

## Workaholism and Well-Being Among Nurses at Egypt Health Care Authority Hospitals in Port Said Governorate

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Received: 08/01/2025

Revised:18/02/2025

Accepted:31/03/2025

### ABSTRACT

**Background:** Workaholism is a psychological condition characterized by excessive and compulsive engagement in work activities, driven by the need to meet organizational standards .Well-being encompasses the holistic health and quality of life of individuals. **Aim:** The study aimed to examine the relationship between workaholism and well-being among nurses. **Design:** A descriptive correlational research design was employed. **Setting:** The study was conducted at As Salam Hospital, El-Zohor Hospital, and Al-Hayah Hospital, all affiliated with the Health Insurance System of the Ministry of Health in Port Said Governorate. **Subjects:** The study involved 380 nurses. **Tools:** The Workaholism Questionnaire and the Nurses' Well-Being Scale were used. **Results:** The study found that a significant proportion of nurses (74.2%) exhibited moderate workaholism, while a similar proportion (77.9%) reported moderate well-being. Conversely, a small percentage of nurses reported low levels of workaholism (10.8%) and well-being (2.1%). **Conclusion:** The correlation coefficient ( $r = -0.033$ ,  $p = 0.524$ ) indicated a non-significant negative correlation between workaholism and well-being. **Recommendation:** Based on these findings, it is recommended that healthcare organizations implement strategies to promote work-life balance, provide support interventions, and regularly assess nurses' well-being to mitigate the effects of workaholism.

**Keywords:** Health Care, Hospitals, Nurses, Well-being, Workaholism.

## **INTRODUCTION**

"Workaholism" and "work addiction" are frequently used interchangeably. They are not interchangeable, according to a recent theory, with workaholism being a far more general term that refers more to routine work-related activities than to psychopathology. Although excessive or compulsive labor is a common feature of both workaholism and work addiction, not everyone who engages in this behavior would be immediately diagnosed as clinically addicted (Clark, Smith, & Haynes, 2020; Morkevičiūtė & Endriulaitienė, 2023).

Workaholism is often defined by two primary components: behavioral and psychological. The behavioral component refers to the excessive time spent working, such as long work hours per day or week. The psychological component manifests as an obsession with work, meaning workaholics cannot detach from work and often engage in compulsive work behaviors even when they are not at the office (Griffith & Erin, 2019).

Workaholism can be further defined by two main characteristics: working excessively and compulsively. When given the opportunity, workaholics spend a substantial amount of time on work-related activities. Additionally, they are unable to limit the amount of time they devote to work, even in the face of negative consequences such as damaged relationships or declining health (Gonçalves, Meneses, Sil, Silva, & Moreira, 2023).

The three components of workaholism are enjoyment of one's job, motivation to work, and involvement in one's work. Those with high scores on the first two dimensions and low scores on the final dimension were labeled non-enthusiastic work addicts, whereas those with high scores on all dimensions were labeled enthusiastic work addicts. The emphasis on enjoying one's job is considered unnecessary by the time the multifaceted perspective is abandoned. Workaholism has been connected to unfavorable organizational outcomes and can have detrimental psychological, physical, and social repercussions on those who suffer from it as well as those who are close to them (Taris, & de Jonge, 2024).

Working excessively interferes with the relationship between the individual's satisfaction and pleasure with work, and quality of life, as his perception is temporal and circumstantial. Quality of life is related to the subjective perception of the individual concerning well-being in the context of life: in a multidimensional perspective that interrelates physical, psychological, and social relations, and aspects related to the environment where one lives (Nath, Rai, Bhatnagar, & Cooper, 2024).

Workaholism can bring both benefits and drawbacks. On the positive side, working long hours may increase productivity, job satisfaction, and financial rewards. However, Overemphasizing work frequently comes at the expense of one's physical and mental well-being. Rather than leading to success and happiness, workaholism usually has negative consequences for an individual's health and relationships (Bashir, Abrar, Yousaf, Saqib & Shabbir, 2019).

A person's overall psychological well-being is a measure of their level of happiness with their living circumstances and their overall quality of life. A person who is in good health is more creative, finds it easier to accomplish their goals, makes better decisions, is more satisfied with their life, has a higher quality of life, is able to release bad emotions, is in better bodily and mental health, and can enjoy life. Overall health can guard against psychopathology (Meeusen, Gatt, Barach, & Van Zundert, 2024).

Higher general well-being among nurses leads to improved outcomes, which in turn ensures employment security, lowers the risk of job changes, and reduces sick days. Additionally, nurses who are generally in good health are much less likely to have job-related fatigue. Improved patient safety and reduced burnout rates are linked to greater general well-being in the healthcare industry. Therefore, enhancing nurses' mental health and retention rate as well as patient health outcomes requires an awareness of nurses' overall well-being and the elements that are related to it (Aiken et al., 2023).

Leaders should, in fact, actively promote a healthy work-life balance in order to support nurses' health and well-being. They should recognize the value of taking time off from work and relaxing, ensure that workers feel free to use holidays and breaks for leisure rather than work, and permit nurses to take flexible work schedules when necessary. Such a mindset could be instinctive for certain leaders. Others, however, would need to take part in official leadership development programs to understand that this is also a part of their responsibilities. Even if they are happy workaholics who help others achieve a healthy work-life balance, overworking executives offer a poor example for nurses (de Jonge & Taris 2023).

### **Significance of the Study**

Workaholism has been identified as a harmful factor that not only compromises the mental and physical health of individuals but also detracts from the quality of patient care and organizational efficiency (Taris & de Jonge, 2024). Nurses, who are a pivotal group within healthcare, often face high work demands and stress, which increases their vulnerability to workaholic behaviors. Given that workaholism is associated with burnout, job dissatisfaction, and reduced quality of patient care (Gillet , Morin, Fernet, Huyghebaert-Zouaghi, & Austin, 2023), healthcare leaders must implement strategies to mitigate these adverse effects.

Despite the importance of this issue, there remain significant research gaps about the clear connection between workaholism and how it affects nurses' health and performance on the job, particularly in non-Western contexts. Although existing studies have highlighted links between workaholism, burnout, job stress, and adverse health outcomes, there is a lack of comprehensive exploration into the mechanisms that drive these effects, especially within the Egyptian healthcare system.

By focusing on this under-researched area, this study addresses these gaps and provides empirical evidence on how workaholism specifically affects nurses' well-being in Egypt. This research offers a foundation for future studies and interventions to improve well-being and job outcomes for nurses in similar healthcare environments.

## **AIM OF THE STUDY**

The present study examines the relationship between workaholism and well-being among nurses in Egypt Health Care Authority hospitals in Port Said Governorate.

### **The specific objectives of the study are to:**

1. Assess the levels of workaholism among nurses.
2. Evaluate the well-being levels of nurses.
3. Explore the relationship between workaholism and well-being among nurses.

## **SUBJECTS AND METHOD**

### **I. Technical design:**

The technical design of this study outlines the research design, setting, subjects, and data collection tools.

### **Research Design:**

A descriptive correlational research design was employed to examine the relationship between workaholism and well-being among nurses.

### **Research Setting:**

The study was conducted at three major government hospitals affiliated with the Egypt Health Care Authority in Port Said Governorate, Egypt. These hospitals include As-Salam Hospital, Al-Hyah Hospital, and El-Zohor Hospital.

- **As-Salam Hospital:** The **total staff** is 365 nurses with 157 bed **capacity**. **Hospital structure:** The hospital consists of three buildings.
- **Al-Hyah Port-Fouad Hospital:** The **total staff of** 348 nurses with 144 beds **capacity**. **Hospital structure:** The hospital consists of three buildings.
- **El-Zohor Hospital:** The total staff is 170 nurses with 69 beds capacity. **Hospital structure:** The hospital consists of one building with five floors.

## Subjects

The study was conducted in three hospitals: As-Salam Hospital (365 nurses), Al-Hyah Hospital (348 nurses), and El-Zohor Hospital (170 nurses), with a total population of 883 nurses.

## Sample Size Calculation

The sample size was calculated using power analysis based on the formula provided by **Crejcie and Morgan** (1970). The equation used for the sample size calculation is as follows:

Substituting the values into the equation:

$$s = \frac{6.656 \times 883 \times 0.50(1-0.50)}{(0.05)^2 \times (883-1) + 6.656 \times 0.50(1-0.50)} = 380 \text{ nurse}$$

*Thus, the total sample size for the study is 380 nurses.*

## Sample Distribution

Using proportional allocation, the sample size of 380 nurses was distributed across the three hospitals based on their respective nursing populations. **Total Sample Size: 380 nurses distributed after calculated as follows:**

- As-Salam Hospital: 157 nurses
- Al-Hyah Hospital: 150 nurses
- El-Zohor Hospital: 73 nurses

## Sampling Technique

Nurses were selected from all inpatient units of the three hospitals using a simple random sampling technique. This approach ensures that each nurse in the target population has an equal chance of being included in the study, reducing selection bias.

## **Tools for Data Collection**

Data was collected using two primary instruments: the Workaholism Questionnaire and the Nurses' Well-Being Scale.

### **Tool I: The Workaholism Questionnaire**

The Workaholism Questionnaire was used to assess the level of workaholism among nurses. It consists of two parts:

#### **Part 1:**

The researcher developed this section to collect personal demographic information, including age, gender, marital status, qualifications, years of experience, and work unit.

#### **Part 2:**

This section assesses the level of workaholism among nurses, which was developed by Aziz, Uhrich, Wuensch, and Swords (2013). The researcher translated the questionnaire into Arabic for use in this study. It consists of five subdomains related to workaholism, encompassing 29 items. These subdomains include: Work-life conflict (11 items), Work perfectionism (5 items), Work addiction (5 items), Unpleasantness (4 items), and Withdrawal symptoms (4 items).

#### **Scoring System:**

A 5-point Likert scale, with 1 denoting "strongly disagree" and 5 denoting "strongly agree," is used to measure responses to the items; higher scores correspond to higher degrees of workaholism. The following cut-off points are used to categorize the overall workaholism score: It should be Low: 29 to 67, Moderate: 68 to 106 and High: 107 to 145.

### **Tool II: Nurses' Well-Being Scale**

Pradhan, Dash, and Jena (2019) and Ryff (1995) developed the Nurses' Well-Being Scale. This scale is designed to assess the well-being levels among nurses and was translated into Arabic by the researcher for this study. The scale consists of four

major dimensions, comprising 33 items: psychological well-being (10 items), Social well-being (10 items), Workplace well-being (9 items), and subjective well-being (4 items).

**Scoring System:**

Responses are measured on a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Total well-being levels are categorized based on cut-off points: Low: 33 to 77, Moderate: 78 to 121, and High: 122 to 165.

**II. Operational design:**

The study's operational design includes fieldwork, the pilot study, validity and reliability evaluation, and the preparation phase. Each component ensures that the survey is well-structured and that the findings are credible.

**Preparatory Phase**

The preparatory phase involved an extensive literature review and theoretical knowledge of workaholism and well-being. This phase included studying relevant books, research articles, and online resources and exploring periodicals and other academic materials. This phase aims to comprehensively understand the existing body of knowledge, identify literature gaps, and build a foundation for the study's design and methodology.

**Tools' Validity**

The two tools used in this study were first translated into Arabic and then retranslated into English to ensure accuracy and clarity. Five nursing experts were consulted to assess the validity of the tools. They reviewed the translated tools to evaluate their content, clarity, and relevance. Based on the experts' feedback and recommendations, necessary revisions were made to improve sentence clarity, content appropriateness, and the overall ease of use for data collection.

**Tools' Reliability**

To assess the internal consistency and reliability of the tools, Cronbach's alpha (coefficient alpha) was calculated. The reliability coefficient for the Workaholism Questionnaire was 0.87, while the reliability coefficient for the Nurses' Well-Being Scale was 0.86. These values indicate high internal consistency for both tools.

**Pilot Study**

Before the main data collection, a pilot study was conducted with 10% of the sample, comprising 38 randomly selected nurses. The time needed for completion of the questionnaires ranged from 15 to 20 minutes. Based on the pilot study's results, no modifications were needed, and all data collected during the pilot study were included in the final analysis.

**Fieldwork**

Fieldwork commenced after obtaining official permissions from the directors of the three hospitals involved in the study. The researcher first met with each hospital's director of nursing services to explain the study's objectives and secure their cooperation during the data collection process. A list of nurses from each hospital was obtained, and a basic random sampling procedure was used to choose the sample. The researcher then met individually with each staff nurse chosen based on availability, explained the study's aim and procedures, and obtained oral informed consent to participate. Nurses who agreed to participate were provided with the study tool and clear instructions for its completion. The researcher was available during this period to address any questions or concerns. Some participants completed the questionnaire immediately, while others returned it after a brief period. Completing the questionnaire took approximately 20–25 minutes. The data collection process, which lasted three months, began in March 2023 and was completed by the end of May 2023. Data was collected during the morning shift, two days a week.

**III. Administrative design:**

An official letter was obtained from the Dean and the Vice Dean of Postgraduate Studies and Research at the Faculty of Nursing, Port Said University.

This letter was sent to the nursing directors of the three hospitals to explain the purpose of the study, seek their cooperation, and obtain the necessary permissions. Subsequently, written permissions were secured from the hospitals after providing a detailed explanation of the study's objectives.

### **Ethical Considerations**

Official approval for the study was obtained from the Ethical Committee of the Faculty of Nursing, Port Said University, under code number NUR (3-11-2024) (43). After thoroughly explaining the study's purpose and nature, informed consent was secured from all participating nurses. Participants were assured that their involvement was voluntary and that they could withdraw from the study without any consequences. Confidentiality and anonymity of the collected data were strictly maintained throughout the study.

## **IV. Statistical design**

### **Statistical Analysis:**

- To guarantee that the data was appropriate for computer processing, the researcher coded, tabulated, and converted it into a format that was specifically created. The IBM SPSS software suite, version 22.0, was then used to evaluate the data.
- The following statistical metrics were used in the data analysis and interpretation process: The Cronbach's alpha coefficient was used to assess the instruments' dependability. The normality of the data distribution was evaluated using the one-sample Kolmogorov-Smirnov test. Numbers and percentages were used to display the qualitative data. The mean and standard deviation were used to summarize continuous variables. The analysis of variance (one-way ANOVA) was used to compare the means of more than two groups in order to examine correlations and differences between groups for categorical variables. To compare the means of two independent samples, use the t-test. Interrelationships between quantitative variables were evaluated using a bivariate Pearson correlation test. High significance was defined as  $p < 0.001^{**}$ , and statistical significance as  $p \leq 0.05^*$ .

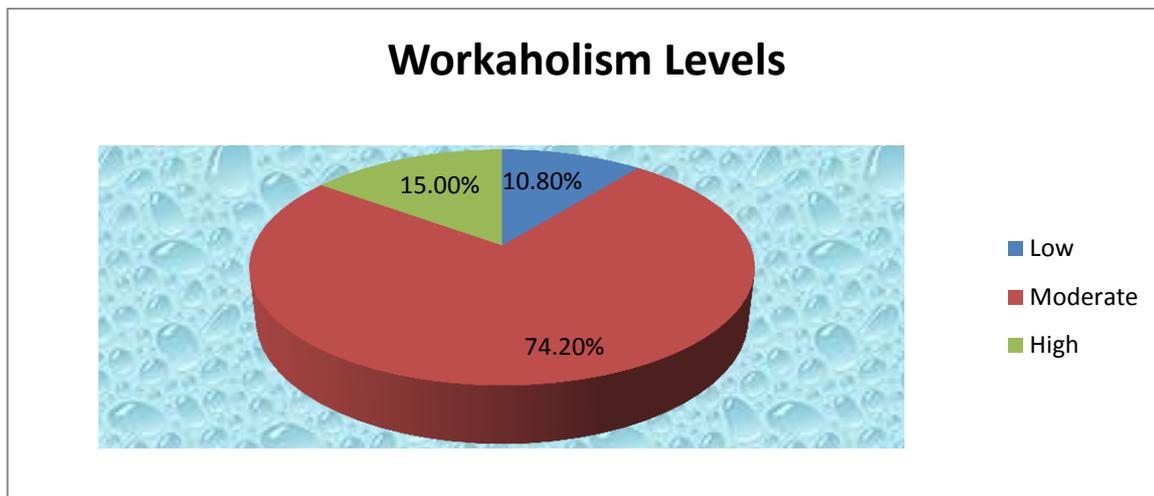
## RESULT

Table 1: Personal Characteristics of the Studied Nurses (N = 380)

Demographic characteristics	N	%
<b>Age groups</b>		
20 < 29 years	281	73.9
29 < 39 years	70	18.4
≥ 39 years	29	7.6
<b>Gender</b>		
Female	254	66.8
Male	126	33.2
<b>Educational levels</b>		
Diploma	53	13.9
Technical	146	38.4
Bachelor	175	46.1
Master	6	1.6
<b>Years of experience in nursing</b>		
< 5 years	222	58.4
5 : < 10 years	85	22.4
10 : < 15 years	17	4.5
≥15 years	56	14.7
<b>Resident area</b>		
Rural	106	27.9
Urban	274	72.1
<b>Marital status</b>		
Single	177	46.6
Married	188	49.5
Divorced	12	3.2
Widow	3	0.8
<b>Hospital</b>		
El Zohor	73	19.2
El Hayah	150	39.5
El Salam	157	41.3
<b>Department</b>		
O.R	47	12.4
Emergency	80	21.1
Incubation	34	8.9
Inpatient departments	84	22.1
Dyaliss Unit	20	5.3
I.C.U and C.C.U	115	30.3

**Table 1:** The personal characteristics of the studied nurses revealed a diverse demographic profile. The majority of nurses were aged between 20 and 29 years (73.9%), followed by those aged 29 to 39 years (18.4%) and those aged 39 years and above (7.6%). Regarding gender, 66.8% were female, and 33.2% were male. Regarding educational levels, the largest group held a Bachelor's degree (46.1%), followed by those with a technical degree (38.4%), a Diploma (13.9%), and a Master's

degree (1.6%). Most nurses had less than 5 years of nursing experience (58.4%), with 22.4% having 5 to less than 10 years, 4.5% having 10 to less than 15 years, and 14.7% having 15 or more years of experience. Regarding residential areas, 72.1% resided in urban areas, while 27.9% lived in rural areas. Regarding marital status, 49.5% were married, 46.6% were single, 3.2% were divorced, and 0.8% were widowed. Nurses were distributed across different hospitals: 41.3% worked at As-Salam, 39.5% at Al-Hyah, and 19.2% at El-Zohour. Finally, regarding departmental distribution, 30.3% worked in the ICU and CCU, 22.1% in inpatient departments, 21.1% in emergency, 12.4% in the operating room, 8.9% in the incubation unit, and 5.3% in the dialysis unit.



**Figure 1:** Levels of Workaholism Reported by Nurses at Egypt Health Care Authority Hospitals (N = 380)

**Figure 1** illustrates the distribution of workaholism levels among the studied nurses. The majority (74.2%) of nurses reported moderate levels of workaholism. High levels were reported by 15.0% of nurses, while 10.8% indicated low levels of workaholism.

**Table (2):** Descriptive Statistics for Workaholism Domains Reported by Nurses at Egypt Health Care Authority Hospitals (N = 380)

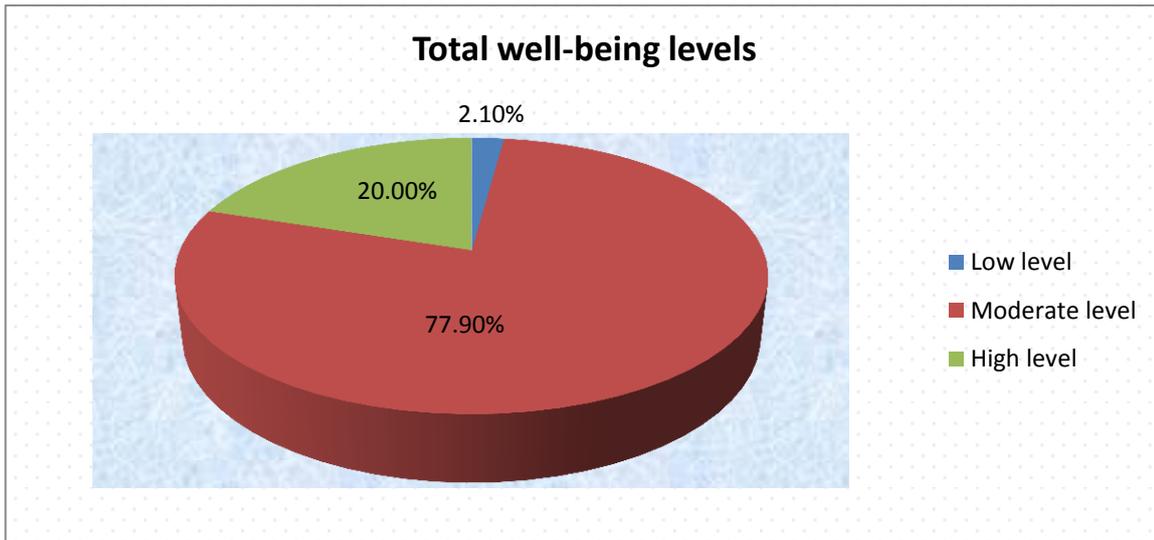
Workaholism domains	No.items	Min-Max	Median	M	±SD	Mean %
Work-Life Conflict	11	15-55	38	38.09	8.063	41.16
Work-perfectionism	5	7-25	16	16.25	3.527	17.56
Work Addiction	5	6-25	15	15.03	3.096	16.24
Unpleasantness	4	4-20	10	9.82	2.601	10.61
Withdrawal Symptoms	4	6-20	14	13.31	2.648	14.38

**Table (2)** presents the descriptive statistics for the workaholism domains reported by nurses at Egypt Health Care Authority hospitals. The domain of **Work-Life Conflict** had the highest mean score ( $41.16 \pm 8.063$ ), indicating a relatively higher prevalence of work-life conflict among nurses, ranging from 15 to 55. The **Work-Perfectionism** domain had a mean of 17.56 (SD = 3.527), with scores ranging from 7 to 25, reflecting moderate levels of perfectionism. The **Work Addiction** domain showed a mean of 16.24 (SD = 3.096) with a range of 6 to 25, suggesting a moderate level of addiction to work. The **Unpleasantness** domain had a mean score of 10.61 (SD = 2.601), indicating lower unpleasantness than the other domains, ranging from 4 to 20. Finally, the **Withdrawal Symptoms** domain had a mean of 14.38 (SD = 2.648), reflecting mild to moderate withdrawal symptoms among nurses, ranging from 6 to 20. The range and standard deviations for each domain highlight the variation in experiences of workaholism among the nurses.

**Table (3):** Distribution of Workaholism Domain Levels Among Nurses at Egypt Health Care Authority Hospitals (N = 380)

Workaholism domains	levels					
	Low		Moderate		High	
	No	%	No	%	No	%
Work-Life Conflict	52	13.7	220	57.9	108	28.4
Work-perfectionism	91	23.9	221	58.2	68	17.9
Work Addiction	71	18.7	277	72.9	32	8.4
Unpleasantness	333	87.6	46	12.1	1	0.3
Withdrawal Symptoms	146	38.4	230	60.5	4	1.1

Table (3) presents the distribution of workaholism domain levels among nurses. The work-life conflict domain shows that most nurses (57.9%) reported moderate levels, with 28.4% reporting high levels and 13.7% reporting low levels of work-life conflict. In the work-perfectionism domain, most nurses (58.2%) were at a moderate level, followed by 23.9% at a low level and 17.9% at a high level. for work addiction, the majority of nurses (72.9%) reported moderate levels, while 18.7% reported low levels and 8.4% reported high levels of work addiction. The unpleasantness domain showed a significant skew, with the majority (87.6%) reporting low unpleasantness levels, only 12.1% reporting moderate levels, and a minimal 0.3% reporting high levels. finally, the withdrawal symptoms domain revealed that 60.5% of nurses reported moderate withdrawal symptoms, 38.4% reported low levels, and only 1.1% reported high levels.



**Figure (2):** Total Well-Being Levels Among Nurses at Egypt Health Care Authority Hospitals in Port Said Governorate (N = 380)

**Figure (2)** displays the distribution of well-being levels among nurses. Most nurses, 77.9%, reported having a moderate level of well-being. A smaller proportion, 20%, reported a high level of well-being, while only 2.1% of nurses indicated a low level of well-being.

**Table (4):** Descriptive Statistics for Well-Being Domains Reported by Nurses at Egypt Health Care Authority Hospitals in Port Said Governorate (N = 380)

well-being domains	No.items	Min-Max	Median	M	± SD	Mean %
Psychological well-being (PWB)	10	21-47	38	37.53	3.870	31.33
Social well-being (SWB)	10	14-50	36	36.06	5.310	30.11
Workplace well-being (WWB)	9	9-45	33	32.39	6.113	27.41
Subjective well-being (SWB)	4	4-20	14	13.77	1.849	11.51

Table (4) reveals that the psychological well-being (pwb) domain had a mean of 31.33 ( $\pm 3.87$ ), with a range from 21 to 47. the social well-being (swb) domain showed a mean of 30.11 ( $\pm 5.31$ ), ranging from 14 to 50. the workplace well-being (wwb) domain had a mean of 27.41 ( $\pm 6.11$ ), ranging from 9 to 45. lastly, the subjective well-being domain had a mean of 11.51 ( $\pm 1.85$ ), ranging from 4 to 20.

**Table (5):** Levels of Well-Being Domains Reported by Nurses at Egypt Health Care Authority Hospitals in Port Said Governorate (N = 380)

well-being domains	level					
	Low		Moderate		High	
	No	%	No	%	No	%
Psychological well-being (PWB)	5	1.3	222	58.4	153	40.3
Social well-being (SWB)	16	4.2	277	72.9	87	22.9
Workplace well-being (WWB)	18	4.7	199	52.4	163	42.9
Subjective well-being (SWB)	2	0.5	319	83.9	59	15.5

Table (5) demonstrates varying distributions across different well-being domains. For Psychological Well-being, the majority of nurses reported moderate levels (58.4%), with 40.3% reporting high levels and a small proportion (1.3%) reporting low levels. In Social Well-being (SWB), most nurses (72.9%) reported moderate levels, followed by 22.9% reporting high and 4.2% reporting low levels. For Workplace Well-being (WWB), most nurses reported moderate levels (52.4%), with 42.9% reporting high levels and 4.7% reporting low levels. Lastly, Subjective Well-being (SWB) had a significant proportion of nurses reporting moderate levels (83.9%), with 15.5% reporting high levels and only 0.5% reporting low levels.

**Table (6):** Correlation Matrix Between Workaholism Domains and Well-Being Domains (N = 380)

Study Variables	Sig	1	2	3	4	5	6	7	8	9	10
1- Work-Life Conflict	<b>r</b>	-									
	<b>p</b>	-									
2-Work-perfectionism	<b>r</b>	.635**	-								
	<b>p</b>	.000	-								
3- Work Addiction	<b>r</b>	.138**	.300**	-							
	<b>p</b>	.007	.000	-							
4- Unpleasantness	<b>r</b>	.209**	.284**	.449**	-						
	<b>p</b>	.000	.000	.000	-						
5-Withdrawal Symptoms	<b>r</b>	.090	.127*	.488**	.379**	-					
	<b>p</b>	.080	.014	.000	.000	-					
6-Psychological well-being	<b>r</b>	-.221**	.184**	-.201**	-.008	.312**	-				
	<b>p</b>	.000	.000	.000	.880	.000	-				
7- Social well-being	<b>r</b>	-.270**	-.170**	.191**	.003	.293**	.278**	-			
	<b>p</b>	.000	.001	.000	.954	.000	.000	-			
8-Workplace well-being	<b>r</b>	-.463**	-.337**	-.186**	-.080	.228**	.130*	.703**	-		
	<b>p</b>	.000	.000	.000	.122	.000	.011	.000	-		
9-Subjective well-being	<b>r</b>	.403**	.277**	.187**	.161**	.233**	.327**	.172**	.061	-	
	<b>p</b>	.000	.000	.000	.002	.000	.000	.001	.239	-	
10-Total workaholism	<b>r</b>	.833**	.771**	.559**	.556**	.457**	.282**	-.101*	-.286**	.423**	-
	<b>p</b>	.000	.000	.000	.000	.000	.000	.048	.000	.000	-
11-Total well-being	<b>r</b>	-.213**	-.139**	.262**	-.011-	.367**	.539**	.879**	.836**	.352**	-.033
	<b>p</b>	.000	.007	.000	.824	.000	.000	.000	.000	.000	.524

Bivariate Person correlation test, Significance is considered if  $p < 0.05^*$ , highly considered if  $p < 0.001^{**}$

Table (6) presents the correlation matrix between workaholism and well-being domains among nurses. Several significant correlations were observed. Work-life conflict, a key domain of workaholism, showed strong positive correlations with total workaholism ( $r = .833$ ,  $P = .000$ ) and moderate negative correlations with psychological well-being ( $r = -.221$ ,  $P = .000$ ) and social well-being ( $r = -.270$ ,  $P = .000$ ). Work-perfectionism was positively associated with withdrawal symptoms ( $r = .488$ ,  $P = .000$ ) and total workaholism ( $r = .771$ ,  $P = .000$ ), but negatively correlated with workplace well-being ( $r = -.337$ ,  $P = .000$ ). Work addiction exhibited moderate positive correlations with total well-being ( $r = .262$ ,  $P = .000$ ) but negatively correlated with workplace well-being ( $r = -.186$ ,  $P = .000$ ). Withdrawal symptoms were positively linked to subjective well-being ( $r = .233$ ,  $P = .000$ ) and total workaholism ( $r = .457$ ,  $P = .000$ ). Overall, the total well-being score was highly positively correlated with psychological well-being ( $r = .539$ ,  $P = .000$ ), social well-being ( $r = .879$ ,  $P = .000$ ), and workplace well-being ( $r = .836$ ,  $P = .000$ ). However, total well-being had a weak negative correlation with total workaholism ( $r = -.033$ ,  $P = .524$ ).

**Table (7):** Correlation Between the Total Score of Workaholism and the Total Score of Well-Being (N = 380)

Study Variables		Total well-being
Total workaholism	r	-.033
	p	0.524

\*\* . Correlation is significant at the 0.01 level (2-tailed). Bivariate Person correlation test used.

Table (7) demonstrates the correlation between the total workaholism scores and nurses' well-being. The results indicate a weak negative correlation ( $r = -0.033$ ) between the two variables, but this relationship is not statistically significant ( $P = 0.524$ ).

## DISCUSSION

Workaholism is a negative condition with harmful effects on health, personal relationships, and general well-being, others distinguish between positive and negative forms of workaholism (Kim, Choi, Park, & Sohn 2022). As conceptualized in this study, well-being represents an individual's holistic assessment of their life, encompassing emotional satisfaction, a sense of purpose, and meaning (Zhang, Song, & Lan, 2020). In nursing, meeting psychological needs through work can positively influence well-being and overall life satisfaction. Therefore, understanding the interplay between workaholism and well-being is critical, as it sheds light on how work behaviors impact nurses' mental and emotional health. This study specifically investigates the relationship between workaholism and well-being among nurses at Egypt Health Care Authority Hospitals in the Port Said Governorate.

Regarding *the total levels of workaholism* among nurses at Egypt Health Care Authority hospitals, the present study found that the majority of nurses reported moderate levels. Fewer nurses reported high levels, while an even smaller proportion reported low levels. This trend may be attributed to the demanding nature of patient care, which often requires nurses to invest additional time and effort, and the work environment itself. Moreover, many nurses felt guilt when not engaging in work-related tasks, contributing to the moderate workaholism observed.

These findings contrast with those of Mohamed, Ahmed, and Hasanin (2024) who reported that more than two-thirds of nurses had high levels of workaholism, with slightly more than one-quarter exhibiting moderate levels and a small minority reporting low levels. Similarly, Sachiko & Isamu (2016) found a generally high level of workaholism among nurses, a result that was not aligned with the current study.

On the other hand, the present findings are inconsistent with those of Nonnis, Massidda, Cuccu, and Massidda (2018) who reported high levels of workaholism among staff nurses, as well as Kunecka and Hundert (2019), who highlighted that approximately less than half of staff were at significant risk of workaholism. Conversely, this result contradicts the findings of Fujimoto (2014); Danuta and Hundert

(2019), and Pinheiro and Carlotto (2018) who reported low workaholism among staff nurses.

Concerning the various *domains of workaholism* among nurses, including Work-Life Conflict, Work-Perfectionism, Work Addiction, and Unpleasantness, the present study indicated that Work-Life Conflict and Work-Perfectionism are the most prevalent domains, with the highest mean scores observed in these areas. Specifically, Work-Life Conflict accounted for more than two-fifths, and Work-Perfectionism was reported by one-fifth of the participants. These findings are consistent with those of Taheri, Asarian, and Shahhosseini, (2019), who found that, across all workaholism dimensions, work perfectionism exhibited the highest mean score among those with high levels of workaholism. On the other hand, Andreassen , Pallesen, and Torsheim, (2018). found that, among all workaholism dimensions, withdrawal symptoms had the highest mean score, followed by perfectionism, in individuals with high levels of workaholism.

Regarding the *levels of workaholism within specific domains*, the current study found that while moderate workaholism is prevalent across most domains, certain aspects, such as unpleasantness, were reported at lower levels among the nurses. However, these results differ from those of Maharana, Abd Al-Fattahb, and Saleh, (2022) who assessed the workaholism levels and found low workaholism overall. In their study, more than two-thirds of participants reported work addiction, and more than half reported unpleasantness, indicating that workaholism was experienced differently across various populations. This result is inconsistent with the findings of Moyer , Aziz, and Wuensch (2017) who reported that low levels of workaholism were present across all workaholism dimensions.

Regarding the *overall well-being levels* among nurses, the present study revealed that most participants over three-quarters reported moderate levels of well-being, while one-fifth reported high levels, and only a tiny proportion reported low levels. This may be attributed to the reflection of a balance between workplace challenges, such as high job demands and limited organizational support, and protective factors like resilience and coping strategies.

While these factors may prevent significant declines in well-being, they also limit the achievement of high well-being. Additional influences, such as organizational culture, leadership styles, and individual circumstances, further shape these outcomes. This finding highlights the need for targeted strategies to enhance workplace conditions, foster resilience, and promote a supportive environment to elevate nurses' well-being to higher levels.

In contrast, Gille et al. (2019) found that most psychiatric nurses experienced poor workplace well-being. Similarly, Prajapati, Rana, and Thapa (2024) and Resilience et al. (2024) found that less than half of the participants reported low levels of well-being. On the other hand, Li et al. (2021) concluded that most nurses in their study demonstrated high levels of well-being. These discrepancies in well-being levels across studies may be attributed to differences in study contexts, populations, or methodological approaches.

Regarding the various *well-being domains*, results highlight the variations in well-being levels across different domains, with the Psychological Well-being domain showing the highest mean, followed by the Social Well-being domain. At the same time, Subjective Well-being had the lowest mean score, suggesting that nurses feel less personally satisfied or fulfilled in their roles. These results are consistent with those of Lorber, Treven, and Mumel, (2020) reported that nurses experienced higher levels of psychological well-being.

The data indicated that most nurses reported moderate psychological well-being, with a small proportion reporting low levels. These findings are consistent with those of Darwish and Elfiky (2022), who noted that more than half of the nurses had moderate psychological well-being. Similarly, Babalola and Olumuyiwa (2015) supported these findings in their study on job satisfaction and psychological well-being among mental health nurses, concluding that most nurses reported positive psychological well-being, with only a minority experiencing psychological distress. In contrast, Ibrahim, Elwekel, Osman, and El-Gilany, (2020); Mahmoud, Elhosany, and Helal, (2020), and Jafarizadeh, Sadeghi, and Azarbarzin, (2019), reported that most nurses exhibited high psychological well-being.

Regarding *subjective well-being*, a significant proportion of nurses in the current study reported moderate well-being. These findings are consistent with Lorber et al. (2020), who found that nurses self-assessed their well-being as moderate. Additionally, the results of the present study align with those of Blumberga and Olava (2016), who reported that the overall sense of psychological well-being among healthcare personnel was at a medium level.

However, these findings contrast with those of Saad, Elsherif, Gemeay, and Wahbaet (2024) reported that more than half of the nurses in their study had poor subjective well-being, while only a minority reported moderate levels. Similarly, the present study's results do not align with those of Oates, Jones, and Drey, (2017) who found that mental health nurses had low subjective well-being.

The *correlation matrix between workaholism and well-being domains* revealed several significant findings. The work-life conflict was negatively correlated with both psychological and social well-being, indicating that higher work-life conflict is associated with lower levels of well-being in these areas. Work perfectionism showed a positive correlation with social well-being but a negative correlation with psychological well-being, suggesting that perfectionistic tendencies may benefit social relationships while harming psychological health. Work addiction was negatively correlated with both psychological and workplace well-being, highlighting that excessive work engagement is linked to poorer well-being in these domains.

These correlations underscore the complex relationship between workaholism and various aspects of well-being, emphasizing the need to address workaholism to improve nurses' overall health and job satisfaction. The findings may reflect the mental, organizational, and emotional demands placed on nurses due to the long hours and unpredictable schedules they often face, particularly while caring for patients in challenging circumstances.

This result is supported by Rosario-Hernández et al. (2024) that workaholism has a detrimental effect on nurses' psychological well-being. Furthermore, they reported that workaholism significantly impacts both positive (problem-solving

pondering) and negative (affective rumination) rumination, with substantial effect sizes for affective rumination.

The present results are similar to Sheta and Hammouda (2022) concluded that workaholics experience a significantly lower quality of life across all domains except for the environment. This finding aligns with Fujimoto (2014) which highlighted that workaholism is linked to several mental and physical health issues, including depression, anxiety, and sleep disorders. These findings reinforce the detrimental effects of workaholism on both psychological and physical well-being.

Additionally, the present study's findings are consistent with those of Deuling and Burns (2017) found that perfectionism is associated with lower work-family conflict, mainly when adaptive perfectionism is present in work and home settings. This suggests that individuals with adaptive perfectionism can better manage work-family dynamics. In line with this, van Wijhe , Peeters, Schaufeli, and Ouweneel, (2013) reported that individuals with high workaholism scores tend to have poorer recovery, more negative emotions when not working, and are more likely to work during evenings and weekends. These findings highlight the impact of workaholism on personal time and emotional well-being.

Moreover, this study agrees with Taheri, Naderibeni, Mirzamani, (2022) found that workaholism negatively impacts subjective well-being. Finally, Wakefield, Bowe, Kellezi, McNamara,& Stevenson (2019) emphasized the contradictory effects of workaholism on self-care and social support, linked to reduced self-care and diminished social well-being.

The overall correlation between total workaholism scores and nurses' well-being indicates a weak, non-significant negative correlation. These findings align with those of Junker, Lorenzo, van Dick, and Kaluza (2024) identified an indirect association between workaholism and well-being. Similarly, the study by Sánchez-Medina et al. (2020) reported no consensus regarding whether workaholics derive enjoyment as a key aspect of positive mental well-being. Similarly, Kasemy et al. (2020) determined that among healthcare workers, workaholism is substantially linked to poor psychological health and a reduced quality of life.

In line with previous studies, Clark, Michel, Zhdanova, Pui,& Baltes (2016) concluded that the positive association between workaholism and changes in well-being is surprising, given that a negative association is typically well-established. Similarly, Schaufeli, Bakker, Van der Heijden, & Prins (2009) revealed that workaholism is associated with poorer general well-being.

In conclusion, workaholism is a multifaceted phenomenon with significant negative implications for physical health, mental well-being, interpersonal relationships, and job performance. Although workaholics may experience external rewards such as higher productivity and financial gain, the toll it takes on their health and social life is considerable. Both individuals and organizations need to recognize the dangers of workaholism and implement strategies to mitigate its impact. Promoting work-life balance, encouraging adequate recovery, and addressing mental health concerns in the workplace can help reduce the harmful effects of workaholism and improve overall well-being.

## **CONCLUSION**

*Based on the findings of the current study, it can be concluded that:*

The findings of this study offer valuable insights into the intricate relationship between workaholism and well-being among nurses. The majority of participants reported moderate levels of workaholism, with work-life conflict and work perfectionism identified as the most significant contributing factors. Regarding well-being, most nurses also reported moderate levels.

The study further revealed a weak negative correlation between workaholism and overall well-being; however, no statistically significant relationship was identified, suggesting that workaholism does not have a strong linear effect on nurses' overall well-being.

## **RECOMMENDATIONS**

*Several recommendations can be made in light of the study's findings, including the following:*

**Recommendations for Nurses:**

1. Professional development programs focusing on stress reduction and mental health awareness may help nurses reduce perfectionistic tendencies.
2. Peer support groups and mentorship programs could be encouraged to promote well-being and reduce work-related stress.

**Recommendations for Nurse Managers:**

1. Training in stress management, time management, and setting boundaries could help reduce workaholism among staff.
2. Establishing fair shift rotations and ensuring that nurses are not overburdened with tasks is vital for maintaining physical and mental health.
3. Nurse managers should advocate for and implement work-life balance programs.

**Recommendations for Hospital Administrators:**

- Hospital administrators should design and implement comprehensive well-being programs that address nurses' physical and mental health needs.

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## إدمان العمل والرفاهية بين الممرضين بمستشفيات هيئة الرعاية الصحية المصرية ببورسعيد

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### الخلاصة

**الخلفية:** يشير مصطلح إدمان العمل لحالة نفسية تتميز بالانخراط المفرط والقهري في أنشطة العمل، مدفوعة بالحاجة إلى تلبية المعايير التنظيمية، وغالبًا على حساب الحياة الشخصية والراحة. **الهدف:** دراسة العلاقة بين إدمان العمل والرفاهية بين الممرضين في مستشفيات هيئة الرعاية الصحية المصرية بمحافظة بورسعيد. **أدوات وطرق البحث. التصميم:** تم استخدام تصميم بحث ارتباطي وصفي. **المكان:** أجريت الدراسة في مستشفى السلام ومستشفى الزهور ومستشفى الحياة، مستشفيات هيئة الرعاية الصحية المصرية بمحافظة بورسعيد. **العينة:** شملت الدراسة 380 ممرض. **أدوات جمع البيانات:** تم استخدام استبيان إدمان العمل ومقياس رفاهية الممرضين. **النتائج:** وجدت الدراسة أن نسبة كبيرة من الممرضين (74.2%) أظهروا مستويات معتدلة من إدمان العمل، في حين أفادت نسبة مماثلة (77.9%) بمستويات معتدلة من الرفاهية. وعلى العكس من ذلك، أفادت نسبة صغيرة من الممرضين بمستويات منخفضة من إدمان العمل (10.8%) والرفاهية (2.1%). **الاستنتاج:** أشار معامل الارتباط إلى وجود ارتباط سلبي ضعيف بين إدمان العمل والرفاهية. التوصية: بناءً على هذه النتائج، يوصى بأن تنفذ منظمات الرعاية الصحية استراتيجيات لتعزيز التوازن بين العمل والحياة، وتوفير التدخلات الداعمة، وتقييم رفاهية الممرضات بانتظام للتخفيف من آثار إدمان العمل.

**الكلمات المرشدة:** الرعاية الصحية، المستشفيات، الممرضين، الرفاهية، إدمان العمل.