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Health and well-being at work: The key role of supervisor support

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ABSTRACT

This study aims to explore whether and in what way social support from different sources and domains makes an additional or different and independent contribution to various health and work-related outcomes. Cross-sectional data were used from an employee survey among the workforces of four service companies from different industries in Switzerland. The study sample covered 5,877 employees of working age. The lack of social support from a spouse, relatives, friends, direct supervisors, closest colleagues at work and other co-workers in case of problems at work and at home were assessed and studied individually and jointly as risk factors with respect to a total number of eight outcomes. Health-related outcomes covered poor self-rated health, musculoskeletal disorders, stress feelings and burnout symptoms. Work-related outcomes included feeling overwhelmed at work, difficulty with switching off after work, job dissatisfaction and intention to turnover. Social support from multiple sources in contrast to only individual sources in both life domains was found to be more frequent in women than in men and proved to be most protective and beneficial with regard to health and well-being at work. However, after mutual adjustment of all single sources of social support from both domains, a lack of supervisor support turned out to be the only or the strongest of the few remaining support measures and statistically significant risk factors for the studied outcomes throughout and by far. Being unable to count on the support of a direct supervisor in case of problems at work and even at home was shown to involve a substantially increased risk of poor health and work-related outcomes (aOR = up to 3.8). Multiple sources of social support, and particularly supervisor support, seem to be important resources of health and well-being at work and need to be considered as key factors in workplace health promotion.

Introduction

Considerable research has been carried out over the past few decades on the role and contribution of social support, social relationships or social networks to and in the context of health and well-being, particularly with regard to disease and mortality (see inter alia Berkman, Glass, Brissette & Seeman, 2000; Berkman and Syme, 1979; Holt-Lunstad, Smith, & Layton, 2010; Kawachi and Berkman, 2001; Schwarzer and Leppin, 1989; Uchino, 2006; Uchino, 2004). Social support of different types (emotional, functional or instrumental, structural) and from different networks (personal, professional, community) or sources (family or relatives, spouse, friends, neighbors, supervisors, co-workers, the organization) and from different domains (work, home or non-work) has turned out to have positive or protective effects on general, physical and mental health as well as on psychological or emotional and occupational well-being.

Numerous studies suggest that social support is (directly) linked and (causally) related to health in general (Holden, Lee, Hockey, Ware & Dobson, 2015; Kumar, Calvo, Avendano, Sivaramakrishnan & Berkman, 2012; Uchino, Bowen, Carlisle & Birmingham, 2012; Van Woerden, Poortinga, Bronstering, Garrib & Hegazi, 2011; Wright, 2006) and positively associated with physical health (Barth et al., 2010; Fiori and Jager, 2012; Uchino, 2009), and with mental health in particular (Kawachi and Berkman, 2001; Plaisier, de Bruijn, de Graaf, ten Have, Beekman & Penninx, 2007; Sinokki et al., 2010; Sinokki et al., 2009). Previous studies and reviews also indicated that (perceived) social support even protects from cardiovascular disease and all-cause mortality (Barth et al., 2010; Brummett et al., 2005; Uchino, 2006). So it is widely undisputed and strongly evident that social support is generally – although not always – beneficial for health (and health behavior).

Since most studies on health effects of social support focus on support from close relations, personal networks or confidants such as a spouse or closest friend who are believed to play the most important role in this regard, evidence about other and multiple sources of social support and their effects on health and well-being is limited and scarce with few exceptions (see inter alia Fuhrer and Stansfeld, 2002; Li et al., 2014; Van Daalen et al., 2005; Van Daalen et al., 2006; Van Woerden et al., 2011). Nevertheless, different sources of social support were found to have different effects on health and well-being in different populations or social groups (Li et al., 2014; Van Woerden et al., 2011).

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Counting on multiple sources of support seems to be more characteristic of women, while men report receiving more but rather exclusive support from a closest person who is most often their spouse (Fuhrer and Stansfeld, 2002). And since network size and number of contacts and relationships were found to be associated with greater availability of social support (Seeman and Berkman, 1988), multiple sources of support likewise are expected to have a greater potential for providing support than individual sources as they presumably go along with a larger network and number of relationships.

Apart from positive health effects, social support seems to be equally beneficial for well-being at work. In particular, social support has been shown to reduce job stress (Beehr, Farmer, Glazer, Gudanowski & Nadig Nair, 2003; Oginska-Bulik, 2005), to enable people to cope better with or provide a buffer against specific job demands or work stressors such as work and time pressure (Willemse, de Jonge, Smit, Depla & Pot, 2012) or work-family conflict (Carlson and Perrewé, 1999; Kossek, Pichler, Bodner & Hammer, 2011; Selvarajan et al., 2013; Van Daalen et al., 2006), to increase job satisfaction (Willemse et al., 2012), to improve job performance (Nagami, Tsutsumi, Tsuchiya & Morimoto, 2010), to prevent turnover intention (Galletta, Portoghese, Penna, Battistelli & Saiani, 2011), to protect from burnout (Jenkins and Elliott, 2004; Gibson et al., 2009) and from work-related musculoskeletal ill-health and associated absence due to sickness as well as early retirement (Woods, 2005).

Many studies have looked at (a lack of) work-related sources of social support and their direct or moderating effects on health and work-related well-being such as job stress, job satisfaction, job performance, turnover intention or work-family conflict (Beehr et al., 2003; Galletta et al., 2011; Gibson et al., 2009; Jenkins and Elliott, 2004; Kossek et al., 2011; Nagami et al., 2010; Nakata et al., 2004; Selvarajan et al., 2013; Willemse et al., 2012). Social support at work comes mainly from supervisors or co-workers. Low supervisor support has been shown to increase the risk of mental health problems and particularly of depressive and anxiety disorders (Sinokki et al., 2009) or severe depressive symptoms (Rugulies, Bültmann, Aust & Burr, 2006). (Perceived) supervisor support has been found to be additionally and positively associated with job satisfaction (Galletta et al., 2011; Willemse et al., 2012), negatively and strongly correlated with emotional exhaustion (Willemse et al., 2012), burnout (Gibson et al., 2009), anxiety and psychological strain (Beehr et al., 2003), and turnover intention (Galletta et al., 2011). Co-worker support was shown to be positively related to job performance (Nagami et al., 2010) and negatively to job dissatisfaction and psychological strain (Beehr et al., 2003) or insomnia (Nakata et al., 2004).

Only very few studies have examined the effects of social support from work-related and non-work-related sources simultaneously (Jenkins and Elliott, 2004; Van Daalen et al., 2005; Van Woerden et al., 2011). And even less interest has been devoted to both health and work-related outcomes in case of difficulties at home as well as problems at work. This is presumably the first study to compare the significance and independent contribution of social support from two domains or settings (support from reference persons in private and work life) and six sources (spouse, friends, relatives, supervisors, closest colleagues at work and other co-workers) in two different situations (in case of problems at work and at home) with regard to a number of poor outcomes in the fields of health and work.

The research questions addressed in this study include the following:

- Do multiple sources of social support from different domains and reference persons produce and provide more (perceived) support and therefore result in better health or more health protection and better well-being at work than individual sources?
- Which sources or reference persons in which situations (problems at home or at work) matter most in this respect, i.e. are most supportive and protective with regard to poor health and work outcomes?

Methods

Data and study sample

The study was based on cross-sectional data collected in 2007 from a large-scale employee survey carried out among the workforces of four large and medium-sized service companies from different industries (insurance, banking, transportation, and healthcare). The participating companies were a multinational reinsurance company, a large Swiss bank, a global cargo and aircraft ground-services company, and a large public hospital in the canton of Zurich. In one company (hospital), a stratified random sample of the personnel was taken. In all other companies, full samples were used. The response or return rates among the four companies ranged from 35% to 68% with an average return rate of 56%. The transportation company recorded the lowest return rate by far (34.8%), followed by the hospital (52.3%), the insurance company (55.0%) and, finally, the banking company (67.5%) with the highest return rate by far. The sizes of the subsamples varied strongly between the four companies, or rather industries, due to differing workforce sizes and participation rates: banking (n = 3,127), insurance (n = 1,696), transportation (n = 766), healthcare (n = 502). In total, the aggregate sample covered a number of 6,091 employees from all hierarchical levels or job positions and various professions. In particular, the large and heterogeneous survey population included blue-collar workers such as unskilled baggage porters or cleaners as well as white-collar workers such as private and investment bankers or risk managers as well as highly qualified healthcare workers such as physicians or therapists. The sample selected for this study was limited to those 5,877 respondents who gave answers on their sex, age and education.

Compared to a nationally representative standard population of employees, i.e. a weighted random sample of the resident and employed population in Switzerland aged 15 to 65 from the 2007 data collection of the Swiss Household Panel (see Table 1), university graduates and other highly educated employees are strongly over-represented in the survey population. The same applies to executive employees, full-time employees and Swiss citizens. Men are also disproportionally represented in the study sample compared to the standard population.

Measures

Social support

The way in which social support is conceptualized, defined and measured often varies between studies (Reblin and Uchino, 2008, Schwarzer and Leppin, 1989). Social support in this study and the underlying survey was measured by a series of dichotomized yes/no questions about both the emotional and instrumental support (understanding, practical help, advice) given by confidants, peers or reference persons (spouse, friends, relatives, supervisor, closest colleague at work and other co-workers) in case of problems or difficulties a) at work, and b) at home (or in private life). Participants were asked about their perceived rather than actually received social support from these sources. This distinction is important since perceived support refers to a person's potential access to or perception of the availability of assistance or help from other people if needed, whereas received support refers to the reported actuality or offer of assistance or help (Uchino, 2009).

Questions of the two 6-item measures on perceived support in case of problems at home and at work were taken and adapted from the so-called and much-noticed Stress Study, a nationally representative telephone survey in Switzerland on the costs and covariates of stress that has been conducted for the first time in 2000 (and repeated in 2010) on behalf of the State Secretariat for Economic Affairs.

Questions and items were fully adopted from this survey and its questionnaire while response scales were dichotomized (yes/no) from