward security and self-sufficiency, control over home and work-family conflict are all part of social formations. They are exhibited in interpersonal associations. The psychosocial elucidations of health are observed as developments that require analyses at various levels (Martikainen, 2002).

1.3 Depression

Depression is a widely diagnosed mental disorder which is characterized by sadness, hopelessness, loss of interest, anhedonia (inability to enjoy activities which were previously enjoyed), feeling guilt or low self-worth, troubled sleep, lack of appetite, feeling tired and poor concentration.

It can be long-lasting or intermittent, significantly marring a person's ability to function in their daily activities. In severe cases, depression can lead to suicide. Individuals with moderate to severe depression usually require medication as well as some form of therapy. In milder cases, it can be treated without medication. (WHO).

The findings of a study by Bromet et al showed that job stress had an impact on affective symptoms. The job demands predicted an affective disorder (depression or generalized anxiety disorder). This impact was reduced by social support from colleagues (Bromet, 2006). In a study by Matsudaira et al (2013) it was found that those who had moderate and high workaholism had significantly higher odds for depressive mood and disabling back pain. Workaholism was more strongly associated with sick absence rather than mental health.
In the current study, depression was assessed by Beck's Depression Inventory.

1.4 Anxiety

Anxiety can be understood as either of two aspects:

1. As an acute emotion and as a personality construct, and
2. As a mental disorder or an illness.

Psychologists often study the first aspect using psychometric tests and focussing on individual differences. The second aspects is looked at on the basis of qualitative components (as provided by Diagnostic and Statistical Manual of Mental Disorders).

Depression is more prevalent in anxious individuals and trait anxiety has been found related to health. For instance, individuals whose gave a positive self-rating of their health scored lower in anxiety. But, the relationship between the two variables is complicated. Anxiety can be the cause of illness, or anxiety can be an effect of illness (MacArthur Foundation, 1997). According to a study by Bartozak, M. & Oginska-Bulik, N. (2012), anxiety, insomnia and social dysfunction were the most common negative symptoms of workaholism.

In the present study, IPAT was used to assess anxiety.

RESEARCH METHODOLOGY

3.1 Rationale of the Study

Workaholism is often viewed as a positive aspect in an employees work experience, but its debilitating consequences are not focussed on. Workaholism does not imply working smartly and workaholic employees may not delegate work and as a result, take a long time to complete tasks. Human Resource employees should recognize workaholism as a serious condition whose removal would ensure productive working and better health of the employees of the organization.

It is also important to understand workaholism as an obsessive behaviour and whether the patterns of this behaviour are similar to other disorders of addiction and OCD. By understanding workaholism, therapists and organizational psychologists can help implement interventions in the work place and family environment of the individual.

By understanding the effects on psychosocial health, the ways to cope with workaholism can be suggested.

3.2 Aim of the Study

The aim of this study is to understand the effect of workaholic behaviour in employees on their psychosocial health, specifically depressive symptoms and anxiety symptoms.

3.3 Objectives of the Study

The objectives were to study the socio-demographic profile of the participants, to understand the relationship between workaholic behaviour and depressive symptoms and to understand the relationship between workaholic behaviour and anxiety.

3.4 Hypotheses

1. Null: There will be no relationship between workaholism and depressive symptoms.
   Alternate: There will be a significant relationship between workaholism and depressive symptoms.
2. Null: There will be no relationship between workaholism and anxiety.
   Alternate: There will be a significant relationship between workaholism and anxiety.

3.5 Operational Definitions

The first definition is on Workaholism which is an addiction to work as assessed by the Work Addiction Risk Test among employees working in the corporate sector in Bangalore. The second definition is on psychosocial health which is the influence of social factors on individuals' mind or behaviour and the interrelation of behavioural and social factors, specifically depression and anxiety of employees working in the corporate sector in Bangalore.

3.6 Research Design and Sampling Design

The researcher used descriptive research design for this study. The universe was employees in the corporate sector in Bangalore. The population was employees in the corporate sector in Bangalore with workaholism. The sample size was 50 employees. The researcher used purposive sampling.

3.8 Inclusion and Exclusion Criteria

The inclusion criteria for the sample were employees working in the corporate sector in Bangalore, male and female employees, employees between the ages of 20 to 60 years. And employees scoring above 57 on the Work Addiction Risk Test. The exclusion criteria was individuals with mild, moderate or severe intellectual challenges who will be unable to complete the questionnaire.

3.9 Tools of Data Collection

The tools used were Work Addiction Risk Test (Robinson, 1999), Beck's Depression Inventory (Aaron T. Beck, Robert A. Steer, and Gregory K. Brown) and I. P. A. T. Anxiety Scale (Raymond B. Cattell, 1957).

3.10 Statistical Analysis

The researcher used SPSS version 21 for statistical analysis. The researcher used Spearman's Rho correlation to determine the relationship between the variables. The researcher had to use a non-parametric test as the sample was not normally distributed.

3.11 Ethical Considerations

The researcher maintained confidentiality and did not disclose information about the participants. The researcher provided an informed consent to the participants and gave the participants the freedom to leave the study at any point, if they wished to do so. The researcher committed no plagiarism at any point in this study.

DATA ANALYSIS AND INTERPRETATION

4.1 SOCIO-DEMOGRAPHIC DETAILS

Table - 4.1 Genders

		Frequency	Percent
	Female	24	48.0
	Male	26	52.0
	Total	50	100.0

Table 4.1 shows the number of male and female participants of the study. Of a total of 50 participants, 24 were female (48%) and 26 were male (52%).

Table - 4.2 Educational Qualifications

		Frequency	Percent
	Graduate	5	10.0
	Postgraduate	45	90.0
	Total	50	100.0

Table 4.2 describes the educational qualifications of the participants of the study. 45 participants (90%) were postgraduates and only 5 participants (10%) were graduates.

Table - 4.3 Marital Status

		Frequency	Percent
	Single	13	26.0
	Married	37	74.0
	Total	50	100.0

Table 4.3 displays the marital status of the participants who were part of the study. A total of 37 participants (74%) were married and 13 participants (26%) were single.

Table 4.4 Workaholism

	Frequency	Percent
Mild Workaholism	27	54.0
High Workaholism	23	46.0
Total	50	100.0

Table 4.4 shows the participants who displayed mild workaholic behaviour and high workaholic behaviour. 54% of the participants have mild workaholism and 46% have high workaholism.

Table 4.5 Workaholism and Depression

			Workaholism	Depression
Spearman's rho	Workaholism	Correlation Coefficient	1.000	.257
		Sig. (2-tailed)	.	.071
		N	50	50
	Depression	Correlation Coefficient	.257	1.000
		Sig. (2-tailed)	.071	.
		N	50	50

As seen in Table 4.5, there is a positive relationship between workaholism and depression, but it is not significant.

Table 4.6 Workaholism and Anxiety

			Workaholism	Anxiety
Spearman's rho	Workaholism	Correlation Coefficient	1.000	.144
		Sig. (2-tailed)	.	.320
		N	50	50
	Anxiety	Correlation Coefficient	.144	1.000
		Sig. (2-tailed)	.320	.
		N	50	50

As seen in Table 4.6, there is a positive relationship between workaholism and anxiety, but it is not significant.

Of the 50 participants, 54% had mild workaholism (scoring within the range of 57 to 66) and 46% had high workaholism (scoring within the range of 67 to 100).

Spearman's rho correlation was used to assess the relationship between workaholism and depression, and workaholism and anxiety. It was found, in the case of workaholism and depression, there was no significant correlation between the two variables, r=0.257, n=50, p=0.071. In the case of workaholism and anxiety, there was no significant correlation between the two variables, r=0.144, n=50, p=0.320.

These results are supported by other research studies. In the study conducted by Matsudaira et al (2013), participants with moderate to high workaholism had higher odds for depressive mood. Bartozak, M. & Oginska-Bulik, N. conducted a study in 2012 which stated that participants with higher levels of workaholism had higher levels of anxiety and symptoms of depression. In the Indian setting, Srivastava M (2012), found that workaholism positively correlated with anxiety.

Thus, it can be seen from the present study as well that workaholism has a positive correlation with depression and anxiety.

4.2 ANALYSIS

The results show that the relationship between workaholism and depression and anxiety is a positive one, but not significant. The results could be attributed to various reasons.

The sample was not representative and thus, the results cannot be widely applied to the population. As workaholism is often viewed as a positive behaviour to practice, participants may not recognize the negative consequences of the behaviour. Participants could also be reluctant about answering the questionnaires honestly and thus, the results may not be accurate.
Another reason may be that as India is continuing to remain a developing economy, the ill-effects of workaholic behaviour has not yet progressed to the levels seen in economies such as Japan and the United States of America.

It was seen that the majority of the participants displayed mild workaholism, rather than high workaholic behaviour. This may play a role in the fact that there are not severe negative consequences seen.

Despite there being an insignificant relationship between the variables, the positive relationship should still be acknowledged. Participants displaying mild and high workaholic behaviour showed levels of depression and anxiety. This means that the variables influence each other in the same direction. If workaholic behaviour increases or decreases then it will elicit a similar change in depression and anxiety levels. Several other research studies have found results which state that workaholism and depressive and anxiety symptoms are positively correlated. These variables have a strong association. Therefore, it is important to control workaholic behaviour in individuals, as it will have a direct effect on psychological health.

FINDINGS

As per the objectives of the study, it was found that:

- Majority of the participants were male (52%), were postgraduates (90%) and were married (74%). 48% were females, 10% were graduates and 26% were single.
- Mild workaholism was more prevalent in the participants (54%) than high workaholism (46%).
- There was a positive correlation between workaholism and depression, but it was not significant ($r=0.257$, $n=50$, $p=0.071$).
- There was a positive correlation between workaholism and anxiety, but it was not significant ($r=0.144$, $n=50$, $p=0.320$)

SUGGESTIONS

It is important for social workers in organizations to recognize workaholic behaviour. Regular testing can be conducted to identify workaholics. Workaholism must be understood as an addiction to work. The pattern of workaholic behaviour often involves behaviour similar to OCD and thus, interventions must be planned involving the individual and family.

Employees need to be engage themselves in their work and not be addicted to it. Conducting employee engagement programmes is integral. These programmes should also spread awareness about workaholism and its negative consequences. By feeling a sense of loyalty and belongingness to the organization could encourage healthy working behaviour amongst individuals.

Some of the limitations of this study could be addressed in further research. The sample size was not adequately representing the population. Other occupations could be taken into consideration instead of solely focussing on the corporate sector. The sampling procedure used was purposive sampling. Due to time constraints, simple random sampling could not be used.

Further studies in India could include the comparison of anxiety and depression between workaholic and non-workaholic individuals and understanding the practices followed by non-workaholic individuals.

CONCLUSIONS

Workaholic behaviour is prominent in organizations and its negative consequences need to be prevented. By identifying workaholic behaviour, changes can be made in the individual which will reduce or completely prevent depression and anxiety from occurring.

The relationship between workaholic behaviour and depression and anxiety is seen consistently in different cultural backgrounds and occupations, which could be attributed to the fact that there are personality characteristics which play a role in determining workaholism.

Several research articles discuss the presence of workaholism among individuals, but the interventions which can be made by professionals is not discussed. Healthy working habits need to be encouraged to prevent workaholic individuals from experiencing depression, anxiety and other harmful results.

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