Work–Family Balance Issues and Work–Leave Policies

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Work–Family Balance Issues

The contemporary US workforce differs dramatically from that of the mid-twentieth century, yet workplace structures and human resource policies and practices addressing work–family balance issues have changed relatively little. Moreover, technological, economic, and globalization forces are reducing job security, while simultaneously increasing productivity expectations and time pressures for those who retain their jobs (Kossek, Lewis, & Hammer, 2010). Employees are increasingly subjected to greater job demands and are asked to be available to work all hours of the day and all days of the week, often with neither schedule consistency (Kossek, 2006; Presser, 2003) nor schedule control (Kelly & Moen, 2007). With the majority of women in the paid workforce, relatively stable fertility levels, increases in single-parent families, and an aging population, many workers are confronted with the need to care for family members while coping with increased work demands. In the USA, few public and limited private sector policies enable workers to balance the dual needs of work and family. The resulting disconnect has increased work–family conflict (Nomaguchi, 2009), a type of

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inter-role conflict where work and family roles are incompatible (Greenhaus & Beutell, 1985), resulting in reduced employee, family, and community health and well-being (Allen, Herst, Bruck, & Sutton, 2000; Bianchi, Casper, & King, 2005; Christensen & Schneider, 2010; Eby, Casper, Lockwood, Bordeaux, & Brinley, 2005; Kossek et al., 2010). Moreover, increased job insecurity, high unemployment, and declining wages for men, along with shifts in gender roles, have generated a steady increase in the proportion of wives and mothers engaged in paid market labor outside the home (Casper & Bianchi, 2002; Sayer, Cohen, & Casper, 2004). In most households with children, all adults are in the workforce, and dual-earner families must coordinate the schedules of two jobs along with responsibilities at home, with no member solely dedicated to family needs (Chesley & Moen, 2006; Jacobs & Gerson, 2004; Moen, 2003; Moen & Hernandez, 2009). To add even more complexity, in 2010, almost seven million Americans (ages 16 and older) were working two or more jobs (Bureau of Labor Statistics, 2011b). Role incompatibility is especially experienced by parents of children who are too young for elementary school, and by families with older relatives who need care (Casper & Bianchi; Moen & Chesley, 2008; Moen & Roehling, 2005).

Increasing rates of nonmarital childbearing and high levels of divorce also result in more single-parent families that have fewer adults available to fulfill work and caregiving obligations (Casper & Bianchi, 2009). Nonmarital childbearing comprised only 10 % of all births in the 1960s, but recent estimates indicate that 40 % of births are now to unmarried mothers (Hamilton, Martin, & Ventura, 2009). Divorce probabilities remain high; about one-third of marriages last less than 10 years, and only about half of married couples are still together at their 20th anniversary (Goodwin, Mosher, & Chandra, 2010). In 1970, 6 % of family households with children were maintained by a single mother,

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and 1 % by a single father. By 2007, these figures were 23 and 5 %, respectively. When cohabiting couples are excluded from the tally of single parents, current estimates suggest single parents account for about one quarter of households with children under 18 (Kreider & Elliott, 2009). Additional shifts in demographic behaviors, such as delayed or foregone marriage and postponed or reduced childbearing, also reflect the growing incompatibility between jobs and families. Young adults increasingly delay marriage—in 2009, the median age at first marriage rose to 28 years for men and 26 years for women (US Census Bureau, 2010). Greater demands of work in terms of both time and energy also result in the postponement of children, especially among the better educated segments of the population. Currently, 20 % of American women aged 40–44 have never had a child, double the percentage of 30 years ago (Dye, 2008). Research that tracked a highly educated cohort of women from 1979 until the end of their childbearing years showed that the women's stated intentions averaged about half a child more than their completed fertility, suggesting that they may have had difficulty reaching their childbearing goals (Morgan, 2010). A plausible explanation for this trend is the demanding nature of jobs highly educated women and their partners are likely to occupy.

Care demands are also heavy for "sandwich" families, who must provide care for young and old alike (Casper & Bianchi, 2002; Neal & Hammer, 2007). Increased mobility for education and employment takes many families geographically away from extended family and other childhood social support networks. Future generations of elderly are likely to have fewer of their own children on whom they can rely for care. At the same time, the number of step-children is expanding due to high levels of union disruption and repartnering. Thus, caregiving is likely to be shared among fewer adult siblings and those who may be more tenuously related. These changes in working families suggest the need for policies promoting greater workplace flexibility and leave access to provide care in circumstances where backup from other family members is becoming less likely (Bianchi et al., 2005; Christensen & Schneider, 2010; Executive Office of the President Council of Economic Advisors, 2010). In addition, the aging US population is another factor pushing workplace flexibility to the forefront of national discussions. The fraction of the population aged 65 and over is projected to increase from the current 12 to 20 % in 2030 (He, Sengupta, Velkoff, & DeBarros, 2005). Older workers may be driven from the workforce earlier than their health dictates by overly demanding jobs or work schedules that do not allow them to fulfill the care needs of aging companions (Dentinger & Clarkberg, 2002; Moen, 2007; Moen & Altobelli, 2007; Sweet, Moen, & Meiksins, 2007). Older workers in full-time jobs with little schedule flexibility risk experiencing both health and safety difficulties (National Research Council and the Institute of Medicine, 2004). New ways of work that incorporate flexibility and part-time possibilities may enable older workers to remain actively engaged. Thus, employees face a variety of stressful situations that lead to work–family balance issues: time deadlines and speedups, increased workloads and overloads, dual-earner and single-parent conflicts and strains, and even routine obligations at work and home are often at odds with one another. Individuals and families may have exhausted their ability to rearrange their lives to fit the existing social organization of work, and so examining workplace policies and practices that can address the dual demands of work and family becomes a priority.

Work–Leave Policies

In the USA, the primary responsibility for providing release time from work responsibilities rests with companies and employers (Kelly, 2005; Stebbins, 2001). The federal government oversees employer compliance with legislation such as the Fair Labor Standards Act and protections such as nondiscrimination requirements, but the enactment of work–leave policies beyond the Family and Medical Leave Act (FMLA) are left to states and municipalities. Most current work-hour and supervisory poli-

cies and practices were designed in the mid-twentieth century, with the unstated assumption that employees have few nonwork responsibilities since another family member, usually the wife, primarily handles the home responsibilities (Moen & Chesley, 2008; Moen & Roehling, 2005; Neal & Hammer, 2007; Perlow, 1997; Rapoport, Bailyn, Fletcher, & Pruitt, 2002; Williams, 2000). Standard types of employer-provided leave in contemporary US workplaces are sick and annual. Sick leave is intended to cover an employee's time needed to obtain medical care for himself/herself, and possibly for dependent family members. Annual leave is intended to cover vacations or other leisure time. Some companies simply offer "personal time off (PTO)" that the employees may use at their discretion for any purpose. These types of leave are invaluable for the households with all adults in the workforce; but there are often restrictions on these types of leave that limit their usefulness for handling work–family balance issues. Annual leave often requires advance approval, which eliminates its use in emergencies. Sick leave is often restricted to the employee themselves, or may be utilized only as entire days rather than on an hourly basis, in which case follow-up visits for a single illness may use up an entire year's allotment. Additionally, access to these types of leave options varies substantially by occupation and wage level, with lower wage and manufacturing or production industries having the least access (Crouter & Booth, 2009). Strikingly, 30 % of American workers lack access to sick and annual leave, and approximately 60 % lack access to nonspecific paid personal time off (Bureau of Labor Statistics, 2011a). Moreover, in 2008, 21 % of US employees had no access to paid vacation days, 37 % had fewer than 5 days of paid personal sick leave (including those with no leave), and 37 % of those with children had fewer than 5 days of paid time off to care for sick children (Tang & Wadsworth, 2010).

The most recently enacted national leave legislation was the FMLA, passed in 1993. It mandates that employers with 50 or more employees provide up to 12 weeks of unpaid sick leave annually for workers to use for themselves or dependent family members. The employer must allow employees to return to their same or a similar job at the same pay and benefits. The mandate provides a right to take leave to the subgroup of US workers who work for large employers and can afford to not receive wages for a period of time. In recent years, some states and municipalities (e.g., Connecticut; San Francisco, CA; Washington, D.C.) have passed paid sick leave mandates for employers within their jurisdictions. The California Family Leave Act is a unique program that uses the workman's compensation model to provide up to 6 weeks of partially paid leave to bond with a new child or care for a parent, child, or spouse/domestic partner. Workers pay into the State Disability Insurance (SDI) program through their regular paychecks. All workers who pay in are eligible, regardless of full-time or part-time status, and benefits are paid out as a percent of wages. However, workers must still rely on provisions from the FMLA or the state-level California Family Rights Act to protect their job (information from www.working-families.org/learnmore/ca_family_leave_guide.pdf.) The success of the program thus far has been difficult to evaluate because public awareness is low, which has resulted in minimal use (Schuster et al., 2008).

Currently, at the federal level, President Obama created The White House Forum on Workplace Flexibility within The White House Council on Women and Girls (www.whitehouse.gov/work-flex-kit). A kickoff event in March 2010 brought together representatives from academic and practitioner professional societies, advocacy groups, and employers. The program has since hosted multiple regional forums to encourage dialogue and action at the local level. A report from the Council on Economic Advisors details the potential economic benefits of workplace flexibility, including paid leave (www.whitehouse.gov/files/documents/100331-cea-economics-workplace-flexibility.pdf).

While public policy moves slowly forward, some employers and unions have made changes at their own initiative. Over the past few decades, organizations have adopted "family-friendly" or "work-life" policies, although these initiatives are often implemented unevenly across and within organizations (Eaton, 2003; Kelly & Kalev, 2006; Kossek et al., 2010). These policies include a range of strategies: time-based (e.g., flexible schedules and leave programs), information-based (e.g., referral programs

and provider fairs), money-based (e.g., dependent care spending accounts), and direct services (e.g., on-site child care) (Thompson, Beauvais, & Allen, 2006). However, even when worker supportive policies are implemented in US companies, the existence of a policy does not necessarily translate into an employee's ability to access it in practice. Work–family policies are often treated as accommodations available to some employees—often those with a record of superior performance—rather than work process adaptations useful to a wide range of employees (Kelly & Moen, 2007; Lee, MacDermid, & Buck, 2000; Williams, 2000). As a result, employee usage of these policies and practices is low; workers fear, and often experience, career penalties such as slower wage growth as a consequence of using them (Blair-Loy & Wharton, 2002; Glass, 2004). Finally, work leave policies and "family friendly" policies may effectively substitute for each other. For example, employees may not require sick leave if flexible hours allow them to shift their schedules around a physician's appointment. Telework may also alleviate the need for annual leave to be present in the home with an older child on a school holiday. Because of the range of policy levers and practices utilized by organizations, we include work–leave policies and other work supportive policies within a larger umbrella of work–family policies for the remainder of this Chapter.

Testing a Biopsychosocial Model of Work–Family Balance and Health

Rigorous evaluations of how policies and programs affect work–family balance issues are rare (for some exceptions, see Hammer, Neal, Newsom, Brockwood, & Colton, 2005; Hammer, Kossek, Bodner, Anger, & Zimmerman 2011; Kelly, Moen, & Tranby, 2011; Thomas & Ganster, 1995). Few studies have systematically modeled the pathway from the reduction of work–family conflict to improved health, and most have not included the psychosocial mechanisms by which these factors affect health across work units and at home (see Bianchi et al., 2005; Kelly et al., 2008; Melchior, Berkman, Niedhammer, Zins, & Goldberg, 2007). Health interventions usually focus on changes at the individual level, and rarely include organizational-level changes such as work process designs (Rapoport et al., 2002). No study, to our knowledge, has tested the existence of a causal relationship between workplace-level policies and practices, work–family conflict, employee health, and organizational health in a longitudinal, experimental design. Furthermore, none has investigated how such policies and practices may have implications for the health of family members. The Work Family and Health Network (WFHN), a multisite longitudinal randomized field experiment, currently underway, was designed to address this scientific gap. The WFHN is a collaborative network of researchers, formed with grant support from several federal government agencies and foundations, to design and test an innovative psychosocial intervention aimed at reducing work–family conflict in order to improve physical and mental health (www.workfamilyhealthnetwork.org). The WFHN comprises research expertise in a wide array of disciplines: biobehavioral health; demography; developmental psychology; economics; industrial/organizational psychology; medicine; occupational health psychology; organizational behavior; social epidemiology; sociology; study design, methodology, and data collection; and the science of translation and dissemination. For its first 3 years (2005–2008), the WFHN conducted observational and intervention pilot studies with hourly workers in the long-term nursing care, hotel, and grocery industries, and in the white-collar headquarters of a multinational, retail corporation. The observational studies examined basic biopsychosocial processes through which workplace conditions affected work–family balance which impacted employee health. These researchers collected data on current usual workplace practices in these industries and examined their associations with objectively measured health, self-reported health, family relationship quality, and workplace outcomes. In the long-term care setting, employees' cardiovascular risk and sleep patterns were associated with supervisors' management of work–family balance issues (Berkman, Buxton, Ertel, & Okechukwu,

2010; Ertel, Koenen, & Berkman, 2008). The study in the hotel industry used a daily diary design to understand the daily stressors and reactivity to stress experienced by hotel managers and hourly employees. In order to extend the conceptual model to the social unit of the family in order to understand how daily work and family experiences can influence one another, the study added data collection with the hotel managers' spouses and hourly employees' children. There, a lack of workplace flexibility was associated with both greater daily stressor exposure and reactivity in the employee, as well as greater potential for stress transmission from employees to their children (Almeida & Davis, 2011; Davis, 2008). These findings also demonstrated the importance of managerial support for employee work–family integration (O'Neill et al., 2009). Other research teams tested interventions that changed policies and practices around work demands and control and workplace social support from supervisors and colleagues. These interventions aimed at all levels of prevention (primary, secondary, and tertiary), as they were designed to prevent work–family conflict among those not yet experiencing it and to ameliorate work–family conflict among those already strained by it. These studies together generated evidence to support a causal relationship between work–family policies, work–family balance issues, and employee health across different populations. The first intervention changed both structure and culture in the workplace in order to increase employees' control over the time and timing of their work. The goal of the intervention was to orient work-group culture away from emphasizing time spent on work activities and toward results achieved (Kelly et al., 2011; Kelly, Ammons, Chermack, & Moen, 2010; Moen, Kelly, & Hill, 2011). The pilot study in the retail corporate headquarters (www.rowe.iambestbuy.com) confirmed that employees in the intervention groups reported greater schedule control, lower levels of negative work-to-family spillover, better sleep, more energy, and better health management (such as seeing a doctor when sick; Kelly et al., 2011; Moen, Kelly, Tranby, & Huang, 2011). This study also showed that reduced work–family conflict improved employee health behaviors and reduced behavioral pathogens (Moen, Kelly, Tranby et al., 2011). Research has also shown that functionally impoverished environments—those lacking in socially supportive interactions—influence a range of negative health outcomes (Taylor, Repetti, & Seeman, 1997). Therefore, a second set of interventions increased supervisors' social support for work–family balance issues. In the grocery industry, managers received training in interpersonal processes, and participated in self-monitoring of their subsequent behaviors. Employees whose supervisors received the family-supportive training had improved reports of physical and mental health, self-reported sleep quality, lower turnover intentions, less actual turnover, and better performance appraisals than employees whose supervisors were in the control group (Hammer et al., 2011; Hammer, Kossek, Yragui, Bodner, & Hansen, 2009; Kossek, Hammer, Michel, Petty, & Yragui, 2009). Significantly, the first intervention study provided evidence for a mediational model in which changes in workplace policies reduce stress from work–family conflict, and this decrease in work–family conflict then leads to increased time adequacy, increased hours of sleep, and improved health behaviors (Kelly et al., 2011; Moen, Kelly, Tranby et al., 2011). The second intervention demonstrated that enriching the social environment improved self-reported physical health for workers with high levels of work–family conflict, a moderated meditational model (Hammer et al., 2011).

The Work, Family, and Health Network Theoretical Model

Based on these above pilot results, an interdisciplinary literature review (Kelly et al., 2008), and previous scholarship by network members, the WFHN created a theoretically and empirically derived biopsychosocial model (see Fig. 15.1). The model represents the critical indicators and causal pathways linking an intervention to increased employee temporal control within the context of family-supportive supervision and job redesign. Figure 15.1 presents the core components of this theoretical model.

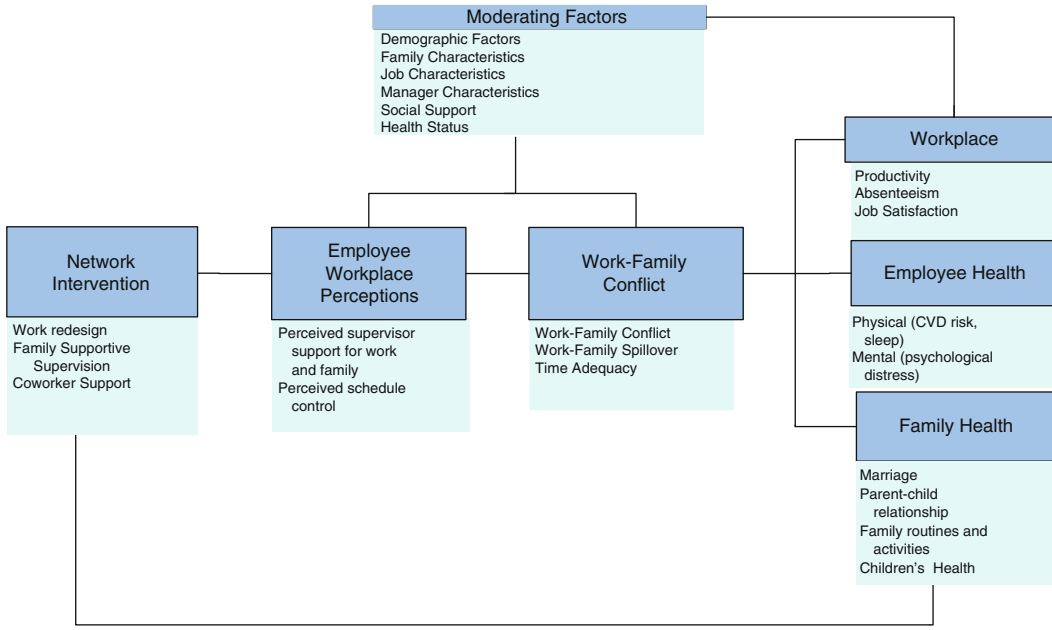

Fig. 15.1 Work, family, and health conceptual model

We theorized that a successful intervention will influence employee perceptions of control and support and reduce work–family conflict, which will improve the health and well-being of employees and their families. We linked the health of the work environment stress, health outcomes for the individual, and the health quality of the individual's work and family social environments (Taylor et al., 1997). The reduction of this stressor should also improve workplace outcomes such as productivity, absenteeism, turnover, and overall job satisfaction. We hypothesized that moderating factors affecting work–family conflict and the intervention's effectiveness include: demographic characteristics; job, family, and manager characteristics; employee health; and social support outside the workplace.

Workplace Intervention and Work–Family Conflict

The evidence discussed above suggests that supervisors' support for family and personal life, as well as employees' control over their work time, is a crucial component for interventions to reduce work–family conflict. Theory from a number of disciplines (Bronfenbrenner, 2005; Karasek & Theorell, 1990; Landsbergis, 1988) postulates an orthogonal relationship between employee schedule control and social support, and that, within the context of reasonable demands, both together produce healthy environments that encourage individual development and well-being. The Network intervention is not a one-size-fits-all or one-time treatment but, rather, a facilitated process in which supervisors and employees look carefully at current supervisory and temporal practices, and then identify concrete changes that may improve their work conditions to ameliorate work–family conflict. The intervention is designed to prompt reflection and improve workplace practices regarding two questions: (1) What concrete actions can work groups take to increase the control team members have over when, where, and how work is done (i.e., hours and/or predictability) while simultaneously meeting business goals? (2) What concrete actions can supervisors take to demonstrate their support of employees' lives and family responsibilities? Workplace change efforts should focus on improving these constructs to

generate measureable change in outcome measures. Specifically, this workplace intervention consists of: (1) a *work redesign*; and (2) increasing *support* from supervisors and coworkers. Both supervisor training and work redesign promoting flexibility occur in the context of an organization's existing policies, regulations, staffing strategies, and financial constraints. Some organizational constraints may be reevaluated in light of the intervention while others, such as collective bargaining agreements, are less amenable to change in the short-term. Family-supportive supervisor training, coupled with actions to ensure transfer of training, such as behavioral self monitoring, provides supervisors with managerial tools to assist employees as they gain more control over their work time. Previous research has found wide variability in supervisors' implementation of flexible work and scheduling policies (Blair-Loy & Wharton, 2002; Hammer, Kossek, Zimmerman, & Daniels, 2007; Kelly & Kalev, 2006; Kossek, 2005). It is therefore essential to teach supervisors how to enable greater schedule control and facilitate greater social support on the part of their employees.

The proposed work redesign initiative is innovative, compared to customary flexible work arrangements (Kelly & Moen, 2009; Moen, Kelly, & Chermack, 2009). It aims to change the organizational structure by having employees and managers focus solely on the desired result of an assignment, not the time that employees spend at the workplace. Employees are instructed that they now have autonomy to decide when and where they work so long as they are meeting their objectives and contributing to their team's goals and effectiveness. Unlike typical arrangements that may accommodate individual employees, this redesign process is implemented by work groups ("teams" of employees and supervisors). Interactive training sessions guide each work group through a critical assessment of their traditional work culture; prompt group members to clarify specific work outcomes and expectations; and help group members identify new strategies for meeting job expectations while providing employees more control over their work time. Measurable changes resulting from the intervention are expected to include increases in employee schedule control, changes in organizational systems supportive of employee time control, changes in managerial self-awareness and supportive behaviors, and changes in employee behavior and organizational citizenship. We hypothesize, as depicted in our model (Fig. 15.1), that the intervention effects are mediated through employee perceptions of the support that the supervisors and coworkers provide (Hammer et al., 2007), and the perceived schedule control they have over the timing and location of work (Kelly & Moen, 2007). These perceptions about the psychosocial work environment then affect employees' experience of work–family balance (Kelly et al., 2008). Changes in workplace behaviors and work-time expectations may also directly affect more objective measures, such as the proportion of schedule changes that are initiated by employees versus managers and turnover.

Work–Family Conflict and Workplace Outcomes

Meta-analyses and reviews show that work–family conflict is significantly correlated with higher work stress, turnover intentions, absenteeism, and family stress (Allen et al., 2000). It is also correlated with lower family, marital, life, and job satisfaction, and lower organizational commitment and productivity (e.g., Allen et al.; Eby et al., 2005; Kossek & Ozeki, 1998). Recent research has demonstrated that higher levels of work–family conflict are also related to lower levels of participation in workplace safety procedures (Cullen & Hammer, 2007). Negative stress in the workplace also creates consequences for businesses, including reduced employee productivity and increased turnover (e.g., Grandey & Cropanzano, 1999; Kelly et al., 2008; Moen & Huang, 2010; Moen, Kelly, & Hill, 2011; Netemeyer, Boles, & McMurrian, 1996; O'Neill & Davis, 2011). Outcomes in our model for employers include turnover, absenteeism, productivity, higher job satisfaction of workers, better safety compliance, and return on investment (ROI). Employers will not implement new policies and practices,

unless they can ensure that the benefits of the implementation outweigh the costs, or that there is a positive return on investment.

Work–Family Conflict and Employee Health

Work–family conflict is correlated with both the mental and physical health of employees (Frone, Russell, & Cooper, 1997). Over time, the effects of work–family conflict appear in objectively measured and self-reported health indicators, such as high blood pressure (e.g., Belkic, Landsbergis, Schnall, & Baker, 2004; Landsbergis et al., 2002), sleep complaints (Lallukka, Rahkonen, Lahelma, & Arber, 2010), and other mental and physical health problems (Frone, 2000; Ganster & Schaubroeck, 1991; Greenhaus, Allen, & Spector, 2006; Grzywacz & Bass, 2003). A recent national study showed that increases in work–family conflict predicted increases in the number of chronic health conditions and self-rated health problems over a 10-year period (Dmitrieva, Baytalskaya, & Almeida, 2007). Negative work-to-family spillover, when an individual's experiences at work continue to affect him or her even after leaving the worksite, is related to lower self-reported health status, more chronic disease, and higher levels of dysphoria, psychological distress, and sickness absence (Grzywacz, 2000; Vaananen et al., 2004). Limited research has also examined the implications of work–family conflict for health behaviors. However, researchers have demonstrated a link between work pressure and problem drinking (Grzywacz & Marks, 2000; Roos, Lahelma, & Rahkonen, 2006), and heavy alcohol and cigarette use (Frone, Barnes, & Farrell, 1994). In addition, Grzywacz and colleagues (2007) found promising support that workplace flexibility can contribute to healthy lifestyle behaviors, including better sleep habits and participation in stress management practices. Furthermore, higher job control has been linked to more regular physical activity (Grzywacz & Marks, 2001). We hypothesize that these effects work in much the same way as classical job strain measures based on high demand and low control. Often, low workplace support has impacted a host of outcomes, especially cardiovascular-related outcomes (Karasek et al., 1998). Health outcomes included in our model for employees include cardiovascular risk, sleep behaviors, tobacco and alcohol use, other indicators of chronic conditions and function, and mental health (e.g., psychological distress, depression).

Work–Family Conflict and Family Outcomes

Drawing from an emotional transmission paradigm (Larson & Almeida, 1999) and family systems theory (Cox & Paley, 1997), our model also considers that employees' work experiences can spill over into their home lives and cross over to their family members' health. Families are a nexus of social exchanges, and the emotional tone of family interactions varies in intensity and valence in ways that have implications for family members' individual well-being and family relationships (Repetti, Taylor, & Seeman, 2002). Extant research has demonstrated that workplace stressors can spill over to family life and strain parent–child and marital relationships evidenced by more conflict or withdrawal (Almeida, Wethington, & Chandler, 1999; Crouter, Bumpus, Head, & McHale, 2001; Repetti, 2005). Furthermore, time conflicts between work and family can interfere with families' daily routines and activities, such as family meals and effective parenting. For example, McLoyd and colleagues (2008) found that among single mothers, work demands were linked to higher work–family conflict which, in turn, was associated with fewer family routines. Family routines provide children with a sense of family cohesion, intimacy, and stability that are important for psychological well-being and for buffering the effects of daily stress (Fiese, Foley, & Spagnola, 2006; Jacob, Hill, Mead, & Ferris, 2008). Family relationship quality and satisfaction are important not only for individual family members'

well-being, but also their experiences at work; there is evidence of spillover from family to work, an often neglected side of the work–family interface (Dilworth, 2004). Growing evidence suggests that the stress employees experience on the job can also cross over to family members. Crossover occurs when the stress and strain of an individual are then experienced by another person in the course of social interactions (Westman, 2001). For example, increased work–family conflict is associated with depression among spouses (Hammer, Allen, & Grigsby, 1997; Hammer, Cullen, Neal, Sinclair, & Shafiro, 2005). Most of the crossover research focuses on spouses (e.g., Hammer et al., 1997; Westman; Westman, Etzion, & Horovitz, 2004), but some research also shows crossover from parents to children (Crouter, Davis, Updegraff, Delgado, & Fortner, 2006; Davis, 2008; McLoyd, Toyokawa, & Kaplan, 2008), and even the children's caregivers (Kossek, Pichler, Meece, & Barratt, 2008). Davis' daily diary study (2008) of female hourly hotel workers and their children demonstrated that work stressors on a given day were associated with boys' lower positive affect that same day. Therefore, based on existing research and family theory, outcomes in our model for family health include marital relationship quality, parent–child relationship quality, effective parenting practices, family routines, and children's psychological and physical health.

Moderating Factors

The links between working conditions (and changes in them), work–family conflict, and health-related outcomes occur in particular social-locational contexts. Accordingly, our model includes the potential for moderating effects. Demographic factors, such as gender, marital status, race, age or life stage, and socioeconomic status, shape family status, the types of jobs people hold, and their health (Casper & Bianchi, 2002). They are also associated with the contexts in which people deal with work and family issues. For example, low wage employees and those in poor neighborhoods are less likely to have access to goods and services that would lessen work–family conflict and improve health. Other factors affecting employees' abilities to manage work–family conflict might include the degree of social support they have in their families and communities and family characteristics, such as the number of children and adults in family or the presence of a disabled family member. These factors help to define the number and types of work–family issues that arise and the availability of others who can be counted on for help should assistance become necessary. The health of employees is also likely related to their ability to perform work and family duties. Manager characteristics may affect employees' level of work–family conflict and their health, irrespective of the job characteristics and the intervention being applied. Thus, moderators in our model include demographic and contextual factors, social support, family characteristics, health status, and manager characteristics.

Summary

Mounting evidence suggests that Americans are experiencing difficulty in meeting work and family responsibilities, leading to negative consequences for the health and well being of employees, their families, and the workplace. Work–family balance issues have been defined more as a "private trouble" (cf Mills, 1959) of individual workers and their families than as a public issue. While family-friendly and leave policies in US workplaces have changed dramatically in recent years (Bond, Galinsky, Kim, & Brownfield, 2005; Glass & Estes, 1997; Kelly, 2003; Kossek, 2005), they are frequently only "on the books" or otherwise defined on the margins, not challenging the basic organization of work (Kelly & Moen, 2007; Kossek et al., 2010). These work–family balance issues cause acute and chronic stress which have negative health consequences. Work–leave and more general family-friendly policies may

serve as a leverage point for psychosocial interventions to forestall or ameliorate this stress, and thus improve physical and mental health. The Work, Family, and Health Network theorizes that changing working conditions is the best prevention strategy for the dilemmas faced by working families. Few theoretically driven longitudinal studies are using experimental designs to evaluate how specific work–family interventions affect work–family conflict and health outcomes. The conceptual model described in this chapter addresses limitations in current studies, and provides a framework for an intervention study that can be applied to diverse industries and employees. We expect to see improvements in both worker's perceptions of their health through self-reported measures and objective improvements in health measured through biomarkers. Because employees' experience of stress tends to last beyond the boundaries of the workday, and because emotional stress is likely to be transmitted to other family members, we also include measures to allow us to examine potential positive effects in social units at home. These interventions should also benefit employers by improving workplace productivity.

Conclusions

Given the limitations at the micro-level (the individual) and the macro-level (the government), the meso-level, or the workplace itself, may be the best scientific focus for designing and evaluating work–leave and related interventions in order to ameliorate work–family balance issues and improve health. Interventions on this level may later inform more macro-level policies in the public and private sectors. Survey and interview evidence links policies and practices, such as flextime, schedule control, and supervisor support, for work–family balance issues to a variety of positive outcomes. These outcomes include increases in job and life satisfaction and organizational commitment, and decreases in work–family conflict, absenteeism, intentions to quit, actual turnover, and health behaviors that are pathogenic (Berkman et al., 2010; Kelly et al., 2008; Kossek et al., 2011; Moen, Kelly, & Hill, 2011; Moen, Kelly, Tranby et al., 2011; O'Neill et al., 2009). Both structure and culture count at the workplace. Work–family conflict increases with both a functionally impoverished social environment and ineffective workplace policies and programs regarding employees' control over the time and timing of work (e.g., Hammer et al., 2007, 2009; Kelly et al., 2011; Kelly & Moen, 2007; Kossek et al.; Kossek & Michel, 2011; Moen, Kelly & Huang, 2008). Therefore, successfully intervening at workplaces may lower work–family conflict; have salutary impacts on workers, their spouses, and their children; and improve the employer's bottom line.

Future Directions

A full evaluation of our theoretical model requires a number of subsequent studies. As noted in the literature, health interventions tend to be programmatically complex and context-dependent, and require: comprehensive evaluations that delineate the efficacy of the implementation of these interventions; the contextual and structural factors that influence the interventions' effectiveness; and the efficacy of the interventions themselves along a continuum of theoretically derived outcomes (Danaher & Seeley, 2009; Rychetnik, Frommer, Hawe, & Shiell, 2002). To accomplish this in future research, we will first undertake a comprehensive test of the model parameters, through a series of methodological studies assessing the reliability and validity of our measures, and testing the meditating and moderating hypothesis. Additionally, because this model relies on a workplace intervention, we have included a process evaluation to document fully the program and the context in which it is implemented. This process evaluation will describe the theoretical underpinnings of the WFHN intervention, the design

strategies for customizing the intervention to meet the program's objectives while adhering to fiscal and regulatory requirements at the workplace, and the implementation strategies for fully deploying a job redesign and adaptive change processes aimed at reducing work and family conflict. These efforts are consistent with existing research which suggests that workplace interventions focusing on job stress and employee well-being require deliberate attention to the linkages among the program objectives, the context, and the intended outcomes (Kelly et al., 2008). However, this redesign will vary depending on the nature of the industry and the job to be performed.

As a means of assessing program fidelity, we will analyze data from our protocols to measure treatment receipt and treatment enactment as measures of program implementation (Bellg et al., 2009; Lichstein, Riedel, & Grieve, 1994). Treatment receipt or program exposure involves an assessment of the extent to which the program participants received critical elements of the program and demonstrate knowledge of, and ability to use, this knowledge or skills. We documented program dosage using observations and tracking logs for each intervention session. Treatment enactment assesses the degree to which the program participant applies the skills or knowledge acquired in the program. We documented program enactments or outputs through structured interviews with key stakeholders and through participant self-report measures. Our implementation study will facilitate the interpretation of the main study findings. Future research should map the terrain of variation in terms of what characteristics allow for which successful adaptations, and document whether some workplaces are simply not fixable. We will also look carefully at variation by our moderators. Particular combinations of work and family characteristics may make individuals more or less vulnerable to stress, and may influence how movable their stress is with this type of intervention. We may need to provide alternate theoretical models of pathways and mechanisms for different employee populations. We may also find that stress manifests in different aspects of health by moderators. For example, we would already expect gender differences in the likelihood of demonstrating internalizing versus externalizing negative health behaviors. If work–family balance issues are more salient for women, then we might find stronger prevention effects of our intervention on depression than alcohol use.

Our outcome analyses will assess program effectiveness using statistical methods accounting for multiple levels of measurement, including the employee, work group, manager, and family. Our study data include longitudinal self report measures, biometric measures, and a daily diary study to examine effects on family functioning and daily stress. Our model examines the intervention effects at each measurement level, and could be extended to include measures of the crossover between levels. Understanding the interactive relationship between work outcomes and health can inform future program development and research. For example, targeted interventions (including non-workplace-based programs) that improve family function might have positive crossover effects on workplace outcomes. Our model could also be extended to include a feedback loop to understand the lasting effects of the intervention and the need for ongoing health promotion interventions. The theoretical model presented here ends with improved health and positive workplace outcomes. Logically, healthier workers in healthier families will both perform more efficiently, and thus face decreased demands for health promotion efforts for themselves and at home. For example, weight loss maintenance is less demanding than the treatment period of exercise and nutritional change. Likewise, alleviation of depression and psychosocial distress should result in an improved outlook on one's work and home situations Thus, changes in our outcomes should theoretically then influence both actual work–family balance demands and the need for leave, as well as perceptions of schedule control and supervisor support in a positive direction. In this scenario, a one-time intervention has lasting effects through feedback over time.

Our theoretical model also directs our efforts toward adapting the environment rather than the individual. The opening chapter to this Handbook notes that adaptation to stress responses may occur in a maladaptive way over time if stressors are unusually persistent. Given that routine family caregiving demands are a feature of major life course stages, stressors from work–family balance issues fall

into this category, calling into question efforts to "fix" the worker. Our workplace redesign includes tracking and evaluation of effects of the adaptation on the workplace to ensure that the outcomes are functional. Finally, we evaluate economic implications for the employers through a robust "return on investment" study, and assess translational potential by identifying key factors related to program adoption and diffusion. We anticipate that our findings will challenge the existing organization of work, which was designed for a workforce in the middle of the last century, without the family care responsibilities prevalent in today's workforce.

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