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Work Addiction as a Behavioral Disorder: Clinical Case Study and Theoretical Implications

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Abstract

Work addiction, also referred to as workaholism, is increasingly conceptualized as a behavioral addiction characterized by compulsive overinvestment in work despite negative psychological, physical, and social consequences. Although it is not formally recognized in major diagnostic classifications such as the DSM-5 or ICD-11, a growing body of empirical evidence supports its clinical relevance. This article presents an in-depth clinical case study of patients exhibiting severe work addiction, integrating contemporary theoretical frameworks and psychotherapeutic approaches. The analysis highlights the central role of cognitive distortions, emotional avoidance, and sociocultural reinforcement in the development and maintenance of the disorder. The therapeutic process underscores the importance of identity reconstruction, boundary-setting, and the development of intrinsic self-esteem. The discussion situates this case within current debates regarding the nosological status of work addiction and its implications for clinical practice and public health.

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Introduction

Historically, addiction has generally been defined as a loss of control over substance use. This leads individuals to engage in compulsive behavior despite harmful consequences. However, over recent decades, this concept has evolved to include behavioral forms of addiction, thereby opening the way for the recognition of other disorders that share similar mechanisms.

Unfortunately, work addiction is difficult to diagnose and also difficult to contain, as it is socially valued in many professional environments. Excessive involvement in work can become pathological when it takes the form of a compulsive and uncontrollable behavior associated with significant impairment in individuals' functioning. Individuals then become unable to disengage from work or think about anything else. Work invades their thoughts and gradually their lives.

In contrast to healthy work engagement, which is based on intrinsic motivation and balance with other spheres of life, work addiction is characterized by emotional dependence and a progressive disengagement from other domains of existence.

This article aims to contribute to this field of research by articulating theoretical perspectives on work addiction and presenting clinical cases. Through this analysis, the objective is to better understand the underlying psychological mechanisms and to derive implications for therapeutic interventions.

Theoretical Framework

Oates (1971) was one of the pioneers in describing work addiction as a progressive and potentially fatal disorder. This addiction is characterized by compulsive overinvestment and an inability to regulate working time. Subsequent theoretical developments have enriched this definition by emphasizing psychological and relational dimensions. Robinson conceptualized it as a dysfunctional relationship with work, rooted in emotional avoidance and identity distortion.

Ng, Sorensen, and Feldman (2007) made a major contribution to the definition of work addiction by proposing a three-dimensional model distinguishing affective, cognitive, and behavioral components. This model highlights the multidimensional nature of the phenomenon. The affective dimension refers to intense emotional investment, often at the expense of relationships. The cognitive dimension includes perfectionism and conditional self-worth. The behavioral dimension corresponds to hyperactive work behaviors reinforced by internal and external factors.

Within this framework, the reward system plays a crucial role. Professional achievements act as powerful reinforcers of behavior, even when they are harmful to the individual. From a neurobiological perspective, this involves activation of the dopaminergic system.

Traits such as perfectionism and the need for external validation increase vulnerability to this condition. From an environmental perspective, organizational cultures that value overinvestment blur the boundaries between professional and personal life, thereby contributing to the normalization of these behaviors.

Method

This article is based on a qualitative methodology using a clinical case study approach, adapted to the in-depth exploration of complex psychological phenomena. The cases presented are based on longitudinal psychotherapeutic follow-up and combine clinical observations with theoretical interpretation.

Certain demographic, occupational, and contextual details were modified or combined to prevent identification

Clinical Presentation and Theoretical Integration

From an integrative perspective, burnout associated with excessive work investment can be understood at the intersection of behavioral addiction models, cognitive-behavioral theories, and developmental approaches to the construction of self-esteem. This clearly highlights a self-maintaining cycle of performance that acts both as a source of emotional regulation and as a vulnerability factor.

The literature shows that some individuals develop work dependence characterized by a loss of control, persistence of the behavior despite harmful consequences, and manifestations that resemble withdrawal during periods of inactivity.

For example, LG is a patient working in the IT sector, a man in his thirties who is highly engaged professionally. Withdrawal-like behavior was observed during his burnout-related leave. He was restless in his apartment, irritable, slept very little, and ruminated constantly. He could not stop checking his emails frantically on his personal phone or talking about work as if he were about to return after a long weekend.

This withdrawal phenomenon was also observed in other patients. ML, who works in healthcare, frequently brought work home, using it as a perfect excuse to work during episodes of insomnia. She worked at night without anyone in her close environment being aware of it. She quickly developed signs of exhaustion that she could not explain. During the first days of her leave, boredom led to dark thoughts.

Finally, a patient in her fifties working in healthcare, referred to as VV, had been experiencing signs of exhaustion for several years that she deliberately ignored. According to her, the body adapts to intense

stress and can therefore continue functioning. This patient, a perfectionist, saw herself only through her work and had never invested in her life as a woman and as a human being.

This pattern is frequently rooted in beliefs linking personal value to success and external recognition, often originating in family contexts that strongly value performance, thus contributing to the construction of a fragile and conditional identity, as illustrated in these cases.

In therapy, I often use the metaphor of a stool to illustrate mental health and help patients understand where imbalance may come from. A stool has four legs: family, work, friends, and romantic life. A three-legged stool can still stand, although one might hesitate more before jumping on it. However, a stool with only one or two legs cannot stand.

In such cases, it becomes necessary to reinvest the different pillars of life. However, the externalization of difficulties toward environmental factors, such as a toxic work environment, is often presented as the explanation for this addiction. Nevertheless, further investigation is required.

As discussed in the theoretical section, perfectionistic individuals are more likely to suffer from this type of addiction, as are individuals whose identity is constructed through and for work.

Although it may seem anecdotal, a person who is disengaged from their work will rarely suffer from work addiction. A person with a purely instrumental job is less likely to experience burnout because they have invested in other areas of their life. Work then becomes only a small part of their identity.

Attributing responsibility for this addiction solely to external causes can be understood not as an error of analysis but as a defensive step masking deeper internal patterns such as overcommitment and dependence on external validation. This was observed in all three patients, whose values and self-esteem were strongly linked to external validation, particularly through work.

When individuals are asked what they want to be in the future, they often respond with a profession rather than expressing a desire to be happy or describing how they would achieve happiness.

On an experiential level, these patients often report a cycle of temporary gratification following success, quickly followed by increased standards and pressure, contributing to behavioral escalation and progressive exhaustion, as observed in LG and VV.

Therapeutic Interventions

The most relevant therapeutic approaches appear to be integrative, aiming to shift identity from externally validated self-worth to a more intrinsic and stable form. This involves cognitive restructuring of performance-related beliefs, including identifying their origins.

In LG's case, these beliefs originated from a highly elitist family environment that strongly emphasized success. In VV's case, it represented a form of revenge against life, as she wanted to prove others wrong after having been predicted to fail. Both had internalized these standards and continuously raised them after each achievement.

The therapeutic goal was to teach them to stop after achieving an objective, to review the experience, and to take the time to acknowledge and reward themselves. This process is similar to how children are encouraged and reinforced for their efforts.

The development of assertiveness allows patients to identify and express their emotions within their social environment. Patients are asked to map their social ecosystems (work, family, friends, acquaintances) and identify levels of intimacy. This helps them identify supportive individuals and gradually learn to express vulnerability.

Experiential work plays a central role. Patients are introduced to non-performance-oriented activities, allowing exposure to imperfection and reconnection with intrinsic motivation.

VV engaged in pottery, which helped her discover creativity as a central dimension of her life. LG learned baking, which helped him tolerate frustration and understand that trial and error is part of the learning process. His tolerance for failure increased, and he understood that mistakes are part of growth rather than something to be avoided.

ML engaged in contemporary dance, Nordic walking, and knitting. These activities helped her disengage from constant availability. Without realizing it, she was no longer constantly reachable, as her schedule became structured around personal activities. She eventually found herself able to refuse helping others simply because she was tired, something she would not have done previously.

Results

From a clinical and theoretical perspective, the favorable evolution observed in patients presenting with burnout associated with excessive work investment and characteristics of behavioral addiction is generally reflected in a progressive reduction in compulsive work-related behaviors, an improvement in emotional regulation, and a rebalancing of the different spheres of life, as observed in LG as well as in VV and ML. This improvement is often accompanied by a reduction in anxiety manifestations, particularly panic attacks, as well as a reinvestment in interpersonal relationships, both within the couple and in the broader social network, reflecting a shift in sources of gratification and recognition, as observed in LG and VV.

A central indicator of change lies in the regained ability to rest without guilt and to experience pleasure in non-productive activities, reflecting a progressive deactivation of beliefs linking self-worth to performance. This process is illustrated in LG (through activities such as horseback riding and tennis) and is also reported in ML.

Regarding the relationship to work, clinical data suggest that the therapeutic objective is not necessarily a complete withdrawal from professional activity, but rather a qualitative transformation of work investment, characterized by the establishment of healthier boundaries, a reduction in dependence on external validation, and a redefinition of the meaning attributed to work, as observed across patients. This change reflects a deeper reorganization of motivational and identity systems, in which work ceases to be the primary regulator of self-esteem and becomes one component among others within a broader life balance, as also observed in ML.

Furthermore, clinical improvement often allows for a more accurate reassessment of the work environment itself. When this environment appears objectively misaligned with the patient's values, needs, or limits, the adaptive response no longer consists of pathological overcompensation but rather in concrete adjustments, such as professional mobility or a changé of employment. This was the case for LG, who decided to change sectors in order to no longer be subjected to performance-based objectives but rather to quality-oriented ones.

This ability to make decisions aligned with one's current needs constitutes an important marker of therapeutic consolidation, indicating not only symptom reduction but also a lasting transformation in psychological functioning.

Discussion

From a general perspective, clinical data derived from patients presenting with problematic work overinvestment support the conceptualization of work addiction as a form of behavioral addiction, while also highlighting the limitations of current diagnostic frameworks in adequately capturing it. The case of LG provides a particularly illustrative example, consistent with similar observations in VV and ML.

A central issue lies in the tension between the social valorization of work and its pathological excesses. Unlike other addictive behaviors, excessive professional engagement is often reinforced by the environment (employers, family norms, and broader societal expectations), which contributes to the normalization of these behaviors, delays their identification, and complicates their management, as also reflected in patients' narratives.

From a theoretical standpoint, these observations confirm the relevance of integrative models that articulate cognitive, emotional, and behavioral dimensions, in which dysfunctional beliefs linking self-worth to performance are combined with emotional avoidance strategies, leading to a self-maintaining cycle of overinvestment.

Within this framework, work is no longer merely an activity but becomes a central tool for psychological regulation, allowing individuals to avoid or attenuate negative affects, progressively leading to a fusion between personal identity and professional performance, as also observed in ML.

Consequently, one of the main therapeutic objectives

consists in supporting the construction of a more autonomous identity, differentiated from performance, within a safe and benevolent therapeutic framework in which error is integrated as a normal component of the learning process. This transformation relies not only on cognitive work but also on concrete experiences chosen by the patient according to their interests or curiosity. Although these experiences may initially appear unusual, they play a significant role in the redefinition of self, as observed in LG and ML.

Furthermore, this type of case highlights the importance of distinguishing high professional engagement from pathological addiction. The distinction does not lie so much in the quantity of work but rather in the quality of the relationship to work, with the central criterion being the loss of control associated with an alteration in overall functioning, as also observed in VV.

From a therapeutic perspective, these findings emphasize the central role of identity processes. Improvement largely depends on the patient's ability to develop alternative sources of self-worth and to reorganize life priorities, as observed in LG and VV.

Finally, the influence of contextual factors appears to be decisive. Professional environments that valorize hyperactivity and performance play a significant role in maintaining addictive behaviors. Therefore, effective preventive and therapeutic approaches must extend beyond the individual level and include consideration of organizational structures and sociocultural norms.

Conclusion

Work addiction appears to be a complex phenomenon situated at the interface between normality and pathology, involving a dynamic interaction between cognitive distortions, emotional vulnerabilities, and environmental influences. The case of LG, similarly to that of ML, highlights that its management requires a profound transformation of the individual's relationship to both self and work.

Although this condition is not yet formally recognized in major diagnostic classifications, the clinical data strongly support the need for increased scientific and clinical attention. A better understanding of its underlying mechanisms is essential for the development of appropriate interventions and for promoting a more balanced, sustainable, and individualized relationship to work.

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