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The Power of Workplace Wellness: A Theoretical Model for Social Change Agency

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As millions of individuals face the complex challenge of adopting prohealth behavior as a core lifestyle attribute, there is an ever-increasing need to take an opportunistic approach to practicing and internalizing such behavior. Time constraints, prioritization, and time mismanagement widely contribute to the perceived inability of individuals to adhere to prohealth behavior. Given vocation as a demand that constitutes approximately one third of daily life activity, the organizational setting has emerged as a context that can potentially offer a vast array of viable workplace wellness (WW) opportunities. Such initiatives go beyond framing organizations as vehicles for health behavior promotion—instead, the workplace is an institution that has the power to redefine corporate culture through the implicit indoctrination of prohealth ideals. As organizations increasingly acknowledge the critical linkage between healthcare costs and employee performance, there emerges an exigent call for the incorporation of health and wellness as foundational cornerstones of the organizational mission statement. However, the extant literature fails to provide a comprehensive model that elucidates the motivational foundations of WW initiatives. The following paper proposes a triadic model that consists of social comparison theory (Festinger, 1954), need theory (McClelland, 1951, 1961), and self-actualization (Maslow, 1954, 1970)— social cognitive theories that serve to highlight the motivational drivers of WW participation and elucidate how participation could potentially motivate individuals to affect change at the community level. Discussion concludes with perspectives on the extent to which WW participants can internalize collaboration, common purpose, congruence, commitment, and citizenship as core values and elements of social change agency.

Keywords: *health, need theory, self-actualization, social comparison theory, workplace wellness*

Introduction

As millions of individuals engage in their fitness paradigm of choice, they silently observe and analyze the health behaviors of others. For many individuals, such observation is perhaps less a matter of social analysis and more a matter of attempting to understand the mechanisms through which fitness behaviors are adopted and maintained. Throughout the course of development, health ideologies are a manifestation of emerging personality; concurrently, such ideals are identified and indoctrinated via learning through the observation of influential others within the social context (Bandura, 1962; Ozer & Benet-Martínez, 2006). Whatever the mode of information dissemination and acquisition, two opposing presumptions suggest that health ideals (a) crystallize at a specific point on the developmental continuum or (b) are perhaps subject to a perpetual learning curve and, thus, in a constant state of evolution.

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Interestingly, Engstrom (2004) posited the notion that to volitionally engage in any prohealth behavior that is not necessary to immediate survival is to defy the innate evolutionary tendency to remain still in an effort to conserve energy. This view has implications for prohealth maintenance as a constellation of behaviors enacted above and beyond one's threshold for the efforts required for mere survival; here, the impetus to engage in health maintenance behavior is perhaps not necessarily a manifestation of a biological need to survive, but catalyzed by a cognitive or affective desire. Therefore, an argument can be established to suggest that the adoption of a prohealth lifestyle is a matter of exerting extra energy to get to the gym, extra attention to maintaining proper nutrition, extra effort to adhere to maintaining regular sleep patterns, and essentially, not merely surviving—but thriving.

The perceived barriers to exercise maintenance are reflected in issues related to time mismanagement and an underestimation of the challenges related to balancing work and family life (Dibonaventura & Chapman, 2008). In addition, the capacity of individuals who engage in sedentary work behaviors to maintain prohealth attitudes throughout the 8, 10, 12, or more hours of the workday has become a growing concern—one that has profound economic and sociocultural implications for both employees and employers in the United States (Van Domelen et al., 2011). Given the ever-increasing prevalence of disease chronicity, in conjunction with ever-present increases in healthcare premiums (World Health Organization, 2014), a staggering 67% of the American employee populace is currently battling obesity or comorbid weight-related conditions—an approximate 35% increase in obesity-related healthcare costs since the dawn of the new millennium that accounts for over $73 billion in medical costs, productivity losses, and associated absenteeism (Archer, 2012; Yang & Nichols, 2011).

With over two thirds of all chronic diseases attributable to sedentary lifestyles, poor nutrition, and cigarette smoking (O'Donnell, 2012), such behaviors account for approximately 85% of all healthcare expenditures in the United States (O'Donnell, 2012). The grim reality of such findings is counterbalanced by the overwhelmingly positive response by employers in recent years in the form of workplace wellness (WW). Blake and Lloyd (2008) defined WW as any biopsychosocially driven modality applied within the organizational setting that promotes the health and wellbeing of employees. Given the wide variety of health issues that may impact employee wellbeing, WW initiatives include but are not limited to the promotion of weight loss, smoking cessation, personal training, health coaching, communication effectiveness, and nutrition-based programming (Archer, 2012) and have deep implications for the indoctrination of a health culture within an organization (Blake & Lloyd, 2008). In a meta-analysis of methodologically rigorous studies conducted by Baicker, Cutler, and Song (2010) that examined the impact of WW on medical costs and absenteeism over a 5-year period, funding allocated for wellness programs proved to be worth the expenditure, with an average savings in healthcare costs and absenteeism at $3.27 and $2.73, respectively—an appreciable return on investment.

From an organizational psychology standpoint, evidence shows that successful WW programming is driven by valued leadership, prohealth ideologies, participation incentives, safe assessment and screening mechanisms, and the clear avoidance of punishment contingencies (Archer, 2012). Further, the inherent characteristics of WW programming reflect two ideologically oppositional viewpoints—specifically, that WW programs are either driven by individualist (e.g., who can become healthier faster) or collectivist (e.g., we are becoming a universally healthier organization) ideals. Given work as a construct that constitutes approximately one third of daily life activity, WW programming has the potential to address needs related to time management, productivity, and health and wellbeing.

In an effort to identify the motivational substrates of WW behavior, the following discussion highlights a triadic model of social cognitive motivation theories. First, social comparison theory (Festinger, 1954) is applied to explain the extent to which individuals are driven by interpersonal evaluation, and how such analysis impacts motivation, performance, and the validation of behavioral choices. Next, need theory (McClelland, 1951, 1961) highlights the roles of affiliation, power, and achievement as drivers of in-group behavior and the extent to which such behaviors result in adherence to health behavior. Finally, self-actualization—the concluding construct in Maslow's (1954, 1970) hierarchy of needs—serves to explain how WW programming participation is first motivated by a need to optimally enhance the self and, subsequently, how such a drive toward personal potentiation could inspire individuals to effect change at the community level.

Theoretical Substrates of Workplace Wellness

Social Comparison Theory: Individual Perceptions of Collective Validity

Within the context of WW, an implicit assumption suggests that despite the prevailing collectivist attitudes of universality and mutuality (e.g., "we are all in this together"), various psychosocial variables may underpin the desire of individuals to compare their perceived status to that of others. Social comparison theory (Festinger, 1954) suggests that individuals are fundamentally driven to evaluate the extent to which their self-perceptions relate to the perceived status of others and, once acknowledged, the extent to which they will use this internal feedback to reduce uncertainty (Festinger, 1954) and validate behavioral choices. As a learning modality, social comparison has profound social cognitive and social learning foundations (Bandura, 1962; Miller & Dollard, 1941), and has significant linkages to conformity (Asch, 1955) and, more recently, self-affirmation (Steele, 1988) and self-validation (Horcajo, Petty, & Briñol, 2010).

The potential applications of social comparison to the WW milieu are many. Behavioral comparisons provide what Festinger (1954) called an "objective benchmark" (p. 118, para. 2) against which one measures their own behavior. Here, validity is a critical consideration in the social comparison framework—specifically, the belief that if others are engaging in prohealth activity, then such behavior must be rational, appropriate, and valid (Horcajo et al., 2010). Implicit within this idea is the idea of "strength in numbers" (Park & Hinsz, 2006, p. 139, para. 8), which suggests that if several people (e.g., WW participants) engage in the same type of behavior (e.g., attend WW programming) to attain a common goal (e.g., to become physically fit), then such behavior is habituated and reciprocally reinforced through group membership (Park & Hinsz, 2006). For WW participants, the ability to motivate others to engage in programming has profound implications for self-efficacy perceptions (Bandura, 1977)—a mechanism of social change agency that has profound value to leadership development (Astin & Astin, 1996).

Despite feelings of confusion and self-doubt frequently associated with initial behavior-change efforts (Prochaska & DiClemente, 1992), Festinger (1954) asserted that individuals are innately oriented toward the establishment of increasingly challenging goals and, as a consequence, seek to establish and maintain connections with those on a trajectory for advancing achievement. Therefore, while WW participants navigate the various stages of change, they perhaps engage in an unconscious search to identify with highly motivating peers. Yet, Festinger (1954) asserted that, depending upon the extent to which individuals can be influenced by their social context, social comparison has the potential to induce conformity. This engenders what are perhaps several important questions for

WW participants. First, when WW participants identify disparities between themselves and others, what factors motivate them to conform to the attitudes and behaviors of others? By contrast, what drives WW participants to attempt to convince others that their behaviors are more adaptive? How do WW participants discern what is most beneficial for themselves versus what is best for others? Festinger (1954) astutely noted that, more often than not, it is the perceived relevance, degree of attraction to others, and value of specific characteristics to one's wellbeing that ultimately catalyze the desire for change.

Need Theory: Affiliation, Power, and Achievement

Within the human motivation paradigm, the needs that drive social interaction are presumably related to the social manifestations of prohealth behavior change in the workplace. A multimodal theory that was constructed by McClelland (1951, 1961) and later advanced by Atkinson (1964) first focuses on *affiliation*, which reflects the innate need of individuals to experience perceived acceptance by others. McClelland (1951, 1961) posited the notion that individuals who possess a high need for affiliation typically go to excessive lengths to be part of a group—a view that has profound implications for group identity (Tajfel & Turner, 1979). Given extrinsic motivation as a fundamentally social phenomenon (Ryan & Deci, 2000), WW participants who possess a high need for affiliation are presumably driven by positive praise and recognition for accomplishments. However, if WW participants are overly concerned about the extent to which they feel accepted by WW peers, such a need for affiliation could undermine their primary focus: changing behavior.

The second component of need theory pertains to the role of *power* as a component of social motivation. McClelland (1951, 1961) purported that power-driven individuals possess an innate need to dominate others, invoking attributes of Nye's (1958) social control theory that suggest that control is often a manifestation of the need to ensure stability within a system. In addition, the need to exert power over others could reflect one's need to teach others, as observed within various group contexts that reflect hierarchical relationships (Tajfel & Turner, 1979). In the organizational context, lack of adherence to ingroup codes of conduct could mean ostracism and subsequent eradication from the group (Tajfel & Turner, 1979). For WW participants who embrace perceived power as a self-defining attribute, such perceptions could perhaps support efforts toward a common goal (e.g., "we are all in this group to achieve weight loss goals"), constructive social influence (e.g., shaping abilities and skills that could potentially benefit other group members), and a respect for individual differences (e.g., acknowledging the idea that not everyone will target the same health goals).

The third and final component of need theory suggests that individuals possess an intrinsic need for *achievement* (Atkinson, 1964; McClelland, 1951, 1961). Intrinsic motivation invokes aspects of self-determination theory (Deci & Ryan, 1985; Ryan & Deci, 2000), which suggests that the motivation of individuals to make choices and engage in behavior is fundamentally driven by internal, not external, stimuli. While WW participants may be highly motivated by the social engagement aspect of agency-wide wellness initiatives, their drive to attain health goals may, in fact, be entirely self-determined, regardless of external influences. Given the need of individuals to satisfy intrinsic desires and maintain idealized self-conceptions (Deci, 1971; Maslow, 1954, 1970), the extent to which WW participants experience self-dissatisfaction with their efforts to attain goals could dramatically influence the extent to which they exert continued efforts to change their behavior.

Maslow's Hierarchy of Needs: The Impact of Deficits on Motivation

For WW participants, the decision to undertake steps toward health behavior change has implications for the physiological, safety, social, esteem, and self-actualization needs posited by Maslow (1954, 1970). A sedentary lifestyle, sleep irregularities, and poor dietary choices that are often perpetuated by perceived time limitations might induce physiological distress in WW participants and, thus, provide the impetus for behavior change (Maslow, 1954, 1970). Similarly, frequent visits to the doctor for obesity-related conditions might have a negative financial impact, and subsequent negative cognitive and emotional impact, on subjective wellbeing (Maslow, 1954, 1970). While such perceptions might have implications for psychosocial stress, engagement in WW programming can potentially instill enhancements in perceived self-efficacy that lead to enhanced perceptions of safety and security.

According to Maslow (1954, 1970), the satisfaction of belongingness needs results in enhanced self-awareness and, subsequently, leads to a desire to explore aspects of self-esteem. Given the presumed impact of accomplishment and recognition on the motivation to succeed, Maslow (1954, 1970) purported that self-esteem—as a driver of goal attainment—is a manifestation of both intrinsic and extrinsic motives. In addition, McClelland's (1951, 1961) views on affiliation needs highlight the innate drive in individuals for interconnectivity (Maslow, 1954, 1970); in the work milieu, the need for belongingness has deep social cognitive implications, including but not limited to social identity (Tajfel & Turner, 1979), social comparison (Festinger, 1954), and social self-efficacy (Bandura, 1977). For WW participants, the communal sense of interpersonal connection experienced within the programming encounter has significant social change relevance; participants who receive peer support can develop the mastery and competence for skills that can ultimately be reciprocated through their newfound ability to support others. For WW participants, the combined impact of personal achievement while feeling acknowledged and valued by peers has deep implications for self-esteem and goal attainment.

At its apex, Maslow's (1954, 1970) hierarchy of needs leads to the enduring pursuit of self-actualization. The distinction between self-actualization and other hierarchical needs is the progression to existential thinking (Maslow, 1954, 1970); where the previous needs are grounded in physiology, cognition, and emotion (Maslow, 1954, 1970), self-actualization—as a potentially infinite process—is comparatively ideological in nature. Here, engagement in routine WW programming may induce participants to consider the deeper, existential implications of their participation, such as the extent to which their participation reflects their personal meaning of life, has shaped their spiritual identity, and has been adopted as a core philosophical value. For many WW participants, achieving a state of happiness and contentment with health status is an experience that could perhaps be internalized by other participants through social learning (Bandura, 1962). Finally, Frankl (1966) extended Maslow's work through his assertion that continued goal attainment leads to the continued drive toward self-transcendence—a state that, for WW participants, is ever-evolving and perpetuates the need to continually reevaluate health goals in an effort to optimize potential—perhaps in both self and others.

Conclusions and Social Change Implications

With ever-spiraling healthcare costs and significant losses in productivity impacting industries at their bottom line (Baicker et al., 2010), there is an expanding body of evidence that reflects a current

2:1 return on investment generated by WW programs in the United States (Archer, 2012). The extant literature reflects the biopsychosocial efficacy of WW initiatives (Archer, 2012; MacDonald & Westover, 2011); however, the success of such initiatives is plausibly due to its emphasis on the universal value of health behavior change—not just within the corporate culture, but across all life domains. Despite the lack of performance standards due to the relative newness of the paradigm (Archer, 2012), nationwide WW programs continue to proliferate during a period of evolution that has the potential to bridge the gap between employee performance, productivity, and health (MacDonald & Westover, 2011). As WW ideologies continue to crystallize in the organizational setting, its proponents strive to determine the most comprehensive and effective designs that elicit best outcomes (Archer, 2012). With WW initiatives projected to expand by close to 20% over the course of the next half-decade (Archer, 2012), such projections have implications for an ever-upward return on investment.

Unquestionably, WW programming strives to optimize outcomes through enhanced self-esteem (Rosenberg, 1979), self-efficacy (Bandura, 1977), and internal locus of control (Rotter, 1954). Given the central focus of WW programming on education (Archer, 2012), participants are perhaps more inclined to view their health with greater objectivity, leading to more accurate health attributions (Weiner, 1974) that result in an enhanced sense of accountability and self-responsibility. In addition, the value of group norms as a determinant of WW success is perhaps inestimable. Here, many WW participants might apply group norms as a mechanism for evaluating how their peers improve their health status; thus, such assessments could further enhance accountability for health behavior in participants (Louis, Taylor, & Douglas, 2005; Louis, Taylor, & Neil, 2004). As organizations enhance efforts to indoctrinate health as an institutional ideal (Anderson et al., 2009; Louis, Taylor, & Douglas, 2005; Louis, Taylor, & Neil, 2004), the ever-growing number of WW participants throughout organizations nationwide reflects a viable mechanism for health promotion in the corporate culture.

While the future benefits of WW programming may be exceedingly clear to employers, how do these initiatives parlay into the social change schema? While a macroperspective would perhaps suggest that WW programming will almost assuredly continue to facilitate health and wellness in the corporate milieu, a microperspective would suggest that such programs have the potential to instill the ideals of commitment, collaboration, and common purpose in those who participate (Astin & Astin, 1996). Here, participants not only commit to engagement in WW programming, but implicitly commit to exercise autonomy, enhance competencies, and promote relatedness as they affect positive change (Deci & Ryan, 1985; Ryan & Deci, 2000)—first, their lives and, subsequently, in the lives of others. As WW initiatives continue to assemble and grow in numbers, participants may consequently experience a sense of universality and collaboration with like-minded others (Astin & Astin, 1996)—phenomenological experiences that serve to decentralize individualist pursuits and, instead, underpin the belief that "we are all in this together."

As WW participants establish a network of peers who share their health and wellness vision, they begin to experience a sense of ingroup congruence (Astin & Astin, 1996)—specifically, that similar ideals (i.e., health values) are universally upheld by members of the same group. As participants begin to acknowledge the value of their behavior, they will experience an enhanced sense of cohesion with and connectedness to other participants (Tajfel & Turner, 1979). It is here that group identity emerges and is reinforced through engendering a common purpose (Astin & Astin, 1996)—an experience that will ideally inspire participants to support their community (i.e., citizenship),

motivate peers to adhere to group values (i.e., congruence), and embrace individual differences (i.e., civility)—fundamental attributes of social change agency (Astin & Astin, 1996).

As a learning mechanism, health education serves to reinforce the adoption and maintenance of the physical, intellectual, social, and spiritual ideological practices that promote health behaviors (Patterson & Vitello, 2006). By definition, health education can be conceived of as "any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions" (Joint Committee on Terminology, 2001, p. 89, para. 1). For WW initiatives, such a definition has implications for (a) how the various modes and styles of programming will be adapted to the future biological, cognitive, affective, and social needs of participants; and (b) how program administrators will use and apply participant feedback for the enhancement of program quality. It is here that WW participants not only have the opportunity to improve program characteristics for their personal benefit, but for the benefit of others—a viable opportunity for participants to exercise their social change voice within the greater community.

The increasing ubiquity of prohealth opportunities in the workplace has implications for a universal, multidisciplinary support network of health professionals who contribute to the ever-expanding health and wellbeing knowledge base. Given the current gravity of global health epidemiology (World Health Organization, 2014), there is perhaps no more critical a time in history than now to begin conceptualizing health as an investment—in both the fiscal and evolutionary sense. Yet, humanistic ideologies dictate that for all of the money saved, bodies conditioned, productivity increased, and goals attained, the true power of WW programming perhaps resides in its capacity to phenomenologically shift the paradigm from the optimization of individual wellbeing to collective wellbeing. Extending this view, it can be assumed that healthier people are happier employees who will ideally treat their colleagues with fairness and respect, will become increasingly aware of their capacity for change, and will be inspired to positively impact the lives of others. As empowering mentors, guides, and role models who possess the potential to affect positive outcomes, the WW experience is an existential conduit for instilling the fundamental attitudes, values, and behaviors that underpin social change agency.

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