

Building a Foundation for Psychologically Healthy Workplaces and Well-Being

Arla Day and Krista D. Randell

Saint Mary's University, Halifax, NS, Canada

Healthy workplace awards, employee choice awards, and “top workplaces” honors have gained a high profile in the media in recent years, with both small businesses and large corporations being recognized as being among the best places to work, in terms of their tangible perks and psychological supports and benefits to employees, their business productivity, and their focus on social responsibility. In 2013, Google retained their title, leading Forbes list of 100 Best Companies to work for, for two consecutive years based on the “100,000 hours of subsidized massages it doled out in 2012 [as well as] three wellness centers and a seven-acre sports complex, which includes a roller hockey rink; courts for basketball, bocce, and shuffle ball; and horseshoe pits” (CNN Money, 2012). In Glassdoor's 2013 Employee Choice Awards, Facebook was named Best Place to Work, offering benefits that “help employees balance their work with their personal lives, including paid vacation days, free food and transportation, \$4,000 in cash for new parents, dry cleaning, day care reimbursement, and photo processing ... employees also commented favorably about the opportunity to impact a billion people, the company's continued commitment to its hacker culture, and trust in their chief executive Mark Zuckerberg” (Smith, 2012a).

The abundance of these types of recognitions has been fueled by research showing the impact of job stress and unhealthy workplaces on worker ill-health (e.g., Kivimäki et al., 2013) and on increasing organizational costs (e.g., Noblet & LaMontagne, 2006), by media reports that summarize this research (e.g., “Lifestyle changes may ease heart risk from job stress,” Fox News, 2013; Gallagher, 2012, both reporting on Kivimäki

et al., 2013; “Tackle work stress, bosses told,” Triggles, 2009), and by a growing interest in the concept of the positive workplace (Luthans, 2002). Despite this relatively recent interest among researchers, organizations, and the popular media in the psychologically healthy workplace (PHW), the concept of a PHW is not new: nearly 20 years ago, Cooper and Cartwright (1994) argued that “financially healthy organizations are likely to be those which are successful in maintaining and retaining a workforce characterized by good physical, psychological, and mental health” (p. 455). Moreover, many of the positive work outcomes (e.g., engagement, Schaufeli & Bakker, 2004; positive job affect, Van Katwyk, Fox, Spector, & Kelloway, 2000; organizational affective commitment, Meyer & Allen, 1997) that may be considered indicative of a healthy workplace have been extensively studied. Finally, the idea that workplaces can be viable domains in which to create and foster positive employee well-being initiatives has been promoted over the years (see, e.g., Elkin & Rosch, 1990).

Given the degree of interest in the general concept of PHW, there has been surprisingly little research on the feasibility of an overall healthy workplace construct and on the impact of such workplaces on employee and organizational well-being and functioning. This apparent lack of research may be due to several reasons: in addressing these healthy workplace issues, a variety of terms have been used, including “organizational health,” “positive workplaces,” and “workplace health and safety,” leading to a somewhat fragmented view of the concept. Similarly, as shown by the examples at the beginning of this chapter, there have been multiple, yet equally compelling, conceptualizations of what a healthy workplace “means” (e.g., tangible benefits and perks, supportive work environment, physical work environment, culture of respect). Finally, the literature has originated from several different disciplines (e.g., ergonomics, industrial/organizational psychology, occupational medicine, and safety management; Smallman, 2001), resulting in a lack of systematic integration across areas. Therefore, in this chapter, we explore these conceptualizations, providing an integrated framework based on past work to examine the components of PHW. This framework provides an organizational basis, upon which subsequent chapters draw to examine these healthy workplaces components further, as well as to examine the context and outcomes of such workplaces.

The Historical Development of the Psychologically Healthy Workplace Construct

Our current notion of a healthy workplace has evolved over the years, emerging from various disciplines (e.g., medicine, occupational health psychology) and incorporating several related, yet diverse, literatures (e.g., epidemiology, health promotion, positive psychology). Earlier conceptions of healthy workplace primarily concentrated on the physical safety of employees, focusing on the physical environment and on employees’ physical safety at work. Because of the increased interest in other aspects of individual health, the healthy workplace perspective expanded from these traditional physical health and safety models, to include models

of health promotion, such that there was an emergence of organizational initiatives that centered around employees' lifestyle and behaviors (e.g., smoking cessation programs, weight-loss programs). More recently, the concept of healthy workplaces has expanded even more to include broad psychosocial aspects of well-being at work (Burton, 2009; Kelloway & Day, 2005a, 2005b; Kelloway, Teed, & Prosser, 2008).

Physical environment Originally, the term "healthy workplace" was predominantly used in the occupational health and safety domains to refer to interventions aimed at the physical environment. Healthy workplace initiatives in this context primarily referred to those aimed at eliminating hazards in physical environment (e.g., poor air quality, exposure to asbestos, noise, poor ergonomic designs, machine safety, electrical safety, falls; Stokols, Pelletier, & Fielding, 1996). This focus is still an important factor in today's healthy workplace: Although there have been substantial reductions in the numbers of workplace deaths and injuries throughout the 20th century, occupational accidents and deaths still occur at an alarming rate (Stout & Linn, 2002). In looking at data from the past 30 years, 250,000–600,000 workers lost work time because of a work-related injury in Canada (Association of Worker's Compensation Boards of Canada, AWCBC, n.d.). Moreover, statistics on work-related fatalities from 1982–2011 show that approximately 1000 Canadians died on the job each year (AWCBC, n.d.). According to the U.S. Bureau of Labor Statistics (2013), almost 4,700 fatalities occur on the job each year in the United States, and over 1,180,000 workers lose time due to a work-related injury in the United States. The physical environment can also create long-term repetitive strain injuries (e.g., carpal tunnel, low back pain, neck pain, and tennis elbow; Hernandez & Peterson, 2012). There also is much research on the general physical environment, in terms of noise, lighting, and temperature (McCoy & Evans, 2004). That is, the spatial organization factors (e.g., division of space, size of work area), architectonic details (i.e., stationary aesthetics of the workplace, in terms of personalizing one's workspace, workplace décor, and color schemes), and ambient conditions (e.g., lighting, temperature, noise, and air quality) all have the potential to create and exacerbate employee stress, leading to negative stress effects (e.g., physiological symptoms; McCoy & Evans, 2004). Conversely, there are many physical workplace factors, in terms of equipment (e.g., computers), services (e.g., parking, fitness area, cafeteria), and ergonomic workstations, which have the potential to alleviate stress and improve well-being (McCoy & Evans, 2004). The physical environment and the physical health and safety of employees are unarguably integral aspects of the concept of healthy workplaces. However, it should not be considered to be the sole attribute of a PHW.

Health promotion In addition to the physical environment, the presence of health promotion programs (i.e., programs that focus on employees' behaviors and lifestyles and that aid them in making healthy choices) can make a significant contribution to a healthy workplace (Grawitch, Tares, & Kohler, 2007). Cooper and Patterson (2008) argued that it is generally accepted that occupational health has three primary goals, in terms of preventing occupational disease, attending to workplace medical emergencies, and assessing employees' fitness to work. However, they also argued

that what previously has “not been accepted as main stream occupational health is the branch of medicine which deals with health promotion and wellbeing” (Cooper & Patterson, 2008, p. 65). They argued that the conceptualization of a healthy workplace needs to include health promotion.

In their study of Australian workers, Richmond, Wodak, Bourne, and Heather (1998) found that only 8% of respondents reported having no unhealthy lifestyle behaviors. There is a large amount of literature on the impact of work-based smoking cessation programs, as well as on other health initiatives, such as nutrition, weight loss, and stress management on employee’s subjective well-being (Griffiths & Munir, 2003). Therefore, “the workplace may be an almost ideal context for smoking cessation programmes since employees are present day in and day out and are accessible to motivation by special incentives” (Henningfield et al., 1994, p. 262).

Data clearly indicate the cost of unhealthy employee lifestyles to employers. For example, it is estimated that every smoker in Canada costs their employer approximately \$3,400 every year as a result of decreased productivity and absenteeism, and increased insurance claims (Hallamore, 2006). In their meta-analysis of 25 studies on smoking, Kelloway, Barling, and Weber (2002) found that compared to nonsmokers, smokers missed an average of 2.07 more days of work each year, representing a 48.25% increase rate of absenteeism for smokers, and this difference seemed to be stable across countries. Similarly, in their meta-analysis of 29 studies, Weng, Ali, and Leonardi-Bee (2013) found that smokers missed an average of 2.74 more days of work each year than did nonsmokers. Smoking also has been found to be associated with higher injury risk (Chau, Bhattacharjee, & Kunar, 2009). Similarly, alcohol consumption has been associated with increased injuries at work (Kunar, Bhattacharjee, & Chau, 2008), absenteeism (Bacharach, Bamberger, & Biron, 2010), and a variety of health symptoms (stroke, Reynolds et al., 2003; liver cancer, esophageal cancer, cirrhosis of the liver, Room, Babor, & Rehm, 2005). Obesity has been a recent target of organizations, not only to improve employee health, but also to reduce insurance costs.

Research suggests that health promotion programs may be able to reduce employee health risks, and thus, reduce the costs of unhealthy employees, proving to provide a good return of investment (e.g., Bertera, 1990; Mills, Kessler, Cooper, & Sullivan, 2007). Despite the positive effects of health promotion programs, critics argued that in focusing solely on the behaviors of employees, such programs take a “blame the employees approach,” ignoring the actions of employers (Burton, 2009; Griffiths & Munir, 2003). However, Day, Francis, Stevens, Hurrell, & McGrath (2014) argued that programs aimed at improving the overall health of employees and minimizing risks may be an effective part of a PHW if applied in a manner that allows employee control over the process and takes the psychological well-being of the employees into consideration.

Psychosocial environment Attending to the physical work environment, ensuring safe work practices, and incorporating health promotion programs all are important to the health and safety of employees. Moreover, researchers and organizations are incorporating other well-known psychosocial demands and resources into the

conceptualization of a PHW. Specifically, researchers have linked aspects of the work environment and relationships at work to the health and well-being of employees, as well as to the success of the organization.

Over 20 years ago, Sauter, Murphy, and Hurrell (1990) outlined NIOSH's national strategy for the prevention of work-related psychological disorders. They argued that "the work environment is generally viewed as a threat or risk factor" to the physical health and safety of workers and "can have adverse consequences for mental health" (p. 1146). Interestingly, they also noted that work can have "an important positive impact" on mental health as well (p. 1146), an argument that has not been fully considered by workplace research and models. They identified six psychosocial risk factors to employee health: (a) high workload and pace, (b) rotating work schedules and night work, (c) high role stressors, (d) job insecurity and career concerns, (e) poor interpersonal relationships, and (f) job content that provides little stimulation and meaning. Hurrell (2005) argued that most psychosocial initiatives tend to focus on the first two categories of reducing workloads and improving work schedules and process.

The Health and Safety Executive, whose mission is to prevent work-related death, injury, and ill-health in Great Britain, created the Management Standards for work-related stress. Similar to the some of the factors identified by Sauter et al. (1990), these standards address six areas of work (i.e., demands, control, support, relationships, role, and change) that must be managed to prevent "poor health and well-being, lower productivity and increased sickness absence" (Health and Safety Executive, n.d.). Similarly, in 2000, the Conference Board of Canada published a report that recommended organizations consider psychosocial organizational factors in developing their organizational programs and policies (Bachmann, 2000).

More recently, Canada has developed a national standard for the psychological health and safety in the workplace, whose purpose is to provide "a framework to create and continually improve a psychologically healthy and safe workplace" (National Standard of Canada, 2013, p. 2) by incorporating these aspects of physical environment, physical safety, health promotion, and psychosocial factors. The Standards call for organizations to have a "documented and systematic approach to develop and sustain a psychologically healthy and safe workplace" (p. 2) by identifying and eliminating hazards that are risks to the workers' psychological health, assessing and controlling risks that can't be eliminated, implementing initiatives that promote psychological health and safety, and fostering a culture that promotes psychological health and safety.

The Workplace as a Source of Demands and Stressors

There is a well-developed literature on the potential job stressors (Hurrell, Nelson, & Simmons, 1998; Kelloway & Day, 2005a) and demands (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001) faced by workers. Although not all "stressors" will affect all individuals in the same manner (e.g., Lazarus & Folkman, 1984), there are

several common categories of workplace stressors, including workload, role stressors (e.g., conflict, ambiguity), career concerns, work scheduling, interpersonal relations, and job content/job control (Sauter et al., 1990). The work stress literature has done an excellent job at identifying the various stressors that contribute to employee strain and ill-health, linking a multitude of workplace factors to negative employee health outcomes, such as workplace injustice (e.g., Francis & Barling, 2005), incivility (e.g., Cortina & Magley, 2009; Leiter, Day, Oore, & Spence Laschinger, 2012), work-life conflict (e.g., Day & Chamberlain, 2006), and poor leadership (Offermann & Hellmann, 1996).

The Workplace as a Health Resource

In addition to the literature on workplace demands and stressors, several research streams have focused on the individual resources and positive aspects of work and workplaces. That is, in addition to the tangible benefits of working (money, health benefits, etc.), work can provide a sense of meaning and mastery for employees, as well as positive social interactions and social support. Fullagar and Kelloway (2012) concluded that incorporating a positive approach into the study of occupational health literature can increase our understanding of these workplace demands. Kelloway, Hurrell, and Day (2008) argued that we need to expand our focus from interventions that reduce stressors to developing more “countervailing interventions,” which they defined as interventions that are “focused on increasing the positive experience of work” (p. 433).

Therefore, when defining a PHW, we shouldn't view it as simply being composed of a “lack” of negative components; we also should view it in terms of encouraging and embracing positive components, such as respect and employee growth. This idea of a positive psychology affirms the constructive aspects of the human experience, focusing on increasing fulfillment as opposed to simply treating pathology (Seligman & Csikszentmihalyi, 2000). Positive psychology examines the three interrelated aspects of how people experience the pleasant life, the good life, and the meaningful life. That is, the “pleasant life” involves how people optimally experience the emotions that are part of normal and healthy living across home and work domains in everyday life. The “good life” involves experiencing “flow,” or a state of absorption in which one's abilities are well matched to the demands. It is characterized by an intense concentration, loss of self-awareness, a feeling of a perfect challenge (neither bored nor overwhelmed), and a sense of time flying (Csikszentmihalyi, 1998). In the workplace, positive psychology is characterized as engagement. There has been a lot of research examining the extent to which workplace characteristics are associated with the components of engagement (i.e., dedication, absorption, and vigor; e.g., Bakker, Schaufeli, Leiter, & Taris, 2008; Hakanen, Schaufeli, & Ahola, 2008). Finally, positive psychology also involves examining how individuals derive a sense of well-being, belonging,

meaning, and purpose from participating in different life domains (e.g., social groups, organizations; i.e., the “meaningful life”; Seligman & Csikszentmihalyi, 2000; Seligman, Steen, Park, & Peterson, 2005).

The importance of deriving some value or meaning from work is well recognized. For example, Locke and Taylor (1990) argued that people “seek to derive certain values from work (e.g., material, a sense of purpose, enhancement of one’s self concept)” (p. 140), to the extent that they experience stress when the attainment of the values is threatened. Baumeister and Vohs (2002) defined this concept of “meaning” as having a “connection.” By creating a degree of stability in one’s life, meaning can have positive outcomes for workers and organizations, in terms of increased resilience and other forms of well-being that are promoted by meaning. At the organizational level, meaningful work is related to higher organizational commitment (Duffy, Dik, & Steger, 2011; Wrzesniewski, McCauley, Rozin, & Schwartz, 1997) and more effective teamwork (Wrzesniewski, 2003).

Moreover, providing a sense of meaning from work is a desirable characteristic when recruiting job applicants. For example, the National Research Council (1999) found the two highest ranked job characteristics were a sense of accomplishment and a chance for advancement. These job factors were considered even more important than “high income,” which was ranked as third out of the five factors. The ability for employers to provide this meaning to new incumbents may have ramifications for their organizational success.

In applying a positive psychology approach to the workplace, Luthans and his colleagues (Luthans, 2002; Luthans, Avolio, Avey, & Norman, 2007; Luthans & Youssef, 2007) developed the concept of positive organizational behavior, emphasizing the importance of positive organizational practices in enhancing well-being. They identified psychological capital, which consists of positive employee well-being factors of hope, resilience, optimism, and self-efficacy that can be influenced by the workplace. Similar to positive organizational behavior, positive organizational scholarship relates the concept of positive psychology to the workplace (Cameron & Caza, 2004; Cameron, Dutton, & Quinn, 2003) by focusing on “positive, flourishing and life-giving” organizational-level factors, such as resilience, resistance, and vitality (Cameron & Caza, 2004, p. 731).

Despite their relatively recent integration into the more formalized frameworks of healthy workplaces, these constructs are not new: in fact, almost 50 years ago, Csikszentmihalyi used the term “flow” to describe the fluid process of creative effort (Csikszentmihalyi & Getzels, 1971), later defining it in terms of “the holistic sensation that people feel when they act with total involvement” (Csikszentmihalyi & Csikszentmihalyi, 1975, p. 36). Based on these historical aspects surrounding the concept of healthy workplaces and positive psychology, we can develop a comprehensive definition and framework for PHW, incorporating literatures on physical health and safety, individual health and health promotion, and psychosocial factors, with a focus both on reducing demands and increasing positive resources. In doing so, we review current conceptualizations of the PHW construct and related concepts, and we then examine the individual components of a PHW.

Definition and Components of a Psychologically Healthy Workplace

As noted previously, despite the increased interest in developing healthy workplaces, the small body of literature on this topic is somewhat fragmented, lacking a clear, consistent definition of a PHW. However, there are many consistent themes, even across various disciplines. Cooper and Cartwright (1994) argued that a “healthy organization can be defined as an organization characterized by both financial success (i.e., profitability) and a physically and psychologically healthy workforce, which is able to maintain over time a healthy and satisfying work environment and organizational culture, particularly through periods of market turbulence and change” (p. 462). This definition was echoed by Grawitch, Gottschalk, and Munz (2006), who emphasized the importance of both positive employee outcomes and positive organizational outcomes to ensure continued operational effectiveness of the organization.

Kelloway and Day (2005a, 2005b) defined PHW as workplaces that not only aim to reduce negative demands and stressors but also promote organizational resources to improve well-being. Canada’s national standard for psychological health and safety in the workplace defines psychologically healthy and safe workplaces as workplaces that promote “workers’ psychological well-being and actively [work] to prevent harm to worker psychological health including in negligent, reckless, or intentional ways” (p. 4). As a more pragmatic definition, we may view psychological healthy workplaces simply as those that incorporate practices, programs, policies, or work design that promote or enhance positive employee health and well-being or that remediate or prevent employee stress or other negative health and well-being. However, how these initiatives “look” may vary across organizations, because there is no particular “one-size-fits-all” approach to creating a PHW (e.g., Grawitch, Ledford, Ballard, & Barber, 2009).

We can integrate these existing definitions and models to define PHW as those that are dedicated to promoting and supporting the physical and psychological health and well-being of their employees while simultaneously incorporating solid business practices to remain as an efficient and productive business entity and having a positive impact on the their clients and community (Cooper & Cartwright, 1994; Cooper & Patterson, 2008; Grawitch et al., 2006; Kelloway & Day, 2005a, 2005b).

Levels of healthy workplace initiatives Based on terminology in public health, health initiatives can be classified in terms of three levels of intervention (primary, secondary, and tertiary interventions; Hurrell, 2005; Hurrell & Murphy, 1996). Primary interventions and initiatives involve reduction of the actual stressful event (i.e., stressor reduction). Secondary interventions/initiatives target individual’s ability to manage their levels of stress (e.g., stress management programs). Tertiary interventions/initiatives (e.g., EAP programs) address treating or “healing” the individual (Cooper & Cartwright, 1994; Quick, Quick, Nelson, & Hurrell, 1997). Stressor reduction

may involve reducing working hours or redesigning the work environment and job tasks (e.g., Elkin & Rosch, 1990). Stress management may involve creating resources and coping mechanisms for employees. Tertiary initiatives may include provide PTSD counseling for firefighters and police officers after witnessing a critical event.

Cooper and Cartwright (1994) argued that the majority of healthy workplace programs tend to “focus on secondary or tertiary levels in terms of health promotion (modifying risk) and health screening for diagnosis, screening, and treatment” (p. 458), to the virtual exclusion of primary interventions. Kelloway and Day (2005b) argued that this focus is akin to treating the wounded, without ever addressing the source of the problems (see Quick et al., 1997). Note, however, that even if organizations switched their focus on reducing demands, secondary and tertiary interventions are still necessary because employees face work and life demands beyond the control of the individual or organization (e.g., people still get sick even though they eat healthy and exercise). Therefore, it is important to create a degree of balance, ensuring all levels are addressed as necessary.

The workplace as a health resource When examining the relationship between organizational factors and employee well-being, much of the research and constructs have focused on the negative side, reflecting situations of *decreased* well-being caused by the workplace (Jex & Beehr, 1991). That is, we have a very good understanding of the factors that create negative individual outcomes. However, influenced by principles of positive psychology, the PHW construct has recently “evolved again”, with a focus on how organizational factors can *enhance* the well-being of employees (e.g., Kelloway & Day, 2005a; Luthans & Youssef, 2007; Parker, Turner, & Griffin, 2003). In addition to its obvious role as a source of income, work can provide benefits to employees, in terms of its important aspect in defining an individual’s identity, self-esteem, and psychological well-being (Warr, 1987). In fact, for many individuals, work can be considered the central defining feature of one’s life (Quick, Murphy, Hurrell, & Orman, 1992).

By integrating the literature outlining these three intervention levels (Sauter et al., 1990) with a positive psychology framework (Luthans & Youssef, 2007), we can develop the types of countervailing interventions as described by Kelloway, Hurrell et al. (2008) to improve employee well-being and increase their overall positive experience of work. That is, in addition to focusing on the reduction of negative work and health factors, primary initiatives/interventions may involve changing the environment to directly promote well-being, flourishing, and fulfillment (e.g., implementation of recognition programs, transformational leadership training). Secondary initiatives/interventions can be developed to increase one’s resources to help improve individual’s ability to manage their demands (e.g., skills training, fitness programs). Finally, although the original conceptualization of tertiary initiatives/interventions involved treating health problems, countervailing interventions may directly address improving one’s positive mental and physical state.

Although we have come a long way in understanding how to combat workplace disease and illness, we know much less about the work contexts that can foster

positive health, well-being, and functioning. Warr (1987) was one of the first to propose a comprehensive model in which he linked organizational factors with positive job-related mental health. Specifically, he identified nine organizational features important to mental health: externally generated goals, task variety, environmental clarity, opportunity for control, opportunity for skill use, opportunity for interpersonal contact, availability of money, physical security, and valued social position. Similarly, Luthans et al. (2007) identified practices that capitalize on employees' talents, such as creating clear and aligned goals and expectations, having positive social support and recognition, and providing opportunities for growth, development, and self-actualization, which can substantially influence employee well-being. Other organizational factors, such as quality leadership (Arnold, Turner, Barling, Kelloway, & McKee, 2007) and employee involvement in decision making (e.g., self-managed work teams, job autonomy; Cohen, Ledford, & Spreitzer, 1996), tend to be associated with employee well-being.

The implication of this positive psychology influence on the workplace is that PHW must be defined not only in terms of the absence of job stressors but also in terms of the presence of certain organizational resources that enhance employee well-being (Kelloway & Day, 2005a). That is, well-being and health in this context is no longer defined as solely the absence of illness but also as the presence of well-being. Ultimately, definitions of PHW should include factors beyond the prevention of workplace stressors that come together to promote wellness and well-being.

Comprehensive healthy workplace models A small body of "PHW" literature is beginning to emerge incorporating the antecedents, consequences, and benefits of both healthy workplaces (e.g., American Psychological Association [APA], 2009; Grawitch et al., 2007; Health Canada, 2007; Kelloway & Day, 2005a, 2005b). Definitions of "healthy workplaces" must be comprehensive. Specifically, it is important for PHW definitions to include both physical and psychosocial factors as *predictors* and psychological, physical, behavioral, and organizational outcomes as *consequences*. Moreover, a "healthy" workplace is no longer one that simply avoids being unhealthy but one that also optimizes health while maximizing organizational productivity.

There are several models of healthy workplaces, as well as several models of "psychologically" healthy workplaces. In a special issue on healthy workplaces, Kelloway and Day (2005a) presented their theoretical PHW model, which entails a holistic approach including psychosocial (e.g., relationships, work-life balance) and physical factors (e.g., safe/ergonomic workspaces), both of which are treated as being equally important components (see Figure 1.1). Their model views several components as being integral to the definition of a healthy workplace: (a) developing a culture of support, respect, and fairness; (b) creating employee involvement and development; (c) providing and promoting a physical and psychological "safe" environment; (d) developing and promoting positive interpersonal relationships at work; (e) ensuring appropriate and fair work content and characteristics; and (f) encouraging positive work-life balance.

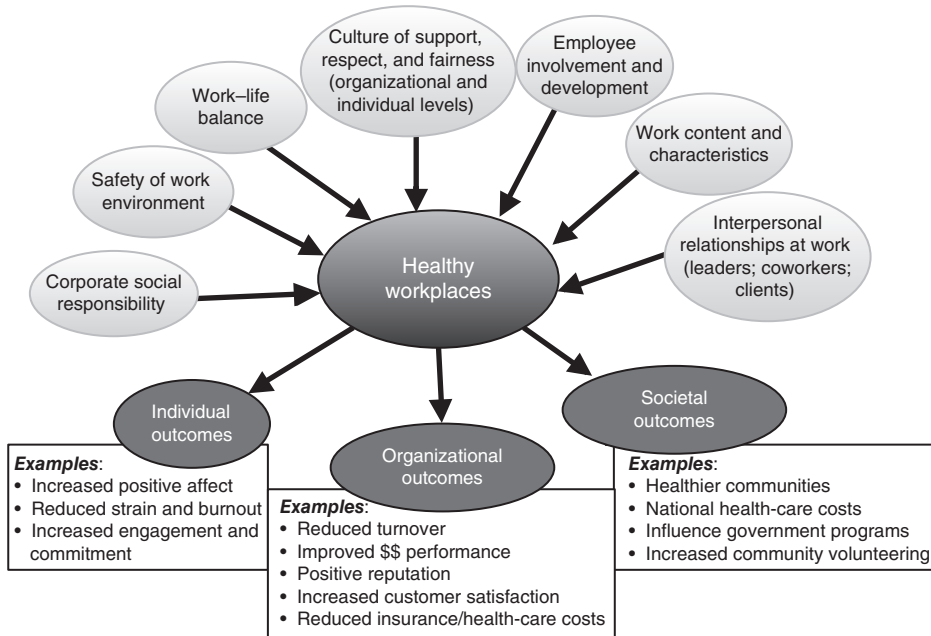


Figure 1.1 Illustrative model of healthy workplaces. Reproduced with permission from Kelloway and Day (2005a).

The underlying assumption of the model is that these antecedents can be viewed both as direct contributors to a healthy workplace and factors that may moderate the negative effects of workplace demands on employee and organizational outcomes. In keeping with the models' holistic approach, consequences of healthy workplaces are included in terms of individual outcomes (e.g., psychological, physiological, behavioral) and organizational outcomes (e.g., employee turnover, fiscal performance), as well as societal outcomes (i.e., in terms of impacts on government programs and national healthcare costs). Although the model doesn't specifically mention organizational and corporate social responsibility, it could easily be viewed as both a (direct) societal outcome and an (indirect) employee outcome (through positive feelings of helping and volunteerism). Similar to the antecedents, the individual outcomes parallel the individual strain reactions in models of job stress.

The Stimulating Health and Practice Effectiveness (SHAPE) framework is a model of PHW, identifying categories of healthy workplace practices, depicting the relationship among these categories, and depicting the organizational context in which they are implemented (APA, 2009; Grawitch et al., 2006). Similar to the Kelloway and Day model, they include broad sets of practices in the framework: employee involvement, work-life balance, employee growth and development, health and safety, and employee recognition (Grawitch et al., 2009). The model was developed by reviewing the literature on healthy workplace practices. In addition to these five key categories, they identified the overarching communication

within an organization as a key component to a healthy workplace. The purpose of communication primarily lies in the view that employee involvement is a crucial component, as employees must be actively involved in the shaping of organizational practices to truly produce long-term win-win benefits for both employees and organizations (Grawitch et al., 2006). Because of the similarities between the Kelloway and Day and Grawitch et al. models, we present a brief review of the general components in more detail.

Employee involvement Employee involvement refers to initiatives aimed at enhancing employees' involvement in decision making, job autonomy, and empowerment (APA, 2009; Grawitch et al., 2007). Employee involvement initiatives can range from simple practices, such as open-door policies, employee feedback, and communication of information about the organization, to elaborate policies, such as self-managed work teams, joint employee-management committees, or employee ownership (Grawitch et al., 2009). There is a great deal of evidence in the management and general organizational literature indicating that forms of employee involvement are associated with important outcomes for employees. Perceived job control, for instance, has been found to be associated with physical health indices, such as decreased blood pressure and heart rate (Steptoe, 2001), as well as psychosocial health and attitudes including increased job satisfaction, life satisfaction, well-being (Day & Jreige, 2002), and overall health (Dwyer & Ganster, 1991). Gibson, Porath, Benson, and Lawler (2007) found that various employee involvement practices were predictive of firm performance, indicating that employee involvement can be beneficial for organizations as well as employees.

Researchers have noted that despite receiving attention in the management literature, employee involvement is rarely studied in a healthy workplace context (Grawitch et al., 2009). This omission is critical: Grawitch et al. (2007) argued that employee involvement practices play a pivotal role in shaping employees' perceptions of *other* forms of PHW practices, and they suggested that other types of practices may play a less influential role in predicting employee outcomes than employee involvement. Given the potential for employee involvement to benefit other healthy workplace programs, this concept certainly needs to be better integrated in the PHW research.

Work-life balance The issue of work-life balance has been well studied. Increasingly competitive business environments are placing further demands on employees, which may contribute to a blurring of boundaries between work and family domains, such that employed individuals struggle to achieve a balance between their work life and their homelife (Bellavia & Frone, 2005). Moreover, the proportion of women entering the workforce is continuing to increase, as is the percentage of dual-career couples (Kinnunen, Geurts, & Mauno, 2004), both contributing to an increasing need to address the balance and integration of work and nonwork domains. Research indicates that work-life conflict is associated with a number of negative outcomes for both employees *and* the organizations in which they are employed, including

psychological and physical impairments (e.g., Frone, 2000; Frone, Russell, & Barnes, 1996), job and life dissatisfaction (e.g., Ernst-Kossek & Ozeki, 1998), and work-withdrawal behaviors (e.g., absenteeism, lateness, daydreaming; e.g., Kirchmeyer & Cohen, 1999). Work–life balance policies are designed to aid employees in balancing their work and nonwork lives (e.g., Rosin & Korabik, 2002). Examples of work–life balance initiatives include flextime, telecommuting, or assistance with childcare or eldercare (Perrewé, Treadway, & Hall, 2003). Some researchers emphasize that in addition to adopting *formal* work–life balance initiatives, the *informal* role of the organization in aiding in the work–life balance of its employees is also important (e.g., supportive attitude of managers; Perrewé et al., 2003). Overall, survey research indicates that employees highly value work–life balance initiatives (e.g., Galinsky, Bond, & Friedman, 1996). However, although there have been some empirical studies on work–life balance policies (e.g., Dex & Smith, 2002; Saltzstein, Sting, & Saltzstein, 2001; Wallace & Young, 2008), researchers note that findings have been mixed and further empirical research on work–life balance initiatives is important (e.g., Perrewé et al., 2003).

Growth and development Industries have become more knowledge-based, which makes it important for employees to continuously learn and update their skills (Burke & Ng, 2006). Providing opportunities for employees to expand their knowledge, skills, abilities, and experiences has also been suggested as a contributor to the well-being of employees (APA, 2009; Grawitch et al., 2007; Pfeffer, 1998). Employee growth and development initiatives can take the form of in-house or outside training opportunities, tuition reimbursement, opportunities for promotion or internal career advancement, or continuing education courses (APA, 2009). Some researchers suggest that providing such opportunities could signal to employees that they are valued by the organization, thus enhancing motivation (Keep, 1989). It has also been suggested that the effectiveness of employee growth and development initiatives is dependent on whether or not the organization provides the opportunity for employees to *use* the obtained skills or knowledge in the workplace (Warr, 1987). Although the effects of specific growth and development practices (e.g., employee training programs; Bartel, 1994, 2000) have been investigated in the management literature, the outcomes of growth and development initiatives are rarely acknowledged in a healthy workplace context. In one of the few healthy workplace studies to study the outcomes of employee growth and development initiatives, Browne (2000) found training and internal career opportunities predicted employee satisfaction and organizational effectiveness.

Employee safety Employee safety refers to initiatives aimed at enhancing and protecting the well-being of employees through the physical environment (APA, 2009) and represents the original concept of “healthy workplaces.” Employee safety practices can be either mandatory or voluntary (Robson et al., 2007). Mandatory safety initiatives arise as a result of government legislation and are enforced through various means (e.g., inspections, fines), whereas voluntary initiatives derive from

the individual efforts of particular organizations or employer groups and are *not* related to regulatory requirement. Despite the fact that employee safety is perhaps the most recognized and utilized form of healthy workplace practice, workplace accidents and injuries are still occurring at startling rates (Stout & Linn, 2002). Clearly, more evaluative studies of the effectiveness of various interventions aimed at enhancing the safety of employees through the physical environment would prove useful.

Employee health Employee health practices refer to initiatives aimed at preventing and treating employee health risks and problems (e.g., health screenings, stress management training, employee assistance programs; APA, 2009; Grawitch et al., 2007), as well as encouraging employee *positive* health through supporting employee healthy lifestyle and behavior choices (e.g., nutrition classes, access to fitness facilities, wellness programs; Griffiths & Munir, 2003). Although some studies have found health promotion programs to have significantly positive effects on employee and organizational outcomes (e.g., Holzbach et al., 1990), and the general consensus on such appears to be optimistic (Heaney & Goetzel, 1997), researchers have noted that many studies evaluating the effectiveness of workplace health programs have methodological flaws and lack rigor (Griffiths & Munir, 2003; Stokols et al., 1996). Overall, future studies investigating the effectiveness of various health promotion practices in enhancing employee and organizational outcomes would be useful.

Culture of support, respect, and fairness This dimension is based on practices and initiatives aimed at providing a supportive, respecting, and fair workplace. Initiatives aimed to enhance a culture of support, respect, and fairness within an organization could take the form of encouraging respectful relationships with and among employees, written policies on workplace respect, sensitivity or diversity training for managers, or simply using fair procedures to make workplace decisions. APA (2009) stresses the key role that communication plays in the development of a healthy workplace and in the success of promoting each healthy workplace component. Communication would be particularly important for developing a culture of support, respect, and fairness, because it serves as the very foundation of these aspects and the channel through which support, respect, and fairness are reinforced to employees.

There are isolated bodies of research on various constructs that fall within the dimension of “support, respect, and fairness” and that emphasize the importance of this component toward developing a healthy workplace. Research on procedural justice (i.e., perceptions that the procedures used to determine outcomes within a workplace are fair; Colquitt, Conlon, Wesson, Porter, & Ng, 2001) has found strong positive relationships between this construct and job satisfaction, organizational commitment, and trust and a negative relationship with employee stress (Elovainio, Kivimäki, & Helkama, 2001). Moreover, research on employee mistreatment and supportive work environments indicates that employees who feel supported at work

experience fewer physical and mental health ailments than those who do not feel supported (International Centre for Health and Society, 2004) and also indicates lower turnover intentions (Rhoades & Eisenberger, 2002). Interactions with individuals who reinforce support and respect are an important part of a PHW (Harlos & Axelrod, 2005), and thus supervisors and managers should ensure their interactions with employees are characterized by politeness, dignity, and respect. Overall, it is important for organizations to provide employees with the support, resources, and respect that are needed to function productively and effectively (Harlos & Axelrod, 2008). More research on how particular aspects of support, respect, and fairness can enhance the healthiness of a workplace would likely prove very useful.

Employee recognition Researchers have acknowledged that recognizing the contributions of employees may be an important component of developing a PHW (e.g., APA, 2009; Grawitch et al., 2007). In addition to the obvious monetary recognition (e.g., fair monetary compensation, performance-based bonuses, and pay increases), there are other ways that employers can recognize the contributions of employees. Employees can be recognized through formal means, such as through recognition ceremonies, employee awards, or organizational documents (e.g., memos, newsletters), or, alternatively, through more informal, day-to-day types of recognition practices such as verbal praise or a simple thank-you note (APA, 2009). Although there is little or no empirical research on this latter form of recognition, some researchers suggest that informal recognition may be particularly important for validating feelings of sincere appreciation (Nelson, 1995; Saunderson, 2004).

Overall, employees tend to highly value recognition within their workplaces, particularly personalized recognition (Lovio-George, 1992; Luthans, 2000). Moreover, studies indicate that employees who feel appropriately rewarded for their efforts display less signs of stress, emotional exhaustion, and various physical symptoms (e.g., back pain) than those who feel underrewarded (e.g., de Jonge, Bosma, Peter, & Siegrist, 2000; Niedhammer, Tek, Starke, & Siegrist, 2004). In one of the few empirical studies to examine *positive* outcomes of providing employee recognition, Browne (2000) found employee recognition to emerge as a significant predictor of employee satisfaction, organizational effectiveness, and decreased employee stress. Grawitch et al. (2007), however, failed to find a predictive relationship between employee recognition and positive employee outcomes, instead finding a *negative* relationship between recognition and employee well-being. Perhaps this unexpected finding may be due to differences in how organizations define recognition, instead treating it as rewards creating perceptions of injustice and competition among employees. Overall, the inconsistency of results highlights the need for more empirical research on employee recognition practices.

Even though there has been substantial work in developing theories and models of PHW, as well as substantial research into individual components comprising the healthy workplace construct, little research has been conducted to examine the

feasibility of operationalizing such a construct, nor to develop comprehensive measures of the construct, nor to assess the factor structure and validity of PHW measures. In one of the few studies to examine this construct, Randell (2013) developed and validated a measure of healthy workplaces based on the components in the Kelloway and Day (2005a) model. She asked organizational representatives to indicate the extent to which their organization promoted these healthy workplace initiatives (e.g., “Overall, the organization recognizes the contributions of employees”; “Employees are encouraged to maintain healthy lifestyles”). Although based on the 6-factor Kelloway and Day model, she found evidence of a three-factor structure of PHW, consisting of (a) clear communication with employees (e.g., communicating appreciation, communicating organizational motives, etc.) and respectful interactions (e.g., treating employees with dignity and respect, ensuring positive relationships between employees and management), (b) opportunities and/or resources to increase control (e.g., control over the ability to balance one’s family and work life, opportunities to expand on one’s knowledge and skills, control to make workplace decisions), and (c) workplace health and safety factors.

Grawitch et al. (2007) examined the factor structure of the five-factor SHAPE model, in which they measure satisfaction with the five components. When examining only four of the five SHAPE factors (i.e., excluding involvement), Grawitch et al. found support for a four-factor structure, accounting for 80.22% of the variance, with high loadings on their respective factor and no cross-loading items. However, the factor structure was “less interpretable” when involvement was included in the analysis (p. 281).

Discussion

There has been increased interest in the concept of PHW by academics across various disciplines, as well as by the popular media and organizational practitioners. Despite this attention, and despite the literature on the individual components, research on the overall construct is scant. Little is known on the extent to which organizations are implementing healthy workplace initiatives, the effectiveness of comprehensive healthy workplace programs, and the validity of the construct overall.

One of the interesting, yet perhaps frustrating, aspects in trying to develop and examine PHW is that there is no one-size-fits-all approach that is equally effective for all organizations and employees (see Grawitch et al., 2007). Just as the interactionist approach of stress depicts stress as the consequence of the “lack of fit” between the needs and demands of the individual and his/her environment (Cooper & Cartwright, 1994), the PHW literature must acknowledge that employee health and positive outcomes are influenced not simply by a “healthy” culture and a preponderance of positive initiatives but also by the congruence of individual and organizational values. Leiter, Frank, and Matheson (2009) and Maslach and Leiter (1997) have argued that value congruence has important implications for well-being and employee burnout. Therefore, it is important to have a solid understanding of the potential components

comprising a PHW, the interaction among these components, and the effects on both employee and organizational well-being and performance.

In this chapter, we have highlighted several existing frameworks of healthy workplaces and briefly identified some of their individual components. The other chapters in this book review these individual components in greater detail, as well as touch upon important contextual factors surrounding healthy workplaces. To avoid having the area defined by fragmented literature of the individual components, it is necessary to develop and validate a comprehensive model of workplace health. The potential danger in moving this work forward is that the model can become so broad as to incorporate any and all positive workplace aspects that are associated with positive outcomes. For example, in using the emotional intelligence literature as an example, Mayer and his colleagues (Mayer, Salovey, & Caruso, 2000a, 2000b) warned that there was a trend of using the term “emotional intelligence” as a catchall phrase to identify any positive individual characteristics. Without solid theory, a validated framework, and integrative research programs, the concept of PHW may fall into this same potential trap. In helping to develop theory and provide an integrated framework, the rest of this book provides strong theoretical rationales for the components of healthy workplaces, backed up by reviews of the extant literatures, as well as providing discussions on the context of healthy workplaces. These seminal overviews should provide the structure to further develop healthy workplace models and provide an agenda for future research into the area.

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