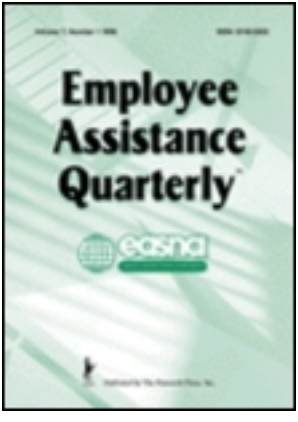

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Wellness, Work and Employee Assistance Programmi

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Wellness, Work and Employee Assistance Programming

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ABSTRACT. Employee Assistance Programs continue to evolve and broaden the scope of programming provided to employees. Many EAPs now claim that wellness programming is a core component. However, the definition of wellness is often limited to only one or two dimensions of the concept. As well, EAPs generally have yet to fully examine the relationship between wellness and the nature of work. This article's premise is that EAPs should be working towards not only improving worker wellness but also workplace wellness. *[Article copies available from The Haworth Document Delivery Service: 1-800-342-9678.]*

INTRODUCTION

It is now generally recognized that the workplace exacerbates existing difficulties while also creating and supporting its own unique complement of problems. These problems are caused by the nature of work itself; the necessity to interact at work with colleagues, supervisors, customers and clients; and the propensity for workers to bring their home life to work and their work life home.

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The provision of occupational-based assistance is by no means a recent phenomenon. Its roots can be traced to the early 1800's and the emergence and growth of Welfare Capitalism throughout North America. The concept of occupational intervention gained a firmer foot hold with the rise of Occupational Alcoholism Programs (OAPs) in the 1940's and 1950's. Policy, procedural and legislative changes in the United States and Canada in the 1970's opened assistance possibilities to a much wider spectrum of problems although fixing the maladjusted employee remained the primary focus. What Welfare Capitalism endeavours and OAPs shared in philosophy and implementation with Employee Assistance Programs (EAPs) was the notion that workers needed to be fixed or moulded to some specific conventional form. Minimal attention was paid to the impact of the work context during this era or to worker wellness. However, with the move to the broadbrush approach and the strengthening of Employee Assistance Programs, the focus of workplace intervention has continued to evolve. Environmental factors and situations beyond the worker's immediate control are now being identified as variables contributing to employees' problems. In the 1980's and 1990's the beginnings of a health promotion orientation and wellness programming have began to emerge in the workplace although the primary focus has essentially been only upon physical well-being. The majority of programming has remained focused upon individualizing the problem and seeing the worker as a troubled employee instead of taking a more ecological approach. Despite some progressive trends it is still the individual employee who is considered sick and who requires reshaping to better fit the needs of the workplace environment. If Employee Assistance Programs are to continue to evolve, the field needs to better understand the full nature of wellness and the relationship between wellness and the nature of work.

WELLNESS

The origins for the contemporary definition of this concept are credited to Halbert Dunn, M.D., Ph.D. whose book *High-Level Wellness* (1961) was initially premised upon the World Health Organization's (1946:1) definition of health:

> Health is a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity.

For Dunn a complete state of well-being involved wellness of the mind, the body and the environment, family, community life and a compatible work interest. Wellness also included a way of living that maximized one's potential, adapting to the challenges of the changing environment, and entailing a sense of social responsibility. Dunn postulated that being well does not merely constitute a state where one is not ill, or "unsick," a position that was echoed by Donald Ardell.

Ardell (1977) believed that even prevention is an inadequate goal. He viewed prevention as a defensive response and mostly reactive. Ardell postulated that wellness should be the true end goal. For him a wellness approach focuses on meeting needs in a positive manner. In pursuing wellness, the mind, body and spirit are not only integrated but inseparable. In achieving a state of wellness, individuals need to consolidate not only their physical selves but also their self-image, their work, their relationships along with their physical and social environments.

In 1974 Marc Lalonde, then Canadian Minister of Health and Welfare, released a landmark report, *A New Perspective on the Health of Canadians*. This was the first government document to suggest that biological factors along with environmental hazards and lifestyle issues such as alcohol, tobacco and other drug misuse and abuse, fitness, recreation and nutrition are all determinants both of sickness and of health. The report was also the first to suggest that money should be directed towards a health promotion strategy rather than into traditional health services to serve the sick. While the document had minimal initial impact in Canada, it formed the basis for the American Surgeon General's report *Healthy People* (United States Public Health Service, 1979) developed during the Carter Administration. The focus of the report was a move away from physician-led, hospital-centered treatment to more lifestyle and environmental strategies by which illness could be avoided. This approach has been reaffirmed in various North American and industrialized jurisdictions since then culminating in the World

Health Organization influenced "Ottawa Charter for Health Promotion" (Raeburn and Rootman, in press).

Wellness is not a static state. Just as there are degrees of illness there are levels of wellness. Positive wellness focuses on the living state rather than on categories of disease that may cause morbidity or mortality. It recognizes that life has extended to the point where its finer differentiation deserves attention (Edlin and Golanty, 1988; Ryan and Travis, 1981).

The ultimate goal of behaviour change is changes in the mediating mechanisms of chronic illness which in turn lead to changes in morbidity, mortality and longevity. For ultimate success this requires both a macro (awareness and education campaigns) and micro (individual and small group programming) approach. Integral to this are social network supports such as those offered by mutual aid groups (Cataldo and Coates, 1986; Health and Welfare Canada, 1986). Social relationships affect wellness by fostering a sense of meaning or coherence that further promotes positive health-related behaviours (Hamilton-Smith, 1992).

For Sefton and her colleagues (1992) the concept of wellness or optimal health involves an interdependent balance among five areas: physical, emotional, spiritual, intellectual and social health. Physical health may be thought of in terms of fitness, nutrition, control of substance abuse, adequate rest and sleep and medical self-care including the absence of disease. Emotional or psychological health involves the ability to maintain relative control over emotional states in response to life events and is associated with stress management and responses to emotional crises. It is the subjective sense of well-being. Themes associated with spiritual health are love, charity, purpose, and meditation. Perry and Jessor (1985) have also equated it with self-actualization. Intellectual health encompasses the realms of education, achievement, role-fulfilment and career development. It also includes the ability to engage in clear thinking and to think independently and critically (Schafer, 1992). Social health involves the ability to interact effectively with others including the development of appropriate relationships among friends, families, co-workers and communities. It also entails role-fulfilment, caring for others and being open to the caring

of others (Perry and Jessor, 1985; Schafer, 1992; Sefton et al., 1992).

In his work on health promotion and empowerment Labonte (1990) focused on the physical, mental and social dimensions of health. Similarly, Green and Shellenberger (1991) have advocated a bio-psychosocial approach to defining wellness:

i. genetic and environmental influences that affect physiological functioning as well as behaviours that affect biological functioning including: smoking, drug use, diet and exercise;
ii. psychological factors including: personality, stress management, life goals, perceptions and feelings along with health inducing and illness preventing behaviours; and,
iii. social systems including: family, work, school, religious affiliation, social values, customs and social supports.

This contrasts with the biomedical model of disease that focuses solely upon biological factors to the exclusion of other practices. Greenberg and Dintiman (1992) stated that when we integrate and maximize social, mental, emotional, spiritual and physical health we achieve high-level wellness. The ideal is to improve all; not one or two at the cost of others. Co-workers are integral to this process in the workplace as they can contribute to the well-being of each other by providing support and encouragement (Cataldo and Coates, 1986; Schaefer, 1992).

When different components of wellness programming have actually been implemented into North America workplaces as components of Employee Assistance Programs the focus has generally been on physical health and on changing employee behaviours believed to increase the likelihood and seriousness of illness or other forms of incapacitation at some future point in time. Wellness criteria are still seen to exist primarily within the person as opposed to within the work setting (Ilgen, 1990). However, to create a healthy working environment the end result of work, itself, should be intellectual, physical and emotional well-being. To achieve this end wellness needs to become incorporated into organizational policies (Herrick, 1981).

WELLNESS AND WORK

> Historically, the workplace has been a major factor in compromising the health of workers in America. Poor working conditions, long hours, and little regard for the human factor all took their toll on the health status of the workforce. Health and safety improvements were imposed on employers. Business and industry apparently viewed the worker as a static commodity and had little appreciation for the relationship between the health status of employees and productivity and profit.
>
> –James Jenkins (1988:125-126)

Employers still tend to equate wellness only with physical health while social problems are viewed as arising because of the shortcomings of individual employees. However, work itself is inherently stressful. The organization of work also inhibits positive health practices and increases feelings of powerlessness and psychosocial stress (Weinstein, 1986). Among the most predominant workplace stressors are:

i. uncontrollable demands over work (loss of autonomy);
ii. monotonous and repetitive work;
iii. machine pacing of work rhythm;
iv. piece work;
v. the manner in which the workplace is organized;
vi. role conflict/ambiguity;
vii. lack of participation in decision making;
viii. organizational downsizing/reorganization; and
ix. lack of social contact as part of on-going work (loneliness and isolation) (Eakin, 1992; Harvey, 1992; Weinstein, 1986).

In recognition of this, there has been a growing literature on the relationship between workplace stress and physical and psychological well-being (Ontario Premier's Council on Health Strategy, 1991). Shehadeh and Shain (1990) in a multivariate analysis found four related sets of variables that influenced workplace wellness:

i. perceived psychosocial stressors in the workplace and home environments;

ii. personal resources in the form of social support and of self-efficacy as related to work and personal health;
iii. personal health practices (sleep, alcohol and tobacco consumption); and
iv. specific socio-demographic variables (education and age).

Stressful life events and excessive demands either at work or outside of it are now commonly believed to suppress one's immune system and lower resistance to infection. While personal susceptibility cannot be overlooked, when demands from personal and work life exceed individuals' abilities to cope or overwhelm their existing coping mechanisms, a personalized psychological stress response occurs. This has been associated with increased negative behaviours including the escalation of tobacco and alcohol consumption. Evidence from both human and animal studies have indicated that both personal and environmentally based stress modulates immunity producing a suppression of the general resistance process leaving persons susceptible to multiple infectious agents and cancers (Cohen, Tyrrell and Smith, 1991; Green and Johnson, 1990; Jemmott and Locke, 1984; Kiecolt-Glaser and Glaser, 1986). Simply, the more negative stress one experiences the greater the likelihood of the person manifesting a physical illness.

This suppression of the immune system by stress has been linked to a variety of different ailments. Cohen, Tyrrell and Smith (1991) demonstrated that the rates of both respiratory infection and clinical colds increased with increases in the degree of psychological stress experienced by subjects. Jemmott and Locke (1984), in their examination of several heterogeneous populations, were able to link stress impaired immunological functioning with increases of upper respiratory tract infections, respiratory illness, herpes simplex and mononucleosis. Cunningham (1985) postulated that stress plays a role in the progression of cancer and by reducing stress the incidence of cancers could also be reduced. Stress reduction is possible at personal, social and environmental levels. As well, once a person had been diagnosed with cancer, stress reducing mechanisms can augment traditional medical treatment. Contrarily, social stress such as isolation or lack of order in one's life can enhance tumour growth in both acute and chronic forms of cancer.

The way people feel at work is largely a function of conditions at work. Likewise, non-work stress is largely a function of factors that occur outside the job. However, excessive stress in either realm can cross over and interfere with life in the other. The stress people experience at work is not simply a reflection of their personal problems but is accentuated by acute and chronic workplace stressors. Non-work settings typically offer considerably more flexibility and malleability than does the work environment. Work conditions such as a lack of information provision and exchange, unequal power distribution, arbitrary allocation of tasks, role conflicts, poor social relations, physically harsh environments, antagonistic labour-management relations and lack of job security are associated with negative physiological changes, somatic complaints and psychological distress (Eakin, 1992; Klitzman et al., 1990). It becomes obvious that people do not only bring their problems from home to work. Employees also bring work problems home and the two types of concerns actively interact in both environments.

Karasek and Theorell (1990) closely analyzed stress produced by the workplace. They postulated that it is not the nature of work that is the primary risk, but rather the lack of control over how one meets the job's demands and how one uses one's skills. Furthermore, unlike others, Karasek and Theorell stated that it is not necessarily the demands of work but the organizational structure of work that was the major culprit in causing stress-related illnesses. A lack of control over work, decision latitude, particularly in instances of high psychological demand was found to seriously damage the health of workers. The researchers claimed that these factors had an interactive effect on workers. It is not the senior decision makers and managers, those normally assumed to be under the highest stress, who suffer the most but those who have no control over decisions who actually endure the greatest ill health. Green (1988) developed a two by two grid examining the health practices which are under worker control and those under management control (Table 1).

Karasek and Theorell (1990) also demonstrated the relationship between workplace induced stressors and an increase in cardio-vascular illnesses including heart attacks and hypertension. Job strain may contribute almost as much to the statistical risk of coronary

TABLE 1. Factors Influencing Workers' Health by Locus of Control

		EMPLOYER CONTROL	
		HIGH	LOW
EMPLOYEE CONTROL	HIGH	• work practices • use of protective equipment • workplace hygiene • equipment maintenance & upkeep	• lifestyle • personal health habits
	LOW	• work environment & process • substances used • machinery design • hazard controls • job design	• biological & genetic features • physical & mental impairment • cultural characteristics

heart disease as conventional risk factors. Ironically, those with the most decision making responsibility have their stress level increased when given more decision making responsibility while those with none have more stress produced illness because of the inability to be involved in decision making. Thus it appears that both too much and too little control produce somewhat similar threats to wellness.

The relationship between smoking and cancer has been extensively documented and discussed (Blanchard and Tager, 1985; Fielding, 1984). Green and Johnson (1990) reported that increased job strain (high psychological demand and low worker control) has also been associated with smoking prevalence and intensity. Thus, any attempts at smoking cessation programs can be hampered and undermined if the issue of workplace stress is not also considered. Likewise, modifying employees' job structure to increase control and decrease strain could enhance the success of cessation programs. Similarly, Cunningham (1985) stated that reducing stress by fostering a sense of control in a supportive social environment helped cancer patients in their recovery. Social support provided by superiors and co-workers is another ameliorating factor and has a

direct positive impact upon a sense of wellness. Isolated employees face a greater risk of experiencing workplace stress induced illnesses compared to those in regular contact with others (Cohen and Willis, 1985; Johnson and Hall 1988; Marmot and Theorell, 1988).

In Karasek and Theorell's model of psychosocial work environment, the three critical components are control, demand and support. These factors in specific combinations can create a situation of learned helplessness among workers that can seriously endanger their long term wellness. Shain (1992) claimed that the lack of participation in the workplace can trigger a series of "psychoneuroimmunological events" that ultimately result in physical pathologies of varying seriousness. However, these findings are not all new. Research dating back to the 1960's discovered a relationship between low mental health, psychosomatic symptoms and the work conditions of Detroit automotive workers (Hampden-Turner, 1972).

CONCLUSION

It is evident from this collection of work that the workplace is a powerful determinant of all dimensions of an individual's wellness. The organization of work involves two separate but extremely interactive spheres, the physical environment and the distinct social facet of work (Eakin, 1992). Both need to be considered when analyzing the relationship between work and wellness. The problem of work design is rooted in conventional economic and management theories. This can be traced back to the industrial revolution and Adam Smith's division of labour but is most obvious in the short sighted and nearly universal acceptance in North America earlier in this century of Taylorism. The specialization of labour briefly led to higher productivity but by restricting power, and minimizing worker input, thought and participation, wellness and eventually productivity itself has been sacrificed. The structuring of the work environment has led to a virtual global acceptance of the hierarchical pyramid model of administration. Despite being constantly critiqued since its initial postulation, hierarchical bureaucratic structures remain the most prominent industrial organizational model. In comparison to other models, this approach is the simplest to control and historically resembles the feudal control of the

peasantry by a lord and his demesne. This model has been called dysfunctional, rigid, not serving the needs of workers and most recently, illness producing (Karasek and Theorell, 1990; Morgan, 1986). By examining only economic factors and the physical environment of work, conventional theories of production organization have not only adversely affected workers for decades but also industrial productivity throughout North America.

> The lifespan and the health of an individual worker is linked to his or her location in the job hierarchy and to associated factors such as degree of authority, freedom to make decisions and the level of social support in the workplace.
>
> –Ontario Premier's Council on Health Strategy (1991:7)

If the future of Employee Assistance Programming includes greater involvement in wellness initiatives two courses of action will be required. Initially, a more holistic and complete definition of wellness will need to be adopted. Secondly, EAPs will need to expand their comfort zone and work towards not only assisting in enhancing workers' wellness but also in creating well workplaces.

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