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Does Health Oriented Leadership and Access to On-Demand Mental Health Therapists via Employee Assistance Programs Improve Employee Well-Being and Engagement?

Amber Rachelle Davis
Missouri University of Science and Technology

Department:

DOES HEALTH ORIENTED LEADERSHIP AND ACCESS TO ON-DEMAND MENTAL HEALTH THERAPISTS VIA EMPLOYEE ASSISTANCE PROGRAMS IMPROVE EMPLOYEE WELL-BEING AND ENGAGEMENT?

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AMBER RACHELLE DAVIS

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Approved by:

Clair Ann Reynolds Kueny, Advisor
Amber M. Henslee
Merilee Krueger

ABSTRACT

Employee mental health effects are informally relevant in all facets of working adults' lives. Considering the life-altering effects of the 2019 pandemic on work and society, mental health and work share applicability in conversations related to organizational outcomes. Based on the job demands-resource theory, personal demands are high in organizations where workers must adjust to returning to onsite work, in settings occupied by varying personalities, and ever-present political tension. These adjustments can be stressful for people and add new workplace challenges.

Work stress was found to be an antecedent for burnout (Tummers & Bakker, 2021), and leaders play an essential role in eliminating or decreasing job demands that lead to burnout. Efforts to decrease the demands, increase useful resources, and encourage employee engagement, are the responsibility of organizational leaders. While employees can benefit from a focus on well-being through health-oriented leadership, the leaders can too.

This study focused on hypotheses regarding the relationships between employee engagement, well-being, leadership style, and employee participation in mental health therapy via employee assistance program (EAP) usage. Hypothesis 1 stated that an on-site mental health practitioner (MHP) can improve employee well-being and engagement. Hypothesis 2 posited that HoL is a predictor for EAP usage. Hypothesis 3 suggested that including on-site MHP in the EAP and health-oriented leadership (HoL) as a strategy for employee wellness can jointly predict EAP usage and consequent employee engagement.

TABLE OF CONTENTS

Page

1. INTRODUCTION

Mental health awareness is prevalent in conversations related to the workplace (Center for Disease Control, 2018), and it can be used to analyze strategies for improving employee mental well-being along with organizational outcomes. With employees returning to the office after extended periods of working from home, generation Z entering the workplace with unprecedented expectations of employers (Evans-Reber, 2021), and organizations working to adapt to new expectations of the workforce (Malinoff, 2023), it would be advantageous for leaders to focus on employee engagement and well-being to positively impact organization outcomes.

According to a Center for Disease Control (2018) study, mental health issues such as anxiety and depression impact one in five people in the United States. Given that 20% of the population is impacted, one could assume these mental health concerns impact workplaces and organizational outcomes. Preiser et al. (2015) stated that mental disorders strongly predict compromised work performance and job applicants. Hunter and Chekwa (2021) cited APA Press (2018) in their assertion that the generation entering the workforce is increasingly disclosing mental health diagnoses of anxiety and were more likely than older generations to share details about their poor mental health. Additionally, young workforce members are more likely to seek treatment for their psychological concerns (Hunter & Chekwa, 2021) than older members of the workforce. According to the World Health Organization (2022), it is the responsibility of employing organizations to make mental health interventions available to employees via strategic health and well-being plans. These strategies can include rehabilitation, prevention, identification, and

other forms of support (WHO, 2022). Hunter and Chekwa (2021) outline two crucial actions employers can take to show employee support: identification of employees experiencing emotional duress and intervening with strategies to help employees manage certain stressors.

Organizations offer employee assistance programs (EAP) to meet the mental health needs of employees. These programs offer therapy sessions for individuals and their family members, grief counseling, and financial counseling, among other resources related to employees' personal and professional successes (Bouzikos et al., 2022). Bouzikos et al. (2022) found evidence that EAPs positively affect mental well-being, innovation, and the ability to gain and employ specific job skills. However, research showed that less than 4% of employees, on average, utilize them (Dimoff, 2019; Sammer, 2019).

EAPs can lead to positive employee outcomes, but the underutilization begs whether the existence of such programs is worthwhile. Organization leaders may find it challenging to increase usage of services. This challenge leads to the following questions: how do organization leaders effectively encourage EAP usage? Do employee assistance programs require alteration? Do leaders need to pay more attention to employee well-being? What therapeutic interventions utilized by EAPs lead to positive employee well-being and engagement?

The health-oriented Leadership (HoL) theory describes the potential influence managers can have on the well-being of employees through their attention to personal well-being and encouraging employees to practice self-care (Vonderlin et al. 2021). Access to mental health services and wise interventions such as mindfulness-based

health-oriented leadership training (Walton, 2014; Vonderlin et al., 2021) may lead to more utilization of these services. According to Walton (2014), wise interventions entail considering employees' psychological experiences to identify harmful thought processes related to the environment and then working to alter those thoughts. Organizational leaders are responsible for employees' occupational health, and – due to their fiscal interests – that responsibility extends to employee outcomes like engagement, which Matthews et al. (2014) found to be a predictor for subjective well-being. Thus, employees' use of mental health resources may, in turn, positively impact job success and organizational outcomes.

Specifically, mental health interventions practiced by mental health practitioners include cognitive behavioral therapy (Lagerveld & Blonk, 2012; McCarthy & Ford, 2019; Mochari-Greenberger et al., 2020; Phillips et al., 2014; Bostock et al., 2016), acceptance and commitment therapy, (Wardley et al., 2016; Brinkborg et al., 2011; Finnes et al., 2019) as well as other techniques related to group therapeutic modalities. McCarthy and Ford (2019) identified CBT as an avenue for business owners to partner with counselors to create a better work environment for employees. According to Lagerveld and Blonk (2012), CBT can help with the acquisition of functional coping skills when one's work is impacted by a culmination of stressors. Additionally, ACT is the use of mindfulness to decrease the influence negative thoughts have on a person's behavior, helping them to keep past negative struggles related to work separate from present work experiences (Wardley, 2016).

Furthermore, the availability of mental health treatment such as CBT in the workplace can decrease the on-site stressors that instigate unhealthy psychological

behaviors, such as eating disorders (Toro et al., 2022). Cognitive work-related abilities, interpersonal interactions, and self-efficacy are employee outcomes that are negatively impacted by stressors that manifest in the workplace (Hunter & Chekwa. 2021). Organizations should make efforts to minimize negative impacts on the occupational mental health of employees. Thus, while many organizations offer employee assistance programs as a solution for employees facing mental health challenges (Greer, 2021), another possible strategy for increasing employee well-being and self-care could be to offer on-site access to a mental health practitioner (MHP). The proximity of an MHP can create easy access and swift response from a professional skilled in mindfulness-based interventions as well as therapeutic interventions that can prevent or respond to mental health challenges. Moreover, considering HoL theory, leadership style could play a role in whether employees take advantage of these resources.

2. THEORETICAL FOUNDATION

Resources provided by organization leaders influence employee outcomes such as employee engagement and subjective well-being (Matthews et al., 2014). Consequently, leaders are responsible for strategically supporting employees' mental and physical health through meaningful interactions and sufficient resources. Matthews et al. (2014) found family-supportive supervisor behaviors to be predictors of employee engagement. This finding led to the interest in analyzing health-oriented leadership's relationship with employee engagement and well-being.

2.1. THE LEADER'S RESPONSIBILITY

According to Dimoff (2019), organization leaders have a direct impact on making employees aware of the resources available that can reduce stress. Sufficient job resources are an antecedent to motivation and engagement. Contrarily, burnout was found to result from high job demands (Tummers & Bakker, 2021). Furthermore, Tummers & Bakker (2021) acknowledge leadership's role in supplying job resources and decreasing job demands for employees; they studied the connection between job demand-resource theory (JD-R) and leadership.

2.2. HEALTH-ORIENTED LEADERSHIP THEORY (HoL)

This study sought to determine the impacts of on-site mental health therapy on organizational outcomes such as employee engagement and well-being. In considering intervention implementation and outcome impacts, the Health-Oriented Leadership (HoL) theory incorporates managerial involvement with encouraging or influencing

employee self-care prioritization (Vonderlin et al., 2021). HoL asserts that when a supervisor prioritizes self-care, it leads to overt engagement with employees' mental health (Vonderlin et. al., 2021). To impact organizational culture and well-being, the organization can develop a strategy that involves taking responsibility for providing mental health support to employees. This strategy would include giving organization leaders the duty of acting as liaisons via HoL. Vonderlin et al. (2021) pointed to two factors with assumed indirect effects on employee health: the supervisor's status as a role model to their employees and the negative impact poor mental health has on a supervisor's behavior that consequently affects employee health. Moreover, the authors' studies showed an association between HoL theory and decreased employee burnout and stress.

Meaningful efforts intended to impact employees' thought processing and behaviors may involve wise interventions. There are many types of workplace mental health interventions. For some organizations, offering an employee assistance program (EAP) may be a sufficient intervention. Vonderlin et al. (2021) studied whether mindfulness approaches could be incorporated into the theoretical framework of HoL. The authors found that wise interventions can be incorporated into the leadership theory and that mindfulness-based interventions can improve the mental health of managers and staff. Examples of interventions that alter harmful thought processes include cognitive behavioral therapy (CBT), mindfulness, and acceptance and commitment therapy (ACT).

Vonderlin et al.'s (2021) study did not involve therapeutic modalities such as CBT or ACT, however, Wardley et al. (2016) identifed mindfulness as a significant element in the ACT approach to psychological intervention. The authors approached the

study from the lens of psychological distress and burnout in the working population. Participants in the study were clinical psychologists, and they reported that ACT techniques led to a stronger sense of connection to the importance of their work and increased engagement (Wardley et al., 2016). One measure of interest in this study was mental health therapy's impact on employee engagement. Bartlet et al. (2019) mentioned CBT as a standard occupational stress or burnout intervention. With Wardley et al.'s (2016) and Bartlet et al.'s (2019) mention of burnout, an additional theory was considered.

2.3. JOB DEMAND-RESOURCE THEORY (JD-R)

Considering the evidence linking employee engagement, motivation, job demands, and job resources, a connection between JR-D and HoL can be posited. Tummers and Bakker (2021) pointed out leadership as essential to job demands and the identification of JD-R as a measure of employee well-being. Galanakis and Tsitouri (2022) found that disengagement and low motivation ensued when job resources were low. The role of a leader is to establish rapport, communication, and trust (Jago & Vroom, 2007), which are job resources that can aid engagement. Additionally, access to sufficient job resources can lead to increased work engagement and decreased job demands (Tummers & Bakker, 2021).

Job demands are identified as being related to employee burnout via psychological challenges (Tummers & Bakker, 2021). Appropriate access to job resources can ease the impacts of job demands, and personal resources can also contribute to well-being through job resources (Galanakis & Tsitouri, 2022). Job

resources, personal resources, and job demands impact psychological states and well-being (Tummers & Bakker, 2021; Galanakis & Tsitouri, 2022), so interventions geared toward improving psychological well-being should be considered the employer's responsibility. One such intervention commonly found in organizations but needing more research is employee assistance programs (EAPs). The existence of EAPs are not necessarily interventions, however, the resources offered via the EAP are.

Job resources, as described by Tomczac and Kulikowski (2023), consist of aspects of the workplace that aid an employee in achieving goals at work, encourage development or employee growth, and decrease psychological and physiological demands. The demands were described as organizational, physical, or social qualities of the job that require sustained effort that results in physiological or psychological exertion (Tomczac & Kulikowski, 2023). EAPs can be effective interventions (or resources) for improving psychological well-being in the workplace (Bouzikos et al, 2022) but they require employee utilization. Thus, this research focuses on strategies that could lead to increased EAP usage and subsequent impact on employee well-being and engagement.

3. HYPOTHESIS DEVELOPMENT

Bakker and Demerouti (2017) found that employee stress levels increased when perceived work demands surpassed the available resources. As a proactive effort to address work-related stress in employees, EAPs can be an employee resource or benefit provided by employers. However, the utilization of EAPs depends on the organization's leaders. A study performed by Bouzikos et. al. (2022) found that EAP treatment led to a decrease in employee psychological distress, but organizational culture moderated employee stress reduction after use of EAP (Bouzikos et. al., 2022).

When organizations face unique challenges related to business outcomes, innovation, empathy, and cohesive systems, leaders may seek guidance from consultants. Maltz (2012) notes that challenges with empathy, innovation, and system cohesiveness related to failure, anxiety, and competing structures. Executive coaches and consultants called on for their experienced perspectives tend to lean on psychological analysis to gather valuable insight on the issues that contribute to undesired business outcomes (Eisold, 2012; Matz, 2012). Eisold (2012) described the connection between clinical psychology and dimensions of life within an organization. They argued that clinical, psychological skills are advantageous because they allow the practitioner to identify perplexing behaviors related to mental illness. The behaviors are often perceived as deficiencies by peers and supervisors who are not knowledgeable of psychological anomalies. Maltz (2012) stated that psychological analysis is rooted in learning from failure, anxiety, confusion of the unknown and how these psychological states materialize in behaviors. They go further to say that this feature of psychological analysis reveals

organizational life as it is impacted by the long-term psychological effects the environment has on the employees' behaviors.

Regarding occupational health, the clinical psychologist's practice of modalities – such as CBT, mindfulness, and ACT – have the potential to reduce work stress, improve mental health (Bartlet et. al., 2019), and positively impact employee return to work after sickness related absences (Lagerveld et. al., 2012). Bartlet et al. (2019) emphasized the problematic effect employee stress has on the mental health and well-being of employees and organization's economic outcomes. They mention the research drawn from occupational health psychology (OHP) that highlighted the impact employee stress had on available resources. As mentioned previously, the JD-R theory determined employees who have more resources are more engaged, and motivated, and they have lower stress levels leading to less burnout.

Stressors that are particularly related to the work environment include a lack of perceived control, difficult relationships, isolation, effort-reward imbalance, uncomfortable work conditions, and perceived injustices, among others (Hargrove et. al., 2011). Bartlet et. al. (2019) describes the impact sustained stress has on the employee, noting that it depletes one's ability to cope with attentional and emotional strain and minimizes the employee's capacity to manage future challenges. Furthermore, the authors noted that a continued state of stress leads to depression, poor immune function, aggression, and substance use.

Beyond the impact work related stressors have on individual employees, they also negatively impact organizational outcomes such as staff attendance, engagement, and can

result in increased worker's compensation claims. In fact, Stetzo and Dobson (2013) found that employees who reported their job as extremely stressful were more likely to have received treatment for a mental health issue within the past twelve months. Bartlet et. al. (2019) found that interventions such as mindfulness-based stress reduction (MBSR) and mindfulness-based programs (MBP) are effective for reducing stress. Notably, psychosomatic consultation in the workplace (PCIW), and the practice of providing psychologically therapeutic consulting on a worksite, makes it possible for employees to access therapists who can potentially aid in the avoidance of common mental disorders (Presier et. al., 2015). Access to treatments such as these can be beneficial for employees suffering from depression and anxiety symptoms in addition to stress (Toro et. al., 2022). These findings indicated that an on-site MHP as part of an EAP, can provide wise interventions by using their skills in psychological therapeutic modalities such as ACT and CBT, via HoL.

Considering the above-mentioned theories and previously described studies, I hypothesize the following:

- H1: The awareness of access to an on-site clinical psychologist or MHP improves employee well-being, and employee engagement.
- H2: HoL is a predictor for EAP usage.
- H3: Including on-site MHP in the EAP and HoL as a strategy for employee wellness jointly predicts EAP usage and consequent employee engagement.

4. METHODS

Determining the relationship between EAP usage, HoL, employee engagement and employee well-being required collection of data from employees in various work settings and industries. A questionnaire was developed and disseminated via an electronic Qualtrics survey on Prolific using items from the following existing measurement tools: Utrecht Work Engagement Scale (UWES) for employee engagement items, Job-related Affective Well-Being Scale (JAWS) for affective well-being, and Health Oriented Leadership (HoL) items to measure employee perceptions of health-oriented leadership. Additionally, the survey included demographic questions capturing gender identity, age, race, job industry, and items related to EAP access, usage, and existence of an on-site MHP.

4.1. DEMOGRAPHICS AND QUESTIONNAIRE STRUCTURE

For this study, eligible participants were working adults aged 18 and older and employed full time by organizations that offer EAPs. Participants included all races and gender identities as well as participants with experience working in various industries. It was also important to capture a sub-sample of persons employed by organizations that provide on-site mental health therapy (demographic survey items found in the appendix). The survey ad included language pointing to the interest in participants who work for organizations that offer on-site mental health therapy as part of their EAP as well as persons employed by organization who do not provide on-site mental health therapy.

With a goal of collecting a minimum of 300 responses from qualified participants, the questionnaire was developed in Qualtrics and posted on the online survey platform, Prolific. Participants were offered a small monetary incentive ($3.00) to complete the sixty-five-item survey that took approximately seven minutes to complete.

The survey consisted of 57 questions on 1to 7 Likert scale, 3 yes, no, don't know questions, and 5 demographic questions. The first survey item asked if the participants' employer offers employee assistance programs. Those who answered "yes" were allowed to complete the survey; "no" responses were excluded. Selected participants were then asked if their employer provides direct access to an on-site mental health therapist or access to an on-demand virtual therapist. This survey item aided in tracking the number of participants that had EAPs with the MHP direct access feature versus those without. The sample of participants without direct access to MHP are considered Group 1 and the sample with MHP direct access are Group 2.

4.2. UWES SCALES AND SUBSCALES

The Utrecht Work Engagement Scale measures employee engagement based on energy, efficacy, and involvement (Schaufeli & Bakker, 2004). These three engagements facets combined with strength, absorption, and dedication, are the opposite of known burnout characteristics, exhaustion, and cynicism (Schaufeli & Bakker, 2004). The UWES is made up of seventeen psychometrically-sound items that measure absorption, dedication, and vigor.

Six items measuring absorption sought to measure the participants' happy immersion and attachment to their work. One absorption item asked the participant to rate

on a scale of 1 (never) to 7 (every day) the following statement "I get carried away when I am working". An example of one of the five items measuring dedication asked the participant to rate on a scale of zero to seven the following statement, "I find the work that I do full of meaning and purpose". An example of a survey item measuring vigor asked the participant to rate the following statement on a scale of zero to seven "At work, I feel bursting with energy" (Schaufeli & Bakker, 2004). Survey items for the UWES can be found in the appendix.

Based on the Schaufeli and Bakker (2004) 17 item UWES survey manual, mean scores of the three sub scales, vigor items, absorption items, and dedication items were calculated for each participant to determine work engagement and the overall mean scores on each participant.

4.3 JAWS SCALES AND SUBSCALES

The Job-related Affective Well-being Scale is made up of thirty items intended to measure employee emotional responses to their work (Van Katwyk et. al., 2000). The full survey has 30 items that participants rate the frequency of their emotional experience on the job using a 1 (never) to 7 (daily) Likert scale rating. These survey items represent emotions that are both positive and negative and ask participants to identify the frequency of their emotional experiences related to work. Of the thirty items, both positive and negative emotions are placed in one of four categories based on intensity. The categories have an arousal and pleasurableness dimension and are identified as follows: high pleasure-high arousal (HPHA), high pleasure-low arousal (HPLA); low pleasure-high arousal (LPHA), and low pleasure-low arousal (LPLA). An example of an HPHA item

asks the participant to rate the following statement, "My job makes me feel excited." An example of an HPLA item asks the participant to rate the following statement, "My job made me feel at-ease." An example of a LPHA item asks the participant to rate the following statement, "My job made me feel disgusted." An example of a LPLA item asks the participant to rate the following statement, "My job made me feel gloomy" (Van Katwyk et. al., 2000). Survey items for the JAWS are in the appendix.

Using Van Katwyk et. al.'s (2000) instructions for scoring the Job-related Affective Well-being Scale (JAWS), six scores were calculated for the four sub scales. While participants responded to all 30 survey items, the 20-item short version survey was used to calculate the overall mean positive and overall mean negative emotional reaction scores for each participant. The four sub scale ratings were summed for each participant and overall negative ratings (low pleasurable scales) and overall positive ratings (high pleasurable scales) were averaged.

4.4 HOL SCALES AND SUBSCALES

As mentioned in the theoretical foundation section, Health Oriented Leadership is a theory focusing on the effects leaders have on employee well-being based on a style of leadership that prioritizes attention to the leader's self-care and encouragement for employees to practice self-care. Lutz et. al. (2023) developed a six-item survey targeting both employees and leaders. For the purpose of this study, only the HoL items related to employee perceptions were included. According to Lutz et. al. (2023) there are four ways in which leadership impacts health both directly and indirectly; via working conditions, personality traits, communication interactions, and manager stress levels. The six survey

items measuring HoL assess employee perceptions of behavior and value related components of leader interactions and focus on health status, and conditions. For example, one survey item asks the participant to rate the following statement on a scale of 1 (extremely disagree) to 7 (completely agree), "My supervisor cares about my health" (Lutz et al., 2023). Survey items for the HoL are in the appendix.

5. ANALYSIS

Within two days, 307 submissions were collected with 291 qualified participants that indicated that they work thirty-two or more hours per week and answered “yes” or “I don’t know” in response to the question “Does your employer have an employee assistance program/ EAP”. Survey results included participants from 70 identified job industries, 189 Male, 96 Female, 3 Non-Binary /Third Gender, and 3 preferred not to identify their gender. Of the qualified participants, 187 did not formally supervise employees, 104 formally supervise employees. Of the 291 qualified participants, 202 answered all sixty-five question. In response to EAP survey items, 58 participants answered “I Don’t Know” to the question of whether they have EAP access. Of the qualified participants, 40% responded “yes” to having access to onsite mental health therapy and 87 participants answered “I Don’t Know” to having onsite access.

Three statistical tests were used to test the three hypotheses: Pearson’s correlation coefficients and effect sizes to determine if there are correlations between EAP use, onsite MHP, HoL, and work engagement, multiple regression models to analyze the impact MHP has on work engagement, and T-tests to assess the difference in responses from participants who have onsite MHP and those without.

6. RESULTS

Since all three survey instruments ask participants to respond to each item with a Likert Scale rating, Pearson's correlation coefficient was calculated to analyze the relationships between HoL and engagement as well as the relationship between direct access to MHP via EAP and HoL. Despite my expectation of an imbalanced number of participants who have access to on site MHP and those who do not, 144 responded "yes" to having on demand access to a mental health therapist in the workplace. T-tests were performed to compare engagement outcomes between employees with direct access to MHP via EAP and those without as well as the relationship between HoL and EAPs with on-site MHP. Considering the hypothesis that HoL leads to increased engagement via increased well-being and EAP usage, I performed a multiple regression analysis. A hypothetical model of independent and dependent variables as well as mediators can be found in appendix E.

There was a strong, positive correlation between engagement and positive employee well-being ($r = .850$, $p \leq 0.001$). HoL appears to have a moderate to strong positive correlation to engagement ($r = 0.594$, $p \leq 0.001$) and positive affective wellbeing ($r = 0.666$, $p \leq 0.001$). With p-values less than 0.05, all the above-mentioned correlation coefficients are statistically significant. HoL appears to have a positive yet weak correlation with access to onsite mental health therapist ($r = 0.102$) however, the correlation coefficient was not statistically significant ($p = 0.08$). There appears to be a positive but weak correlation between HoL and EAP use ($r = 0.177$) which was shown to be statistically significant ($p = 0.003$).

T-tests comparing participants with access to an on-site therapist (M = 5.64) versus no access to an on-site therapist (M = 5.33) suggest there was no significant difference in perceptions of HoL (t = -1.43, p = .155). However, T-tests comparing participants with access to an on-site therapist (M = 4.76) versus no access to an onsite therapist (M = 4.42) suggests there was a significant difference in work engagement ratings (t = -2.25, p = 0.026).

Multiple regression analysis suggested that the combination of HoL and onsite mental health therapy explained 43% of the variance in work engagement (adjusted R^2 = 0.428). Additionally, HoL was a significant predictor of work engagement (b = 0.489, p < 0.001). However, onsite therapy was not a statistically significant predictor for work engagement (b = 0.193, p = 0.125). There is not enough evidence to support onsite MHP as a predictor of work engagement when accounting for other explanations, such as HoL (see table in appendix).

Further analysis of HoL, onsite therapy, and EAP usage reveals additional information. Multiple regression was used to determine whether HoL and onsite mental health therapy predicted EAP usage. These predictors explained 5.56% variance in EAP usage (adjusted R^2 = 0.056). Onsite therapy was found to be a significant predictor for EAP use (b = 0.176, p = 0.041) as well as the HoL (b = 0.075, p = 0.005). The overall model shows that the data is statistically significant (p = 0.002) and the combination of HoL and on-site therapy predict EAP usage. As HoL ratings increase, EAP usage is also expected to increase. Similarly, the presence of an onsite mental health therapist can lead

to an increase in EAP use. A final regression analysis found a 0.8% variance in work engagement is explained by EAP usage. EAP usage is not a statistically significant predictor for work engagement ($b = 0.189$, $p = 0.221$).

7. DISCUSSION

Revisiting the three hypotheses; H1: the awareness of access to an on-site MHP improves employee well-being, and employee engagement, H2: HoL is a predictor for EAP usage and H3: including on-site MHP in the EAP and HoL as a strategy for employee wellness jointly predicts EAP usage and consequent employee engagement, we found support for all hypotheses, although a correlation between HoL and onsite MHP ($p = 0.088$) was not statistically significant.

With regards to hypothesis 1, while there is a weak correlation between access to MHP and positive JAWS scores, the relationship was statistically significant. Access to an onsite MHP was also found to have a weak yet positive significant correlation to work engagement. T-tests also showed a statistically significant difference in engagement with onsite MHP versus without. These outcomes show that, while minimal, the presence of an onsite mental health therapist does have a positive impact on employee well-being and employee engagement.

Regarding hypothesis 2, while the correlation between health-oriented leadership and EAP use was found to be weak, it was statistically significant. Furthermore, the combination of HoL and onsite MHP were found to be statistically significant predictors for EAP use.

With regards to hypothesis 3, the combination of HoL and access to an onsite MHP were statistically significant predictors for employee engagement and EAP use. When HoL is accounted for, on-site therapy presence is not the stronger of the two

predictors. However, onsite MHP alone was found to be a significant predictor for work engagement.

The introduction posed a few questions: how do organization leaders effectively encourage EAP usage? Do EAPs require alteration? Do leaders need to pay more attention to employee well-being? What therapeutic interventions utilized by EAPs lead to positive employee well-being and engagement? A couple of these questions can be answered by the outcomes of this study, the others cannot. Organization leaders interested in effectively encouraging EAP usage can do so by ensuring they use health-oriented leadership. The prioritization of self-care modeled by this leadership style leads employees to emulate self-care behaviors, thus increased EAP use can be expected. Since our survey did not collect information about use of specific therapeutic modalities the study outcomes did not determine which modalities lead to positive engagement and wellbeing. Organizations that provide the added resource of onsite MHP can also expect increased work engagement. Additionally, the impact HoL has on engagement may be in response to prioritizing self-care over job demands. Both HoL theory and JD-R theory are supported by the outcomes of this study.

7.1. LIMITATIONS

Participants of this study were able to identify the existence of a MHP on their work site, whether the employer offered an EAP, and whether they used the EAP. One metric that was not collected was whether the onsite MHP was a feature of the EAP and whether those who utilized the EAP worked with the onsite therapist. While the study provided a glimpse into the impacts EAPs and HoL have on employee outcomes and can

be useful for industrial organizational psychology, the data is less useful to the area of clinical psychology.

The 87 participants who answered “I don’t know” to MHP access and the 58 participants who answered “I don’t know” to the question about EAP access may have contaminated the data because they may not have had EAP access. Also, common method variance may have artificially inflated some effect sizes as participant ratings for JAWS, UWES & HoL were subjective on the 1-7 scale and the responses to EAP and MHP items were more objective (i.e., presence of feature or not). Thus, the effect sizes for onsite MHP presence and EAP usage are less like to be inflated. Additionally, variables such as organizational trust, variables related to individual differences, and climate/culture differences found across various industries were not accounted for; these extraneous variable may have impacted participant responses.

7.2. FUTURE RESEARCH

While this study did not directly assess therapeutic interventions, it found that onsite MHP combined with EAPs lead to positive employee well-being and higher work engagement. Further research is needed to determine if EAPs should be altered to ensure effective employee and organization outcomes. Considering advice from WHO, CDC, and SHRM regarding the organization’s responsibility for employee mental health, combined with the 2018 CDC finding that one in five people are impacted by mental health concerns, it can be assumed that leaders need to pay more attention to employee well-being. Further research is needed to determine if EAPs should be altered to ensure effective employee and organization outcomes.

Health oriented leadership and onsite mental health practitioners work together to impact employee wellbeing, work engagement, and EAP usage. The outcome from this study hopefully contributes to the body of HoL research and future IO psychology research related to onsite mental health therapy for employees. The statistical significance of the study outcomes warrants further research into mental health interventions that impact employee and organizational outcomes other than engagement and well-being. Additional research related to job industry may help with understanding trends and differences across industries and contribute to future research related to occupational mental health of employees in various industries.

8. CONCLUSION

The data collected from this study hopefully contributes to future research on employee well-being, engagement, leadership as it relates to mental health, and EAP usage. Job demands and resources are ultimately the responsibility of organization leaders. This assertion combined with the impact work stress has on employee mental health and well-being confirms the notion that organization leaders are partially responsible for employee mental health. Including onsite mental health therapy as a resource for employees could be one leadership approach. Although further research into the most effective therapeutic modalities for organization and employee outcomes is needed.

The findings of this study highlight the impact leader behaviors and mental health have on overall organization outcomes and can be a starting point for researchers interested in studying employee mental health interventions related to effective leadership. It is also worth reiterating the responsibility organizations have: identifying employees who are under stress and intervening with resources that help with reducing work related demands that are detrimental to employee mental health.

APPENDIX

FULL QUESTIONNAIRE WITH DEMOGRAPHIC ITEMS

This survey is divided into five sections: a) employment information, b) job engagement, c) work well-being, and d) perceptions of your manager/supervisor, e) demographic information.

A. Employment Information: select the most appropriate response.

1) How many hours do you spend at work each week? [10-20 | 21-30 | 32-40 | 40+]
2) Does your employer have an employee assistance program/ EAP (a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related problems)? [yes | no | I don't know]
3) Does the EAP program include an on-site mental health therapist or direct access to a virtual therapist? [yes | no| I don't know]
4) Have you used your organization's EAP? [yes | no| I don't know]
5) (if yes) My organization's EAP provided helpful treatment for my concerns. [Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree]
6) My organization's EAP was easily accessible. [Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree]
7) I took advantage of my organization's EAP without any apprehension. [Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree]

B. Job Engagement: Please rate your response as follows – 0 = never | 1 = almost never/a few times a year | 2 = rarely/once a month or less | 3 = sometimes/a few times a month | 4 = often/once a week | 5 = very often/a few times a week | 6 = always/every day

1) At my work, I feel bursting with energy
2) I find the work that I do full of meaning and purpose
3) Time flies when I'm working
4) At my job, I feel strong and vigorous
5) I am enthusiastic about my job
6) When I am working, I forget everything else around me
7) My job inspires me
8) When I get up in the morning, I feel like going to work
9) I feel happy when I am working intensely
10) I am proud on the work that I do
11) I am immersed in my work
12) I can continue working for very long periods at a time
13) To me, my job is challenging
14) I get carried away when I'm working
15) At my job, I am very resilient, mentally
16) It is difficult to detach myself from my job
17) At my work I always persevere, even when things do not go well

C. Well-Being at Work: Please rate each item that best indicates how often you've experienced each emotion at work over the past 30 days.– 0 = never | 1 = almost never/a

few times a year | 2 = rarely/once a month or less | 3 = sometimes/a few times a month | 4 = often/once a week | 5 = very often/a few times a week | 6 = always/every day

1) My job made me feel at ease
2) My job made me feel angry
3) My job made me feel annoyed
4) My job made me feel anxious
5) My job made me feel bored
6) My job made me feel cheerful
7) My job made me feel calm
8) My job made me feel confused
9) My job made me feel content
10) My job made me feel depressed
11) My job made me feel disgusted
12) My job made me feel discouraged
13) My job made me feel elated
14) My job made me feel energetic
15) My job made me feel excited
16) My job made me feel ecstatic
17) My job made me feel enthusiastic
18) My job made me feel frightened
19) My job made me feel frustrated
20) My job made me feel furious
21) My job made me feel gloomy

22) My job made me feel fatigued

23) My job made me feel happy

24) My job made me feel intimidated

25) My job made me feel inspired

26) My job made me feel miserable

27) My job made me feel pleased

28) My job made me feel proud

29) My job made me feel satisfied

30) My job made me feel relaxed

D. Supervisor's interest in employee well-being: Please rate your response as follows – 0 = completely disagree | 1 = disagree | 2 = mildly disagree | 3 = neither agree nor disagree | 4 = mildly agree | 5 = agree | 6 = completely agree

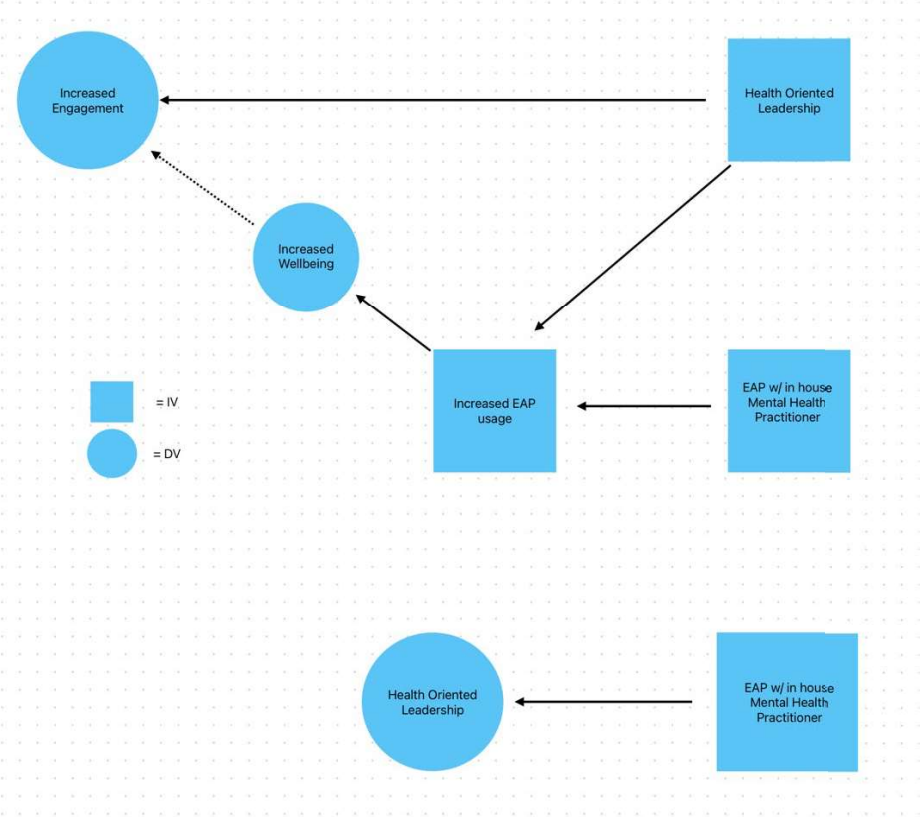
1) My supervisor cares about my health
2) My supervisor supports me in achieving the best possible work-life balance
3) It is important to my supervisor to have healthy employees
4) My supervisor gives me the acknowledgment I deserve
5) My supervisor takes all possible measures to reduce health hazards at my workplace or to prevent them from occurring in the first place
6) My supervisor cares about occupational safety in my workplace

E. Personal Information:

1) Age [18-25 | 26-34 | 35-42 | 43-50 | 51-58 | 59-older]
2) Race [Asian | Black | Hispanic/Latinx | Mixed Race | White | Other]

3) Gender identity [cis-gender woman | trans-gender woman | cis-gender man | trans-gender man | gender non-conforming | other]
4) Job Industry [open response]

PROPOSED HOL AND EMPLOYEE ENGAGEMENT MODEL WITH EAP AND WELL BEING MEDIATION



Data Analysis Tables

Correlation N = 284	**JAWS Mean positive**	**JAWS Mean negative**	**UWES Means**	**HoL**	**Onsite MHP**
UWES Means	*0.850	*-0.614			
HoL	*0.666	*-0.618	*0.594		
Onsite Therapist?	*0.201	-0.093	*0.148	0.102	
EAP Used?	*0.225	-0.031	0.113	*0.177	*0.155

* = statistically significant

t-Test: Two-Sample Assuming Unequal Variances		
	Onsite Therapist	
HoL	**no**	**yes**
Mean	5.325	5.640
Variance	1.963	1.904
Observations	57	145
Hypothesized Mean Difference	0	
df	101	
t Stat	-1.434	
P(T<=t) one-tail	0.077	
t Critical one-tail	1.660	
P(T<=t) two-tail	0.155	
t Critical two-tail	1.984	

t-Test: Two-Sample Assuming Unequal Variances		
	Onsite therapist	
UWES	**no**	**yes**
Mean	4.417	4.764
Variance	0.888	1.173
Observations	57	145
Hypothesized Mean Difference	0	
df	117	
t Stat	-2.252	
P(T<=t) one-tail	0.013	
t Critical one-tail	1.658	
P(T<=t) two-tail	0.026	
t Critical two-tail	1.981	

SUMMARY OUTPUT	**HoL & Onsite MHP by UWES**
Regression Statistics	
Multiple R	0.658
R Square	0.433
Adjusted R Square	0.428
Standard Error	0.798
Observations	202.000

ANOVA					
	df	SS	MS	F	Significance F
Regression	2.000	96.874	48.437	76.096	0.000
Residual	199.000	126.668	0.637		
Total	201.000	223.542			

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%	Lower 95.0%	Upper 95.0%
Intercept	1.810	0.241	7.503	0.000	1.334	2.286	1.334	2.286
HoL	0.489	0.041	12.020	0.000	0.409	0.570	0.409	0.570
on-site therapist	0.193	0.125	1.543	0.125	-0.054	0.441	-0.054	0.441

SUMMARY OUTPUT	**EAP Use by UWES**
Regression Statistics	
Multiple R	0.091
R Square	0.008
Adjusted R Square	0.003
Standard Error	1.037
Observations	184.000

ANOVA					
	df	SS	MS	F	Significance F
Regression	1.000	1.623	1.623	1.509	0.221
Residual	182.000	195.663	1.075		
Total	183.000	197.286			

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%	Lower 95.0%	Upper 95.0%
Intercept	4.642	0.108	42.945	0.000	4.429	4.856	4.429	4.856
EAP Used?	0.188	0.153	1.229	0.221	-0.114	0.489	-0.114	0.489

SUMMARY OUTPUT	**HoL & MHP by EAP Use**
Regression Statistics	
Multiple R	0.257
R Square	0.066
Adjusted R Square	0.056
Standard Error	0.487
Observations	184.000

ANOVA					
	df	SS	MS	F	Significance F
Regression	2.000	3.031	1.515	6.384	0.002
Residual	181.000	42.969	0.237		
Total	183.000	46.000			

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%	Lower 95.0%	Upper 95.0%
Intercept	-0.063	0.166	-0.378	0.706	-0.390	0.264	-0.390	0.264
HoL	0.075	0.027	2.844	0.005	0.023	0.128	0.023	0.128
on-site therapist	0.176	0.086	2.059	0.041	0.007	0.345	0.007	0.345

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VITA

Amber Rachelle Davis studied Industrial Organizational Psychology at Missouri University of Science and Technology. For baccalaureate studies, she majored in Human Resources Management at Upper Iowa University where she earned a Bachelor of Science degree in 2016. Amber has been employed with nonprofit organizations and educational institutions, contributing to equal opportunity, DEI, human resources, and organization development. She entered Missouri S&T as a student in the Applied Workplace Psychology graduate certificate program in 2020 and completed a Master of Science in IO Psychology in December of 2023.