Csiernik, R. (1995). Wellness, work and Employee Assistance Programming. *Employee Assistance Quarterly*, 11 (2): 1-13.

1. 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. The provision of occupational-based assistance is by no means a recent phenomenon. Its roots can be traced to the early 1800s and the emergence and growth of Welfare Capitalism(1) throughout North America. The concept of occupational intervention gained a firmer fold hold with the rise of Occupational Alcoholism Programs (OAPs) in the 1940s and 1950s. Policy, procedural and legislative changes in the United States and Canada in the 1970s 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 molded 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 emergence of Employee and Family

Assistance Programs (EFAPs), 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 (Duxbury & Higgins, 2003; Health Canada, 1996; 1999). In the 1980s and 1990s the beginnings of a health promotion orientation and wellness programming 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 rather than 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. What is now required as we enter the 21st century is a more comprehensive understanding of wellness and of the relationship between wellness and work.

2. WELLNESS

The origin for the contemporary definition of wellness was 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 infirmity."

A complete state of well being involves wellness of the mind, the body and the environment, family, community life, and a compatible work interest. Wellness also includes a way of living that maximizes one's potential, adapting to the challenges of the changing environment, and entailing a sense of social

responsibility (Dunn, 1961). Being well constitutes more than merely a state of being not ill, or being “unsick”. In fact even prevention alone is an inadequate goal as prevention can also be viewed as a mostly reactive, defensive response (Ardell, 1977). A wellness approach focuses upon meeting needs in a positive manner and in pursuing wellness as the mind, the body, and the spirit are not only seen as being integrated but are acknowledged as being 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 a landmark report*, A New Perspective on the Health of Canadians* was released (Health and Welfare Canada, 1974). 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 were 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 only into traditional health services to serve individuals only after they became ill. 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). The focus of that 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 a variety of industrialized nations since then

culminating in the World Health Organization influenced “Ottawa Charter for Health Promotion” (Raeburn & Rootman, 1995).

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 & Golanty, 1988; Ryan & 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 macro, awareness and education campaigns, and micro, individual and small group programming, approaches. Also integral to this process are social network supports such as those offered by mutual aid/self-help groups as social relationships further affect wellness by fostering a sense of meaning or coherence that further promotes positive health-related behaviours (Cataldo & Coates, 1986; Hamilton-Smith, 1992; Health and Welfare Canada, 1986).

A holistic and comprehensive concept of wellness, or optimal health, involves an interdependent balance among five areas: physical, emotional, spiritual, intellectual, and social health (Figure 1.1) (Sefton, Wankel, Quinney, Webber, Marshall, & Horne, 1992). Physical health may be thought of in terms of fitness, nutrition, adequate rest and sleep, and medical self-care including the absence of disease and genetic influences that affect physiological functioning as well as behaviours that affect biological functioning including smoking, and drug use. 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 including personality, stress management, life goals, perceptions and feelings along with health inducing and illness preventing behaviours (Green & Shellenberger, 1991). Prominent themes associated with spiritual health include love, charity, purpose, inner peace, caring for others and meditation (Adams & Csiernik, 2001; 2003; Sefton, et al.,1992). The spiritual dimension of wellness has also been equated with Maslow's concept of self-actualization (Perry & Jessor, 1985). Intellectual health encompasses the realms of education, achievement, role-fulfillment, and career development. It also includes the ability to engage in clear thinking and to think independently and critically (Schafer, 1992). Social health involves social systems including: family, work, school, religious affiliation, social values, customs and social supports and the ability to interact effectively with others including the development of appropriate relationships among friends, families, co-workers, and communities. It too entails role-fulfillment, as well as caring for others and being open to the caring of others (Green & Shellenberger, 1991; Perry & Jessor, 1985; Schafer, 1992; Sefton, et al.,1992).

This holistic view of wellness contrasts with the biomedical model of disease that focuses solely upon biological factors to the exclusion of other practices. When we integrate and maximize social, mental, emotional, spiritual, and physical health we achieve high-level wellness (Greenberg & Dintiman, 1992). The ideal is to improve all, not one or two at the cost of others. Interestingly, in the workplace co-workers have been identified as being integral to this process as

they can contribute to the well-being of each other by providing support and encouragement (Cataldo & Coates, 1986; Schaefer, 1992).

When different components of wellness programming have actually been implemented into North America workplaces, primarily as components of EAPs and EFAPs the focus has traditionally 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. In these instances wellness criteria are still seen to exist primarily within the person as opposed to within the primary work setting (Ilgen, 1990). However, to create a healthy working environment the end result of work, itself, should be intellectual, physical, social, emotional and spiritual well-being. To achieve this end wellness needs to become incorporated into organizational policies (Herrick, 1981).

3. 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 psychosocial 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 (Duxbury & Higgins, 2003; 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 as seen through loneliness and isolation (Brun, 2002; Eakin, 1992; Harvey, 1992; Weinstein, 1986).

In recognition of this, examinations of the relationship between workplace stress and physical and psychological well being have occurred. Four related sets of variables that influence workplace wellness were found:

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 including adequate sleep, and use of alcohol, tobacco and other psychoactive drugs; and,

iv) specific socio-demographic variables such as education and age (Ontario Premier's Council on Health Strategy, 1991; Shehadeh & Shain, 1990).

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 & Smith, 1991; Green & Johnson, 1990; Jemmott & Locke, 1984; Kiecolt-Glaser & 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 including respiratory infections and clinical colds (Cohen, Tyrrell & Smith, 1991) upper respiratory tract infections, respiratory illness, herpes simplex and mononucleosis (Jemmott & Locke, 1984) and the progression of cancer (Cunningham, 1985). However, as stress reduction is possible at personal, social and environmental levels these conditions can all be controlled or

minimized. 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 (Duxbury & Higgings, 2003; Eakin, 1992; Klitzman, House, Israel, & Mero, 1990; McCubbin, Labonte, Sullivan & Dallaire, 2003). 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 that these factors had an interactive effect and thus were able to seriously damage the health of workers. However, it is not 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 (Table 1.2) (Green, 1988).

The relationship between workplace induced stressors and an increase in cardiovascular illnesses including heart attacks and hypertension has also been empirically demonstrated (Karasek & Theorell, 1990). Job strain may contribute almost as much to the statistical risk of coronary 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.

Table 1.2 : 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
EMPLOYEE CONTROL LOW	• work environment & process • substances used • machinery design • hazard controls • job design	•biological & genetic features •physical & mental impairment • cultural characteristics

Source: Green, 1988.

The relationship between smoking and cancer has been extensively documented and discussed (Blanchard & Tager, 1985; Fielding, 1984). Increased job strain, entailing high psychological demand and low worker control, has also been associated with smoking prevalence and intensity (Green & Johnson, 1990). 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, reducing stress by fostering a sense of control in a supportive social environment has been shown to assist cancer patients in their recovery (Cunningham, 1985). 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 & Willis, 1985; Johnson & Hall 1988; Marmot & Theorell, 1988).

There are three significant components that comprise the psychosocial aspects of the work environment: control, demand, and support. These factors can create a situation of learned helplessness among workers that can seriously endanger their long-term wellness. A lack of participation in the workplace can also trigger a series of psychoneuroimmunological events that ultimately result in physical pathologies of varying seriousness (Shain, 1992). However, these ideas are not all new as studies dating back to the 1960s discovered a relationship between low mental health, psychosomatic symptoms, and the work conditions of automotive workers (Hampden-Turner, 1972). More recently a Canadian study found that workers in four major industries in Quebec had greater rates of distress than the general population. This difference was attributed to workers having too much work and not enough time to complete their tasks, a lack of appreciation for their efforts by colleagues and superiors, inharmonious relations with the employer, inadequate participation in decision making and limited access to information

(Brun, 2002). Similarly, a positive working environment providing appropriate challenges that people can meet stimulates physical and mental health while the opposite conditions have negative wellness implications (McCubbin, et al, 2003).

4. CONCLUSION

It has become readily evident 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 wellness and the workplace. 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 & 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.

One existing system that has the potential to address and influence the issues surrounding worker wellness and influence processes to enhance workplace wellness is Employee Assistance Programming but only if it is allowed to evolve beyond its traditional function into an *Integrated Model of Occupational Assistance.*

Endnotes

1. See chapter 2 for a more in depth discussion of Welfare Capitalism.

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