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An Exploration of Healthy Leadership in the New Zealand Context

A thesis submitted in partial fulfilment of the requirements for the degree of

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Abstract

Workplace Health Promotion (WHP) is becoming an increasingly integral part of organisational Health and Safety (H&S) systems designed to positively impact employee wellbeing and business performance. A comprehensive approach to WHP emphasises that the organisation of work (i.e., physical and psychosocial aspects of the work environment) can have a profound influence on the wellbeing of employees. Leadership research indicates that within the psychosocial environment, management's relationship with their direct reports can serve as a key determinant of employee wellbeing. Following that research strand, a specific stream of leadership research – the healthy leadership literature – has identified several health-promoting behaviours by which managers can positively affect the wellbeing and performance of their direct reports. However, the factors which drive managers to actually engage in these important behaviours have been largely unexamined.

Drawing on the Self Determination Theory (SDT) of motivation as the theoretical framework, this research examines how managers and non-managers conceptualise a healthy workplace in the New Zealand context, which behaviours they consider as health-promoting, and what managers report doing to support the wellbeing of their teams. Importantly, this research explores the enablers and barriers to managers' Health-Promoting Leadership Behaviours (HPLB), and how these behaviours lead to positive wellbeing and performance outcomes for non-managers. This research proposes that multiple factors may shape a manager's motivation to engage in HPLB, ranging from organisational support (such as psychosocial safety climate (PSC)) to managers' job characteristics (such as perceived job autonomy) or even managers' personal characteristics (such as authentic leadership). Together, these factors suggest that perceived autonomy and authentic leadership may shape managers' perceptions of PSC. Accordingly, this research examines the role of a manager's

autonomy perceptions and their authentic leadership behaviours in shaping their perceptions of organisational Psychosocial Safety Climate (PSC).

The study utilises a sequential explanatory mixed-method design. In the first phase, quantitative data was collected via an online survey from managers and non-managerial employees working in New Zealand. In the second phase, in-depth interviews were conducted with a selection of managers and non-managers to further explore the research questions. The quantitative and qualitative data were analysed using SPSS and NVivo, respectively.

The research findings indicated that both managers and non-managers conceptualise a healthy workplace as catering to both the *wellbeing-related* needs and the *work-related* needs of employees. Non-managers further emphasised the *human aspects* of the work environment as a dimension of managers' HPLB, whereas managers regarded *authentic leadership* as an important dimension. Several factors were identified as important enablers of managers' HPLB. These included *organisational support, managers' job-related factors, technological factors, managers' personal values, beliefs, and preferences, and employee-related factors*.

On the other hand, the absence of these factors, including a lack of organisational support, poorly designed managerial roles, a lack of managers' or employees' commitment to health, and a lack of technological support, appeared to be barriers to managers' HPLB. The findings further indicated that managers' perceptions of autonomy had a strong positive relationship with their perceptions of the PSC. Furthermore, psychological wellbeing (PWB) mediated the relationship between non-managers' perceptions of their managers' HPLB (both positive and destructive leadership behaviours) and their self-reported performance (both in-role performance and extra-role behaviours).

This research contributes uniquely to the healthy leadership literature by providing a richer understanding of the role of healthy leadership in the New Zealand context, while also identifying specific enablers and barriers of managers' health-promoting leadership behaviours, and their impact on non-managers' wellbeing and performance. These findings address an important theoretical and practical gap in the research and practice relating to the domain of healthy leadership. Theoretically, the identification of autonomy as an important predictor of a managers' perceptions of organisational PSC extends the PSC literature and also offers opportunities for future studies to explore how other elements of a manager's job design may relate to their perceptions of PSC. A detailed understanding of the dynamics of a healthy workplace in the New Zealand context, specific health-promoting behaviours of frontline managers, and the identification of the enabling factors along with barriers for managers' engagement in HPLB contribute to wider leadership research and specifically to the healthy leadership literature. The strong association between managers' HPLB and employee job performance through PWB underscores the wellbeing-supportive role of healthy leadership. These findings also add to workplace health promotion research and the occupational health psychology literature by adding further evidence of the importance of psychosocial aspects of the work environment in promoting employee wellbeing and performance outcomes. Practically, the findings offer significant insights for intervention research and for how organisations can invest in reshaping their PSC and redesigning the roles of their frontline managers to promote managers' wellbeing-supportive behaviours that will improve employee performance and business success.

Dedication

This thesis is dedicated to my late parents, whom I lost shortly after beginning my PhD journey during the COVID-19 pandemic. Their lives were taken in the blink of an eye. I wish they were here to be part of this moment and celebrate it with me!

May Allah Almighty bless them always!

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List of Abbreviations

ANZSIC	Australian and New Zealand Standard Industrial Classification
CMV	Common Method Variance
COR	Conservation of Resources
DCM	Demand Control Model
EAP	Employee Assistance Program
EFA	Exploratory Factor Analysis
EL	Ethical Leadership
ERI Model	Effort Reward Imbalance Model
FRLM	Full-range Leadership Model
HDPLB	Health and Development Promoting Leadership Behaviour
HDPLBQ	Health and Development Promoting Leadership Behaviour Questionnaire
HOL	Health Oriented Leadership
HP	Health Promotion
HPL	Health-Promoting Leadership
HPLB	Health-Promoting Leadership Behaviour
HPWT	Happy Productive Worker Thesis
H&S	Health and Safety
ILO	International Labour Organisation
JDR	Job Demand Resources
LMX	Leader Member Exchange
MBE	Management by Exceptions
MVA	Missing Value Analysis

P-P plots	Probability-Probability Plot
PSC	Psychosocial Safety Climate
PWB	Psychological Wellbeing
Q-Q plots	Quantile-Quantile Plot
SDT	Self-Determination Theory
SDG	Sustainable Development Goals
SEM	Structural Equation Modelling
SL	Servant Leadership
SPSS	Statistical Package for the Social Sciences
SWB	Subjective Wellbeing
TA	Thematic Analysis
VBL	Value-Based Leadership
VDL	Vertical Dyad Linkage
WHO	World Health Organisation
WHP	Workplace Health Promotion

Chapter 1

Introduction

1.1 The Value of Healthy Leadership

Healthy and productive working people are vital to organisational success. Employee ill health is associated with productivity loss, which can lead to huge organisational costs (Eng et al., 2016; Guest, 2017). Estimates indicate that around 50,000 life-years are lost each year in New Zealand due to work-related injuries and ill-health, costing the economy around $2 billion (WorkSafe, 2021). Given these estimates, the New Zealand Government's Health and Safety at Work Strategy (2018-2028) has emphasised employee physical and psychological health as a priority area of concern.

Workplace factors have been internationally recognised as a significant contributor to employee health and wellbeing (Burton, 2010; European Network for Workplace Health Promotion, 2007; International Labour Organization, 2014). Safe working environments with adequate social support and participation opportunities make employees feel healthier and motivated, which translates into improved productivity and a positive reputation for the organisation (Dickson-Swift et al., 2014). In contrast, health-damaging working conditions, such as high workload, inadequate autonomy or a lack of support from colleagues, can lead to general health-related risks such as stress and fatigue. A recent report shows that 14% of New Zealanders feel pressured to work long hours, which is up from 10% in 2021, and that 43% of people neglect some of their tasks (Umbrella Wellbeing NZ, 2023). Research also links high workload with increased job strain, making employees distressed, thus thwarting their wellbeing (Hasin et al., 2023). These risks in workplaces can lead to human and financial

costs for the individual and organisation, which can lead to a general downstream impact on society (Gurt et al., 2011).

Acknowledging the dynamic interaction between people and their work environment, numerous international bodies such as the World Health Organisation (2009), the International Labour Organisation (2015), and the European Network for Workplace Health Promotion (2007) have broadly recommended the workplace as an effective setting for health promotion. The concept of workplace health promotion has evolved from its focus on physical health and injury prevention through individual behavioural change (Noblet & LaMontagne, 2006) to the physical, psychological, and social wellbeing of employees through multiple influences outside individual control such as organisational, social, and environmental conditions (Ljungblad et al., 2014). This advancement recognises that individuals are not solely responsible for their health, but that several external factors also play a role in determining health. This recognition implies that small changes in the workplace environment can considerably improve employees' health, leading to better organisational performance (Dickson-Swift et al., 2014).

Contributing to the work-health relationship, leadership research has mainly explored the organisation's social context to investigate how other people at work can influence employee wellbeing. In this regard, manager-employee relationships are reported to be an important determinant of employee wellbeing (Gilbreath & Benson, 2004). In addition, certain positive leadership behaviours such as consideration, better control over the job, and social support have been directly or indirectly linked to followers' wellbeing (Arnold et al., 2007; Skakon et al., 2010). However, critics have pointed out that constructive and inspirational leadership models are too general and do not describe the health-specific effects on followers' health and wellbeing (Franke et al., 2014; Vincent-Höper & Stein, 2019). Therefore, to capture the health-specific influence of leaders' values, attitudes, and

behaviours on employees' health and wellbeing, different models of "healthy leadership" have emerged over the last decade. For example, see Rudolph et al. (2020) for an in-depth review and critique of healthy leadership.

While the focus on healthy leadership is an important advancement within the leadership literature, the existing research mainly focuses on the relationship between different healthy leadership constructs and employee health outcomes such as emotional exhaustion, stress and burnout, health complaints, and depression (Jimenez et al., 2017; Kranabetter & Niessen, 2017; Santa Maria et al., 2019). Some important gaps still exist within healthy leadership scholarship. For example, a recent review by Lundqvist et al. (2023) emphasises the need to conduct more qualitative studies to know more about the concept of healthy leadership and how strongly it relates to other constructs. Specifically, within the New Zealand context, where high workloads are a leading cause of work-related stress (Workplace Wellness Report, 2021), there is a need to understand what healthy work looks like. Another gap is the need to explore the factors that might motivate leaders to engage in a health-promoting way in the challenging work environment of New Zealand. As Rudolph et al. (2020) note in their review, there is a need to understand the conditions that give rise to "healthy leadership." If organisations want to foster healthy leadership behaviours in support of employee wellbeing, a detailed understanding of the genesis of these behaviours in local conditions is a crucial prerequisite. Identification of the precursors of these behaviours is particularly important at the level of front-line managers who interact with their direct reports daily.

In this regard, organisational Psychosocial Safety Climate (PSC) – a facet-specific part of organisational climate focusing on employees' psychological health and wellbeing – could act as an important precursor to managers' health-promoting behaviours. As Zohar (1980) has shown, safety climate acts as a predictor of leaders' safety behaviours. Similarly,

PSC could act as a driver for managers' health-promoting behaviours. Before looking into the impact of PSC on managers' health-promoting behaviours, it is crucial to understand the factors that shape perceptions of a positive PSC in an organisation. Recent studies emphasise the importance of focusing on PSC for organisations that want to foster their employees' psychological health (Loh et al., 2021). In addition, it is important to know how managers' health-promoting behaviours relate to their direct reports' wellbeing and performance, as the focus of existing healthy leadership research is mainly on employee wellbeing, while largely ignoring its relationship to performance, see for example Kaluza et al. (2021) and Chen and Wu (2023). Thus, this research explores the concept of a healthy workplace from the perceptive of managers and those who are being managed.

Recognising that leadership motivation is a driving force for leadership behaviours (Barbuto, 2005) and that leaders in immediate managerial positions affect and are affected by multiple factors within their work environment (Veer et al., 2019), this research also draws on Self-Determination Theory (SDT). SDT is a meta-theory of motivation (Deci & Ryan, 1985) that provides a framework to capture the intrinsic and extrinsic sources of motivation. Utilising SDT enables the contextual and motivational antecedents of managers' health-promoting behaviours to be explored.

SDT underpins this research through both its need-satisfaction mechanism and its motivational mechanism. This theory explains how workplace conditions support or undermine individuals' basic psychological needs, and how these conditions shape different types of motivation that drive behaviour. Together, these mechanisms provide a foundation for understanding how managers' motivational states develop and how these states influence their engagement in Health Promoting Leadership Behaviours (HPLB). Drawing on these constructs collectively forms the conceptual basis of this research. PSC represents the organisational conditions that signal the value placed on employees' psychological health.

These conditions fulfil managers' needs and shape their motivational experiences, which are understood through SDT. In turn, managers' motivation influences their engagement in HPLB, which directly affects employees' wellbeing and performance. Utilising PSC and SDT in combination to examine HPLB highlights how organisational climate, managerial motivation, and leadership behaviours interact to create healthy workplaces.

1.2 Research Aims

Specifically, the research aims to explore:

1. How managers and non-managers conceptualise healthy work in the New Zealand context.
2. The leadership behaviours that support a healthy workplace and what managers do to support the wellbeing of their teams.
3. The motivators and barriers for managers to engage in Health-Promoting Leadership Behaviours (HPLB) for the wellbeing of their teams.
4. The extent to which managers' job-related factors (perceived work autonomy) and personal traits (authentic leadership) shape their perception of organisational Psychosocial Safety Climate (PSC).
5. Direct reports' perception of their managers' HPLB, and how these perceptions relate to their wellbeing and performance at work.

1.3 Research Contribution

Based on those aims, this research contributes to the healthy leadership literature by providing a broader understanding of healthy leadership in the New Zealand context. This research also contributes to the healthy leadership literature by identifying how managers and non-managerial staff conceptualise a healthy workplace, and which specific managerial behaviours they consider health-promoting. This research identifies potential contextual and

motivational antecedents of HPLB of managers at the organisational, job, and individual level using Self Determination Theory. In doing so, the research also explores potential barriers to managers' HPLB. This research further examines how managers' HPLB relate to their direct reports' performance and wellbeing outcomes. This research also contributes by demonstrating how managers' perceived autonomy and authentic leadership shape their perceptions of organisations' PSC. A detailed understanding of managers' health-promoting behaviours could contribute to the broader leadership literature by guiding researchers and practitioners in developing intervention programs, such as training and development of organisational leadership at multiple levels, to promote behaviours that support employee wellbeing and positive organisational outcomes.

Chapter 2

Wellbeing and Performance

2.1 Conceptualising Wellbeing

Wellbeing is a debated concept that can be defined and measured in different ways. The complexity of this construct is evident from its understanding as an everyday interpersonal inquiry in the form of 'how are you?' through to a topic of complex scientific research carried out in different disciplines such as psychology, sociology, economics, management science and public policy. Although each discipline uses different operational and conceptual definitions and titles to describe wellbeing such as welfare, happiness, prosperity, human development, etc. (Thompson & Livingston, 2018), a general theme of wellbeing discussion is that it describes an individual's life situation at a point in time.

Sometimes, 'wellbeing' is used interchangeably with 'health' yet these are different concepts. The World Health Organisation (WHO) defines health comprehensively as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (World Health Organization, 1946). In contrast, wellbeing is also seen as a broader term which goes beyond wellness and encompasses the feelings of being healthy, happy, and comfortable (Oxford English Dictionary, 2024). An examination of the literature shows that wellbeing is often seen as an overall subjective feeling of being healthy and flourishing (Aboulafia et al., 2015). The philosophical origins of wellbeing date back to the ancient Greeks. For many Greek thinkers, finding an answer to the question of what constitutes a good life was a central concern (Ryff et al., 2021). Addressing this question led to the development of two distinct but overlapping paradigms with foundations based on two distinct philosophies – hedonism and eudaimonism.

2.1.1 Hedonic Wellbeing

The word hedonic is derived from the Greek word *hēdonē*, which means pleasure (Holte et al., 2014). Wellbeing from the hedonic perspective means experiencing happiness or pleasure, which ranges from bodily pleasures and ease in life to fulfilling self-interests. The ancient Greek philosopher Aristippus (3rd century BCE), defined hedonism as experiencing maximum pleasure, which is achieved in pursuit of a life which fulfils our human appetites (Tatarkiewicz, 1976). Centuries later, Utilitarian philosophers such as Bentham (1781) also promoted the argument that the foundations of a good society are based on people who attempt to maximise their pleasure and self-interest (Ryan & Deci, 2001).

Aligning with the ancient Greeks, psychologists who believed in the hedonic view, such as Kahneman et al. (1999), defined wellbeing as life experiences that make life pleasant or unpleasant. Some other psychologists described it as a subjective judgment about different domains of life in terms of feeling an overall pleasure or displeasure (Andrews & Withey, 1976; Campbell et al., 1976). Thus, for hedonic psychologists, happiness was not restricted to physical hedonism; rather, it spanned across different life domains. These psychologists explained hedonic wellbeing by using different terms to measure human experiences along the pleasure versus pain continuum, for example, happiness, positive affect, negative affect, life satisfaction, and subjective wellbeing (Bradburn, 1969; Gurin et al., 1992). Happiness – to these researchers – was defined as a person's ability to balance positive and negative affect, and life satisfaction was seen as an evaluative judgement of people about the quality of their life. With further refinement in describing the concept of wellbeing, contemporary hedonic psychologists described a good life as one in which a person can experience positive and negative feelings (affective subjective wellbeing) in addition to making an overall positive evaluation of life (cognitive subjective wellbeing) (Holte et al., 2014). These

advancements led to the development of a term which was labelled as Subjective Wellbeing (SWB).

2.1.2 Subjective Wellbeing

SWB is an umbrella term which has gained a lot of attention since the middle of the last century, led by efforts to gain a deeper insight into the psychology of wellbeing (Land & Spilerman, 1975). The term SWB emerged to shift the focus of wellbeing away from objective parameters such as income toward subjective evaluations about quality-of-life, which includes life in general as well as specific domains of life, e.g. work life, social life, or financial situation (Andrews & Withey, 1976; Campbell et al., 1976). After decades of research, a contemporary structure of SWB was presented, comprising three elements, i.e. positive affect, negative affect, and life satisfaction (Diener, 1984; Lucas; et al., 1996).

SWB has been used to assess the quality of life for a long period of time (Andrews & Withey, 1976; Campbell et al., 1976; Diener, 1984). Early studies on SWB were conducted by Wilson (1967) who defined a happy person as "a young, healthy, well-educated, well-paid, extroverted, optimistic, worry-free religious, married person with high self-esteem, job morale, modest aspirations, of either sex and of a wide range of intelligence" (p.294). Wilson's research provided a pathway for later studies to explore the factors leading to SWB. Behavioural researchers then focused on the factors that lead people to make positive evaluations of their lives.

Later research supported the view that SWB is a broad phenomenon which includes emotional reactions, domain satisfaction and global life satisfaction. Such a view means that social indicators alone are not enough to define the concept (Diener et al., 1999). A person's evaluation of their satisfaction with their life should be considered as an important component in their assessment of their quality of life. Diener et al. (1995) argued that while

social and economic indicators are essential to define SWB, it is a complex construct which requires the integration of multiple approaches from different theoretical perspectives to gain an understanding of one's overall life. Since then, a range of psychological processes have been used to describe the impact of personal and environmental factors in the holistic evaluation of one's life.

In its refined form, SWB is described as a multi-dimensional construct comprising two affective components, namely frequent positive affect and infrequent negative affect, which are used to assess short-term moods and emotions. A cognitive component called life satisfaction makes up the third dimension (Diener, 1984; Diener et al., 2006; Diener et al., 1998). People are categorised as having a high SWB if they experience or believe themselves to experience life satisfaction, frequent positive affect and infrequent negative affect (Diener et al., 1997). For example, involvement in interesting activities and feeling more pleasure and less pain characterise high SWB. In contrast, individuals who are categorised as having low SWB experience frequent negative affect, infrequent positive affect, and overall dissatisfaction with life.

While the three components of SWB collectively describe the concept, different views exist regarding their inter-relationship. Some studies support the view that the affective and cognitive components of SWB are correlated with each other, and a mutual relationship exists among them, e.g. Diener et al. (2000). Others are of the view that although life satisfaction is a part of SWB, it is an independent element and all three components should be studied and measured separately, e.g. Lucas et al. (1996). Furthermore, compared to positive and negative affect that are just momentary responses to life events, life satisfaction is a more stable and enduring component of SWB because it does not change with short-term emotions, moods and trivial events of life (Diener et al., 1995). In contrast to emotions and moods, no time

frame is specified for this global evaluation. Thus, the life satisfaction component of SWB remains a complicated concept to define.

Diverse perspectives have been used to conceptualise the dimension of life satisfaction. Some scholars define it as satisfaction with specific domains of life, such as Rode (2004) who views life satisfaction as satisfaction with work, family, and social life. Others define it from a global perspective, such as Karatepe et al. (2008) who describe it as wellbeing in interpersonal relations, social activities, personal development, and physical and recreational activities. However, the interpretation of life satisfaction varies from person to person because individuals assign different weights to different domains of their lives. When basic level needs are fulfilled, they then seek the accomplishment of post-materialistic needs (Inglehart, 1990). Therefore, for some people, achievement in the work-life domain is the source of life satisfaction, while for others, a successful social life is a determinant of overall quality of life (Pavot & Diener, 2008).

Critics of the concept of SWB point out that equating satisfaction with different life domains and overall wellbeing is not that simple because life domains interact with each other, and satisfaction or dissatisfaction in one domain affects other domains (Loewe et al., 2014). Others believe that this confusion in conceptualising wellbeing is quite normal and thus should not be considered unusual (Kashdan et al., 2008; Wallander & Koot, 2016). The ongoing criticisms of the concept of SWB prompted interest in the concept of eudaimonic wellbeing and its associated concept, Psychological Wellbeing (PWB). These concepts are explained below.

2.1.3 Eudaimonic Wellbeing

The term eudaimonic is derived from the Greek words *eu* (good) and *daimōn* (spirit), which collectively has come to mean human flourishing (Holte et al., 2014). While this term

is difficult to both spell and pronounce, it is also difficult to define. The concept of eudaimonic wellbeing emerged to challenge the hedonic perspective of happiness. Russell (1930) – a key utilitarian philosopher – explained eudaimonia as happiness, which was similar to the hedonic view of wellbeing. However, Aristotle – as a key advocate of the eudaimonic perspective – explained that not every experience that makes people happy is good for their wellbeing.

In terms of human flourishing, eudaimonia is the highest form of wellbeing that a person can achieve. It's attained by understanding the true purpose of life and by actualising one's real potential to live a fulfilling life. Unlike hedonic wellbeing – the focus of which is only on momentary happiness or pleasure – eudaimonic wellbeing is a continuous process that leads to feelings of accomplishment. The result is a sense of internal satisfaction, which is superior to short-term pleasure (Ryff et al., 2021).

Eudaimonic researchers such as Ryff and Singer (2008) added that achieving the highest level of wellbeing varies from person to person, depending upon their interests and life aspirations. A prerequisite to achieving eudaimonia is to "know yourself" through self-realisation and act accordingly in order to experience internal satisfaction. This implies that not all fulfilled desires lead to wellbeing no matter how pleasure-producing they are, for example smoking or recreational drug use. It depends upon the extent to which life activities are in congruence with deeply held values (Waterman, 1993) or whether people are authentically engaged in those activities (Ryan & Deci, 2001).

Drawing from the ideas of Aristotle about eudaimonia, Ryff and Singer (1998) tried to extend the understanding of wellbeing and the essential elements that constitute it. They explained that happiness is not something that just happens to us; rather, people have to strive for it by utilising their full potential (Ryff, 1995). Thus, by extending the understanding of

eudaimonic wellbeing, Ryff and Keyes (1995) differentiated the idea of Psychological Wellbeing (PWB) from SWB.

2.1.4 Psychological Wellbeing

Ryff (1989) criticised the concept of SWB by arguing that it only focused on healthy living, was limited in scope, and lacked definitional clarity and theoretical grounding. On that basis, Ryff and Keyes (1995) developed a model of Psychological Wellbeing (PWB), presenting it as a multidimensional concept that captures what it means to be fully functional, optimally developed, and self-actualised. According to the model by Ryff and Keyes, PWB helps individuals achieve physical and emotional wellbeing, indicating the extent to which people feel fully functional and healthy. Diener et al. (1998) maintained that while Ryff's model explains PWB as a pathway to achieve physical and emotional wellbeing, SWB explains what it means to live a good life. Thus, a debate continued for a long time with both hedonic and eudaimonic views of wellbeing being recognised as two different approaches to understanding happiness, rather than two types of happiness (Diener et al., 2009). This debate supported the multidimensionality of wellbeing construct (Grant et al., 2007; Page & Vella, 2009; Warr, 2012), and variations in its understanding based on individual values, beliefs and preferences (Bourke & Geldens, 2007; Carlquist et al., 2017; Delle et al., 2011; Fattore et al., 2007; Navarro et al., 2017; Oishi et al., 2009).

Not all scholars promote the hedonic or eudaimonic understanding of wellbeing. For some researchers, integrating both the hedonic and eudaimonic perspectives is necessary to gain a deeper understanding of wellbeing, its determinants, and outcomes. This approach emphasises that wellbeing is not static; rather, it varies depending on the level at which it is evaluated (Warr & Nielsen, 2018). Based on this notion, people may evaluate their *"context-free"* wellbeing, which involves appraising their overall life, or their "domain-specific"

wellbeing, where they evaluate a specific domain, such as family life, work life, or leisure activities. In its narrowest form, people may evaluate their *"facet-specific"* wellbeing by evaluating a specific component of their life, for example satisfaction with their salary or manager within the broad domain of the workplace.

The interplay between hedonic and eudemonic wellbeing was viewed from two different perspectives. For some people, overall life experiences or even certain activities in a particular domain may foster SWB or momentary happiness, but might not lead them to experience eudaimonic wellbeing because those life activities might not be aligned with their life goals or aspirations (Nix et al., 1999). For others, hedonic and eudaimonic views of wellbeing overlap and, while being distinct, sometimes intersect in shaping people's evaluation of life. Thus, engagement in an autonomously motivated activity may lead to happiness as well as self-actualisation, leading to eudaimonic wellbeing. For example, Diener et al. (1998) advocate that SWB is an essential ingredient to live a happy and fulfilling life, and that short-term feelings of happiness aggregate over time and serve as a building block of long-term wellbeing (Diener et al., 1999; Fisher, 2002; Kim et al., 2005). Even short breaks from work demands or involvement in an activity of interest help to unwind and regain focus on a complicated task or a long-term goal. Based on this, the present research evaluates the PWB of people working in New Zealand by taking their view of satisfaction with a specific facet of their life, i.e. work life.

The above discussion of different views on wellbeing indicates that employees' psychological functioning is shaped not only by affective experiences but also by the meaning that they assign to those experiences. While multiple theories of wellbeing exist, when applied to a workplace context, the question arises of how workplace experiences and conditions support or undermine employee wellbeing. Additionally, it highlights the need for a motivational framework to help explain why managers attempt to engage in HPLB to

support employee wellbeing. Self-Determination Theory provides that framework by explaining why managers feel motivated to support employees' basic needs and how the satisfaction of autonomy, competence, and relatedness drives optimal functioning and wellbeing at work. The following section explains the role of SDT.

2.2 Self-Determination Theory

A well-known theoretical perspective that has emerged to explain the concept of PWB is Self-Determination Theory (SDT). This theory has been utilised in the health field for over a decade to explain the underlying mechanisms of specific health behaviours (Ntoumanis et al., 2021) and has also contributed towards understanding how a person can experience the highest level of wellbeing (Deci & Ryan, 2000). According to SDT, there are three needs: *autonomy*, *competence*, and *relatedness*, which are essential to experiencing psychological growth and wellbeing. Although the desire to fulfil each of these needs may vary among individuals – some may have a high need for autonomy compared to others who might have a high need for relatedness – a complete failure to fulfil these needs may affect psychological functioning. SDT further suggests that the satisfaction of basic psychological needs fosters SWB as well as eudaimonic wellbeing because being satisfied with one's life and feeling more positive and less negative affect points towards a more fulfilling life. Consequently, living a fulfilling and meaningful life makes it more pleasurable (Deci & Ryan, 2000). Thus, SDT goes beyond the definition of happiness and incorporates eudaimonic concepts of wellbeing that are linked with meeting intrinsic needs (Ryan & Deci, 2001).

As a meta-theory of human motivation, SDT has been utilised in an organisational setting to explain an individual's engagement in a particular work behaviour. SDT indicates that two factors influence an individual's engagement in specific work behaviours: (i) workplace contexts such as organisational or managerial support, and (ii) individual

differences (Deci et al., 2017), as illustrated in Figure 2.1. These two factors interact and influence work behaviours and wellbeing through two possible mediators: (i) basic psychological needs (autonomy, competence, and relatedness), and (ii) autonomous and/or controlled motivation (Deci et al., 2017). The mechanisms related to basic psychological needs explain that human beings select certain behaviours in an effort to satisfy their need for autonomy (a sense of being self-determined, not controlled), competence (a feeling of effectiveness in one's social environment by exercising one's capacities), or relatedness (a sense of being supported by and supportive of others) (Deci & Ryan, 2000). Fulfilment of these needs fosters an individual's enjoyment of an activity, thereby enhancing motivation towards a behaviour (Ryan & Deci, 2002).

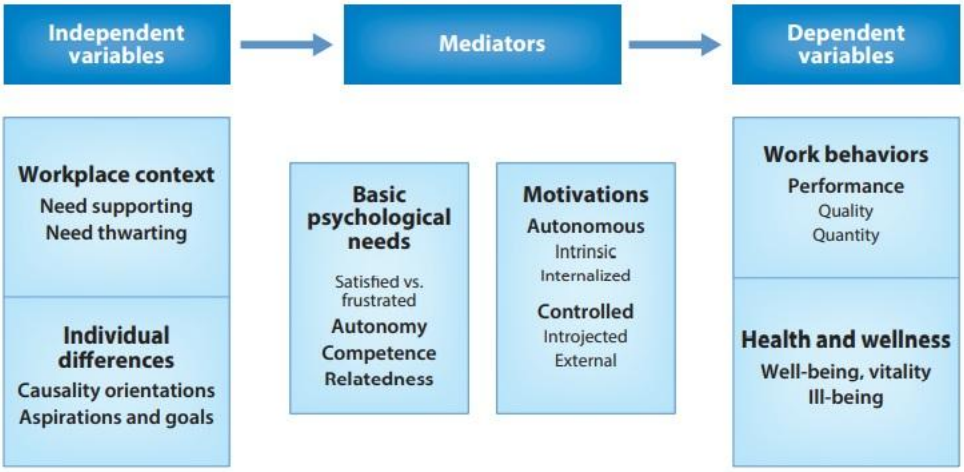


Figure 2.1 An Overview of the SDT Model in the Workplace (Deci et al., 2017, p. 23)

The motivational mechanism explains that human beings may engage in certain behaviours due to different types (not the amount) of motivation, which lead to a range of performance and wellbeing outcomes. These motivations range from autonomous to controlled motivation, as shown in Figure 2.2. On a motivational continuum, these motivations range from *intrinsic motivation* through *extrinsic motivation* to *amotivation* (Ryan & Deci, 2000), with each type of motivation having different catalysers and

consequences. *Intrinsic motivation* refers to highly self-determined behaviour in which an individual is engaged in an activity due to inherent feelings of pleasure, interest, and accomplishment. *Extrinsic motivation* can either be controlled or autonomous depending upon the degree of self-determination, which could range from highly self-determined to least self-determined. So, an individual might be highly self-determined because the desired behaviour might be congruent with one's values or personal importance to oneself. Alternatively, an individual may engage in a behaviour not because of internal desire but due to contingent rewards or self-esteem. Finally, SDT explains a completely non-self-determined behaviour called *amotivation*. Amotivation describes a situation in which individuals lack any intention to engage in a particular behaviour. These different motivations help explain an individual's engagement in a specific behaviour for multiple reasons, and this aspect makes SDT of motivation well-suited for the health and work domain.

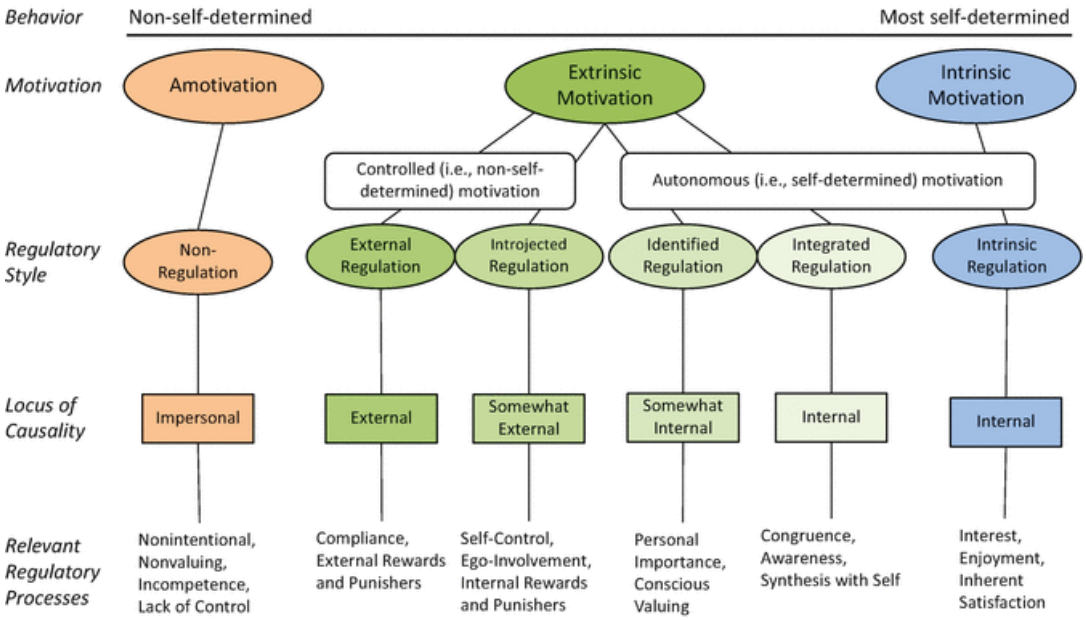


Figure 2.2 The Self Determination Continuum (Deci & Ryan, 2000, p. 72)

Some studies, such as Baard et al. (2004) use need satisfaction variables, while others (Fernet et al., 2012; Williams et al., 2014) use motivational variables to explain engagement in specific work behaviours. Yet others, such as (De Cooman et al., 2013), have used both to

show how motivation can be predicted by need satisfaction, leading to work outcomes such as performance and/or wellbeing. It is important to acknowledge that these are distinct perspectives on motivation, however, and neither of them provides a complete explanation as human behaviour is inherently complex.

Overall, SDT provides an empirical perspective on wellness and development and offers a theoretical reasoning for why people engage in certain behaviours, which lead to different outcomes. The current research uses the SDT framework in two ways. Firstly, it is used to understand managers' motivation to engage in health-promoting behaviours for the wellbeing of their teams by using the motivational continuum of this theory. Secondly, it is used to explain how managers' health-promoting behaviours influence the wellbeing and performance of their teams by using the basic psychological needs mechanism. Core to SDT is that the satisfaction of autonomy, competence, and relatedness is not only central to wellbeing but also to high-quality performance. When these needs are met, individuals are more likely to internalise work goals, sustain effort, and engage constructively with their tasks. This provides a clear pathway from motivation to performance and aligns with the Happy-Productive Worker perspective, which proposes that wellbeing and performance are mutually reinforcing outcomes of supportive work environments. The following section discusses how performance is conceptualised in this research and the link between wellbeing and work performance.

2.3 Work Performance

Work performance is an essential parameter for understanding an individual's contribution to an organisation. Previous studies show that employees' good job performance relates to organisational success, while poor employee performance relates to low

productivity and organisational ineffectiveness (Alqarni et al., 2023; Okoye & Ezejiofor, 2013; Terglav et al., 2016).

Due to the rapidly changing external environment and increased globalisation, there has been a considerable shift in how job performance is conceptualised. Organisational scholars define performance as ranging from a behaviour (input) to the outcome of an activity (output) (Dalal et al., 2012; Darko, 2020). Organisational behaviour research defines job performance as a set of individual or group behaviours that create value for the organisation and achieve desired organisational goals (Campbell et al., 1993; Campbell & Wiernik, 2015) by meeting performance expectations (Afzali et al., 2014). This view brings together all the behaviours that are essential for the attainment of organisational goals, such as adaptability (Berg et al., 2010), proactivity (Parker et al., 2006), and citizenship behaviours (Podsakoff et al., 2009) in addition to core task performance (Williams & Anderson, 1991). Refining the view of work performance, Griffin et al. (2007) provided a comprehensive multidimensional performance model that comprises three different forms of behaviours, i.e., *proficiency* (synonymous with in-role performance), *proactiveness* (i.e., extra-role behaviour), and *adaptivity* (ability to adapt to change and refocus rapidly from one task to another).

In-role performance includes all those behaviours that are officially required by an individual to achieve organisational goals, for example meeting productivity targets or performing assigned duties at work (Motowidlo & Van Scotter, 1994). Extra-role behaviours, also known as contextual performance or citizenship behaviour (Organ & Paine, 1999) refer to all those acts that an individual does voluntarily to contribute towards the organisational, psychological or social environment (Motowidlo & Van Scotter, 1994) for example by helping colleagues or avoiding conflicts with people at the workplace. Taking both types of performance into account is important because they are highly related to each other as they incorporate everything that people do at the workplace, ranging from task performance and

doing fixed duties (Koopmans et al., 2011) to performing additional roles which support others and the organisation.

Since part of this research focuses on examining how managers' health-promoting behaviours relate to their employees' ability to perform assigned tasks proficiently in addition to voluntary good-to-have behaviours, this research adopts a multidimensional view of performance comprising *in-role* performance and *extra-role* behaviours as proposed by Borman and Motowidlo (1993). More precisely, this research takes work performance as a parameter to understand employees' wellbeing at work and seeks to explore how non-managerial staff's evaluation of their managers' health-promoting leadership behaviours impacts their work performance by influencing their wellbeing.

2.3.1 Do happy workers perform better at work?

The roots of research into the wellbeing-performance relationship date back to the Hawthorne Studies, which were conducted in the early 20th century to explore the relationship between employees' psychological states and productivity (Wyatt & Fraser, 1925). Since then, numerous studies have been conducted to examine the role of employees' emotions in boosting or suppressing their performance at work. Fredrick Herzberg's Human Relations Movement was one such research strand which asserted that increased employee morale should be linked to better work performance (Herzberg et al., 1959). Many other studies acknowledging the importance of employee performance at work have tried to identify the factors that are associated with high work performance (Diamantidis & Chatzoglou, 2019; Fisher, 2010; Pawirosumarto et al., 2017).

With the emergence of the field of Positive Psychology in the late 1990s, researchers claimed that employees who experience wellbeing at work should perform better (Wright & Staw, 1999). This view was labelled as the *Happy Productive Worker Thesis (HPWT),* which

proposes that employees who are satisfied and happy perform better at work (Ledford, 1999; Staw et al., 1994). According to this view, people who have positive emotions or feel better at work put extra effort into their work (Foo et al., 2009; Hersey, 2015; Seo et al., 2010) or alternatively, when people are most productive, they tend to be happiest (Sender et al., 2021). Daniels and Harris (2000) also provide evidence in their review that PWB relates positively to performance. Therefore, improving employee wellbeing should lead to increased productivity.

Warr (2008) explained the mechanism through which external factors influence wellbeing and mental health by presenting *the Vitamin Model.* Warr argued that job characteristics affect mental health in a non-linear way such that some job features (like an optimum workload or autonomy) enhance wellbeing, but too much of them (such as extreme workload or too much autonomy) may have a decremental effect on mental health and wellbeing. This model implies that it is not compulsory that people who work under the best conditions would experience the highest level of wellbeing.

A criticism of the HPWT is that the connection between job satisfaction and performance is not simple (Brayfield & Crockett, 1955). Those who perform better at work may experience more happiness because they might be getting more rewards or appreciation (Lawler & Porter, 1967), which, as per SDT, might be fulfilling their intrinsic need for recognition. In addition, as some researchers have noted, HPWT implies that unhappy workers should be the least productive (Oswald et al., 2015), which is not always the case. These findings point towards the fact that happiness and productivity are not a simple bivariate relationship; there could be many other variables, such as individual differences in age, gender, and personality traits, for example, or elements of work design, that could influence these relationships.

The criticism of HPWT therefore brings back the importance of workplace factors such as how managers' behaviours at work relate to the wellbeing and performance of their direct reports. Changes in leader behaviour to place a greater focus on the fulfilment of employee needs may influence employees' wellbeing, as evident in the existing leadership-wellbeing literature (Arnold, 2017; Nielsen, 2017). SDT also implies that when employees experience the fulfilment of basic psychological needs, this leads to positive, measurable behavioural outcomes such as better performance (Diener, 1984; Diener et al., 1999; Kim et al., 2005). Based on these arguments, this thesis suggests that when employees experience frequent positive events at work, such as autonomy, recognition, or opportunities for participation, they develop positive feelings which enhance their wellbeing and may lead to improved work performance. The next section reviews some of the literature on leadership and its integration with employee wellbeing and performance.

Chapter 3

Leadership, Employee Wellbeing, and Performance

3.1 Approaches to Leadership

Before exploring the relationship between leadership behaviours and employee wellbeing and performance, it is important to define the concept of leadership. Scholars have made many attempts to conceptualise leadership, but there is little consensus. The disagreement stems from each scholar's different approach to explaining this concept. Initial studies on leadership were conducted by numerous philosophers, historians, and practitioners. Early studies by philosophers mainly focused on what leaders ought to do and what leadership comprises. However, those studies lacked empirical support and were quite basic. In comparison, historians primarily aimed to describe the characteristics of leaders using examples of politicians, military figures, or monarchs, but these studies were not grounded in theory and were mainly descriptive. Practitioners then advanced understanding by describing leadership as it was experienced by leaders. However, a key limitation of the practitioner's literature was its anecdotal nature.

Social scientists have extended leadership research by defining, explaining, and describing it through empirical studies. However, some limitations of this literature include its overly positivist approach, reliance on quantitative research methods, and lack of critical focus (Collinson, 2011; Schruijer & Vansina, 2002). Within social science, three main disciplines that have dominated the work on leadership are political science, sociology, and psychology, which have provided unique perspectives in understanding leadership. Political science has mainly tried to describe leadership by using psychological concepts and qualitative studies, but its key focus has mostly remained on analysing the roles, strategies,

and tactics of leaders within different political systems (Barber, 2009; Goodin & Klingemann, 1998; Roskin et al., 2012; Wolff, 2023). The key contribution of sociology to the field of leadership has been the concept of charisma (Weber & Eisenstadt, 1969), which served as a base for studying modern charismatic leadership (Conger, 1989; Conger & Kanungo, 1987; Yukl, 1993). Sociologists contributed to the qualitative understanding of the concepts of power, inequality within social systems and exploitation, but many did not directly address organisational leadership (Alvesson, 1996; Sinclair, 2005; Western, 2019). Social psychology has served as a base for the widely accepted psychology-based leadership literature. The key focus of this literature has been identifying the influence of leaders on followers in the context of theories relating to personality, behaviour, and motivation. Today, these areas of study fall under the main field of organisational behaviour (Jackson & Parry, 2018; Northouse, 2021), a key aim of which is to empirically refine leadership theories by addressing gaps in the literature (Avolio et al., 2009; Bass & Bass, 2009) and conducting qualitative and quantitative studies. The following section describes some aspects of the evolution of leadership theories.

3.2 Leadership Theories

With the advancement in knowledge about leadership, different theories and paradigms of leadership have evolved. Jackson and Parry (2018) explain this with a timeline, as shown in Table3.1 below.

Time	Dominant Theoretical Paradigm
1840 - late 1940	Great Man / Trait Theory
Late 1940s – late 1960s	Leader Behaviour
Late 1960s – 1978	Situational / Contingency Models
1978 – Present	New Leadership – (Charismatic, Visionary, Transformational Theories, Ethical, and Authentic, etc.)

Table 3.1. Evolution of Leadership Theories

3.2.1 Great Man theory

The main idea of this theory was that leaders are born, not made. From around the middle of the 19th century until World War II, scholars were interested in identifying what distinguishes leaders from non-leaders. A variety of views were prevailing at that time, with discussions around whether leaders are born with some inherent qualities or whether the environment shapes the personality of leaders (Gowin, 1919; Taussig & Joslyn, 1932). Despite the varying debates, some scholars had a general agreement that leadership is a personality trait (Shartle, 1979; Smith & Krueger, 1933; Stogdill, 1948).

In this regard, Carlyle (1841) was a key advocate of the great man theory. His arguments in favour of this theory were based on his biographical analysis of the lives of some of the great leaders of the world, such as prophets, poets, priests, and kings (Carlyle, 1841). His work established that great men have some exceptional inherited abilities that distinguish them from other people; therefore, they are inherently superior and worthy to be role models for other people.

Although Carlyle's idea was quite convincing at the time (early 19th century), his work received criticism based on the lack of scientific evidence. His theory served as a base for subsequent researchers who became interested in identifying the traits or qualities of

leaders that make them superior. Thus, early leadership studies were conducted to discover the traits or characteristics that make someone a leader (Smith & Krueger, 1933; Stogdill, 1948). This research strand was then extended to study physical and psychological traits and personal characteristics of leaders, such as intelligence, self-control, flexibility, etc. (Stogdill, 1948). Trait theory also proposed that leaders are people who have more of some exceptional qualities than their followers, such as scholarship, dependability, intelligence, participation, and even socio-economic status, which enable them to lead their followers – the undifferentiated, inferior non-leaders (Stogdill, 1948).

However, trait theories received criticism for lacking empirical evidence, presenting a heavily gendered view of leadership, and for not specifically measuring leaders' characteristics. It was also unclear which leadership traits were more important than others, how traits linked to each other, whether possessing certain traits was enough to make someone a leader, and whether leadership traits and characteristics can be trained and developed. This criticism led to further research into leadership behaviours, resulting in behavioural theories.

3.2.2 Behavioural Theories

By the end of 1940, leadership theorists had moved beyond trait theories and started thinking about leadership behaviours (Fleishman, 1953a, 1953b; Katz et al., 1950). Following this idea, researchers started to explore the leadership behaviours that could enhance productivity (Avery, 2003; Bass & Bass, 2009). The early behavioural studies conducted at Ohio State University came up with two prominent leadership behaviours: consideration and initiating structure (Judge et al., 2004; Schriesheim & Kerr, 1974). According to this theory, leaders who show consideration behaviours express care and concern for their team members, respect and appreciate them, and support their wellbeing (Judge et al., 2004). Such leaders

were considered to be empathetic and to believe in building trust-based relationships through active listening and treating employees well. In comparison, leaders who exhibit initiating structure type behaviour were described as having a well-defined role for themselves and their followers. They were believed to be clear in developing policies and procedures and setting clear expectations and targets for their team members to minimise uncertainties around achieving organisational goals.

Studies conducted at Michigan State University added to the behaviour-based studies of leadership and introduced two similar sets of behaviours: production orientation and employee orientation. Production-oriented leaders were described to be more focused on technical aspects of the job, whereas employee-oriented leaders were more focused on human relations, synonymous with the leadership behaviours found in Ohio State University studies. Initially, these behaviours were considered two opposite ends of a continuum of leader behaviour. However, re-evaluation through more data collection found them to be independent leadership behaviour dimensions (Bowers & Seashore, 1966).

Behaviour-based studies continued to dominate until the 1960s. These studies started receiving criticism regarding their knowledge base which, according to the critics, only talked about the consequences of leadership behaviours but not their antecedents. Critics pointed out that leaders cannot solely choose certain types of behaviours; rather, many situational factors in the environment affect their behaviours. For example, a study showed that leaders dealing with ineffective teams displayed less considerate behaviours towards their team members than leaders working with effective teams (Lowin & Craig, 1968). This criticism led the researchers to incorporate situational factors while studying leadership behaviours.

3.2.3 Contingency or Situational Theories

Contingency theories combine leadership behaviours with external situational factors. The idea was that there is no best way to lead a team and that aligning leadership behaviours with external situational factors is essential to achieving the required results (Fiedler, 1967; Hersey & Blanchard, 1974; House, 1971; Vroom & Yetton, 1973). A prominent name that emerged in situational leadership theories was Fiedler, who developed a model and proposed that leaders should be matched with the situational factors that best aligned with their behavioural patterns (Fiedler, 1967). One after another, many other situational theories were presented (Hersey & Blanchard, 1974; House, 1971; Vroom & Yetton, 1973). While all of them presented different situational leadership models, the key contribution was recognition that the best way to lead is to match the leadership style with situational factors rather than trying to adopt a 'one size fits all' kind of leadership.

Among different situational factors identified by researchers, considerable attention was given to followers. Thus, in addition to situational factors such as the nature of work, there was increasing research into followers and the relationship between leaders and followers. Among different points of view, one school of thought was that followers' behaviours or performance at work was the direct consequence of leaders' behaviours towards them. Thus, leaders were required to understand followers' state of mind and their attitude towards the workplace in order to deal with followers' problems and extract the maximum possible performance from them.

This increasing importance given to the leader-follower relationship led to the relational perspective within the leadership literature, starting from the Vertical Dyad Linkage (VDL) approach (Dansereau Jr et al., 1975) to what later emerged as Relational Leadership theory (Graen & Uhl-Bien, 1995). From a relational perspective Leader Member Exchange

(LMX) theory was one of the early dyadic theory grounded in the concepts of 'reciprocity' (Gouldner, 1960), 'social exchange' (Blau, 2017), 'similarity attraction' (Byrne et al., 1971), and 'role' (Kartz & Kahn, 1978). LMX suggested that a positive, high-quality exchange relationship between leaders and employees was essential to achieve positive behavioural and organisational outcomes such as psychological health, wellbeing, performance, satisfaction, and commitment at individual, group, and organisational levels (Gerstner & Day, 1997; Graen & Uhl-Bien, 1995).

Like other theories of leadership, LMX also underwent a critical examination. For example, Karanika-Murray et al. (2015) emphasised that leaders are not a uniform group across the whole organisation; the extent to which leader-member exchange relationships yield positive outcomes depends upon the position of leaders within the organisation. Other scholars critiqued the over-simplification of dyadic relationships in this theory by pointing out that different situations might require different types of exchange relationships, and that if there is any imbalance, the leader should come forward and rectify the problem (Sheer, 2015). This view reiterated the importance of leaders within the organisations and gave rise to new leadership concepts that resulted in the full-range leadership model.

3.2.4 Full-range Leadership Model

The roots of the Full-Range Leadership Model (FRLM) (Avolio, 2004; Bass, 1999) were grounded in the late 1970s when Burns (1978) presented the idea of transformational leadership. Burns's model proposed that leadership types range from transactional to transformational. Avolio (1999) clarified the scope of FRLM by describing leadership as ranging from passive avoidant to high-level charismatic leadership. The theory fascinated many scholars and researchers and underwent rigorous research to explore a full set of leadership behaviours and styles ranging from transformational to laissez-faire leadership.

The first leadership style within FRLM was the transformational leadership style, which was initially introduced by Burns (1978). This style comprised four leadership behaviours: *Individualized Consideration* (special attention given to employees to foster their growth and development), *Intellectual Stimulation* (encouraging employees to challenge assumptions and come up with new ideas), *Inspirational Motivation* (motivating employees to perform beyond expectations through communicating a compelling vision), and *Idealized Influence* (exerting influence on employees by acting as a role model) (Bass & Avolio, 1994). Over time, a variety of studies have linked transformational leadership with positive performance and wellbeing-related outcomes, such as high team performance (Lim & Ployhart, 2004), wellbeing (Arnold et al., 2007), organisational commitment (Barling et al., 1996), and reduced stress (Sosik & Godshalk, 2000).

Within the FRLM, transactional leadership was described as exchange-based leadership that focused on clearly defining employees' expectations, targets or goals, measuring performance against those goals, and rewarding employees for achieving them. Theoretically, transactional leadership was described as a combination of constructive and corrective forms of leadership. Constructive leadership involved assigning tasks to employees, clarifying expectations and offering contingent rewards to employees based on their performance or fulfilment of given targets or goals. The corrective form of leadership comprised Management by Exceptions (MBE), which could be active or passive. The idea behind these types of leadership was that in MBE-active, leaders actively monitor employees' performance to ensure that set standards are met. In comparison, MBE-passive leaders only come forward and intervene when they see employees are not making progress as they should or if they are making some mistakes (Antonakis et al., 2003).

Transactional and transformational leadership styles have been widely researched and found to be associated with employees' wellbeing and job performance. For example,

transactional leaders establish transaction-based relationships with their followers, where they swap rewards for performance. These leaders associate desired behaviours with rewards and unwanted behaviours with punishments (Burns, 1978). On the other hand, transformational leaders try to inspire employees (Bass et al., 2003; Dvir et al., 2002) by communicating their organisational vision to them and empowering them to achieve that vision (Kim, 2014). Transformational leaders do this by displaying a high level of ethical and moral values, gaining followers' trust and energising them by articulating a compelling vision. These leaders also empower employees to achieve that vision, pay attention to their individual needs, and encourage them for their efforts and creativity.

Bass (1999) added further clarity by stating that transactional or transformational leadership approaches are not mutually exclusive but should complement each other. Therefore, a leader or leadership team can be transactional and transformational simultaneously (Bass, 1999; Howell & Avolio, 1993). Further research confirmed that transactional and transformational styles of leadership are not opposite (Lowe et al., 1996) but can be complementary. However, a considerable number of studies have shown that transformational leadership was more effective in enhancing performance, productivity of people, and their citizenship behaviour than the transactional style (Bass et al., 2003; Dvir et al., 2002; MacKenzie et al., 2001; Piccolo & Colquitt, 2006).

The third leadership category within the FRLM is Laissez-Faire Leadership, which was characterised as the absence of any form of leadership (Bass & Avolio, 1994). Leaders who display this style do not interfere with followers' tasks. Their decision-making is slow; they avoid giving feedback and do not offer rewards to employees. Thus, employees get no motivation from working under such leaders (Avolio, 2004). Considerable evidence has shown that employees working under leaders who exhibit a Laissez-Faire leadership style have low job satisfaction and low satisfaction with their supervisors (Bass & Stogdill, 1990;

Kelloway et al., 2005; Lopez et al., 2025). Based on these research findings, this style of leadership was considered ineffective.

The exceptional qualities associated with transformational leaders within FRLM gave rise to the description of other forms of leadership, such as charismatic (Shamir et al., 1993), visionary (Conger & Kanungo, 1988), and inspirational leadership (Yukl & Van Fleet, 1982). These forms of leadership were associated with follower outcomes in ways that distinguished them from the early theories and styles of leadership. For example, charismatic leadership was described as the most exemplary form of transformational leadership, characterised by the relational and symbolic dimensions of leadership behaviour rather than leaders' innate traits (Conger, 1999). Charisma also became embedded within the transformational leadership model as synonymous to "idealised influence" (Conger, 1999). However, some critics noticed the dark side of charismatic leadership by pointing out that before investing organisational resources into developing or nurturing charismatic and inspirational leaders, it is essential to ensure that leaders do not use their charisma in a manipulative way or for self-seeking purposes (House & Howell, 1992). These concerns gave rise to moral and ethical perspectives on leadership, and further advancements in leadership studies started to explore it from a moral or values-based perspective.

3.2.5 Values-Based Leadership

Values-based leadership (VBL) started to emerge as the result of leadership failures when many charismatic and transformational leaders were found to be lacking ethical, moral and authentic dimensions in their leadership (Avolio & Gardner, 2005; Brown et al., 2005; Cooper et al., 2005; Ilies et al., 2005). Leadership scholars started to emphasise that to restore trust and confidence in leaders and organisations, leaders needed to possess a strong set of moral and ethical values. VBL was characterised as a set of leadership behaviours anchored

in an ethical and moral foundation. Examples of a VBL approach to leadership include ethical, servant, and authentic leadership. For a complete review of VBL, see Copeland (2014)

Research on *Ethical Leadership (EL)* described it from either a normative or a descriptive perspective. Researchers from a normative perspective focused on how individuals "should" behave in the workplace (Bass & Steidlmeier, 1999; Ciulla, 1995). However, the normative approach did not examine the perceptions of employees about their leader, or antecedents and consequences associated with ethical leadership. Psychologists and organisational scientists defined EL from a descriptive perspective, which focused on the characteristics associated with ethical leaders, such as fairness, integrity, and ethical guidance (Brown et al., 2005; Kalshoven et al., 2011). Although, like other leadership styles, EL has received considerable criticism, there is a general consensus that the ethical behaviours of leaders have a strong positive impact on employees' performance, as ethical leaders serve as role models for employees (Wright et al., 2016). Specifically, those leaders who demonstrate ethical behaviours and who are in supervisory or managerial positions (Terglav et al., 2016) can influence their employees by shaping and supporting employees' ethical behaviours (Avolio et al., 2004; Grant, 2008).

Servant Leadership (SL) emerged as a holistic leadership approach which aims to empower followers in a way that allows them to grow and achieve their full potential. The foundations of SL lie in the altruistic and ethical orientation of leaders who seek to maximise the resources available for supporting their followers' performance rather than prioritising organisational goals over employee wellbeing (Greenleaf, 2013; Sendjaya, 2015). Thus, servant leaders motivate employees to perform their best by emphasising the importance of serving others and presenting themselves as a role model for employees (Judge et al., 2004; Lowe et al., 1996; Sarwar et al., 2021; Schwarz et al., 2016). In their review of servant

leadership, Van Dierendonck (2011) clarified the overlap between transformational and servant leadership and contended that servant leadership is more focused on the psychological needs of followers, whereas transformational leadership is more inclined towards achieving organisational goals. However, despite all the positive outcomes associated with servant leadership, this leadership style also comes with critical evaluations such as inconsistent definitions, a lack of empirical evidence, and unintentional reinforcement of gendered stereotypes which undermine its credibility as a distinct leadership theory (Herbert, 2005; Minnis & Callahan, 2010). For a complete review of servant leadership, see Eva et al. (2019).

Authentic leadership is a construct that has been under continuous development for more than thirty years (Erickson, 1995). The foundations of authenticity can be traced back to the ancient Greeks, who conceptualised it as knowing oneself (Harter, 2002). Socrates defined authenticity as a self-examination of one's life, while Aristotle introduced the importance of ethics and self-realisation as important ingredients of authenticity (Aristoteles & Ostwald, 1962). Aristotle also linked authenticity to the feelings of eudemonia that are achieved by engaging in satisfying activities that align with one's true self (Kernis & Goldman, 2006).

Contemporary scholars have made significant progress in conceptualising authenticity (Erickson, 1995; Harter, 2002; Kernis & Goldman, 2006; Novicevic et al., 2006), which fundamentally involves understanding how people discover themselves, own their personal experiences, emotions, and beliefs, and act according to their true selves in different situations (Harter, 2002; Luthans & Avolio, 2003). Luthans and Avolio (2003) integrated work on ethics and morality (Schulman, 2002), positive organisational behaviour (Luthans, 2002), transformational leadership (Avolio, 1999) and the FRLM to provide a comprehensive view of authentic leadership. Luthans and Avolio (2003) noted that although authentic and

transformational leadership sound like positive forms of leadership, there are considerable differences in their meanings. Unlike transformational leadership, two key elements were attributed to this relatively new values-based authentic leadership model – leaders' self-awareness and positive self-regulation. Self-awareness encapsulates the knowledge of the ethical values that authentic leaders can reinforce or strengthen, which also includes awareness of their "work-related" identity (Gardner et al., 2021), and knowing their own work-related strengths and weaknesses that enable them to understand workplace situations and act accordingly. The other component, self-regulation, involves adjusting thinking and behaviours according to situational and contextual factors (Luthans & Avolio, 2003). For example, the ability to understand the culture and beliefs of other team members while possessing strong personal values were denoted as essential elements for behaving authentically at the workplace (Luthans & Avolio, 2003). The concept of authentic leadership has undergone several iterations, see, for example, Gardner et al. (2011). The original model now comprises four components: self-awareness, relational transparency, internalised moral perspective, and balanced information processing (Walumbwa et al., 2008), which were adopted from the multi-component conceptualisation of authenticity developed by Kernis and Goldman (2005) and highly influenced by Self Determination Theory (Deci & Ryan, 2000).

In a workplace context, the core of authentic leadership is said to lie in leaders possessing humanistic values such as caring for staff, which motivates leaders to engage in supportive as well as goal-directed behaviours (Wong & Cummings, 2009). Leader authenticity helps build high-quality relationships with subordinates through behaviours such as transparency, ethical conduct, open information sharing, and inclusive decision-making (Gardner et al., 2005). The genuine interest in employees' needs helps leaders build a healthy work environment which is safe, empowering, satisfying, and associated with positive employee outcomes and better organisational performance (Alilyyani et al., 2018; Avolio et

al., 2004; Hmieleski et al., 2012; Leroy et al., 2012; Wong & Cummings, 2009; Wong et al., 2010). The behavioural integrity, predictability, and sound moral convictions of authentic leaders are said to help them to build trustworthy and productive relationships with their followers (Clapp-Smith et al., 2009; Hassan & Ahmed, 2011; Hmieleski et al., 2012; Hsieh & Wang, 2015; Leroy et al., 2012; Peus et al., 2012; Wong & Laschinger, 2013). Wei et al. (2018) advanced the research by exploring boundary conditions. Their findings showed that leaders' competencies are important in boosting employees' performance and citizenship behaviours. Therefore, encouraging authentic leadership behaviours when leaders are competent may help boost positive outcomes.

Despite the positive framing of authentic leadership, the concept has received considerable criticism, ranging from a lack of definitional clarity (Cooper et al., 2005) to presenting a heroic view of virtuous, authentic leaders with an overly simple view of corporate life, and ignoring theory development (Alvesson & Einola, 2019). Critics also point out that organisations face many challenges which cannot be solved by leaders' authenticity alone. As Tourish (2019) contends, it is easy to behave authentically and 'say exactly what you mean' when everything is favourable and leaders encounter the 'right' followers. In less ideal circumstances, for example, when the organisation is going through a change requiring confidentiality, then authentic openness may not be appropriate (Alvesson & Einola, 2022).

Gardner and McCauley (2022) considered the criticisms of authentic leadership and advised leaders to be authentic in a balanced way. Authenticity is not a static or binary state where leaders are either authentic or inauthentic (Erickson, 1995; Gardner et al., 2005); it is better seen as a process where people strive to be more authentic to reap positive outcomes. This may involve leaders being aware of their own and others' values, the context in which they work, and individual and situational differences. This information then needs to be balanced against leaders' personal beliefs and values in order to adapt their behaviours to

enhance followers' motivation, optimism, and trust (Avolio et al., 2004; Edú-Valsania et al., 2016; Gardner et al., 2021; Liu et al., 2018; Muntz et al., 2019; Walumbwa et al., 2008; Wong & Cummings, 2009). Thus, authentic leadership can play an important role in building relationships with followers, although it might not be sufficient to achieve desired goals on its own (Avolio et al., 2004).

3.3 Summarising the Leadership Discussion

The above discussion shows that leadership studies provide ample empirical evidence linking leadership with employee wellbeing, health-related outcomes, and work-related outcomes such as motivation, satisfaction, creativity, productivity, and performance (Barling & Frone, 2017; Harms et al., 2017; Kelloway et al., 2013; Samad et al., 2021). While some studies identify leadership as one of the factors associated with employees' wellbeing and performance at work (Diamantidis & Chatzoglou, 2019; Pawirosumarto et al., 2017), others go further to explain how different types of leader behaviour lead to different organisational outcomes (Ogbonnaya & Valizade, 2018; Zhang & Morris, 2014). The discussion also shows that effective leaders achieve organisational goals by motivating employees and directing their efforts, as well as supporting their wellbeing (Babatunde & Emem, 2015). This not only helps achieve organisational outcomes but also helps retain capable and talented employees.

However, leadership alone does not determine employee wellbeing or performance. DeJoy and Wilson (2003) contend that efforts to support employee wellbeing should start with the organisation itself. Organisations can place a priority on caring for employees' wellbeing and enabling supportive leadership behaviours. Maximisation of employee wellbeing is not solely dependent on leaders, as it requires the integrated effort of all managerial levels and support from organisational policies. A large number of studies support the importance of the organisational context for health promotion (Green, 1991; O'Donnell,

2002), wellbeing, (Alfes et al., 2012), and shared values. Before going into the details of how organisational health-promoting activities (broadly) and leaders' health-promoting behaviours (specifically) translate into better health and wellbeing outcomes for employees, it is essential to examine the concept of Workplace Health Promotion (WHP) in the following chapter.

Chapter 4

Healthy Leadership and Health-Promoting Leadership Behaviours (HPLB)

4.1 Workplace Health Promotion

The idea of Workplace Health Promotion (WHP) developed from the understanding that organisational factors have a strong impact on employees' health and wellbeing. WHP is defined as a "combined effort of employers, employees, and society to improve the health and wellbeing of people at work" (European Network for Workplace Health Promotion, 2007, p. 1). The concept of workplace health promotion originated from a traditional approach to occupational health and safety, which primarily focused on injury and illness prevention with a reliance on individual behaviour change. Examples included programs for smoking cessation or reducing weight through physical activity to improve the health of people at work, as well as an emphasis on safe work practices (Fishwick et al., 2013; Mache et al., 2015; Sorensen et al., 2004).

While an individualistic approach to workplace health promotion is widely used to change individual behaviours, organisational health practitioners have strongly criticised this approach (Noblet & LaMontagne, 2006; Noblet & Rodwell, 2010). Critics have pointed out that work-related individual health problems often indicate organisational-level problems rather than a simple lack of personal coping skills (Daykin, 1998). As one example, healthy eating initiatives assume employees have access to, and can afford, healthy food options while at work. Additionally, critics contend that even individual approaches which lead to short-term health benefits may not be related to long-term organisational effectiveness (Whatmore et al., 1999).

Contemporary trends across the globe further extend the responsibilities of organisations to go beyond *health protection* and injury prevention to *health promotion* and improving overall health and wellbeing (Shain & Kramer, 2004). This approach maintains that a psychologically healthy work environment is as crucial to health and wellbeing as it is to managing physical hazards (Goetzel et al., 2008). Therefore, workplace health promotion is now recognised as an essential element of occupational safety and health management systems to ensure the highest degree of psychological, physical, and social wellbeing for workers (Biswas et al., 2021; Goetzel, 2005). This approach underpins several influential and binding international charters and frameworks, such as the Ottawa Charter for Health Promotion (WHO, 1986), the Luxembourg Declaration on Workplace Health Promotion (European Network for Workplace Health Promotion, 2007), the WHO Healthy Workplace Framework (Burton, 2010), and the Decent Work Agenda of the International Labour Organisation (International Labour Organization, 2015). Furthermore, this comprehensive approach acknowledges that occupational health is not totally under individual control. Instead, it is collectively influenced by two forces: (a) employees' beliefs, attitudes, and behaviours towards their health, and (b) organisational practices regarding how work is organised and managed in terms of physical and psychosocial aspects (Shain & Kramer, 2004). Societal issues, resources and constraints also play an important role in how individuals maintain their health.

While a focus on the physical aspects of work has dominated, the psychosocial risks, i.e., the elements of work within a social or environmental context, can be equally responsible for causing physical, social, or psychological harm to employees' health (Cox et al., 2000). Research has shown that other people at work, especially managers who act as the main point of contact with employees, can influence employees' wellbeing on a day-to-day basis (van

Dierendonck et al., 2004). That is the reason that the leadership literature has extensively linked leadership styles and behaviours to employee wellbeing.

While some leadership constructs appear to be relevant to employee wellbeing and performance, others are not. One of the reasons for this inconsistent evidence could be that each study explores a different leadership style with respect to a chosen aspect of wellbeing or performance. For example, different leadership styles such as transactional, transformational, laissez-faire, and leader-member exchange have been associated with varying indicators of subordinate wellbeing, such as stress, mental health, affective or psychological wellbeing, in-role performance, and organisational citizenship behaviours, via different mechanisms (Arnold, 2017; Babalola, 2016; Harms et al., 2017; Inceoglu et al., 2018; Montano et al., 2017; Skakon et al., 2010)

Another issue within the leadership literature is the ambiguity which occurs when using the word 'leadership' in an unclear way. It is important to define the word 'leadership' clearly because leaders who are sitting at the top of the organisational hierarchy may influence or think about the wellbeing or performance of front-line employees in a different way than the immediate supervisors or managers of those employees. This ambiguity is reflected in the current leadership literature and emphasised in the LMX literature. For example Murray et al. (2015) contend that leaders are not a uniform group and that their position across different tiers of the organisation influences employee work experiences in distinct ways. While most of the studies implicitly use the term leaders to refer to immediate managers (Arnold et al., 2007; Tafvelin et al., 2011), only some studies explicitly analyse the behaviours of immediate managers concerning subordinate wellbeing or performance, such as Babalola (2016), who explored the influence of the supervisor-employee relationship on organisational commitment and job performance. Similarly, Gilbreath and Benson (2004)

investigated the extent to which supervisors' behaviours influence employee psychological wellbeing.

Despite these variations, there is general agreement that leaders in immediate supervisory or managerial positions act as an intermediary between front-line employees and higher-level management of the organisation (Yarker et al., 2008). Management practices and interpersonal behaviours of managers shaped by their personal preferences, values, and beliefs can facilitate subordinates' wellbeing or can harm employee wellbeing, for example, when managers withdraw support or act in a bullying way towards subordinates. Given the variety of ways in which managers can influence employees' day-to-day experiences with their job, they can have an important influence on their direct reports' health, wellbeing, and performance. To explore which aspects of leadership are especially relevant to subordinate wellbeing and the underlying mechanisms governing this relationship, more research was needed into leadership from employees' health and wellbeing perspectives. To fill this gap, a health-specific stream of leadership research emerged during the last decade – the healthy leadership literature. The following section discusses the literature on healthy leadership to explore the links between leaders' health-promoting behaviours and subordinates' wellbeing.

4.2 Healthy Leadership

Healthy leadership accounts for the health-specific influence of leaders on followers' physical and psychological health (Rudolph et al., 2020). Since the early 2000s, a range of studies conducted in this domain have attempted to explain how leaders impact the health and wellbeing of their team members, which has resulted in more than a dozen healthy leadership models. These models relate leaders' health-specific values (such as health prioritisation), attitudes (such as the importance given to subordinates' health), and behaviours (such as health-supportive behaviours) to employees' health-related outcomes. Although considerable

theoretical and conceptual overlap exists within these models in terms of how they conceptualise 'health and wellbeing' – varying from physical and emotional wellbeing to social wellbeing – all of the models try to explain how leaders influence the health or wellbeing of subordinates (Dunkl et al., 2015; Franke et al., 2014; Horstmann, 2018). These models illustrate how healthy leadership has been explored from multiple perspectives. For example, *health-specific leadership* (Gurt et al., 2011), *management support for worksite health promotion* (Della et al., 2008), *organisational leadership for health promotion* (Barrett et al., 2005), *health-promoting managerial work* (Dellve & Eriksson, 2017), and *salutogenic leadership* (Eberz & Herbert Antoni, 2016) all present an interrelated set of frameworks to define and describe healthy leadership. Rudolph et al. (2020) provides a useful summation of these models (see Table 4.1). Aspects of these models extend from leaders' awareness of followers' health and their supportive behaviours, for example, managing work demands, to creating a health-promoting culture within the organisation.

Construct	Definition	Citation
Health-promoting leadership	"...creating a culture for health-promoting workplaces and values that inspire and motivate employees to participate in such a development." (p. 17)	Eriksson (2011)
Health-oriented leadership	Leaders' values toward and awareness of their followers' health, and behaviours such as effective health-related communication and the design of health-promoting working conditions.	Franke and Felfe (2011)
Health and development-promoting leadership	"...leaders' direct impact on the demands, task requirements and resources of their employees." (p. 42)	Vincent (2012a, 2012b)
Health-specific leadership	Health-specific leadership is conceptualised as the leader's explicit consideration of and engagement in employee health. (p. 108)	Gurt et al. (2011)
Healthy leadership	"...style of humane and relationship-oriented leading with focus on the subjective wellbeing of employees and managers." (p. 1)	Jiménez et al. (2013)
Leadership support for health promotion	"Business alignment with health promotion objectives, awareness of the health-productivity link, worksite support for health promotion, and leadership support for health promotion." (p. 359)	Della et al. (2008)
Organisational leadership for health promotion	"A multidimensional process in which members, across multiple levels, exert influence on: 1. The development of health promotion (HP) objectives and action strategies for the improvement of community health 2. The implementation of action strategies to achieve community heart health objectives, 3. Organisational practices that strengthen group involvement and commitment to ongoing HP efforts,	Barrett et al. (2005)

	4. The development of a learning culture that sustains up-to-date HP actions and effective community interaction by the organisation." (pp. 197–198)	
Salutogenic leadership	Leadership behaviour that involves building trust, managing problems, and reducing work-related pressure faced by subordinates.	Eberz and Antoni (2018)
Health-promoting managerial work	"...managers' evidence-based knowledge of health-promoting psychosocial work conditions, as well as their capability to apply, adapt, and craft sustainable managerial work practices." (p. 1)	Della and Eriksson (2017)
Health-promoting leadership conditions	"...the provision of feedback about the leaders' efforts to create health-promoting working conditions in seven key aspects: health awareness, workload, control, reward, community, fairness and value-fit" (p. 1)	Vincent et al. (2012a, 2012b); Ulvenblad and Bregnzer (2017)
Individual leadership for health promotion	"...individual leadership behaviours as well as individuals' perceptions of different aspects of organisational leadership, but in relation to themselves only." (p. 4) Including: "individual actions characteristic of ongoing learning and reflection, and characteristic of leaders (i.e. reflective practices and professional development); and organisational practices and characteristics which foster individual leadership for health promotion (i.e. opportunity for change, skills and work conditions)." (p.4)	Anderson et al. (2005)
Health leadership	"Healthy leadership is usually understood as direct leadership behaviour and less as a general controlling function of structural leadership. Thus, healthy leadership focuses on personal leadership, which is practised and lived by executives, or not. Healthy leadership does not focus solely on employee leadership: Healthy leadership starts with one's own self in the form of self-management."	Möttner et al. (2016)
Health-focused leadership	Leader's behaviour that protects, enhances, and restores the health of employees.	Böhm and Baumgärtner (2016)

Table 4.1 Healthy Leadership Constructs (Rudolph et al., 2020, p. 2)

Following Rudolph, Yao et al. (2021) presented a thorough review of the concept of health-promoting leadership, and proposed a definition from a general and a specific perspective. They also critically examined the scales that have been developed to investigate health-promoting leadership and presented a research framework for Health Promoting Leadership (HPL). Their HPL framework explored potential antecedents such as leaders' health awareness and values, outcomes at individual (such as health and wellbeing) and organisational levels (health culture and practices), and the possible mechanisms based on Conservation of Resource (COR) theory, Social Learning Theory, Social Exchange Theory, and the Job Demands-Resources (JDR) model.

A critical examination of both reviews (Rudolph et al., 2020; Yao et al., 2021) indicates that out of all the existing models of healthy leadership, the Health-Promoting Leadership (Jiménez et al., 2016) and Health-Oriented Leadership (Franke & Felfe, 2011b) models have received the most empirical and theoretical attention and remain the most commonly cited. These two models emphasise the importance of leaders' health awareness and the creation of health-promoting working conditions for the wellbeing of employees. These models are explained below.

4.2.1 Health-Promoting Leadership

The idea of Health-Promoting Leadership (HPL) developed from the initial work of Hanson (2004) that focused on supportive leadership behaviours and the development of strategies for the enactment of a healthy workplace. Extending the ideas of Hanson (2004), Eriksson et al. (2011) analysed different views of health-promoting leadership along with the critical conditions that facilitate the development of such leadership. By conducting a qualitative study in Swedish municipalities, Eriksson et al (2011) explored how administrators, middle managers, and senior managers described health-promoting

leadership. Their studies showed that health-promoting leadership was a holistic leadership approach that was mainly concerned about "organising health-promoting activities, supportive leadership style, and developing a health-promoting workplace" (Eriksson et al., 2011, p. 77), for which organisational conditions, individual characteristics of managers, and financial and structural support available to managers were the critical conditions.

In their other studies, Erikson and colleagues showed the importance of organisational leaders in developing and influencing organisational culture, building organisational capacity for health promotion, and adopting a collaborative approach to designing and developing health-promoting workplaces (Eriksson, 2011; Eriksson et al., 2012; Eriksson et al., 2008). While none of these studies included non-managerial employees' perspectives about how they perceived health promotion at the workplace, a valuable addition to the literature was that managers in the higher administrative positions described the importance of employee health promotion for reducing sickness-related costs, while middle managers mainly related it to general service improvement. A limitation of Erikson and his colleagues' studies was that they were theoretical and qualitative explorations of the concept of health-promoting leadership, thus limiting their ability to present a scale to measure it.

The concept of HPL continued to evolve until Jimenez et al. (2017) critiqued the existing healthy leadership models by pointing out their over-reliance on individual leaders' characteristics. They emphasised that healthy leadership is not a leadership strategy or specific leadership style. Rather, healthy workplaces develop and are nurtured when individual leadership behaviours interact with organisational factors (Jimenez et al., 2017). They proposed seven important elements that constitute a healthy workplace culture. These elements include *health awareness, fairness, community, value-fit, reward, control, and appropriate workloads* (Jiménez et al., 2017).

Jiménez's work on these seven dimensions was inspired by Maslach and Leiter (2008) who reported on six areas of work related to burnout, i.e., *workload*, *control*, *reward*, *community*, *fairness*, and *values*. Based on the areas presented by Maslach and Leiter (2008), Jimenez et al. (2017) came up with a measurement scale for their health-promoting leadership model. However, Jimenez's scale received a lot of criticism as there was no guidance on how to use it, and no studies have examined the interactive relationship among the identified dimensions. The HPL framework also remains vague in terms of describing its theory-based processes, pathways, contexts, or variables.

4.2.2 Health Oriented Leadership

The concept of Health Oriented Leadership (HOL) evolved as a result of the critique of HPL. Franke and Felfe (2011b) made a critical evaluation of existing 'good' leadership styles and proposed their perspective on healthy leadership in terms of the Health Oriented Leadership model. They maintained that HOL is a unique type of leadership style, as it focuses on designing health-promoting workplaces through leaders' self-care. That is, the extent to which the leaders give importance to their personal health serves as a basis for their follower-directed care for staff – the extent to which leaders give importance to the health of their staff (Franke & Felfe, 2011a).

Franke and Felfe (2011a) presented their concept as a 'house of HOL', creating a link between leaders' self-care, which then serves as a foundation for leaders' care for staff and inspires followers to take care of their own health, i.e. self-care (see Figure 4.1). In the HOL house, the leaders' care for staff, and the leaders' and employees' individual self-care, are comprised of three components. The first component is the *value of health*, i.e., the extent to which leaders or followers give importance to their health and to the health of their subordinates. This component then links to the other two components. *Health awareness*,

which refers to knowledge and sensitivity to the factors that may affect one's health, e.g. job-related stress. The third component is *health behaviours,* which involve engagement in health-promoting activities, for example, managers designing employees' jobs in a way that provides flexibility and promotes their health. Health and wellbeing sit at the top of this model to show that these are the ultimate outcomes of all the above behaviours. It is noteworthy that three out of four parts of health and wellbeing in this model reflect ill-health and poor wellbeing (health complaints, irritation, and work-family conflict), while the fourth part, 'state of health', is relatively neutral. There is nothing in this model about positive aspects of wellbeing, such as thriving, engagement, or other positive indicators of wellbeing.

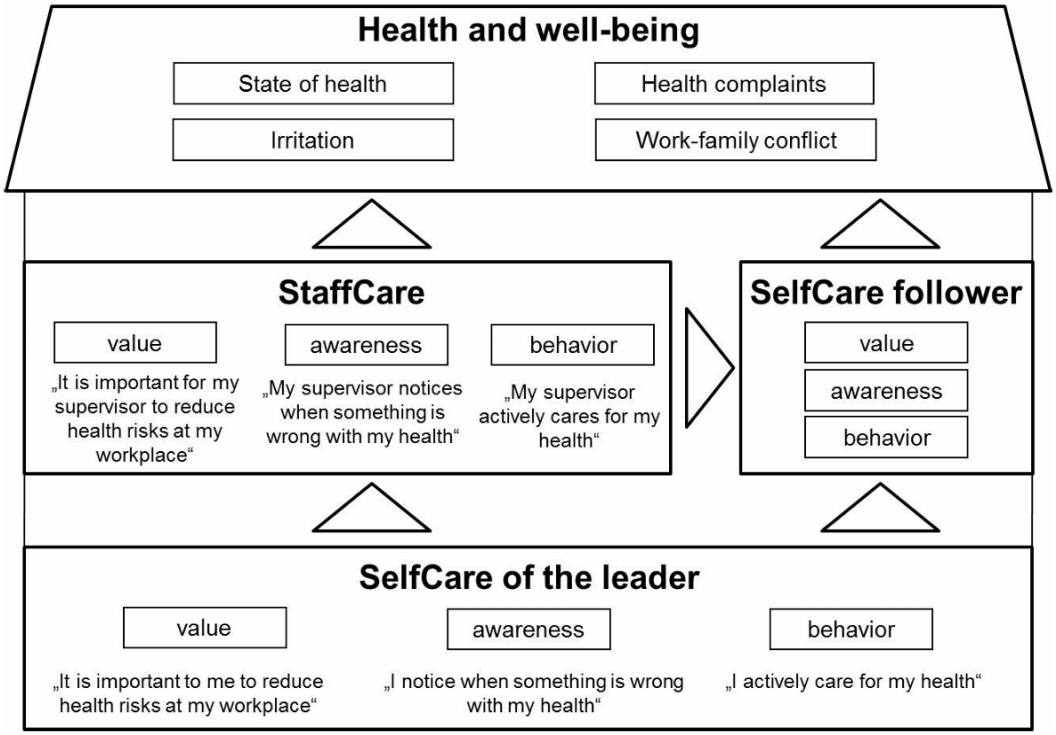


Figure 4.1 The House of Health Oriented Leadership (Franke et al., 2014, p. 142)

Although the HOL model has been widely cited, it has also received considerable critique for lacking conceptual clarity around how a leader's health awareness interacts with the organisational working environment to yield healthy outcomes for subordinates. Regarding its measurement, the HOL scale was initially developed by Franke and Felfe

(2011b) in German. However, it was later translated into English by Franke et al. (2014), who renamed HOL to Health-Promoting Leadership, which only added to the conceptual confusion. Also, as most of the studies collect data at a single point in time, knowing the actual impact of a leader's staff-care on their followers' health and wellbeing is almost impossible to measure (Rudolph et al., 2020).

This discussion shows that while Health Promoting Leadership (Jiménez et al., 2016) and Health-Oriented Leadership (Franke & Felfe, 2011a) remain prominent in the literature, the reality is that a considerable variation in how healthy leadership is conceptualised and measured puts a question mark on the validity of these constructs. Therefore, a dedicated healthy leadership model explaining the extent to which leaders influence employee wellbeing, along with a detailed pathway and an instrument to measure the health-specific influence of leaders on employees' health, was warranted. This gap was addressed by the Health Promoting Leadership Behaviour (HPLB) construct (Vincent, 2012) which is explained below.

4.2.3. Health Promoting Leadership Behaviour Model

The Health Promoting Leadership Behaviour (HPLB) model (Vincent, 2012) serves as an important advancement within the developing literature on healthy leadership. In contrast to the other healthy leadership constructs, this model explains *how* certain leadership behaviours influence subordinates' wellbeing by integrating the research on leadership and wellbeing, and work characteristics and wellbeing, into a single framework.

The HPLB model uses the Job Demand Resources (JDR) model (Bakker & Demerouti, 2007) as the underpinning theoretical framework. The JDR model is an advancement on previous models like the Demand Control Model (DCM) (Karasek, 1979) and the Effort Reward Imbalance (ERI) model (Siegrist, 1996), both of which tried to identify

the causes of job strain but are considered over-simplified due to the use of a limited set of variables to quantify job demands and resources. The JDR model maintains that every job has factors which may cause or reduce stress; these can be broadly categorised into job demands and job resources. The JDR model explains that job resources are not only essential for balancing work demands but also for personal growth and development. This explanation aligns with the Job Characteristic Model (JCM) (Hackman & Oldham, 1976) and Conservation of Resource (COR) theory (Hobfoll, 2001), both of which emphasise the motivational potential of job resources. From the JDR perspective, different resources available to employees at work influence their wellbeing and performance differently. For example, for some employees, the attainment of goals and receiving positive feedback might indicate their performance, whereas for others, having a high level of autonomy in how they can organise their work may indicate that they are performing well in the workplace (Putterill & Rohrer, 1995). Optimal job demands and resources have the potential to positively change employees' motivation, satisfaction, and dedication towards work, improve productivity and reduce health-related issues.

The JDR model also explains the two underlying processes – health impairment and motivational process – that influence how people experience job strain or motivation at work. The health impairment process describes how excessive demands exhaust employees and may lead to energy depletion and poor wellbeing over time. Conversely, the motivational process illustrates how optimal levels of job resources promote positive outcomes, reduce the impact of job demands, and lead to better work engagement and improved performance (Demerouti & Bakker, 2011). These points also connect to the happy worker-productive worker thesis, indicating that employees who experience wellbeing-related positive experiences tend to perform better at work.

Based on the JDR model, the HPLB model integrates research on leadership and wellbeing, and on job characteristics and wellbeing, and proposes that leaders influence their subordinates' wellbeing by shaping the work characteristics of their teams, with support from the organisation. Relying on the previous research, which shows that employees' work characteristics, such as role clarity, meaningful work, and growth opportunities, mediate the relationship between leadership and employee wellbeing (Arnold et al., 2007; Nielsen et al., 2008), the HPLB model emphasises the leaders' ability to shape employee work characteristics, which may lead to positive wellbeing outcomes. The HPLB model categorises work characteristics into three parts: *requirements*, *stressors*, and *resources*, and identifies the different effects of respective managerial behaviours on the mental health of employees (Vincent, 2012). *Stressors* in this model are described as stress-inducing factors that hinder growth and development at the workplace, for example, excessive workload. *Requirements* or *conditions* are described as development opportunities in the workplace, for example, skill enhancement or opportunities to transfer acquired knowledge. Finally, *resources* are those characteristics of work that help manage stressors and meet requirements, for example, autonomy and role clarity. Figure 4.2 illustrates this model.

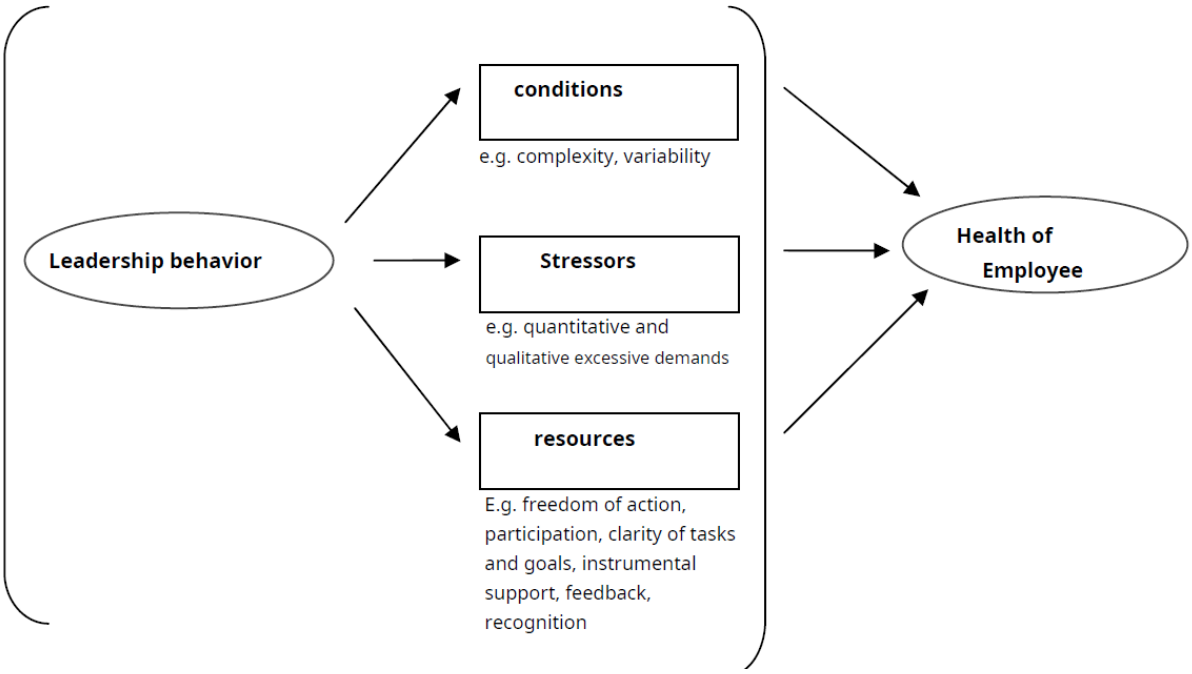


Figure 4.2 Theoretical Framework for Assessment of Health and Development Promoting Leadership Behaviours (Vincent, 2012, p. 44)

Vincent's model proposes that health-promoting leaders exhibit behaviours that relate to providing resources to employees at the workplace, for example, support, fairness, recognition, and autonomy, while managing demands such as workload, thus creating a conducive work environment in which subordinates thrive and experience wellbeing. This type of work design aligns with previous research, which shows that personalising the work for employees relates to health promotion (Ducki, 2000). The HPLB model is a rich model that aligns with the existing leadership literature, showing the importance of work characteristics in the leadership-wellbeing relationship (Arnold et al., 2007; Nielsen et al., 2008).

A notable contribution of Vincent is the development of a validated instrument for the measurement of health and development-promoting leadership behaviours (Vincent-Höper & Stein, 2019; Vincent, 2012). This measurement instrument – the Health and Development

Promoting Leadership Behaviour Questionnaire (HDPLBQ) – consists of 35 items each indicating a leadership behaviour. Collectively these 35 items represent 14 scales (see Table 4.2). The instrument helps to understand leaders' behaviours and their ability to influence their subordinates' health and wellbeing by affecting demands and resources at work. See Vincent-Höper and Stein (2019) for the detailed process of item generation and item review.

Scales	My direct supervisor…	Items
Demanding leadership		
Quantitative overload	…often puts me under time pressure.	3
Qualitative overload	…assigns me too much responsibility.	3
Development-oriented leadership		
Complexity/variability	…assigns me tasks which require me to use various skills and capabilities.	3
Control	…hands over most of the planning, execution and checking of my work to me.	2
Participation	…takes up my ideas and suggestions.	3
Trust in employees' abilities	…shows trust in my abilities and actions	2
Support-oriented leadership		
Instrumental support/information	…supports me in the work process when I have difficulties	3
Clarity/transparency	…clarifies who is responsible for what.	3
Recognition/feedback	…lets me know how well I do my job.	2
Conflict management	…searches for solutions to conflicts with those involved.	2
Cooperation	…encourages the employees to support each other.	2
Career support	…supports the advancement of my career.	2
Integrity/fairness	…is open and honest with me.	3
Care	…asks me about my well-being.	2

Table 4.2 Scales of the HDPLBQ with sample items (Vincent-Höper & Stein, 2019, p. 5)

The HDPLBQ labels the *stressors*, *resources, and requirements* described in the model as: *demand-oriented behaviours, support-oriented behaviours,* and *development-oriented behaviours*. ***Demand-oriented leadership behaviours*** denoted as stressors in the model are the behaviours that create quantitative and qualitative work overload, such as assigning employees too complex tasks, putting them under time pressure, etc. This dimension of a leader's behaviour aligns with previous studies that support the view that putting employees under quantitative or qualitative strain (for example, assigning too many tasks, or assigning tasks that are beyond their capacity) can have a poor impact on their health (Sonnentag & Frese, 2003).

Support-oriented leadership behaviours consist of leaders' actions that either have a direct health-promoting effect on employees or reduce the impact of stressors (Vincent-Höper & Stein, 2019). The aim is to provide resources to employees that allow for the achievement of organisational goals without putting employees' health at risk. Support-oriented leadership behaviours also reduce employees' uncertainty while performing tasks, e.g. through transparent communication, clear expectations, performance feedback, and instrumental support such as contributing through practical help or tangible assistance to complete a task rather than only offering emotional reassurance.

Development-oriented leadership behaviours involve leaders' actions that help employees upskill themselves, for example, delegating complex tasks, providing flexibility and showing confidence in employees' abilities. Vincent (2012) contends that supporting employees (through resources such as appropriate training or supervision) to effectively perform complex and variable tasks that are aligned with organisational performance requirements can have a positive impact on employees' health.

Taken together, the review of healthy leadership models demonstrates that Health-Promoting Leadership (HPL) and Health-Oriented Leadership (HOL) both offer valuable insights for understanding how leaders influence employee wellbeing. HPL contributes the broader idea of creating health-promoting working conditions and highlights the importance of leaders' health awareness and supportive behaviours. HOL adds the distinction between leaders' self-care and staff-care, emphasising that leaders' personal health values shape their follower-directed behaviours. However, both models have limitations: HPL remains largely conceptual and lacks clear theoretical pathways and a measurement instrument, while HOL suffers from conceptual ambiguity, an overemphasis on ill-health indicators, and measurement inconsistencies. In contrast, the HPLB model addresses these gaps by providing a more comprehensive and theoretically grounded framework, explaining how leaders shape employee wellbeing through work characteristics derived from the Job Demands-Resources model. Its validated measurement instrument further strengthens its applicability. For these reasons, HPLB is adopted as the guiding framework for the present research.

Before examining how managers' HPLB influence employees' wellbeing and performance in New Zealand, first, there is a need to understand what drives leaders to engage in health-promoting leadership behaviours.

4.3 Why do leaders engage in HPLB?

Understanding what drives managers to engage in health promoting leadership behaviours is important for knowing how organisations can cultivate and sustain a healthy workplace that protects employee wellbeing. As Nielsen (2017) points out, leaders do not operate in a vacuum. They need optimum conditions to deliver the best outcomes. Using Self-Determination Theory (SDT) (see Chapter 2), Deci et al. (2017) present a model of work

motivation which proposes that two factors account for an individual's engagement in a desired workplace behaviour: *workplace context* and *individual differences*. Based on this argument, this research proposes that managers' motivation to engage in HPLB might originate from three levels: *organisational level* (for example, the Psychosocial Safety Climate (PSC) of the organisation); the *job level* (for example, managers' perceived autonomy); and the *individual level* (for example, leaders' authentic leadership style).

While PSC, HPLB, and wellbeing models provide important insights into the organisational conditions, leadership behaviours, and employee outcomes associated with healthy workplaces, they do not explain *why* leaders choose to enact these behaviours in the first place. Because the central aim of this research is to understand managers' motivation to engage in HPLB, an explanatory framework is required to illuminate the underlying psychological processes that drive these behaviours. Self-Determination Theory (SDT) provides that framework by clarifying how workplace conditions, job characteristics, and individual differences shape the internalisation of health-promoting behaviours. Integrating SDT with PSC, perceived autonomy, and authentic leadership therefore allows this research to move beyond outcome-focused models and examine the motivational antecedents that lead managers to engage in HPLB.

These levels are compatible with the motivational continuum of SDT (see Chapter 2), which ranges from autonomous to controlled regulation (Deci & Ryan, 2000). Based on this continuum, managers might engage in HPLB because it is required by their organisation in the form of written policies and procedures (external regulation). The motivation might become more internalised when managers feel that their job allows them to support employee wellbeing, for example, providing them with appropriate resources in the form of job autonomy (introjected regulation). Finally, at the most self-determined level, managers might

promote employee wellbeing as they feel intrinsic satisfaction in creating a supportive workplace for their teams (intrinsic regulation).

Although different factors can explain motivations arising from organisational, job, and individual levels, this research focuses on three variables to reflect these levels: PSC, perceived autonomy, and authentic leadership. Together, these variables are used to explain managers' engagement in HPLB. These variables are examined in the first phase of this research – the quantitative study 1, Chapter 7. Figure 4.3 illustrates these enablers as proposed in this research. The blue circle in the middle represents managers' HPLB (demanding leadership behaviours, support-oriented leadership behaviours, and development-oriented leadership behaviours) as described by Vincent (2012) and explained in section 4.2.3.

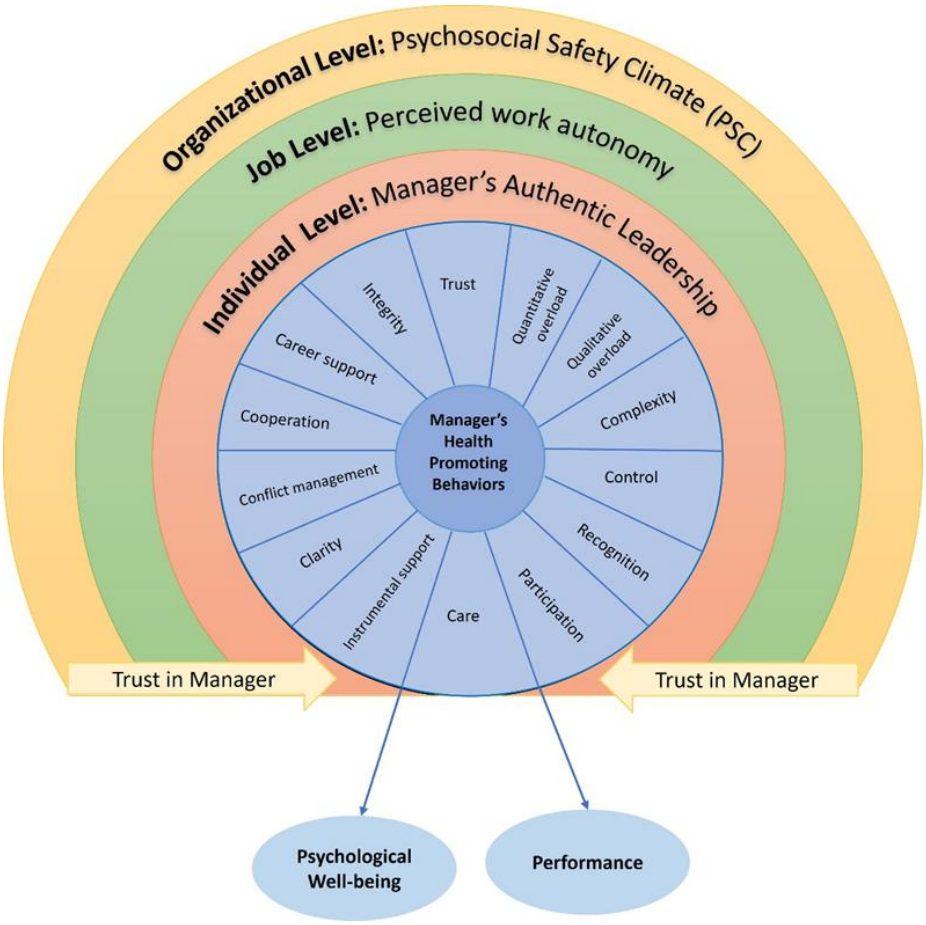


Figure 4.3 Research framework

4.4 Factors affecting managers' engagement in HPLB

Based on the above research framework outlining the drivers of managers' HPLB, this section elaborates on each of the focal variables in detail. The section starts with an explanation of PSC, perceived autonomy, authentic leadership, and perceived trust. The next section then details the associated research hypotheses.

4.4.1 Psychosocial Safety Climate (PSC)

Organisational climate is a broad term referring to the "shared perceptions of organisational policies, practices, and procedures" (Reichers & Schneider, 1990, p. 20). Research into organisational climate has identified facets, such as *safety climate*, which describes the impacts of organisational climate on physical health and safety (Zohar & Luria, 2005), and *Psychosocial Safety Climate (PSC),* which pertains to those facets of organisational climate related to psychosocial risks. The psychosocial risks within organisational climate may range from work overload to bullying, harassment, discrimination, or even abusive supervision (Loh et al., 2018; Zadow et al., 2019).

What does PSC look like in an organisation?

PSC refers to the "policies, practices, and procedures for protecting worker psychological health and safety" (Dollard & Bakker, 2010, p. 208). Consistent with the safety climate literature, which indicates that safety climate acts as a significant predictor of safety behaviours (Coyle et al., 1995), research has shown that PSC is strongly related to the attitudes and behaviours of leaders and employees (Kaluza et al., 2018). A positive PSC communicates that the organisation places a high priority on caring for its employees' psychological health by providing support, opportunities for participation, and involvement, and by managing psychosocial risks (Dollard & Bakker, 2010). Specifically, line managers,

who serve as a bridge between frontline employees and top management, are seen as being considerate of the wellbeing of their direct reports.

One way to analyse what PSC looks like in an organisation is to examine the characteristics of organisations where employees feel psychologically safe. Organisations characterised by a high level of PSC (high scores on measures of PSC) demonstrate a more explicit recognition of employees' psychological health and wellbeing. In such contexts, senior leadership is more likely to take steps or devise policies aimed at identifying and managing employees' stress and psychosocial risks (Dollard & Bakker, 2010), in addition to maintaining a focus on achieving organisational economic goals.

Dollard and Bakker (2010) present four essential components of PSC. First, PSC reflects senior management support and involvement in the prevention of work-related stress. Second, it reflects the extent to which psychological health and safety are prioritised as compared to productivity only. Third, organisational communication is given due importance to seek employees' input. Finally, it involves organisational participation, such as consultation, which is considered important to facilitate shared responsibility for managing psychosocial risks.

Ample evidence exists showing that organisations with a high level of PSC not only provide a buffer to prevent work-related stress for employees but also focus on improving working conditions and designing employees' jobs in a way that fosters their wellbeing and performance (Amoadu et al., 2025). These types of workplaces are rich in resources such as job control, autonomy, organisational and coworker support (Bronkhorst, 2015; Dollard et al., 2012; Tariq et al., 2021). Conversely, they have a low level of work-related pressure, job insecurity, and conflicting demands (Bronkhorst, 2015; McLinton et al., 2018). Therefore, people working in such work environments tend to report more resilience, a high level of

psychological wellbeing (Idris et al., 2012), and a low level of stress (Havermans et al., 2017), higher work performance (Platania et al., 2022; Taylor et al., 2019), and an elevated level of work engagement. Thus, frontline managers working in a high PSC work environment are more likely to exhibit wellbeing supportive behaviours for their teams. This aspect is discussed further in Section 4.5 on hypothesis development.

4.4.2 Perceived Autonomy

Autonomy as an essential social-contextual factor forms the basis for goal-directed, self-determined behaviours. Self-determined behaviours signify engagement in an activity out of innate interest rather than due to the enticement of an extrinsic reward. When extrinsic rewards are introduced, people lose interest in an activity and display less intrinsic motivation due to a shift in the focus from intrinsic to extrinsic motivation (Deci et al., 1999). Ryan (1982) contends that autonomy occupies a unique position, so much so that feelings of competence or relatedness alone cannot enhance intrinsic motivation unless complemented with autonomy. Research shows that it is not just rewards that undermine intrinsic motivation; other events, such as threats, surveillance, and strict deadlines, also reduce it. In contrast, facilitating conditions such as providing choice and encouraging self-initiation, satisfy the need for autonomy and result in positive outcomes (Deci & Ryan, 1985).

The motivational continuum of SDT (see Chapter 2) also differentiates three individual orientations for initiating and regulating behaviour, referred to as the general causality orientation. These orientations are labelled *autonomous-orientation, controlled orientation,* and *impersonal orientation* (Deci & Ryan, 1985). Autonomous orientation refers to an individual's general tendency to engage in behaviour by acknowledging that the social context supports employee autonomy. SDT further explains that to be self-determined means having a sense of discretion or choice in initiating an action (Deci et al., 1989). Since

managers within an organisation are often in a very complicated situation where they have to deal with their teams daily, resolve their issues and provide them with the best working environment in addition to complying with and enforcing the organisational rules and regulations and deliver work outcomes for the achievement of organisational goals. In this situation, senior leadership can support frontline managers by fulfilling their need for autonomy (Deci et al., 2017), which, according to SDT, may become a reason for managers to actively engage in desired behaviours.

4.4.3 Perceived Authentic Leadership

As a positive construct, authenticity refers to individuals owning their personal experiences and acting as per their true selves (Harter, 2002). Luthans and Avolio (2003) connect research on ethics and morality (Schulman, 2002) with positive organisational behaviour (Luthans, 2002), and transformational leadership (Avolio, 1999) to give a broad view of authentic leadership. Two key elements attributed to this values-based leadership model are leaders' *self-awareness* and positive *self-regulation*. Self-awareness encapsulates knowledge of the ethical values that authentic leaders can reinforce or strengthen, whereas self-regulation involves adjusting thinking and behaviours according to situational and contextual factors (Luthans & Avolio, 2003).

The core of authentic leadership lies in possessing superior humanistic values (Wong & Cummings, 2009) of caring for their staff, because it corresponds to their values and beliefs and gives them inherent satisfaction. In addition, managers' authenticity helps build high-quality relationships with subordinates through their actions, such as transparency, ethical conduct, open information sharing, and inclusive decision-making (Gardner et al., 2005). Through self-responsibility of exhibiting a caring attitude, genuine interest in employees, and open communication, authentic leaders serve as a key driver in building a

healthy work environment, which is safe, empowering, and satisfying and associated with positive health as well as work outcomes such as higher job satisfaction and better performance (Alilyyani et al., 2018; Avolio et al., 2004; Wong & Cummings, 2009).

Despite the positive outcomes of authentic leadership, the concept has also received considerable criticism. Cooper et al. (2005) point out that there is no agreed-upon definition of authentic leadership, which leads to considerable conceptual confusion. Critiquing the conceptual, theoretical, and practical aspects of authentic leadership, Alvesson and Einola (2019) add that most of the authentic leadership literature focuses excessively on the positivity associated with authentic leadership, accompanied by a simple view of corporate life. Influential researchers like Avolio et al. (2004) acknowledge that authentic leadership plays an important role in the relationship with followers, but it's not sufficient to achieve the desired goals on its own.

While critics of authentic leadership view the positivity and knowledge of one's moral values as the problematic part, this concern ignores that authentic leaders are flexible enough to self-regulate their behaviour. Authentic leaders are aware of their values and those of others, and the context in which they work (Avolio et al., 2004). Thus, they acknowledge both individual and situational differences and adapt their behaviours accordingly, which influences subordinates' attitudes and behaviours and enhances followers' motivation, optimism, and trust in management (Avolio et al., 2004; Walumbwa et al., 2008; Wong & Cummings, 2009). Accordingly, the capability of authentic leaders to adjust their behaviours as per employees' needs provides their members with a psychologically supportive environment that enhances employees' trust in their leaders.

4.4.4 Perceived Trust

There is no single agreed-upon conceptualisation of trust, as it has been used in multiple disciplines differently (Burke et al., 2007). One way to understand why one party will trust another party is to understand the attributes of the trustee. Mayer et al. (1995) ascribe three characteristics essential for developing trust: *integrity*, *benevolence*, and *ability*. Authentic leaders' trustworthy behaviours, such as individualised concern, respect, care, open communication, and information sharing, help them build a realistic social relationship with their staff (Avolio et al., 2004; Jung & Avolio, 2000). Subordinates (trustors) make inferences about the characteristics of their managers (trustees), such as their degree of honesty, integrity, and fairness, which helps them build the foundation for a robust and optimistic relationship with their managers. The resulting trustworthy and transparent relationship based on managers' moral standards enhances followers' willingness to cooperate with them to achieve organisational goals.

This research uses the term *felt trust* to refer to a manager's perception of being trusted by their team members (Lau et al., 2007). Lau et al. (2007) propose that felt trust enhances feelings of self-efficacy and confidence of the trustee (managers) and enhances obligation towards trustors (team members). A feeling of being trusted reduces uncertainty, improves competence, and the perception that the other person is willingly relying upon the perceiver (Skiba & Wildman, 2019). Together, these views position felt trust as a key psychological resource that defines how managers perceive their relationship with their teams, enabling them to care for employee wellbeing.

Building on the theoretical framework given above, the following section focuses on presenting the hypothesis developed for this research.

4.5 Research Hypotheses

Managers in the frontline position have to deal with competing demands, i.e., on one hand they have to work on the priorities set by senior leadership, on the other hand, they have to oversee day-to-day work done by frontline staff, which can limit their ability to care for staff's wellbeing. It becomes crucial to understand that what is their motivation to engage in health-promoting leadership behaviours for the wellbeing of their teams.

A strong PSC has the potential to serve as a strong foundation of managers' HPLB. Organisational climate is widely understood to be shaped by the decisions, priorities, and behaviours of organisational leaders. Through the signals that they send about what is valued, the practices that they endorse, and expectations that they set, top management plays an important role in constructing an organisational climate. Existing research shows that leaders working in highly health-focused climates are more likely to engage in behaviours that support employee health than leaders in climates where health is given lower priority (Loh et al., 2021). A reason could be that when leaders, specifically in the frontline positions, work in an organisation, they become aware of the extent to which the organisation deploys its resources for employees' health and wellbeing (Vandenberg et al., 2002), which then shapes their behaviours towards their team members.

A possible research strand that could link a manager's concern for the employees' health and PSC could be the work of Dollard and Bakker (2010), where they contend that organisational PSC is a precursor to conducive psychosocial working conditions. Frontline managers internalise the values set by the high PSC organisations because they get positive signals from the senior leadership in the form of optimum resources and adequate support. Therefore, it can be assumed that managers who perceive themselves to be working in a positive PSC context are more likely to engage in health-promoting behaviours as the

upstream organisational climate supports them. Consequently, managers are more likely to provide a favourable work environment to their subordinates to support their wellbeing, e.g., by reducing work demands and enhancing work resources.

This view is also consistent with the healthy leadership literature, where, for example, Vincent-Höper and Stein (2019) propose that leaders who act as co-designers of work characteristics reduce job demands and enhance job resources to positively influence their subordinates' health and wellbeing. Health-promoting managers specifically influence the climate of their workgroup by facilitating their team members, providing them with the best working environment, and reducing unnecessary stressors and work overload.

Based on the argument that PSC shapes and is shaped by leaders' behaviours (Loh et al., 2021), it can be assumed that, on one hand, managers transmit the effects of organisational PSC onto their subordinates, positively affecting their wellbeing and performance; on the other hand, they themselves are dependent on their work characteristics to perceive PSC positively. Therefore, this research proposes that the combined interplay of managers' perceived autonomy and authentic leadership might shape managers' perceptions of PSC which then impacts their onwards engagement in HPLB.

This proposition is also supported by need fulfilment and motivational mechanisms of SDT (see Chapter 2). Individuals make evaluations of their work environment based on the extent to which workplaces support or thwart their basic psychological needs. In a work climate where employees' basic psychological needs are satisfied, people have a feeling of vitality and exhibit favourable work behaviours (Ryan et al., 2022). In contrast, workplaces where employees' needs are not fulfilled lead them to experience psychological malnourishment and low-quality interactions at work (Dollard et al., 2017). Integrating SDT with Psychosocial Safety Climate (PSC) research, Shee et al. (2025) demonstrate that PSC

acts as a need supportive social context. Specifically, when organisations support the need for autonomy, it also helps to fulfil other needs, i.e., competence and relatedness, as people feel more capable in their roles and make a positive evaluation of their work environment and feel proud to be associated with it. A high PSC work environment reflects the degree to which the organisation supports psychological health and provides a safe working environment to employees. Thus, need fulfilment makes people in the organisation positively evaluate the broader organisational climate.

Deci's model of work motivation further highlights that individuals differ in their characteristics such as values, personality, and leadership styles, and that these individual differences underpin varying levels of autonomous motivation to engage in a particular behaviour (Deci et al., 2017). The motivational mechanism of SDT supports the idea that the greater the autonomous motivation to engage in a behaviour, the more likely people are to exhibit that behaviour, as it aligns with their internal self. In addition, empirical research supports the view that employees' self-directed, autonomous behaviours are associated with a positive PSC (Hu et al., 2022; Loh et al., 2018). While extensive literature links leadership styles such as transformational leadership with safety climate (Kapp, 2012; Wu et al., 2008; Zohar, 2002), the research on the association between PSC and value-based leadership is still developing. Previous leadership research shows that team leaders who exhibit a high level of self-awareness and self-regulation (components of authentic leadership) boost their team's wellbeing (Kim, 2018). However, little is known about how these characteristics are associated with PSC perceptions. Based on these arguments, this research proposes that managers who perceive themselves as authentic are more likely to make a positive evaluation of organisational PSC, as the organisational climate aligns with their internal values and supports them in exhibiting authenticity at work through internal regulation.

Based on these arguments, the quantitative phase of this research, which comprises two survey-based studies, explores frontline managers' perceived autonomy and authentic leadership as precursors of their PSC perceptions. The following sub-sections discuss these hypotheses.

4.5.1 PSC and Perceived Work Autonomy

The PSC literature shows that managers make a positive evaluation of organisational climate when they observe senior management commitment to the psychological health and wellbeing of employees (Hall et al., 2010). PSC shapes the broader psychosocial work environment, which includes employee involvement and availability of job resources, such as autonomy at all levels of the organisation. Since frontline managers are the first point of contact with employees and are considered most responsible for employees' positive workplace experience, caring for frontline managers' need for autonomy is most crucial for organisations so that they can sense a positive PSC and transmit its desired outcomes to employees. Recent research shows that PSC supports employee wellbeing through the satisfaction of their basic psychological needs (Shee et al., 2025). Since PSC shapes and is shaped by leaders' behaviours, support provided to frontline managers in the form of autonomy from senior leadership to prioritise the wellbeing of employees might enable frontline managers to perceive PSC positively, leading to positive employee wellbeing outcomes.

Although healthy leadership research has not been explored in the context of SDT, existing transformational leadership research does indicate that when transformational leaders experience the satisfaction of their basic psychological needs, they become more transformational in their actions (Trépanier et al., 2012). The fulfilment of basic psychological needs has other far-reaching benefits. For example, need fulfilment is very

interrelated (though these needs can't be combined), such that when employees experience an autonomy-supportive culture at work, they make a positive evaluation of their role (feel more competent) or sense more connectedness with the organisation, see a review of SDT by Van den Broeck et al. (2016). Similarly, other studies (De Cooman et al., 2013; Otis & Pelletier, 2005) have demonstrated that the fulfilment of basic psychological needs can lead to more autonomous motivation to engage in certain behaviours.

Perceived work autonomy has also received considerable attention in the context of the work environment, so much so that autonomy has been described in work motivation theories as an intrinsically motivating job characteristic that acts as a precursor for engagement in autonomously motivated behaviours (Gagné & Deci, 2005). When individuals perceive that the job provides substantial freedom, independence, and discretion in scheduling tasks and related procedures, it triggers positive personal and work-related psychological states (such as perceived meaningfulness of the role), leading to positive employee outcomes (Hackman & Oldham, 1976). Various research strands support this view by arguing that work autonomy is an essential element of job design that positively relates to intrinsic motivation (Humphrey et al., 2007), role breadth, increased task mastery, motivation to accept challenging tasks (Morgeson et al., 2005), and enhanced employees' confidence to solve problems (Parker, 1998). Contrary to this, a lack of autonomy relates to stress, absenteeism, and burnout (Humphrey et al., 2007).

By connecting these research strands with healthy leadership, this research proposes that an autonomy supportive work environment may act as a precursor to a manager's positive perceptions about organisational PSC. Although no empirical evidence exists to support autonomous motivation as a predictor of positive PSC perceptions. A recent review by Amoadu et al. (2025) shows that, in healthcare settings, jobs with enriched resources positively correlate with high PSC perceptions and play an important role in shaping the work

environment. Feelings of being the originator/controller of their behaviours can potentially enhance a manager's perception of the purpose and value of their job and make a positive evaluation of their work climate. Autonomously motivated managers may shape the work characteristics of subordinates by enhancing their resources and reducing demands, thereby giving subordinates inherent satisfaction of their needs that may lead to positive wellbeing and performance outcomes. An autonomy supportive work environment communicates to managers that the organisation is committed to prioritising employees' psychological health and, to achieve this goal, understands the importance of frontline managers' need fulfilment. Autonomy supportive work climate enhances frontline managers autonomous motivation, and they make positive evaluations of their work climate. Therefore, this research proposes that perceived work autonomy may act as an antecedent for a manager's perception of their organisation's PSC:

> ***Hypothesis 1:*** *Managers' perceived autonomy support positively relates to their perceptions of PSC in the organisation.*

4.5.2 PSC and Perceived Authentic Leadership

Work psychology literature supports that people engage in activities based on their mindset and self-awareness, which acts as a precursor to shaping their behaviours (Crum et al., 2013). Authentic leaders' flexibility and tendency to regulate their behaviours according to the organisational requirements could also lead to their varying perceptions of organisational climate. As SDT contends that variations in causality orientation (Deci et al., 2017) may serve as catalysts to engage in distinct behaviours ranging from autonomously motivated to controlled behaviours. Existing leadership research identifies positive associations between leadership and PSC perceptions (Laloo et al., 2023). Within value-based leadership, authentic leaders' values align closely with the priorities of a high PSC

environment. Shirey (2009) contends that a positive organisational culture and authentic leaders are the foundations of a healthy work environment. A high PSC work environment is focused on the psychological health and safety of employees and embodies a supportive and participative management style (Dollard & Bakker, 2010), which offers authentic managers to evaluate it positively. Authentic leaders tend to foster trust, psychological safety, and high-quality relationships within their teams (Liu et al., 2015; Maximo et al., 2019). Such leaders have a highly internalised self-motivation to emphasise openness, ethical conduct, and genuine concern for employee wellbeing. This value congruence leads to the assumption that managers who perceive themselves to be authentic are more likely to evaluate organisational PSC positively because it aligns with their values. This reasoning leads to the following hypothesis:

> ***Hypothesis 2****: Managers' self-reported authentic leadership positively relates to their perceptions of PSC in the organisation.*

The resulting belief of subordinates in their managers' integrity may help to build a trusting relationship with their managers because it relates to leadership effectiveness (Bass, 1999) and a range of other organisational outcomes such as enhanced citizenship behaviour, greater belief in information, lower turnover intention and more commitment (Dirks & Ferrin, 2002). The following section discusses the role of employees' trust in their managers' authentic behaviours and how trust mediates this relationship:

4.5.3 Role of Perceived Trust

Considerable research supports the contention that employees' trust in their manager is associated with their ongoing dedication, positive attitudinal, behavioural, and organisational outcomes such as citizenship behaviour, organisational commitment, better performance, and wellbeing (Boğan & Dedeoğlu, 2017; Chughtai et al., 2015; Dirks &

Ferrin, 2002; Hendriks et al., 2020; Krosgaard et al., 2002; Liu et al., 2010). Trustful relationships between managers and their team members also lower teammates' tendency to engage in negative behaviours (Megeirhi et al., 2018). Leadership research also supports the view that employee trust in their manager is associated with the perceived effectiveness of that manager (Gillespie & Mann, 2004). A manager's authentic relationship with their team members fosters an environment where their team members feel psychologically safe (Nielsen et al., 2013). In terms of SDT, positive leader-member relationships strengthen the positive effect of authentic leadership and also enhance a manager's perceptions of being connected to a psychosocially safe work environment by fulfilling their need for connectedness. Thus, interpersonal trust-based leader-member relationships can yield a dual positive effect, increasing team members' confidence in their managers while simultaneously enhancing positive perceptions of managers regarding the psychosocial safety climate of the organisation.

As authentic leaders create a trustworthy environment within the organisation, employees believe that their actions are consistent with the desired policies. Managers' authenticity also shapes a positive organisational climate supported by a high level of subordinate trust. Thus, in the context of this research, when a manager feels that their team members trust their behaviours and integrity, they get a validation of their competency and may make a positive evaluation of their work environment (PSC in this research). This discussion leads to following hypothesis:

> ***Hypothesis 3:*** *Managers' perception of subordinate trust mediates the relationship between managers' self-reported authentic leadership and PSC.*

Based on this discussion, the present research proposes that a work environment where managers feel fulfilment of their basic need for autonomy and can be authentic by

exhibiting their true self are more likely to make a positive evaluation of organisational PSC. These positive PSC perceptions may serve as a motivator for managers to engage in HPLB. The motivational mechanism of SDT also supports that when managers sense that the organisation prioritises employees' health and wellbeing, and has written down policies and procedures for that, they feel obligated to exhibit health promoting behaviours through external regulation. While existing PSC literature shows that a positive PSC leads to the creation of a favourable work environment for employees, a gap that remains unfulfilled is what factors shape organisational PSC. Therefore, acknowledging that PSC is a key organisational factor that affects and is affected by leader behaviour, this thesis explores PSC as a key enabler of managers' engagement in HPLB, where perceived autonomy and authentic leadership serve as the factors that help managers to evaluate PSC positively. HPLB.

Based on this discussion and hypotheses outlined above, the quantitative study 1 (Chapter 7) of this thesis examines managers' perceived autonomy and authentic leadership as antecedents of their PSC perceptions. The effect of PSC on managers' engagement in HPLB is explored in the qualitative studies (Chapters 10 and 11) to gain rich insights into their motivations for exhibiting these behaviours.

The following section elaborates on the remaining part of the theoretical framework and discusses how managers HPLB relate to employee wellbeing and performance.

4.6 Health-Promoting Leadership Behaviours, Employee Wellbeing and Performance

The key link between Vincent's HPLB model (Section 4.2.3) and employees' wellbeing and job performance lies in the underlying explanation provided by the JDR model. The HPLB model suggests that health-promoting leaders provide job resources to

employees while reducing the burden of job demands, thereby promoting their health. The model explains that prioritising employee wellbeing is the key for health-promoting leaders while designing their jobs. Although no empirical evidence exists to examine the influence of the HPLB model on employee performance, the model provides a convincing theoretical explanation for why leaders who provide the best job characteristics to employees are likely to see a range of positive employee outcomes, including wellbeing. The model, on the other hand, supports that when jobs fail to provide a positive and supportive employee experience, wellbeing is affected.

As explained in Chapter 2, performance-wellbeing literature also provides ample evidence showing that employee wellbeing and performance are affected by poor work design (De Jonge & Schaufeli, 1998; Jeurissen & Nyklíček, 2001; Warr, 2011). Previous studies have also shown that when managers carefully design jobs for employees and facilitate them at work, it fulfils their basic psychological needs, leading to positive outcomes such as autonomous motivation, better job performance, and satisfaction (Gagné et al., 1997; Humphrey et al., 2007; Millette & Gagné, 2008). Gillet et al. (2012) further support that satisfaction with basic psychological needs leads to greater hedonic and eudemonic wellbeing; in comparison, the frustration with these needs leads to poor wellbeing and greater exhaustion (Vander Elst et al., 2012).

General leadership studies consistently demonstrate that work characteristics serve as an important mechanism through which leadership influences employee wellbeing. For example, transformational leadership has been associated with employee wellbeing through fostering meaningful work, role clarity, and opportunities for growth and development (Arnold et al., 2007; Nielsen et al., 2008; Yasin Ghadi et al., 2013). These studies suggest that transformational leaders create a more favourable work environment for employees by enhancing resources and reducing demands, thereby contributing positively to their wellbeing

(Fernet et al., 2015; Hentrich et al., 2017; Stordeur et al., 2001; Thomas & Lankau, 2009). Within the leadership literature, other studies have shown a positive association between authentic leadership and work engagement and organisational justice (Bamford et al., 2013; Kiersch & Byrne, 2015). Likewise, LMX has been linked to job demands and job resources (Jiang, 2014). Toxic leadership, on the other hand, is associated with decreased employee satisfaction, commitment, increased employee turnover and poor performance (Yavaş, 2016). Similarly, abusive leadership has been associated with emotional tiredness and feelings of worthlessness (Lavoie-Tremblay et al., 2016).

Despite conceptual overlaps of HPLB model with the existing positive leadership approaches, a basic difference exists in that HPLB model places employee wellbeing at the centre of the leadership role rather than treating it as a secondary outcome, though this model does not directly examine the relationship between HPLB and performance outcomes. As a new promising management approach, a key focus of health-promoting leaders is to exhibit the behaviours (described in section 4.2.3) that protect employees' health and boost their wellbeing by fulfilling their basic psychological needs, reducing their work-related pressure and enhancing their support to fulfil job demands.

This thesis integrates the underlying mechanism of the HPLB model with the SDT framework to explain how managers' behaviours may affect employees' wellbeing and performance. Although SDT has not been examined through a job-characteristics lens, managers' efforts to fulfil employees' needs align with providing a well-designed work environment that supports need satisfaction and motivation. The HPLB model supports the same idea, with managers designing employees' roles by providing job resources and reducing demands. Well-designed jobs then lead to positive wellbeing and health-related outcomes. Studies conducted with the SDT lens show that managers' job supportive behaviours lead to the fulfilment of basic psychological needs and autonomous motivation,

which in turn lead to positive outcomes such as greater work engagement, enjoyment at work, better performance, greater psychological wellbeing, less burnout, fewer turnovers, less emotional exhaustion, and greater commitment (Andreassen et al., 2010; Fernet et al., 2012; Fernet et al., 2010; Richer et al., 2002; Van den Broeck et al., 2008).

The above discussion proposes following hypotheses:

Hypothesis 4: *Non-managers' perceptions of their managers' health-promoting leadership behaviours positively relate to their self-reported performance.*

Hypothesis 5: *PWB mediates the relationship between non-managers' perceptions of their managers' health-promoting leadership behaviours and their self-reported performance*

The discussion in Chapters 2-4 shows that employee wellbeing alongside their performance at work are fundamental concern for organisations. Leadership research has attempted to establish a connection between leadership and employees' wellbeing and performance outcomes. However, leadership literature has mushroomed with the beneficial effects of the different leadership conceptualisations on followers' health outcomes. For example, many leadership styles within leadership research, such as transactional, transformational, charismatic, ethical, servant, and, more recently, authentic leadership, have been linked to different employee outcomes such as stress, burnout, wellbeing, and productivity (Arnold et al., 2007; Hoert et al., 2018; Kranabetter & Niessen, 2017; Kuoppala et al., 2008). Even after more than a decade since the emergence of the healthy leadership concept, the current theorising leaves a significant gap in identifying and understanding the precursors that motivate frontline managers to engage in HPLB and the barriers to exhibiting these behaviours at work. Based on the literature, this thesis identifies the important role played by managers' PSC perceptions to foster a healthy workplace and covers the gap as to how managers' autonomy perceptions and authentic leadership relate to PSC perceptions. The

thesis then examines how managers' HPLB influence employee wellbeing and performance outcomes.

The following chapter details the methodology employed in this research to answer these questions.

Chapter 5

Research Methodology

5.1 Introduction

A clear understanding of the research design and process is essential to undertake a research project successfully. The research process entails making informed choices about research philosophy, approaches to reasoning, choice of research strategy, techniques of data collection and data analyses, and choosing the best possible way to report and present the data (Saunders et al., 2019). The main criteria for choosing a research methodology are not a matter of the researcher's personal preferences; rather, they should be driven by the type of available data, what has already been researched and whether they will appropriately address the research objectives and answer the research questions (Reiter et al., 2011) .

This chapter starts by discussing the key elements of the research process. It then discusses the methodological approach adopted and the methods used to conduct this research.

5.2 The Research Process

Research is an iterative process during which a researcher makes several choices at several stages to answer specific questions. It is quite common for a researcher to start thinking about the method to collect the data at the beginning of the research. However, other stages should be given due consideration before thinking about the research methods. Saunders et al. (2019) depict these stages in the research process as layers of a research onion (see Figure 5.1). The layers of the research onion comprise research philosophy, approach(es)

to theory development, methodological choices, research strategy, time horizon, and techniques for data collection.

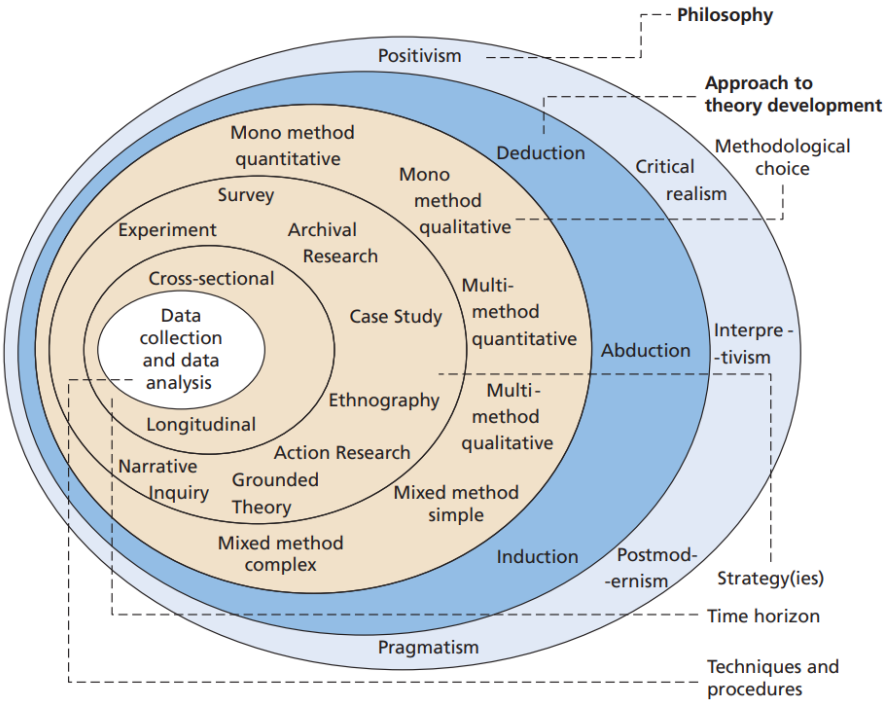


Figure 5.1 The 'Research Onion' (Saunders et al., 2019, p. 130)

Collectively, the layers of the research onion shape decisions around how to formulate research *methodology* and *methods* to carry out a research project. The terms method and methodology are often used interchangeably; however, the ***method*** is used to refer to the actual procedures used to collect and analyse the data, for example, quantitative or qualitative methods such as interviews, surveys, focus groups, etc. In contrast, ***methodology*** describes the overarching approach taken to answer the research questions (Saunders et al., 2019). Therefore, the choices about research methodology, which rest on underlying assumptions about reality and knowledge, guide the choice of research methods or data collection procedures (Tamminen & Poucher, 2020).

The remaining part of this chapter discusses each layer of the research onion in two sections. First, the methodological approach which encompasses the philosophical assumptions underpinning the research and approaches to theory development. Secondly, the research methods used, which include the choice of research strategy, and techniques to collect and analyse the data, are outlined.

5.2.1 Research Methodology – Philosophy

A research philosophy refers to the worldview, assumptions and beliefs that guide a researcher in carrying out the research (Guba & Lincoln, 1994; Morgan, 2007). A well-thought-out philosophy provides a foundation for credible research and underpins how researchers approach their work, including the methods they choose for data collection and analysis. The most important assumptions are those that relate to assumptions about the nature of reality (ontology), knowledge (epistemology) and values and ethics (axiology).

The ontological position of this thesis

Ontology refers to the philosophical assumptions about the nature of reality and entities constituting those realities (Creswell & Poth, 2016; Guba & Lincoln, 1994; Saunders et al., 2019). This research is positioned within business and management studies and aims to understand the reality of organisations, people working in the organisations, and the related phenomena; therefore, it adopts a relativist ontological position. A researcher taking a ***relativist*** position believes that reality is dependent upon how individuals or groups interpret a phenomenon (Lawson et al., 2013). In comparison, a researcher taking a *realist* perspective assumes that reality or the phenomena happening in the world can be tested, measured and evaluated.

The relativist ontological position is justified in this research because the examination of leadership behaviours is largely dependent upon the human interpretation and the

contextual meaning associated with those interpretations. This variation in the interpretations of managers' behaviours is based on the experiences and values of managers and non-managers. This stance is specifically appropriate for studying organisational behaviours because behaviours do not exist independently; they are strongly linked to the people who enact and experience them. What counts as health-promoting behaviour for one group of managers or employees might not be equally important for others. Therefore, by adopting a relativist ontology, this study acknowledges the diverse set of perspectives reflecting the complex nature of organisational behaviours.

The pragmatic stance adopted

Focusing on business and management research, Saunders et al. (2019) provide a categorisation of the five most commonly used research philosophies. These include positivism, critical realism, interpretivism, postmodernism, and pragmatism. The ontological position of this research is grounded in ***pragmatism*** to answer the research questions outlined in Chapter 1. The reason for adopting this philosophical stance was that reality from a pragmatic philosophical stance is not a static phenomenon; rather, it is shaped through the practical experiences, actions, and meanings that people ascribe to it. This view believes that multiple forms of knowledge can coexist; therefore, it is not necessary to hold a purely objective or subjective view of the world to find complex interrelationships between social entities. Pragmatists tend to see research philosophy as a continuum rather than choosing opposite ends (Teddlie & Tashakkori, 2009). They cautiously consolidate the concepts of objectivism and subjectivism and support the idea that qualitative and quantitative philosophies and different research methods can be meaningfully combined in one study (Johnson et al., 2007).

The pragmatist stance aligns with this research, as health-promoting leadership behaviour is a phenomenon that is observable in practice, while at the same time it is dependent upon personal perceptions, organisational context, and social interactions. As Tashakkori and Teddlie (1998, p. 26) report, “at some points, the knower and the known must be interactive, while at others, one may more easily stand apart from what one is studying”. Considering this, the present research was designed in a way to quantitatively test the relationships among study variables, in addition to qualitatively exploring the meaning and understanding of participants about a healthy workplace, health-promoting leadership behaviours, motivations to engage in those behaviours and the outcomes associated with those behaviours.

Although pragmatism receives considerable criticism just like other research philosophies, notably by Guba and Lincoln (1994) and Lincoln et al. (2011), it has remained an appealing research philosophy. For example, critiquing pragmatism, Guba and colleagues argue that qualitative and quantitative research philosophies cannot be combined in a single research study, although they agree that this is possible at the methods level. Even advocates of pragmatism agree that although it is not a perfect research philosophy (Cavana et al., 2001) it is the researchers’ unique interpretation of reality that provides pragmatism with a strong philosophical position (Mertens, 2019). These aspects of pragmatism provide strong philosophical foundations for combining different research paradigms, as is done in mixed methods research (Biesta, 2010).

Based on these arguments, pragmatism provides a flexible foundation for adopting a mixed method design, and thus, enabling the integration of the quantitative patterns and qualitative depth to develop a deep understanding of how managers and non-mangers conceptualise a healthy workplace, the health-promoting behaviours that managers engage in

at the workplace including their motivations behind exhibiting those behaviours, in addition to examining the outcomes associated with those behaviours.

The epistemological position adopted

Epistemology refers to the assumptions made about knowledge. A researcher's epistemological position concerns how knowledge can be produced and communicated, and how reality can be understood by obtaining valid and legitimate knowledge (Burrell & Morgan, 2017; Guba & Lincoln, 1994; Lincoln et al., 2011; Saunders et al., 2019). The two most common epistemological positions adopted by researchers are objectivist and subjectivist epistemologies. A researcher holding an *objectivist position* assumes that reality can be tested and understood by completely separating the researcher from the phenomenon being researched (Daly, 2007). Thus, a true understanding of the phenomenon can be achieved by separating the reality of the phenomenon from the researchers' own perspectives, preferences and biases. In contrast, researchers holding a *subjectivist* epistemological position assume that it is impossible to separate the influence of the researcher from what they are researching because researchers' perceptions and interpretations play an important role in choosing what to research, how to collect information, and the interpretation of findings (Cunliffe, 2003). Thus, knowledge cannot be created independently of the researchers' subjectivities.

With a pragmatic research philosophy, this research adopts a ***pluralistic*** epistemology that acknowledges the benefits of relying on both objectivist and subjectivist assumptions. This position understands that the value of knowledge lies in its usefulness and its ability to generate workable solutions. Therefore, it takes into account the benefits of both objective measurements and subjective interpretations to address the research questions. Adopting multiple methods, and sources of evidence are considered legitimate.

Epistemological positions steer a researcher toward different research methods. For example, in business and management research, a variety of knowledge ranging from numerical data to subjective opinions is considered legitimate and acceptable depending upon research questions or objectives. A challenge that may arise for the researcher is to be aware of the strengths and weaknesses of each method of data collection as it can impact the quality of research. For the present research, a pluralistic epistemological stance supports mixed method research as it integrates both quantitative and qualitative methods of data collection to find the relationship among research variables and explore the interpretations associated with healthy workplace and health promoting leadership behaviours.

The axiological position of this thesis

Axiology refers to the "role of values and ethics" (Saunders et al., 2019, p. 134) while conducting the research. Axiology shows how important it is for a researcher to consider their values and the values of research participants while conducting research. It is the value position of the researcher that guides views about the importance of one research topic over another. Consequently, researchers' values influence their ways of looking into reality, the entities that constitute a particular phenomenon, methods of acquiring knowledge, the choice of methods to carry out research, and the way findings should be presented to make a valuable contribution to theory (Tsang, 2016).

From an axiological perspective, this research is guided by a pragmatist stance. The researcher believes in conducting value-based research with a commitment to produce knowledge that is valuable for the world and aligns with real-life problems. Pragmatists acknowledge their understanding of which problems are worth investigating, how problems should be framed and which methods should be used to answer the research problems. In this research, it's important for the researcher to improve employee wellbeing and for that, it's

important to understand how managers and non-managers conceptualise a healthy workplace, which behaviours managers exhibit at the workplace to improve employee wellbeing, and what drives them to engage in those behaviours. Based on these questions, the researcher adopts a mixed-method design to conduct the research. Adoption of a pragmatist axiological stance ensures transparency and ethical responsibility of the researcher to find answers to the research questions while contributing to organisational science.

5.2.2 Research Methodology - Approaches to Theory Development

The extent to which research is concerned with theory testing or theory building gives rise to different approaches to theory development. Traditionally, there have been two approaches to reasoning, i.e., deductive and inductive (Saunders et al., 2019). The *deductive* approach, or the "top-down" approach to reasoning, starts with a theory-driven hypothesis, which is then tested by collecting relevant data to reach a conclusion. The *inductive* approach, on the other hand, starts with making observations about a specific phenomenon and identifying patterns in those observations, leading to theory formulation (Mitchell, 2018; Saunders et al., 2019). There is also a third approach to theory development known as an **abductive** approach (Mitchell, 2018; Saunders et al., 2019). *The abductive* approach adopts a pragmatist stance and addresses the weaknesses of inductive and deductive approaches, which rely on either qualitative (without concern for generalisation) or quantitative data (focused on getting an appropriate sample to generalise findings), respectively. The starting point for this approach is a "surprising fact" (Ketokivi & Mantere, 2010) which cannot be explained by using existing theories. Therefore, to solve the "puzzle," the researcher combines numerical and cognitive reasoning to contribute to knowledge.

The abductive approach for this thesis

This thesis employs the abductive approach for reasoning, as it aims to provide solutions to real-world problems by offering explanations based on experience. Abductive reasoning mirrors the pragmatic stance that starts with a research problem and aims to generate knowledge that is suitable for the given context. Abductive reasoning integrates observations and ideas to generate the most plausible explanations for the phenomenon under consideration. This approach is particularly suitable to explore managers' health-promoting leadership behaviours as it explains the way managers' interpretations of organisational context interact with their actions to influence employee wellbeing. Together, pragmatism and abductive reasoning serve as a foundation for explaining how managers see a healthy workplace and how their interpretations of their organisation enable them to support employee wellbeing.

5.2.3 The Use of Mixed-Method Design

Based on the above research philosophy, this research uses a *sequential explanatory mixed-method design* consisting of two distinct phases: quantitative and qualitative (Creswell et al., 2003). The conceptual models were tested in the first phase through quantitative survey-based studies. In the second phase, in-depth interviews were conducted to further expand on the survey results. The rationale for using this approach was that the quantitative data helps analyse the relationships among variables, while the analysis of qualitative data helps explain and contextualise those results by exploring participants' views in more detail. Thus, both phases complemented each other by capitalising on the strengths of each method while avoiding the inherent biases, enhancing the meaningfulness of the results (Greene et al., 1989).

A mixed-method design suited this research because although theory-based variables can be used to examine the antecedents of managers' HPLB and the outcomes associated with them, it was important to explore what managers' thoughts and motivations were behind supporting employee wellbeing and how those HPLB were experienced by non-managerial staff. The qualitative inquiry allowed exploration of the lived experiences of participants and helped build understanding of the contextual factors that shape those behaviours, and how managers' HPLB are enacted and received. The use of quantitative data allowed the research to identify patterns and relationships among variables based on the conceptual model (Tashakkori & Teddlie, 1998). An integration of these two methods allowed for strengthening the explanatory power of the study and aligned with the pragmatist stance that focuses on using the methods that best suit the research problem. By using the breadth and depth of mixed method design, this study provides practical insights to enact a healthy workplace and guide leaders in frontline managerial positions to effectively promote employee wellbeing.

5.3 Summarising the Methodology of the Present Research

The above discussion shows that no single research philosophy can be labelled as 'the best' to answer research questions. Previous research shows that each philosophy has its pros and cons, and the choice of the best philosophical stance depends upon the research questions that need to be answered (Creswell & Creswell, 2017). For example, to find answers to questions that begin with "what", "how", or "why", a qualitative inquiry provides the depth needed to explore the meanings and underlying interpretations shared by participants through their experiences. The quantitative survey is also important, as it provides valuable insights into patterns and relationships among study variables.

Based on these facts, the present research adopts a *pragmatic* research philosophy with an *abductive* approach to reasoning to answer the questions presented in Chapter 1. A

pragmatic research stance suits this research because adopting a single philosophical position may not answer the research questions (Onwuegbuzie et al., 2009). Although enablers and barriers of managers' health-promoting leadership behaviours can be measured quantitatively by asking about their perceptions of the identified variables, and non-managers' perceptions of their wellbeing and performance can also be measured quantitatively, the real value comes when the numerical survey results are combined with interviews with managers and non-managers. The quantitative and qualitative stages together guide the researcher to find answers to the nature of the phenomenon, as well as relationships between measured variables (Williams, 2007) by interpreting the findings and conveying the exact meaning of the answers attached to the research questions. Thus, this research uses a *mixed-method approach* to collect reliable, credible and relevant data to answer the research questions.

Subsequent chapters (6-8) describe quantitative studies conducted with managers and non-managerial staff, the methods adopted for each study, their respective findings, and a discussion of their results. The succeeding chapters (9-11) detail the qualitative studies conducted on both groups of participants, the methods adopted for each study, the findings and the discussions of results. The final chapter, chapter 12, concludes the thesis with an integrative discussion and conclusion.

Chapter 6

Phase 1: Quantitative Studies Method and Design

Phase I of this research comprised two quantitative studies conducted simultaneously through an online, cross-sectional survey of two groups of respondents. The first group comprised people working in managerial positions in New Zealand-based workplaces who had at least one direct report. The second group consisted of non-managerial staff working in the same or different New Zealand-based workplaces who had no direct reports. Both groups of respondents were independent of each other (i.e. not matched), and any connection was purely coincidental. The following sections present the methods adopted to conduct both of these studies:

6.1 Method

Data was collected from two groups of respondents: managers and non-managers. For this research, *managers* were defined as participants who had at least one other employee directly reporting to them. *Non-managers* were defined as those employees who had no line management responsibilities. To fulfil the eligibility criteria, both managers and non-managers were required to have been working in their current organisation for at least six months. The six-month duration was based on evidence that leadership development is a long-term process and takes time to unfold the effects of leadership behaviours (Day et al., 2014).

6.1.1 Research Design

An anonymous online cross-sectional survey was used to collect the data from both groups of participants. Qualtrics was used to design a branched survey for both groups (Figure 6.1). The survey started with the information sheet and asked the respondents if they

would agree to participate in the research. Those who responded “yes” were then directed to two forced-choice questions, which helped determine the eligibility of prospective participants.

- The first question asked about the respondent's tenure in the current organisation. Those respondents who had been working in the current organisation for less than six months were thanked for their interest in the research and were excluded from the survey.
- The next screening question differentiated between managers and non-managers. This question asked how many employees directly reported to the respondent. Those who answered “none” were then directed to the questions relating to “non-managers”. Those who indicated they had one or more direct reports were categorised as “managers” and directed to the respective questions.

Managers answered questions relating to Psychosocial Safety Climate, and its hypothesised predictors, i.e., Perceived Autonomy, Authentic Leadership, and Perceived Subordinate Trust. Non-managers answered questions about the perceived Health Promoting Leadership Behaviours of their managers and the outcomes associated with them, i.e., Psychological Wellbeing and Performance. At the end of the survey, demographic questions were asked, for example, gender, age, contract type, etc. The final survey question asked about interest and consent in participating in the second, qualitative, phase of the research. Those who agreed to participate in the second phase were asked for their contact email. This information was solely required for the purpose of contacting interested respondents for the second phase of research, i.e., interviews. To ensure confidentiality, email addresses were not

linked to survey responses and stored separately, with limited accessibility to the researcher only.

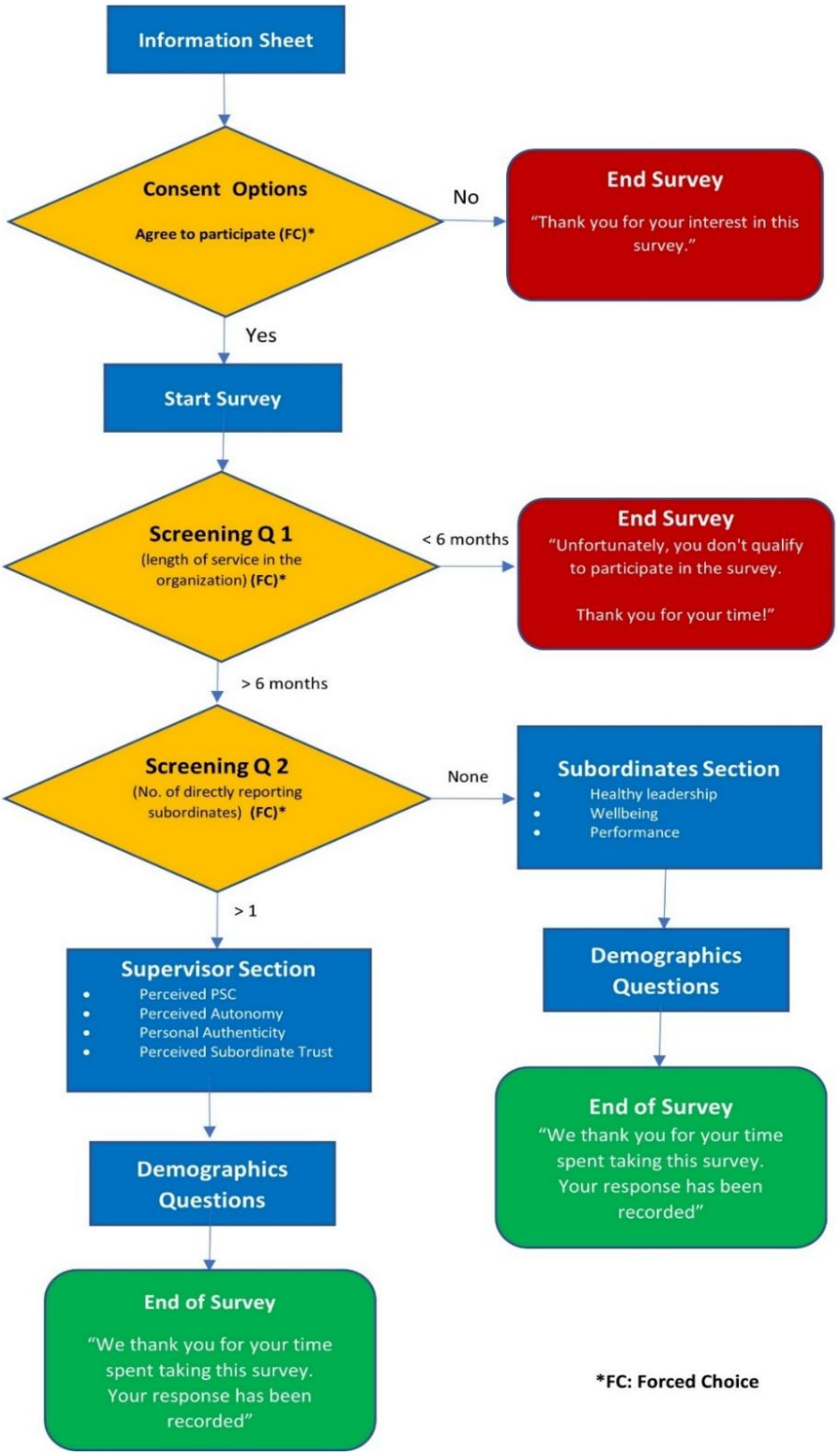


Figure 6.1 Research Design

6.1.2 Research Ethics for Phase 1

This research was carefully designed, incorporating principles referred to in the Massey University Human Ethics Committee (MUHEC) Code of Ethical Conduct, so that it offered the minimum possible risk to the research participants and the researcher. Full ethics approval was obtained from Massey University Human Ethics Committee, Southern B, at their meeting on 14 April 2022. The ethics approval letter is attached in Appendix I.

Informed and voluntary consent was obtained from the participants before starting the survey. The survey began with an information sheet describing the research objectives and participants' rights. Complete confidentiality was maintained throughout the survey, and no individually identifying information was requested from the participants. The electronic distribution of the survey provided an additional layer of privacy to all the participants as no one was aware of who else from within the organisation had participated in the research.

Those who participated were free to respond to or decline to answer survey questions, except for the first two forced-choice screening questions, which determined eligibility. Participants were able to withdraw from the research without harm or cost until the point where they clicked the option to 'submit' their survey data. Respondents were also given the right to request access to the summary of research findings. The researcher received 15 emails (8 individual participants and 7 organisations) requesting the research findings.

6.1.3 Participant Recruitment

The Ministry of Business Innovation and Enterprise (MBIE) is the New Zealand government agency responsible for the development and regulation of economic enterprise. MBIE categorises organisations into small (less than 20 full-time employees), medium 20-49 full-time employees) or large (50 or more full-time employees) (Ministry of Business Innovation and Employment, 2019). For the present research, employees working in medium

to large-sized organisations in New Zealand were selected. The Small Business Council NZ (2019) estimates that approximately 71% of organisations have no employees, in other words, they are owner-operated businesses. Thus, medium businesses with 20 to 49 full-time employees and large businesses with more than 49 full-time employees were most relevant for this study, as they would have managerial and non-managerial staff. Data collection was not limited to any specific industry to gain insights from a range of respondents employed across different work environments.

Quantitative data collection started on 7 August 2022, and the survey closed on 7 October 2022. To ensure a usable sample size, four different strategies were used to contact potential participants. First, the researchers' supervisors connected her with organisations that specialised in providing services in the wellbeing domain. These organisations circulated information about the study, an invitation to participate and a link to the survey within their workplace via email, in their newsletters, and on their social media pages.

Second, the researcher utilised her own contacts to recruit participants. Some contacts completed the survey themselves and/or passed the survey information along to others in their networks. These contacts also helped by reaching out to their organisations' Human Resources (HR) departments to facilitate the wider distribution of the survey within their organisations. Two large public sector organisations agreed to distribute the link to the survey via their internal communication channels.

The third important approach to participant recruitment was an internet search, which identified the contact details of 377 government departments and organisations on the New Zealand Government website (NZ. Government, 2023). The health and education sectors – the two largest in terms of the number of people employed – were searched separately for contact details. Directories of NZ tertiary providers, schools, and Early Childhood services

were found on the Education Count page maintained by the Ministry of Education (https://www.educationcounts.govt.nz/directories). A health and wellbeing services directory was found on the Health Pages website (healthpages.co.nz). To communicate with the HR/administration department of these organisations, a formal invitation email (Appendix II) and information sheet (Appendix III) were sent to each organisation via the publicly listed email address. Several of the public and private sector organisations, from a range of industry sectors, showed interest in the research and confirmed the survey link would be distributed to employees within their organisation.

The fourth recruitment strategy was to utilise social media forums such as Facebook, WhatsApp, and LinkedIn. Some of the researchers' personal contacts and some participating organisations also posted the survey link on their LinkedIn pages, which a number of people then re-shared. The survey link was also posted on some major Facebook groups that belonged to large cities/suburbs of NZ, such as Christchurch NZ, Dunedin News, and I Love Karori NZ, etc.

6.1.4 Determination of Sample Size

These four recruitment strategies resulted in responses from 745 individuals. A minimum number of participants required to perform the data analyses and to test the hypotheses was calculated via an online power calculator (Soper, 2023) to decide if data collection should continue. Based on the number of variables in the model, the power calculator indicated that complete responses from at least 119 non-managers and 137 managers would be required to perform analyses on the model. As these numbers had been reached, data collection was closed.

6.2 Data Preparation

6.2.1 Initial Data Screening

After closing the survey, the responses were imported into the Statistical Package for the Social Sciences (SPSS) version 29.0. All 745 responses were imported into SPSS, and data were scrutinised based on three criteria.

- Cases were sorted with respect to the respondents' consent to participate in the research. Five respondents started the survey but did not confirm their consent to participate in the research. All responses from these 5 respondents were deleted from the data set.
- The data were sorted according to the answers to the first screening question, i.e., participants' experience. Seven respondents did not answer the question on experience and subsequently exited the survey. Thirty participants did not qualify to proceed as they had less than six months of work experience in their current organisation. Therefore, these 37 participants were removed from the data set.
- To identify managers and non-managers, participants' data was sorted for the number of directly reporting subordinates. Six respondents did not provide an answer to the screening question, and their responses were removed. As a result of this process, 697 responses were retained – 372 subordinates and 325 supervisors.

6.2.2 Extraction of Usable Responses

Not all of the responses from the 697 respondents could be utilised. There were 69 non-managers and 61 managers who left the survey blank after answering the screening questions. These respondents were deleted from the data set, leaving 567 responses – 303 non-managers and 264 managers. Unfortunately, not all of these 567 responses were usable,

as some respondents only completed part of the survey. All responses in which half or more of the survey questions remained unanswered were excluded from the analysis (1 non-manager, 23 managers). The final result was 543 usable responses – 302 non-managers and 241 managers, indicating 73% of usable data out of 745 recorded responses. The sample characteristics of each group are given in chapters 7 and 8.

6.3 Data Analysis

6.3.1 Structural Equation Modelling

Descriptive data were analysed using SPSS version 29.0. Hypotheses and mediation were tested using Structural Equation Modelling (SEM) with AMOS 29.0 software. SEM is a multivariate statistical analysis technique which is considered more robust than simple linear regression (Bagozzi & Fornell, 1982). SEM was chosen as an analysis technique because it aligned with the requirements of the research models being tested. Both quantitative studies comprised latent constructs which could not be measured directly through simple linear regression. For example, Psychological Wellbeing (PWB) was a latent variable as it consisted of five observed variables or questions measuring the latent construct of PWB. SEM allowed these latent variables to be modelled accurately and to explore the relationships among observed and latent variables.

In this study, SEM also enabled the researcher to evaluate relationships among dependent and independent constructs and to test the measurement model through confirmatory factor analysis procedures (Gefen & Straub, 1997). By providing flexibility for assessing and modifying theoretical models, SEM offered convenient procedures for construct validation and theory development (Anderson & Gerbing, 1988). SEM also allowed the analysis to take measurement errors into account, resulting in more reliable estimates than

using simple regression or factor analysis alone. Thus, SEM permitted the researcher to analyse the research questions systematically in a single comprehensive analysis to find the relationships among multiple intercorrelated constructs (Anderson & Gerbing, 1988).

A two-step approach was used to test the inter-relationships among constructs (Anderson & Gerbing, 1988). The key advantage of this approach was that it allowed two distinct steps to test the hypothesised relationships. Initially, the researcher developed the measurement model by allowing the constructs to correlate freely. This model tested relationships between observed and latent variables, and goodness of fit for each construct in the model. According to Anderson and Gerbing (1988), this preliminary investigation helps assess whether the structural model will provide an appropriate fit. This step also allowed for the re-specification of the measurement model until an acceptable model fit was obtained. In the second step, the researcher specified the structural model by drawing relationships among constructs to test whether the data support the hypothesised relationships. The structural model was examined by evaluating the output estimates and model fit.

While this chapter has provided an overview of the methods used for the quantitative studies of this thesis, the next two chapters (7 and 8) present the research objectives, hypotheses, methods, findings and discussion of studies conducted on managers and non-managers, respectively.

Chapter 7

Phase 1 Quantitative Study 1: Managers' perspectives on PSC

This chapter covers the research objectives, hypotheses, methods, findings and discussion related to Study 1, the survey data for managers.

7.1 Introduction

A key objective of this thesis was to explore the motivators for, and barriers to, managers engaging in Health-Promoting Leadership Behaviours (HPLB). The focus of the present study, the first of two quantitative survey-based studies, was on Psychosocial Safety Climate as a key variable hypothesised to act as an organisational contextual factor relating to managers' potential engagement in HPLB (Chapter 4). Chapter 4 outlined that a limitation of existing PSC theory is the narrow understanding of what factors shape perceptions of PSC. This study aimed to understand and identify what factors might act as precursors to positive perceptions of PSC in an organisation.

Based on Self-Determination Theory (SDT), two pathways were explored to identify antecedents of PSC perceptions (see Chapter 4). First, *perceived autonomy support* was hypothesised as an antecedent of PSC perceptions. It was theorised that an autonomy supportive work environment communicates to managers that the organisation is committed to prioritising employees' psychological health and, to achieve this goal, understands the importance of frontline managers' need fulfilment. In an autonomy supportive work climate, managers can exercise the discretion and authority associated with their position and evaluate the organisational climate positively. Thus, the following hypothesis was generated:

> ***Hypothesis 1:*** *Managers' perceived autonomy support positively relates to their perceptions of PSC in the organisation.*

Secondly, managers' self-reported *authentic leadership* was hypothesised as another potential precursor to positive PSC evaluations. A high PSC work environment is focused on the psychological health and safety of employees and embodies a supportive and participative management style (Dollard & Bakker, 2010). Authentic leaders tend to foster trust, psychological safety, and high-quality relationships within their teams (Liu et al., 2015; Maximo et al., 2019). Such leaders have a highly internalised self-motivation to emphasise openness, ethical conduct, and genuine concern for employee wellbeing, which could be associated with high ratings of PSC. This value congruence leads to the assumption that managers who perceive themselves to be authentic are more likely to evaluate organisational PSC positively because it aligns with their values. This reasoning yields the following hypothesis:

> ***Hypothesis 2****: Managers' self-reported authentic leadership positively relates to their perceptions of PSC in the organisation.*

Through self-regulation, authentic leaders create a mutually trusting environment within the organisation, so employees believe that their managers' actions are consistent with the desired policies. Managers' authenticity shapes a positive organisational climate supported by a high level of subordinate trust (Agote et al., 2016). Shirey (2009) contends that a positive organisational culture and authentic leaders are the foundations of a healthy work environment. Thus, it is hypothesised that when managers feel that their team members trust their behaviours and integrity, they get a validation of their competency and may make a positive evaluation of their work climate (Figure 7.1).

Hypothesis 3: *Managers' perception of subordinate trust mediates the relationship between managers' self-reported authentic leadership and PSC.*

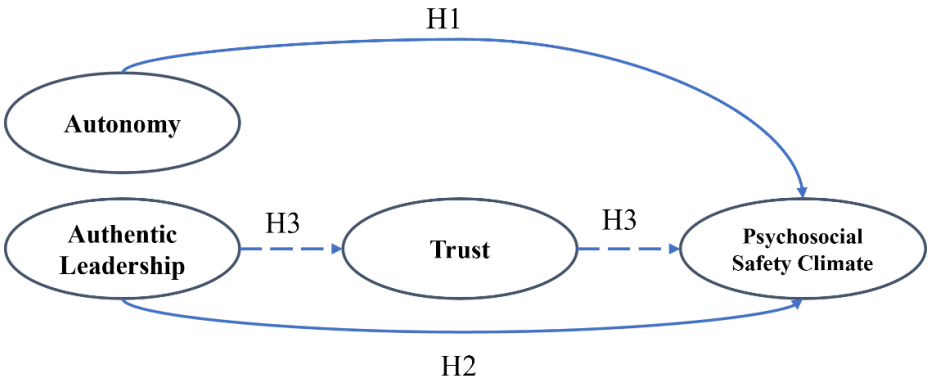


Figure 7.1 Conceptual Model – Study 1

7.2 Method

An anonymous online cross-sectional survey was used to collect the data from research participants. The research was carefully designed, incorporating principles outlined in the Massey University Human Ethics Committee (MUHEC) Code of Ethical Conduct, to minimise the risk to both the research participants and the researcher. Informed and voluntary consent was obtained from the participants before starting the survey. Chapter 6 details the research design, ethics, participant recruitment strategy, initial data preparation, and analysis technique adopted for both quantitative studies. The following sections detail participant demographics, measures used to conduct Study 1, the results of the preliminary statistical test, the findings of hypothesis testing, and a discussion of results.

7.2.1 Participants' Demographics

A total of 241 managers participated in the survey. 224 participants responded to the questions about gender and age, 74.1% (n = 166) of them identified themselves as female, 24.6% (n = 55) as male, and 1.3% (n = 3) as gender diverse. Out of the given age brackets, 1.8% (n = 4) were aged 25 or under, 15.2% (n = 34) were 26-34, 53.1% (n = 119) were 35-54, 27.7% (n = 62) were 55-64, and 2.2% (n = 5) were aged 65 or over. A total of 227 managers responded to the question about their contract type and working hours. Cumulatively, 96.5%

of them (n = 219) reported working permanently in their current roles, 2.2% (n = 5) were under fixed-term contracts, 0.4% (n = 1) reported working as contractors, and 0.9% (n = 2) had other contractual arrangements. Altogether, 92.5% of participants (n = 209) reported satisfaction with their contract type; 7.1% (n = 17) were not satisfied, and the remaining 6.2% (n = 15) of participants did not respond to this question. Across the sample, 24.7% (n = 56) of participants reported working up to 39 hours per week, 50.2% (n = 114) worked 40 to 50 hours per week, and 25.1% (n = 57) reported working over 45 hours. Potentially related to long work hours, only 63.9% (n = 145) reported being satisfied with their working hours. Based on the Australian and New Zealand Standard Industrial Classification (ANZSIC), participants were provided with a list of 12 industries to choose from, with an additional option of "other industry." In aggregate, 48.2% (n = 106) of participants belonged to the Education and Training industry, followed by 11.2% (n = 27) of participants who belonged to Public Administration, and Safety industry. Nine percent (n = 21) did not respond to this question. A complete list of the number and percentage of participants' demographics is given in Appendix IV.

7.2.2 Measures: Study 1

Established measures with adequate reliability and validity were used, and all scale items were measured on Likert-type scales. All items were in English. IBM SPSS version 29, AMOS version 29, and Microsoft Excel were the tools used for data analysis. The following subsections detail the four measures used in the study.

Perceived autonomy

Managers' self-reported perceptions of autonomy were measured using a 9-item autonomy scale from the Work Design Questionnaire (Morgeson & Humphrey, 2006). This scale measures three types of autonomy at work: *work scheduling autonomy, decision-making*

autonomy, and *work method autonomy*. A five-point scale was used ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). A higher score indicated that a manager had a stronger sense of freedom in scheduling their work, making decisions, and choosing the methods to do their work. A sample item was "The job provides me with significant autonomy in making decisions". Cronbach's alpha for this scale was 0.96.

Authentic leadership

Managers' self-reported authenticity was measured by using the Authentic Leadership Questionnaire (ALQ version 1.0 Self) (Walumbwa et al., 2008). Permission was obtained from the authors to use this scale in this study (Appendix V). This scale asks respondents to provide answers on a five-point Likert-type scale ranging from 1 (Not at all) to 5 (Frequently, if not always). A higher score indicates that a manager perceives themselves to be aware of their true selves and able to regulate their behaviours and make decisions transparently. A sample item was "As a leader, I say exactly what I mean". Cronbach's alpha for this scale was 0.89.

Trust

Trust was measured by using a 10-item trust scale developed by Gillespie (2003). This scale measures the extent to which managers perceive that their immediate team members are willing to trust them. The scale measures four dimensions of trust: *benevolence*, *integrity*, *competence*, and *predictability*. The responses were anchored on a seven-point Likert scale ranging from 1 (not at all willing) to 7 (completely willing), so a higher score indicates that a manager felt more trusted by their team members. A sample item was "How willing are your subordinates to rely on your work-related judgments?". Cronbach's alpha for this scale was 0.90.

Psychosocial safety climate

The PSC was measured using the 12-item Psychosocial Safety Climate scale (Hall et al., 2010). This scale measures the priority that senior management or organisational policies and practices place on employees' psychological health. Responses were obtained on a five-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Thus, a higher score indicated that a manager perceived that the organisational climate supports employees' psychological health and wellbeing. A sample item was "Senior management clearly considers the psychological health of employees to be of great importance". Cronbach's alpha for this scale was 0.96.

Table 7.1 presents the mean, standard deviations, and Cronbach's Alpha – internal consistency reliabilities for all four scales.

	Mean	SD	Cronbach Alpha
Autonomy	3.95	0.88	0.96
Authentic Leadership	4.13	0.49	0.89
Trust	6.20	0.71	0.90
PSC	3.58	0.92	0.96

Table 7.1 Mean, Standard Deviation, and Cronbach's Alpha (α) for Study 1 variables

7.2.3 Preliminary Statistical Tests

Treatment of missing values

Study 1 utilised the 241 responses from managers, as outlined in Chapter 6. Missing Value Analysis (MVA) identified that the percentage of missing data was low (0.4% - 5.8%). The highest number of missing responses (5.8%) was found in the trust scale, possibly due to respondent fatigue, as it was the last section of the survey. However, 5.8% is a small number of non-responses, and up to 20% to 30% of missing data can be remedied statistically

(Eekhout et al., 2014; Hair et al., 2013). Data imputation is considered an appropriate alternative to deleting responses, which can lead to a loss of usable data (Collier, 2020). Therefore, the most widely used data imputation technique was applied, i.e., replacing missing values with the mean of the indicator. This technique has received criticism for not considering individual differences and for potentially reducing variance (Schafer & Graham, 2002), but it also offers advantages such as limiting the effect of outliers. However, imputation was only carried out for scale variables and not for demographic variables, as this could lead to misclassification.

Normality

Normality refers to the distribution of data for a variable. Examining the normality of the data is a prerequisite because unclear distribution assumptions can lead to unreliable conclusions. Normality can be assessed by using visual and numerical methods. Visual normality can be assessed by inspecting histograms, box plots, P-P plots (Probability-Probability plots), and/or Q-Q plots (Quantile-Quantile plots) (Ghasemi & Zahediasl, 2012). Numerically, normality can be assessed by looking into measures of central tendency, i.e., mean, median, mode, measures of shape, i.e., skewness and kurtosis, and measures of variability, i.e., standard deviation and variance (Field, 2018; Kline, 2015).

In this study, both graphical and numerical tests were used to check for normality. A careful examination of the histogram, P-P plot, and box plot indicated no serious normality issues in the data in Study 1. Normality was further confirmed numerically by using the recommendations of Brown (2015). For structural equation models, acceptable skewness values range from -3 to +3, and acceptable kurtosis values range from -10 to +10. The numerical values of skewness and kurtosis for all variables fell within an acceptable range except for two variables in the trust scale, i.e., Trust 4 (“subordinates rely on you to represent

their work accurately to others") and Trust 5 ("subordinates depend on you to be backed up in difficult situations") which were slightly kurtotic (10.79 and 10.88 respectively). One reason for this could be that managers self-reported the degree to which their subordinates trust them; therefore, they may have overrated themselves. Taking advantage of the Central Limit Theorem (Altman & Bland, 1995), which states that "as the sample sizes get bigger, the sampling distribution becomes normal" (Field, 2018, p. 233), bootstrapping was used to generate large samples while testing the hypotheses, and data were assumed to be normally distributed.

Common method variance

Common method variance (CMV) refers to the systematic error variance in results caused by using the same method to measure the study constructs (Podsakoff et al., 2003; Richardson et al., 2009). When CMV is present in the data, it can distort the true relationship between study variables, influencing the validity and reliability of results (MacKenzie & Podsakoff, 2012) and thus impacting the research findings.

To address potential issues with CMV, both procedural and statistical measures were adopted (MacKenzie & Podsakoff, 2012; Podsakoff et al., 2003; Viswanathan, 2005). Procedural controls were applied before data collection, while statistical controls were applied after data collection (Baumgartner & Steenkamp, 2001; MacKenzie & Podsakoff, 2012; Podsakoff et al., 2003; Podsakoff et al., 2012),

The following procedural steps were taken to minimise the effects of CMV.

1. Data was collected online, the survey link was sent to potential respondents via email, so all participants, their organisations and their responses were anonymous.
2. Participants were informed there were no right or wrong answers. This reduced the likelihood of social desirability responding.

3. As no incentive was offered to the respondents, it was expected that they participated due to interest in the research and were therefore less likely to provide spurious answers.
4. Different scales were used for different variables to reduce the possibility of consistency bias.

Along with procedural measures, the following **statistical tests** were also used to reduce the risks of CMV.

1. **Harman's single-factor test** was performed (Podsakoff et al., 2003). Exploratory factor analysis (EFA) was performed on all the items of the model to test the amount of variance caused by a single factor. The unrotated solution revealed that a single factor accounted for only 27.7% of the variance, suggesting that CMV is unlikely to be an issue in this study.
2. **Common latent factor (CLF) analysis** was performed (Podsakoff et al., 2003). A new latent variable was introduced into the structural model, and all observed variables were related to it. The variance of the new latent factor was fixed to one, and paths going to observed variables were constrained to be equal. The latent factors of the original model were allowed to correlate. CMV is considered to exist in the model if the square of the common factor of any path accounts for more than 50% of the variance (Eichhorn, 2014). The result of the CLF analysis indicated that the new latent factor accounted for 6.76% of the variance in Study 1, confirming that CMV was not present in this study.

Factor Analysis

The results of the exploratory factor analysis for each of the four variables are reported below.

Psychosocial safety climate

The *Kaiser-Meyer-Olkin (KMO)* test (Dziuban & Shirkey, 1977) of sampling adequacy and *Bartlett's test of sphericity*, indicated that the data were suitable for factor analysis. Principal Component Analysis with Varimax rotation (Kaiser Normalisation) produced only one factor with an Eigenvalue greater than 1.0 (8.15), accounting for 67.97% variance in the data. A single-factor solution was therefore suitable for PSC.

For the SEM, Confirmatory Factor Analysis (CFA) was performed using maximum likelihood estimation. Factor loadings of the observed variables were checked on the respective latent variables to confirm that each construct fitted the data well. CFA confirmed a single-factor solution for the 12-item PSC scale. The single-factor solution was therefore used in the subsequent analysis and hypothesis testing.

Perceived autonomy

KMO and Bartlett's test (KMO = 0.928, $p < 0.001$) confirmed that the scale was suitable for factor analysis. This resulted in a single factor with an Eigenvalue of 6.68, accounting for 74.29% of the variance in the data. CFA further confirmed a single-factor 9-item structure for the autonomy scale with standardised factor loadings ranging from 0.75 to 0.89, which was retained for further analysis.

Authentic leadership

KMO and Bartlett's test (KMO = 0.879, $p = <0.001$) provided strong support for the factorability of the data. Factor analysis resulted in four factors. The initial four-factor solution showed one strong factor (Eigenvalue = 6.23, 38.98% variance) and three weak factors with Eigenvalues marginally above one (1.24, 1.13, 1.12). Each of these three factors explained about 7% of the variance, together accounting for 60.79% of total variance; however, this solution showed extensive cross-loadings and low reliabilities for two factors.

A three-factor solution also produced cross-loadings and poor reliability for the third factor, and a two-factor solution, although showing acceptable reliabilities, was unconvincing due to cross-loadings and three items with loadings below .50. The scree plot, factor structure, and internal consistency analyses all indicated that authentic leadership functioned as a single-factor construct with 16 items, which was further examined using CFA. CFA confirmed that three items (AL5, AL11, AL1) consistently showed poor loadings and reduced model fit, and removing them sequentially improved fit to acceptable levels, with remaining items loading between .52 and .71. As a result, a refined 13-item single-factor scale was retained for subsequent analyses.

Trust

KMO and Bartlett tests confirmed that factor analysis could be performed on the data (KMO = 0.882, $p < 0.001$). EFA resulted in two factors with eigenvalues greater than 1.0. The first factor (Eigenvalue = 5.37) accounted for 53.69% of the variance in the data. The second factor (Eigenvalue = 1.58) accounted for an additional 15.81% of the variance, resulting in a cumulative 69.50% of the variance in the data. Based on the factors in the rotated component matrix, the first factor was named *"Competence Trust".* This factor comprised items such as the willingness of subordinates to rely on work-related judgments, task-related skills, handling of important issues, work representation, and dependence under challenging situations. The reliability of this factor was 0.87. The second factor was called *"Emotional Trust"*, which comprised items such as subordinates' willingness to share personal feelings, personal issues, feelings about work, problems and difficulties, and personal beliefs. The reliability of this factor was 0.90. The two-factor solution for the 10-item trust scale was also confirmed through CFA with two factors (Competence Trust and Emotional Trust), having factor loadings ranging from 0.74 to 0.90. The fit statistics for the CFA for all the constructs

utilised in Study 1 are provided in Appendix VI. The following section details the results of SEM.

Demographic differences in study variables.

There were no statistically significant gender differences with regards to perceptions of PSC ($t(219) = -0.89$; *p>.05);* autonomy ($t(219) = 0.06$; *p>.05)*; authentic leadership ($t(219) = -1.0$; *p>.05)*; or competence trust ($t(219) = -.136$; *p>.05).* Men reported lower levels of emotional trust than women ($t(219) = -3.23$; $p = 0.001$) however this difference was not considered important to the analysis since trust was neither a predictor nor a criterion variable in this study.

Due to the small number of participants in some categories, the years of experience variable was recoded from the original six categories into three: up to five years of experience ($n = 144$), six to ten years of experience ($n = 42$), and more than 10 years of experience ($n = 55$). A one-way ANOVA indicated no statistically significant difference in competence trust ($F(2, 238) = 0.246$, $p = >.05$); or emotional trust ($F(2, 238) = 1.187$, $p = >.05$). However, a one-way ANOVA results showed a statistically significant difference in PSC ($F(2, 238) = 3.120$, $p = <.05$) and perceived autonomy ($F(2, 238) = 4.019$, $p = <.05$) with respect to managers' experience. A further exploration through Games-Howell post-hoc tests revealed no significant pairwise differences between the three experience groups (all $p > .05$). This suggested that while experience level was associated with overall variation in PSC and autonomy perceptions, no specific group differed significantly from one another. Thus, experience was not completely irrelevant to PSC perceptions, rather its influence on PSC perceptions was diffused or non-linear. This information was recorded to integrate with the results of hypothesis testing and will be discussed further in the discussion section.

7.3 Results

7.3.1 Measurement Model

A measurement model was tested using the maximum likelihood estimation technique to specify the model. To specify the measurement model, the variables related to each latent construct were assigned to that construct. The degree to which each measured variable was related to its latent construct was represented by the factor loading of that variable. Since a latent factor does not represent a measured variable accurately, an error term was added to each measured variable. After that, all the latent constructs were correlated with each other. The model was tested to find relationships between constructs. Significant correlations were present among all the study constructs except for emotional trust and PSC. Table 7.2 presents the correlation matrix for constructs.

	Correlation Matrix				
	1	**2**	**3**	**4**	**5**
1. Autonomy					
2. Authentic Leadership	0.31*				
3. Competence Trust	0.35*	0.42*			
4. Emotional Trust	0.22**	0.42*	0.62*		
5. PSC	0.59*	0.21**	0.23**	0.09	

* Correlation is significant at p <0.001
** Correlation is significant at p < 0.01

Table 7.2 Correlation Matrix – Study 1

Based on the recommendation of Jackson et al. (2009), a combination of model fit indices with different measurement properties was used to evaluate the model fit of the data. These indices included absolute fit indices, relative fit indices, and residual-based fit indices. For example, chi-square ($\chi 2/df$), Goodness-of-Fit Index (GFI), Cumulative Fit Index (CFI), TLI, SRMR, Root Mean Square Error of Approximation (RMSEA). The chi-square serves as a parsimonious indicator of overall fit (Kline, 2015), GFI reflects how well the model can

reproduce the observed covariance matrix (Jöreskog et al., 1979), CFI (Bentler, 1990) and TLI (Tucker & Lewis, 1973) both compare the target model with the baseline model. SRMR is used to assess residual-based fit (Hu & Bentler, 1999), while RMSEA provides a parsimony-adjusted estimate with confidence intervals (Browne & Cudeck, 1992). All the model fit indices showed that the measurement model fitted the data well. Table 7.3 presents the results of the measurement model fit indices. A CFA diagram of the measurement model for all the observed variables (tested together) is shown in Appendix XII.

χ^2/df	GFI	CFI	TLI	SRMR	RMSEA
1.51	0.81	0.94	0.94	0.05	0.05

Table 7.3 Fit Indices for Measurement Model – Study 1

7.3.2 Hypothesis Testing: The Structural Model

Specifying the structural model involved investigating the nature and magnitude of the relationships among the study variables. The validity of the structural model was assessed by examining the fit indices and testing the structural relationships and hypotheses.

A full structural model was specified with all of the observed variables of this model (Figure 7.2). The analysis showed that the standardised direct effect of perceived autonomy was significantly related to PSC ($\beta = 0.57$; $p < 0.001$), thus **hypothesis 1 was supported,** which predicted that *managers' perceived autonomy support positively relates to their perceptions of PSC in the organisation*. Analysis further showed that the standardised direct effect of authentic leadership did not significantly relate to PSC ($\beta = 0.03$; $p > 0.05$), thus **hypothesis 2 was not supported,** which predicted that *managers' self-reported authentic leadership positively relates to their perceptions of PSC in the organisation*. Analysis of mediation showed that authentic leadership had a strong positive relationship with

competence trust (β = 0.47; p < 0.001) and emotional trust (β = 0.43; p < 0.001). However, competence trust had no significant relationship with perceptions of PSC (β = 0.06; p > 0.05). Emotional trust also showed an insignificant negative standardised effect on PSC (β = -0.05; p > 0.05). These findings indicated that perceived trust did not mediate the relationship between authentic leadership and PSC; thus, **hypothesis 3 was not supported,** which predicted that m*anagers' perception of subordinate trust mediates the relationship between managers' self-reported authentic leadership and PSC*. The statistics for squared multiple correlations showed that all the predictors of PSC (i.e., autonomy, authentic leadership, competence trust, and emotional trust) collectively explained 34.1% of its variance. Overall, the fit statistics showed that the model fitted the data well. Table 7.4 reports the fit statistics for the structural model. Figure 7.2 shows these findings in the form of the structural model.

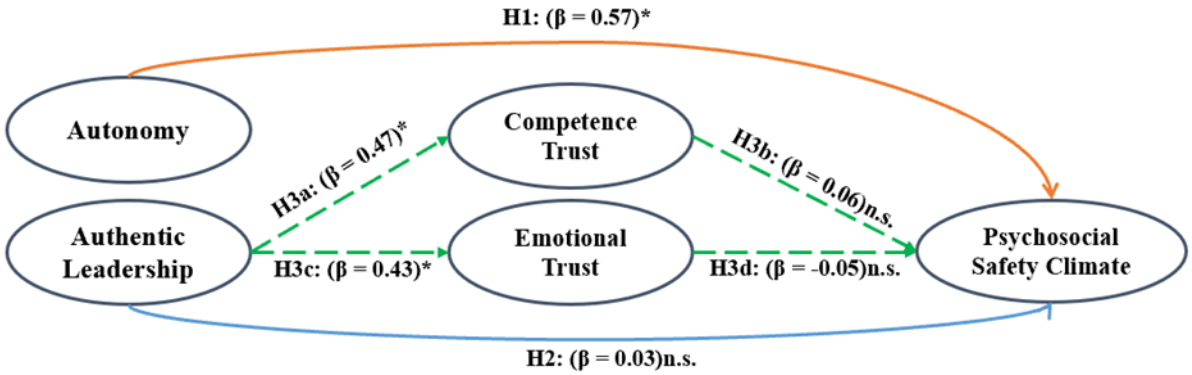


Figure 7.2 Full Structural Model – Study 1

χ^2/df	GFI	CFI	TLI	SRMR	RMSEA
1.58	0.80	0.94	0.93	0.07	0.05

Table 7.4 Fit Statistics for the Full Structural Model - Study 1

The bootstrapped results (Preacher & Hayes, 2008), obtained by generating 5000 samples, confirmed the same findings that the total standardised indirect (mediated) effect of

authentic leadership on perceived PSC (through both mediators) was not significantly different from zero at $p < 0.05$ with $\beta = 0.003$ and $p = 0.88$ at a 95% confidence interval. This bootstrapped approximation was obtained by constructing two-sided bias-corrected confidence intervals (lower bound = -.089 and upper bound = 0.074). Since the bias-corrected confidence interval included zero, it was confirmed that both mediators' collective mediated effect was insignificant. Table 7.5 summarises the above findings:

Hypotheses	Supported/Not Supported
Hypothesis 1: Managers' perceived autonomy support positively relates to their perceptions of PSC in the organisation.	Supported
Hypothesis 2: Managers' perceived authentic leadership positively relates to their perceptions of PSC in the organisation.	Not Supported
Hypothesis 3: Managers' perception of subordinate trust mediates the relationship between managers' authentic leadership and perceived PSC.	Not Supported

Table 7.5 Summary of Findings – Study 1

7.4 Discussion

This research aimed to explore the role of perceived autonomy, authentic leadership, and employee trust in relation to managers' perceptions of their workplace psychosocial safety climate, a key factor hypothesised to be related to managers' engagement in health-promoting behaviours. PSC, being the key indicator of senior management's commitment to the psychological health and wellbeing of employees, was the focus of the first study. Study 1, therefore, aimed to identify the factors that might shape managers' perceptions of PSC. It was hypothesised that *managers' perceived autonomy support and authentic leadership positively relate to their perceptions of PSC in the organisation.* It was further hypothesised

that *managers' perception of subordinate trust mediates the relationship between managers' authentic leadership and perceived PSC.*

This study contributes to both the PSC and leadership literature by identifying managers' autonomy as a specific antecedent to PSC. As hypothesised, the findings showed a positive association between managers' perceptions of autonomy and their perceptions of PSC. Previous research has suggested that PSC, as an upstream organisational factor, fosters a psychologically healthy work environment (Dollard & Bakker, 2010). This suggests that when managers have a work environment which supports their autonomy, they are more likely to make a positive evaluation of PSC, perhaps because support for managers' autonomy signals that senior management empowers them to build a safe and empowering work environment. By highlighting autonomy as a key driver of PSC perceptions among managers, the current study expands existing PSC theory and underscores the importance of leadership practices that promote autonomy in shaping PSC in organisations.

An important observation in this research was a non-linear relationship between managers' work experience with their current organisation and their PSC perceptions. This finding suggests that PSC perceptions are shaped by working conditions or other organisational factors as well as by managerial experience. This finding is worth exploring in future studies by using a continuous scale to measure years of experience rather than broad categories, which may hide important patterns in the data.

A strong positive association between managers' self-reported authentic leadership and both types of trust indicates that authentic leadership and trust are strongly correlated at the bivariate level. Also, at the bivariate level, competence trust also correlates significantly with PSC, but collectively in the full structural model, when the shared variances among constructs are taken into account, they do not significantly predict PSC. This finding shows

potential for future studies. It has long been said that "leaders create a climate" (Lewin et al., 1939), which supports the belief that line managers' self-reported authentic leadership, being a reflection of their mindset to care for the wellbeing of their teams, should contribute toward shaping organisational PSC. The ability of authentic leaders to self-regulate their behaviours relates to their tendency to be flexible and cater to employees' needs. Managers who exhibit authentic behaviours should receive confirmation from their subordinates in the form of a mutually trusting relationship, which would help to strengthen the organisational climate. Managers who perceived that their subordinates trusted them could also influence the PSC of the organisation. However, one possibility could be that a strong association between autonomy and PSC might be hiding the impact of authentic leadership on PSC via trust. These findings were noted for further exploration in the qualitative part of this research.

Subordinates' trust in their managers was a product of both trust in their managers' *competence* and their *emotional support* for employees. However, trust did not appear to mediate the relationship between managers' self-reported authentic leadership and their perceptions of psychosocial safety climate. This complexity is worth exploring in future studies. Trust could also be studied in future as a moderator of the authentic leadership and PSC relationship or as a reason for managers to keep engaging in health-promoting leadership behaviours, making their healthy leadership behaviours sustainable.

Theoretically, this study fills an important gap in the existing PSC literature by identifying autonomy as a specific precursor to building a strong PSC in the organisation. This finding reinforces the importance of the job resources that are available to managers to enable them to enact a healthy workplace that focuses on the psychosocial safety of people. Overall, the study findings link together the importance of leadership, workplace climate, and job design to build a work environment where everyone thrives.

For practitioners, this study emphasises the importance of enabling leaders in frontline managerial positions as a first step toward investing in PSC. Knowledge and understanding of precursors to building a high-level PSC in the workplace is beneficial in establishing a strong climate in the organisation that is focused on employees' psychological health and wellbeing. Enabling frontline managers to enact a strong PSC could then serve as a building block to building a healthy workplace where frontline managers are motivated to promote the wellbeing of their teams. A thoughtfully built PSC via senior management commitment and involvement could also serve as a basis for the creation of related policies, which are essential for organisations.

Chapter 8

Phase I Quantitative Study 2: Employees' perspectives on HPLB

This chapter covers the research objectives, hypotheses, methods, findings and discussion related to Study 2, the survey data for non-managers.

8.1 Introduction

One of the objectives of this thesis was to explore the impact of managers' Health Promoting Leadership Behaviours (HPLB) on the wellbeing and performance of their direct reports. For this purpose, this second study was conducted on non-managers to explore the relationship between their perceptions of their managers' HPLB and their self-reported wellbeing and performance. Utilising the theoretical support of HPLB theory (Vincent-Höper & Stein, 2019; Vincent, 2012) and SDT (Deci et al., 2017), it was hypothesised that non-managers would perceive that health-promoting managers, as co-designers of employees' work characteristics, would reduce employees' job demands and engage in supportive and development-oriented behaviours leading to positive wellbeing and performance outcomes through fulfilment of employees' basic psychological needs.

Previous research supports the view that providing appropriate resources to employees and reducing excessive demands on them relates to improved wellbeing and enhanced performance at work (Bakker & Demerouti, 2007; Lopez-Martin & Topa, 2019). The needs satisfaction mechanism of SDT also proposes that need fulfilment in the form of increased autonomy, competence, and feelings of relatedness promote psychological health and relate to positive behavioural outcomes such as better performance and enhanced

wellbeing (Gagné & Deci, 2005). Several laboratory and field experiments have shown that workplaces that can satisfy employees' intrinsic needs enhance their motivation to yield more positive work outcomes, including better wellbeing and improved work performance (Baard et al., 2004; Deci et al., 2001). Previous research also supports PWB as a predictor of better work performance (Wright & Cropanzano, 2000). Besides these research strands, the healthy leadership literature seems to lack an exploration of HPLB and employee wellbeing and performance, as most of the studies in the healthy leadership domain remain restricted to wellbeing-related outcomes. Therefore, based on the above arguments and previous discussion on HPLB and employee wellbeing and performance (see Chapter 4), the following hypotheses were generated (Figure 8.1).

Hypothesis 4: *Non-managers' perceptions of their managers' health-promoting leadership behaviours positively relate to their self-reported performance.*

Hypothesis 5: *PWB mediates the relationship between non-managers' perceptions of their managers' health-promoting leadership behaviours and their self-reported performance.*



Figure 8.1 Conceptual Model – Study 2

8.2 Method

Similar to Study 1 (Chapter 7), an anonymous online cross-sectional survey was used to collect the data from research participants. The research design, ethics, participant recruitment strategy, initial data preparation, and analysis technique adopted for this study

were given in Chapter 6. The following sections detail participant demographics, measures used to conduct Study 2, the results of the preliminary statistical testing, the findings of hypothesis testing, and a discussion of the results.

8.2.1 Participants' Demographics

A total of 302 non-managers participated in this study. Of these, 297 responded to the demographics question. Among those respondents, 21.9% (n = 65) identified as males, 75.4% (n = 224) as females, and 2.7% (n = 8) identified as gender diverse. In total, 12.1% reported being 25 years of age or under, 22.6% were aged 26-34, 41.4% were 35-54, 19.5% were 55-64, and 4.4% were aged 65 or over. Cumulatively, 79.1% (n = 235) of participants reported working permanently in their roles, 16.5% (n = 49) reported working under a fixed-term contract, 1.7% (n = 5) worked casually, 0.7% (n = 2) were contractors, and 2% (n = 6) reported working under other contractual arrangements. Overall, 87.8% (n = 260) of participants reported satisfaction with their contract type. Altogether, 49.7% (n = 147) reported working up to 39 hours per week, 40.2% (n = 119) worked 40 to 45 hours, and 10.1% (n = 30) reported working above 45 hours per week. In total, 72.3% (n = 214) reported that they were satisfied with their current working hours. The majority of participants (48.5%, n = 143) belonged to the Education and Training industry based on the Australian and New Zealand Standard Industrial Classification (ANZSIC). A complete list of the number and percentage of participants' demographics is given in Appendix IV.

8.2.2 Measures: Study 2

Established measures with adequate reliability and validity were used. All scales were in English, and all items were measured on Likert-type scales. IBM SPSS version 29, AMOS version 29, and Microsoft Excel were used for data analysis. The following are the details of the measures used in Study 2.

Healthy leadership

Non-managers' perceptions of healthy leadership were measured using the 35-item Health and Development Promoting Leadership Behaviour Questionnaire (HDPLBQ) (Vincent, 2012). This scale measures leadership behaviours conducive to subordinates' health and wellbeing through three higher-order factors, i.e., *demanding leadership*, *development-oriented leadership*, and *support-oriented leadership*. These three dimensions consisted of a further 14 sub-scales. *Demanding leadership* consisted of two sub-scales, asking employees about their perceptions relating to a leader's demanding behaviours, such as a high quantitative/qualitative workload. *Development-oriented leadership* consisted of four sub-scales, such as participation, complexity/variability, job control, etc. *Support-oriented leadership* consists of a further eight sub-scales, such as support, care, integrity, etc. Responses were recorded using a five-point Likert scale, which ranged from 1 (strongly disagree) to 5 (strongly agree). A sample items included "My direct supervisor often puts me under pressure". Cronbach's alpha for this scale was 0.94.

Psychological wellbeing

Employees' psychological wellbeing was calculated using the 5-item WHO-5 Wellbeing Index (Topp et al., 2015), which measures the psychological wellbeing of participants. Responses were recorded via a 6-point Likert-type scale, which ranged from 1 (At no time) to 6 (All of the time), with a higher score indicating a greater sense of wellbeing. A sample item was "Over the past two weeks, I have felt cheerful and in good spirits.". The reliability coefficient for this scale was 0.91.

Self-reported performance

Performance was measured using the 7-item employee performance scale (O'Reilly & Chatman, 1986). This scale measures two dimensions of employee performance: (a) in-role

performance and (b) extra-role behaviours. Responses were obtained using a five-point scale which ranged from 1 (never) to 5 (always), with a higher score indicating more of the specific behaviour. A sample item for this scale included *"I complete my assigned duties on time"*. The reliability coefficient for this scale was 0.69, slightly below the accepted level of 0.70. The following section on factor analysis explains how this slightly low level of reliability was treated. Table 8.1 shows the Mean, Standard Deviation, and Cronbach's Alpha (α) for the Study 2 variables.

	Mean	SD	Cronbach Alpha
Healthy Leadership	3.43	0.59	0.94
PWB	3.62	1.14	0.91
Performance	3.72	0.60	0.69

Table 8.1 Mean, Standard Deviation, and Cronbach Alpha (α) for Study 2 Variables

8.2.3 Preliminary Statistical Tests

As with quantitative study 1, the same preliminary statistical tests were applied to this study, consisting of 302 non-managers.

Treatment of missing values

Results from the statistical tests showed that for the constructs of Study 2, no missing values were present in the Healthy Leadership scale. For the other two scales, i.e. PWB and Performance, some scale items had missing values, the percentage of which ranged from 1.7% to 2.3%. These missing values were imputed with the series mean of the indicator, in the same manner as described for Study 1.

Normality

The findings from the normality tests showed that in Study 2, all skewness and kurtosis values fell within the acceptable range. Visual tests also confirmed that study 2 was free from serious normality issues.

Common method variance

Like Study 1, both procedural and statistical measures were performed to deal with potential issues related to CMV (MacKenzie & Podsakoff, 2012; Podsakoff et al., 2003; Viswanathan, 2005). Results confirmed that CMV was not an issue in this study.

Factor analysis

Healthy leadership

The *Kaiser-Meyer-Olkin (KMO)* test (Dziuban & Shirkey, 1977) and *Bartlett test* indicated a substantial correlation in the data (KMO=0.955, p = <0.001). Factor analysis was performed using the Principal Component Analysis method of extraction and Varimax rotation (Kaiser Normalisation), which resulted in four factors. The first factor, with and Eigenvalue of 17.7, accounted for a 50.59% variance in the data. The other three factors resulted in a collective 68.22% of variance in the data. This factor solution was not retained as the fourth factor barely reached the Eigenvalue of 1.0, with many items cross-loading onto each other. A three-factor solution also resulted in an unclear factor solution with cross loading items. Factor analysis was repeated to yield two factors. The first factor comprised six items representing the 'demanding leadership' dimension of the original scale, which was re-named as *'Destructive Leadership'*. The reliability of this scale was 0.92. The second factor comprised 28 items representing the 'support and development-oriented leadership'

dimensions of the original scale. This factor was re-named *'Positive Leadership'.* The reliability of this sub-scale was 0.97.

The CFA results also confirmed strong factor loadings for the 'Destructive Leadership' latent factor with standardised factor loadings ranging from 0.60 to 0.89 and for the 'Positive Leadership' latent factor with standardised factor loadings ranging from 0.51 to 0.86. Only two items of the positive leadership sub-scale had a factor loading less than 0.5. These two items were deleted since other questions in those dimensions (control/variability) were already addressing these questions. The resulting factor structure showed a good-fitting model.

Psychological wellbeing

Psychological wellbeing was a short 5-item scale; therefore, no factor analysis was required for this scale (Czerwiński & Atroszko, 2023). CFA results showed that standardised factor loadings of this scale ranged from 0.75 to .94.

Performance

The KMO and Bartlett test indicated that the performance scale was suitable for conducting factor analysis (KMO = 0.731, p = <0.001). Factor analysis resulted in a two-factor solution with Eigenvalues of 2.55 and 1.36, accounting for 36.39% and 19.41% variance in the data, respectively, and collectively accounting for 55.80% of the variance. The first factor contained three items relating to "In-role performance" (Cronbach Alpha = 0.42), and the second factor contained four items relating to "Extra role behaviours" (Cronbach Alpha = 0.77). The EFA results showed that the first item in the in-role performance factor had a very low loading (0.45), possibly due to overconfidence or self-report bias. The factor loadings for all the other items were above 0.7. A CFA on this scale confirmed the same findings. Therefore, the first item was deleted. The remaining two items loaded well onto the

data with loadings of 0.72 and 0.57. CFA showed strong factor loadings for all four items of the extra-role behaviours subscale, ranging from 0.61 to 0.75. Fit statistics for the CFA of all constructs of Study 2 are provided in Appendix VII.

Demographic differences in study variables

In Study 2, the number of males (n= 65) was lower than the number of females (n = 224). However, the results of the independent sample t-test confirmed that there were no statistically significant gender differences in the sample. There were no statistically significant differences in men and women regarding perceptions of their managers' positive leadership behaviours (t(287) = -0.31; p>.05); destructive leadership behaviours (t(287) = -0.51; p>.05); wellbeing (t(287) = -0.86; *p>.05)*; or extra-role behaviour (t(287) = -0.68; *p>.05).* Statistically significant gender differences between men and women were found regarding in-role performance (t(287) = -3.74; *p<.001)* where males reported lower on in-role performance. Since the effect size was medium, Cohen's d = -0.53, 95% CI [-0.81, -0.25], and gender was not included in the structural model, this finding was not accounted for.

ANOVA was performed to compare whether respondents of different age groups in Study 2 reported any statistically significant differences in PWB. Age was recoded into three categories, labelled as younger workers (35 years and under, n = 103), middle-aged workers (35 to 54 years old, n = 123), and older workers (55 years and over, n = 71). A one-way ANOVA indicated no statistically significant difference in positive leadership (F(2, 294) = 0.30, p = >.05); destructive leadership (F(2, 294) = 2.14, p = >.05); PWB (F(2, 294) = 2.008, p = >.05); in-role performance (F(2, 294) = 2.14, p >.05); and extra-role behaviours (F(2, 294) = 1.25, p >.05).

8.3 Results

8.3.1 Measurement Model

A measurement model was tested using the maximum likelihood estimation technique to specify the model, as detailed in Study 1. The results showed that all the study constructs correlated significantly with each other. The measurement model also fitted the data well. Table 8.2 presents the correlations among the constructs. Table 8.3 shows fit statistics of the measurement model. A CFA diagram of the measurement model for all the observed variables (tested together) is shown in Appendix XIII.

	Correlation Matrix				
	1	**2**	**3**	**4**	**5**
1. Destructive Leadership					
2. Positive Leadership	-0.55*				
3. PWB	-0.43*	0.54*			
4. In-role Performance	-0.26*	0.31*	0.37*		
5. Extra-role Behaviours	-0.15**	0.21***	0.31*	0.32*	

* Correlation is significant at $p < 0.001$
** Correlation is significant at $p < 0.05$
*** Correlation is significant at $p < 0.01$

Table 8.2 Correlations Matrix – Study 2

χ2/df	GFI	CFI	TLI	SRMR	RMSEA
1.75	0.81	0.94	0.93	0.05	0.05

Table 8.3 Fit Indices for Measurement Model of Study - 2

8.3.2 Hypothesis Testing: The Structural Model

A structural model was specified to investigate the nature and magnitude of the relationship among the study variables. The validity of the structural model was assessed by examining the fit indices and testing the structural relationships and hypotheses.

A full structural model was specified with all the observed variables of this model (Figure 8.2). The results showed a non-significant relationship between destructive leadership and in-role performance (β = -0.08; $p > 0.05$), and destructive leadership and extra-role behaviours (β = 0.004; $p > 0.05$). The results further showed a non-significant relationship between positive leadership and in-role performance (β = 0.14; p > 0.05), and positive leadership and extra-role behaviours (β = 0.06; p > 0.05) as shown in Figure 8.2. Thus, **hypothesis 4 was not supported,** which predicted that *non-managers' perceptions of their managers' health-promoting leadership behaviours positively relate to their self-reported performance*.

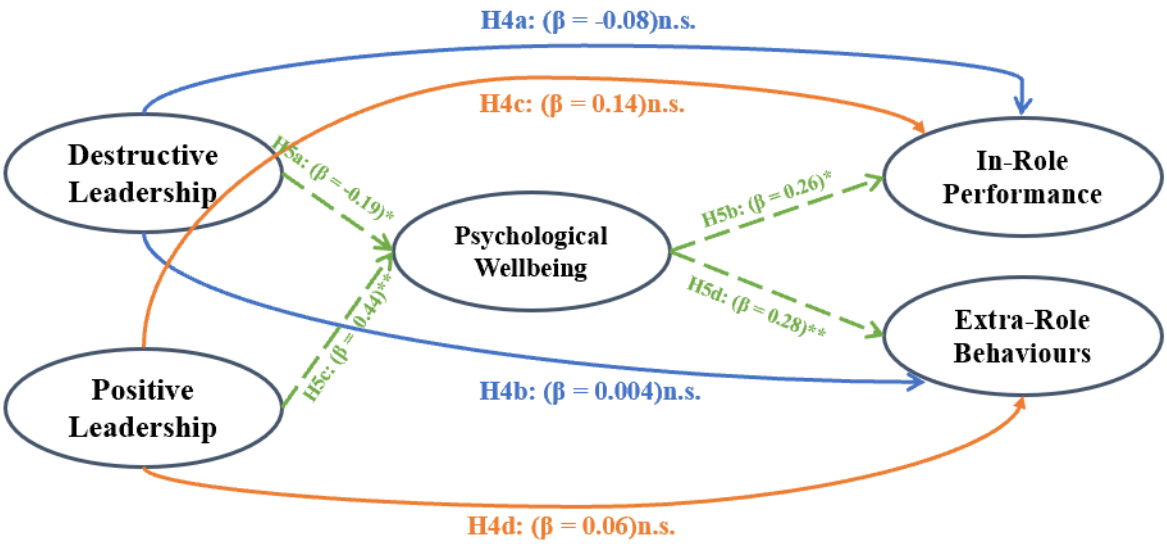


Figure 8.2 Full Structural Model – Study 2

An analysis of mediation for the relationship between **destructive leadership and in-role performance** through PWB showed that destructive leadership related significantly to PWB (β = -0.19; $p < 0.01$), and PWB related significantly to in-role performance (β = 0.26; $p < 0.01$). This finding showed that PWB mediated the effect of destructive leadership on in-role performance. The bootstrapped results confirmed that the total standardised indirect

(mediated) effect of destructive leadership on in-role performance (through PWB) was significantly different from zero (β = *-0.05; p < 0.01* at 95% confidence interval). This bootstrapped approximation was obtained by constructing two-sided bias-corrected confidence intervals (lower bound = -0.118 and upper bound = -0.012). Since the bias-corrected confidence interval did not include zero, it was confirmed that the effect of destructive leadership on in-role performance was mediated by PWB, showing a **complete mediation.**

Analysis of mediation for the relationship between **destructive leadership and extra-role behaviours s**howed that destructive leadership related significantly to PWB (β = -0.19; p < 0.01), and PWB related significantly to extra-role behaviours (β = 0.28; p < 0.001). This finding showed that PWB mediated the effect of destructive leadership on extra-role behaviours. The bootstrapped results confirmed the same findings (β = *-0.05; p < 0.01* at 95% confidence interval, lower bound = -0.117 and upper bound = -0.015), confirming **complete mediation**.

The analysis of mediation for the relationship between **positive leadership and in-role performance** through PWB showed that positive leadership related significantly to PWB (β = 0.44; p < 0.001), and PWB related significantly to in-role performance (β = 0.26; p < 0.01), showing the mediation was happening. The bootstrapped results confirmed that the total standardised indirect (mediated) effect of positive leadership on in-role performance (through PWB) was significantly different from zero (β = 0.114, p < 0.01 at 95% confidence interval, lower bound = 0.028 and upper bound = 0.221), confirming **complete mediation.**

Similarly, the analysis of mediation for the relationship between **positive leadership and extra-role behaviours** showed that positive leadership related significantly to PWB (β = 0.44; p < 0.001), and PWB related significantly to extra-role behaviour (β = 0.28; p < 0.001).

The bootstrapped results confirmed that the total standardised indirect (mediated) effect of Positive Leadership on extra-role behaviour (through PWB) was significantly different from zero ($\beta = 0.121$ and $p < 0.001$, at 95% confidence interval, lower bound = 0.058 and upper bound = 0.206), confirming **complete mediation.** These findings show that **hypothesis 5 was supported,** which predicted that *PWB mediates the relationship between non-managers' perceptions of their managers' health-promoting leadership behaviours and their self-reported performance.*

The resulting model fitted the data well. Table 8.4 shows fit statistics for the structural model of Study 2, and Figure 8.2 above depicts these results.

$\chi 2$/df	GFI	CFI	TLI	SRMR	RMSEA
1.78	0.81	0.94	0.93	0.05	0.05

Table 8.4 Fit Statistics for the Full Structural Model – Study 2

Table 8.5 summarises the results of the study hypotheses. The sub-hypotheses 4a-d and 5a-d were created as a result of the factor structure of the respective variables.

Hypothesis	Results
Hypothesis 4: *Non-managers' perceptions of their managers' health-promoting leadership behaviours positively relate to their self-reported performance.* • H4a: Destructive Leadership negatively relates to employees' in-role performance. • H4b: Destructive Leadership negatively relates to employees' extra-role behaviours. • H4c: Positive Leadership positively relates to employees' in-role performance. • H4d: Positive Leadership positively relates to employees' extra-role behaviours.	Not Supported
Hypothesis 5: *PWB mediates the relationship between non-managers' perceptions of their managers' health-promoting leadership behaviours and their self-reported performance*. • H5a: PWB *completely mediates* the relationship between destructive leadership and employees' in-role performance. • H5b: PWB *completely mediates* the relationship between destructive leadership and employees' extra-role behaviours. • H5c: PWB *completely mediates* the relationship between positive leadership and employees' in-role performance. • H5d: PWB *completely mediates* the relationship between positive leadership and employees' extra-role behaviours.	Supported

Table 8.5 Summary of Findings – Study 2

8.4 Discussion

This study aimed to explore *the relationship between non-managers' perceptions of their managers' HPLB and their self-reported performance. The study further aimed to examine the role of PWB within this relationship.*

Consistent with the existing HPLB model (Vincent, 2012) the findings of this study showed that managers' HPLB can be categorised into *destructive leadership* and *positive leadership* behaviours, indicating that managers can influence the wellbeing and performance of their direct reports in two different ways, i.e., negatively through their demanding behaviours or positively through their support and development-oriented behaviours. Similarly, consistent with O'Reilly and Chatman (1986), findings of this study show that performance is also a complicated construct, consisting of *in-role performance* and *extra-role behaviours*.

Findings of this study contribute to the leadership literature by showing that managers' HPLB exerts an indirect rather than direct influence on the performance of non-managers. This impact operates through employee wellbeing, which then affects performance outcomes. Positive leader behaviours are related to better wellbeing and better self-reported performance, while negative leader behaviours are related to lower performance via reduced wellbeing.

Based on the JDR model (see chapter 4), this finding bridges the leadership and occupational stress research to identify the process through which leaders in the workplace influence their subordinates' performance. This finding also serves as an extension of previous leadership studies, which explore a chosen leadership style with respect to a chosen aspect of wellbeing or performance (Arnold et al., 2007; Franke & Felfe, 2011b; Milner et al., 2015; Samad et al., 2021; Wang et al., 2005; Wolor et al., 2022).

This study showed that managers' destructive leadership behaviours do not directly influence their direct reports' work performance. However, these managerial behaviours do indirectly influence non-managers' performance by negatively influencing their PWB. This finding is consistent with the toxic leadership literature, which shows that toxic leadership negatively impacts employee performance via a negative impact on job satisfaction (Wolor et al., 2022). This relationship also implies that managers' demanding behaviours at work, e.g., putting too much time pressure on their direct reports or overwhelming them with too many or too complex tasks, may not negatively impact their work performance immediately, but perhaps gradually by psychologically draining them.

The findings further showed that managers' positive leadership behaviours, such as recognising their direct reports' initiatives, trusting their abilities, supporting them in addressing work-related problems, cooperating with them, and caring for their developmental needs, were directly related to their subordinates' PWB and ultimately to their performance. This finding aligns with the need fulfilment mechanism of SDT (Deci et al., 2017), which shows that the fulfilment of employees' need for autonomy, competence and relatedness relates to their enhanced intrinsic motivation to yield positive work outcomes such as performance. These findings also align with the HPLB theory (Vincent-Höper & Stein, 2019), which shows that employees' work characteristics are an important pathway through which leaders can influence their wellbeing.

Theoretically, this study links the literature on leadership research, occupational health psychology, workplace health promotion, and research on work characteristics by using the theoretical lenses of SDT and HPLB. The findings offer a new perspective on the assumption that leaders' behaviours automatically boost employee performance by emphasising the importance of indirect pathways in leadership research. Consistent with the workplace health promotion literature (Shain & Kramer, 2004), this study re-emphasises the

role of the organisation of work as an important way to impact the wellbeing of workers. This study also contributes to the healthy leadership literature by identifying specific dimensions of healthy leadership behaviours, i.e., positive and destructive leadership behaviours, in the context of New Zealand workplaces and the way those behaviours can affect employee outcomes, such as wellbeing and better performance.

For practitioners, this research offers important insights into the necessity of investing in leadership development. This study suggests that organisations should not expect performance gains to arise directly through leaders' positive behaviours. Organisations should ensure that initiatives aimed at improving managers' performance actually improve employee wellbeing. This study further emphasises that individuals in leadership roles are most able to shape the work environment and subsequently impact both the wellbeing and performance of other workers. Knowledge and understanding of how best to develop health-promoting leadership behaviour may act as precursors to building a psychosocially safe work environment that is focused on employees' psychological health and wellbeing.

While the quantitative studies of this research create a foundation for understanding healthy leadership in New Zealand, it does not indicate why and how managers engage in healthy leadership behaviour. Phase II of this research interviews several managers and non-managerial staff to explore that dimension, as presented and explained in Chapters 9-11. The qualitative studies explore how managers and non-managers conceptualise a healthy workplace in the NZ context, the drivers of, and barriers to, managers' engagement in health-promoting behaviours, the specific behaviours that managers and non-managers see as health-promoting, and employees' perceptions of the impact of managers' HPLB on their wellbeing and performance.

Chapter 9

Research Method – Phase II: Qualitative Studies

Phase II of this research consisted of two qualitative studies, conducted via in-depth, semi-structured interviews with two groups of participants. The first group consisted of 16 individuals holding managerial positions in New Zealand workplaces. The second group consisted of 14 non-managerial staff working in New Zealand who had no direct reports. Both groups of participants were independent of each other. While briefing participants about the research, they were informed about this independence to make them comfortable while answering the questions.

9.1 Method

9.1.1 Research Design

Much of the existing healthy leadership research that aims to investigate the relationship between leadership constructs and employee wellbeing predominantly relies on quantitative methods, for example, Liu et al. (2021) and Turgut et al. (2019). Based on the reviewed literature, which showed that the climate in which people work influences their behaviours (Zohar, 1980), Study 1 in Phase 1 of this thesis (Chapter 7) adopted a quantitative methodology to examine the antecedents of PSC. The purpose was to examine the relationship of managers' perceptions of autonomy support, employee trust and authentic leadership with their perceptions of PSC. While the quantitative study conducted on managers showed that managers' perceptions of their work autonomy were a strong determinant of their PSC perceptions, a gap that remained was the exploration of how perceptions of PSC shape managerial engagement in HPLB, and the need to explore other factors that might support these behaviours. Similarly, Study 2 in Phase 1 of this research

(Chapter 8) explored the non-managers' perceptions of their managers' HPLB, and the impact of those HPLB on their self-reported performance by utilising a quantitative approach. Although Study 2 showed that managers' HPLB influenced employee self-reported performance by influencing their wellbeing, there was a need for qualitative exploration of which managerial behaviours non-managers consider health-promoting, and how those behaviours impact non-managers' wellbeing and performance. Therefore, Phase 2 of this thesis aimed to gain in-depth insights into these questions through qualitative research involving semi-structured, in-depth interviews with managers and non-managers (Chapters 10 and 11).

The interview method was adopted because it allowed for the collection of rich, first-hand data through insights into participants' "lived experiences" (Brinkmann & Kvale, 2018). In-depth interviews range from completely unstructured to semi-structured to highly structured interviews (DiCicco & Crabtree, 2006). Structured interviews involve asking a standardised set of questions, which can allow for the possibility of applying quantitative analysis techniques, while semi-structured or unstructured interviews allow the collection of rich data through a more conversational style (DiCicco & Crabtree, 2006). Semi-structured interviews allow the researcher to prepare a set of questions with additional prompts, which provide flexibility to explore the details of the topic under discussion (Nestel et al., 2019). Keeping in mind the benefits of semi-structured interviews and the nature of the research questions, this approach was used for this research.

For both groups of participants, interviews were conducted online using Zoom or Teams. The online interview approach was deemed suitable for four reasons. Firstly, the change in work environments in the post-COVID world has meant that many people are comfortable with online interactions (Segbenya & Okorley, 2022). Secondly, electronic interviews provide a safe and convenient way to conduct interviews, as they can provide

more flexibility around time scheduling, and provide some protections around participant privacy compared to, for example, face-to-face interviews (Christmann, 2009; Oates, 2015). Thirdly, conducting interviews online may be more cost-effective due to reduced travel time and expenses. Fourthly, online interviewing allows participants to be located across New Zealand rather than remaining limited to the researcher's location.

In the first study, 16 managers were interviewed, and in the second study, 14 non-managers were interviewed. Once the collection and analysis of data from the first group were finished, interviews with the non-managerial group commenced. The purpose of adopting this strategy was twofold. First, it helped to keep the data collection and analysis systematic, and second, it allowed for the possibility of gaining insights from the managerial interviews, which could be explored in the interviews with non-managers. Based on this study design, Massey University risk assessment guidelines and the expert opinion of my supervisors, participants were deemed to be at the lowest risk of harm. Accordingly, a low-risk ethics approval was obtained for both studies from Massey University under Low-Risk Notification – 4000027076 dated 26th April 2023 (see Appendix VIII).

9.1.2 Recruitment Strategy

The identification of participants for the interviews started during the first (quantitative) phase of the research. At the end of the survey, managers and non-managers were asked about their willingness to participate in the interview phase of the research. This recruitment strategy was adopted to ensure that all the respondents who agreed to participate in the interviews were genuinely interested in this research and willing to share information. In addition, survey participation helped ensure that each participant had the opportunity to speak about their own relevant direct life experience, should they wish (Auerbach & Silverstein, 2003). As a result of this strategy, 30 participants were recruited for the two

studies. For the first study, each participant was assigned a number from P01 to P16. Similarly, for the second study, participants were numbered from P01 to P14, in the order in which interviews were conducted.

9.1.3 Determination of Sample Size

In qualitative research, both the *composition* and *size of the sample* are important considerations (Vasileiou et al., 2018). The sample size in qualitative research is usually smaller than in quantitative research because qualitative research aims to gain a deep insight into the topic under discussion. However, as opposed to quantitative research, there is no formula to calculate sample size. Most of the qualitative research experts relate sample size to epistemological, methodological and practical issues relating to a particular study (Baker & Edwards, 2012). A considerable debate exists in qualitative research regarding the issue of finding the 'right' sample size. However, despite substantial methodological discussions, information about sample sufficiency remains inconsistent (Vasileiou et al., 2018).

A widely used justification to explain the chosen sample size is *saturation* (Mason, 2010; Morse, 1995). Saturation, either *data* or *thematic* saturation (Hennink et al., 2017), is defined as a point when gathering more data (e.g. conducting more interviews) or conducting further analysis does not yield any new information, themes, theoretical insights, or changes in the codebook (Charmaz, 2006; Guest et al., 2006). Saturation of data depends upon many factors, such as (a) the extent to which research participants are heterogeneous, (b) the expertise of the researcher to elicit more information from each participant, and (c) the time frame or budget allowed to collect data.

Using the above definition of saturation, in both qualitative studies of this research, an initial estimate of sample size was obtained from a recently published systematic review of empirical studies (Hennink & Kaiser, 2022). This review maintained that a sample of 9-17

interviews is sufficient to reach saturation when the study population is relatively homogenous and the research objectives are clearly defined. Since both studies comprised homogeneous categories of participants, i.e., one group was managers, and the other was non-managers, and the research objectives were identified, these features were expected to make it easier to assess when no more new information was elicited from the interviews.

While saturation is used as a "gold standard" to justify the sample size, considerable criticism exists about how it is defined, measured, achieved, and justified (Carlsen & Glenton, 2011; Francis et al., 2010; Marshall et al., 2013; Vasileiou et al., 2018). Therefore, another consideration in deciding when to stop further data collection is *sampling adequacy*. Sampling adequacy refers to the appropriateness of the sample to answer the research question (Bowen, 2008; O'Reilly & Parker, 2013). Although determining sampling adequacy is also highly dependent on the researchers' judgment and experience, in this research, sampling adequacy was considered to be achieved based on purposeful sampling, which ensured that participants occupied roles directly related to the research questions.

Recently, there has been considerable debate about the *transparency* and *trustworthiness* of data and the overall process of data analysis, as essential aspects of qualitative research (Aguinis et al., 2017; Aguinis et al., 2018; Lincoln & Guba, 1985). *Transparency* refers to the extent to which the researcher provides details and discloses specific steps, decisions taken, and assumptions made while conducting a qualitative study (Aguinis et al., 2018). *Trustworthiness* in qualitative research is the extent to which the researcher can convince readers that their findings are worthy of attention and can be generalised to a similar context (Denzin & Lincoln, 2000; Lincoln & Guba, 1985).

Four parameters were used in this research to establish the trustworthiness of qualitative studies: *credibility*, *transferability*, *dependability*, and *confirmability,* as suggested

by Lincoln and Guba (1985). *Credibility* refers to the 'fit' between the participants' views and the researcher's interpretation of them. *Transferability* implies that the research findings are to some extent generalisable beyond the immediate study context. *Dependability* refers to the extent to which the analytical process is traceable and clearly documented. Finally, *confirmability* is established when all the above three conditions are fulfilled, so that readers may know that the analytical process was transparent (Koch, 1994; Lincoln & Guba, 1985).

All of the above considerations were contemplated while collecting data for the two studies. To ensure transparency, details of the recruitment strategy, interview process, and interview ethics are provided in the remainder of this chapter. Interview questions were framed clearly and straightforwardly. Pilot interviews were conducted for both studies to ensure that participants could understand the questions. Budgeting was not an issue as all the interviews were conducted online, and sufficient time was allocated to data collection to get good-quality responses.

9.1.4 Interview Process

Survey participants who had indicated that they were interested in taking part in the interview phase of the research were contacted by email once Phase 1 was complete. Those who were still interested in taking part were emailed study information and a consent form, information about how to arrange a day and time for the interview, and information on using Zoom or Teams videoconferencing. After getting each participant's consent to participate in the interview, a date and time were agreed upon. All interviews were conducted using either Zoom or Teams.

At the beginning of each interview, the information sheet, which had been previously emailed to each participant, was briefly reviewed. The information sheet detailed the research purpose, participant rights, and protocols regarding confidentiality and recording of the

interview (Appendix IX). Participants were reminded that participation was voluntary and that they could withdraw at any stage or decline to answer any question. Additionally, participants were informed that a summary of the research findings could be provided by the researcher upon completion of the research. A logbook was created to record the emails of those interested in receiving the findings. Before starting, participants were invited to ask any questions about the process. Once they confirmed their readiness, the interview recording commenced with gaining participants' recorded verbal consent.

An interview guide had been prepared in advance to ensure that each interview began with introductory notes and basic questions, and that prompts were prepared to enable in-depth exploration of relevant information. Notes were taken as needed. Upon completion, the interview duration was recorded, and the audio file was immediately transferred to a secure OneDrive location. Automated online transcripts were checked against the recordings for accuracy and completeness, and, for a further check on accuracy, the corrected and transcribed copy of their own interview was sent to each participant. Some participants confirmed satisfaction with the transcript; most did not respond.

9.1.5 Interview Ethics

Qualitative research can be more prone to ethical issues than quantitative studies, and interviews can be “saturated with moral and ethical issues” (Brinkmann & Kvale, 2018). Specific ethical issues that were considered during this research were participant privacy and confidentiality and ensuring informed consent. To mitigate these risks, all the key information relevant to the participants was disclosed in the invitation email, information sheet, and verbally before and after the interview. Interviews were conducted online via Zoom or Teams, which provides encrypted communication. All of the software used for data collection, transcription and analysis had security and privacy statements available online which met

research requirements. No identifying information was disclosed to the third-party services except for the interview audio file, which was necessary for the transcription. All transcribed files were saved on a password-protected computer and backed up in a secure cloud storage system accessible to the researcher only. While writing research findings, each participant was assigned a number, which was written as a citation beside each quote to make it easier for the reader to trace back the quotation, enhancing the credibility of the findings while maintaining participants' confidentiality. No information which could identify people or organisations was released.

9.1.6 Analysis

Transcription

Two forms of transcription were used to transcribe the interviews. First, the in-built transcription features of Teams and Zoom were used to generate an initial copy of the transcript. Secondly, the online software, *Otter.ai* was used to create a transcribed copy of the interview audio. Initially, copies of both transcripts (Zoom/Teams and Otter.ai) were compared, and one semi-final text transcript was generated for each interview. This draft text transcript was compared to the interview audio file at least twice, and the final transcript was prepared. This process was done as soon as possible after conducting each interview. The final transcript was transferred to NVivo version 20 for analysis. NVivo allows for the coding of data and for coded data to be retrieved, classified, and collated by using *queries*, *coding stripes, maps, charts, or diagrams* while allowing the researcher to see the coded text.

Thematic Analysis (TA)

Thematic Analysis (TA) was the method chosen to analyse the data. TA is a systematic method of identifying, analysing, organising, describing, and reporting themes within a dataset, which then provides useful insights into patterns across the data (Nowell et

al., 2017). TA was chosen for two main reasons. First, it offers a structured approach to treating data and allows for identifying meaningful themes through critical data analysis in a credible, consistent, and exhaustive way, which contributes to the trustworthiness of the findings. Secondly, TA has an inherent flexibility, making it applicable to a variety of epistemological positions.

Thematic analysis offers many ways to examine data, ranging from identifying semantic or obvious meanings to exploring hidden or latent patterns across data sets (Braun & Clarke, 2006). Different assumptions can be made throughout the TA, ranging from an *inductive* to a *deductive* approach for coding and analysis. In the *inductive* approach, the researcher identifies codes and themes based on the contents of the data. In the *deductive* approach, the researcher brings pre-determined concepts or ideas to the data analysis (Braun & Clarke, 2012). Utilizing the flexibility of TA and based on the pragmatic philosophical position of this research, a mix of inductive and deductive approaches was used. A deductive approach was used initially because the broad research topics to be explored were clear. For example, qualitative Study 1 aimed at conceptualising managers' understanding of a healthy workplace and HPLB, and the enablers and barriers to HPLB. Similarly, Study 2 aimed at exploring non-managers' understanding of a healthy workplace, which managerial behaviours they consider health promoting, and the impact of those behaviours on their wellbeing and performance. The inductive approach was then used to further explore the meanings and themes in the data, which yielded rich, persuasive and organised findings. The analysis of the data for each research question in both studies was not limited to each respondent's direct answers to the questions, but also included relevant data and codes generated from throughout the interview data.

Steps followed for thematic analysis

A six-phase approach to TA was used, as outlined in Braun and Clarke (2006).

Phase 1 started with getting familiar with the data. For this purpose, each interview transcript was read carefully to become familiar with the content of the data, keeping the research questions in mind. While reading each transcript, a diary of notes and ideas was maintained to capture initial ideas, thoughts and findings.

In ***Phase 2,*** initial codes were generated, which served as the basic building blocks for further analysis. The purpose of the initial coding was to create a provisional template that could be applied to the full data set. The data coding started with higher-order code or topics, so that relevant text was initially categorised under specific topics, e.g. participants' conceptualisations of healthy work. Higher-order codes were qualitatively rich and were not redundant or interchangeable. Sections of the transcripts covering general conversation before or after the interview were not coded. The highlight function of NVivo was used to ensure that no important piece of data was left uncoded.

In ***Phase 3,*** more fine-grained themes were identified within each higher-order code or topic. For this purpose, an in-depth analysis of each higher-order topic was done to identify further themes or patterns in the data. While higher-order topics were pre-defined deductively based on the research questions, themes were identified inductively in relation to the research questions (Boyatzis, 1998). For example, participants' conceptualisations of healthy leadership were a higher order code or topic identified in phase 2, then phase 3 analysis identified two aspects (work-related and wellbeing-related) within that topic. Notes were maintained throughout the process of coding, and a description was written for each code by using the *"code properties"* command in NVivo.

In Phase 4, the themes were reviewed and refined to ensure that the identified themes meaningfully reflected the data. As a quality control process, the content of each theme was read and edited to ensure the highest level of clarity and consistency with the data.

In ***Phase 5,*** each identified theme was named and defined to provide a clear explanation of each theme's contents and to make sure that the themes were concise, informative, and did not overlap. This process was undertaken by critically re-reading the themes and organising them so that they represented the data in a meaningful and sequential way.

In ***Phase 6,*** the results of the TA were written up. Unlike quantitative analysis, where results are written after completing the analysis, in qualitative research using TA, the analysis and report writing process go side by side. The purpose of this phase was to tell a compelling and comprehensive narrative based on the data to answer the research question. Special care was taken to report the results in a way that was concise, logical, interesting, and non-repetitive (Braun & Clarke, 2006). Direct quotes from participant transcripts were used to clarify and illustrate the themes (Rockmann and Vough (2023), to preserve the authentic voice of participants, and to enhance the readers' understanding of researchers' interpretations of participants' thoughts (Starks & Brown Trinidad, 2007). The findings of the TA for Study 1 are presented and discussed in the next chapter.

Chapter 10

Phase II Qualitative Study 1 – Perspectives of Managerial Staff

Phase II of this research comprised two qualitative studies. In Study 1, managerial staff working in New Zealand were interviewed, and in Study 2, non-managerial participants were interviewed. The previous chapter described the general methodological steps used to undertake both qualitative studies. This chapter provides the specific methodological details, including research objectives, methods, findings, and the discussion of the results for Study 1. The following chapter then details corresponding insights from Study 2, based on interviews with non-managerial staff.

10.1 Introduction to Qualitative Study 1

Previous studies conducted on organisational climate have shown that a positive work climate, as an upstream organisational factor, can serve as a precursor to the creation of a potentially favourable work environment (Dollard & Bakker, 2010). Conversely, a poor climate can lead to an unfavourable work environment. This implies that frontline managers who work in organisations where top management supports employee wellbeing have a mandate to support employee wellbeing by creating a positive work environment. The first quantitative survey-based study detailed in Chapter 7 extended the PSC literature by providing evidence that frontline managers' perceptions of autonomy support (as a supportive element of their work environment) related positively to their perceptions of PSC. This suggested that organisational climate and work environments had a complex two-way relationship because, on the one hand, frontline managers were in a position to influence the work environment for their team members based on the organisation's priority for employee

wellbeing, but on the other hand, they were dependent on the commitment and support of top management to create a supportive work environment to promote employee wellbeing.

To explore frontline managers' perspectives on these issues further, a detailed conversation with managers was required to understand their perceptions of what enables them to engage in health-promoting behaviours and what factors prevent them from engaging in such behaviours, and how they work to prevent or enhance those behaviours. Furthermore, the emergence of two dimensions of healthy leadership, i.e., non-managers' perspectives of positive and destructive leadership behaviours, in the second survey-based study (Chapter 8) warranted exploration from managers' perspective, i.e., how managers perceive a healthy workplace, what their understanding of HPLB is and which HPLB they report engaging in to promote wellbeing of their team. Based on this, the purpose of the first qualitative study was to interview frontline managers to explore the answers to the following research questions:

RQ1: How do managers understand a healthy workplace, and why do they hold these perspectives?

RQ2: Which behaviours do managers consider to be health-promoting, and what do they report doing to support the wellbeing of their teams?

RQ3: What factors support managers to engage in health-promoting behaviours for their teams, and how do these factors facilitate engaging in those behaviours? What are the barriers to managers' engagement in health-promoting behaviours, and how do these barriers prevent them from engaging in those behaviours?

10.2 Method

10.2.1 Sample Size

Out of the 241 managers who participated in Phase 1 of Study 1, 59% were not interested in being interviewed, and 25% did not respond to the invitation. However, 38 (16%) respondents did express an interest in participating in a follow-up interview. Those respondents who expressed an interest were asked to provide their contact email within the survey. Recruitment for the interviews began by contacting all 38 managers who had indicated an interest in the next phase of the research. An invitation email (see Appendix IX) and information sheet (Appendix X) were sent to the potential participants. Of the 38 managers, 10 responded positively (25% response rate). Due to the limited uptake from survey respondents, a supplementary recruitment strategy was also adopted. The researcher utilised her personal contacts who were working in diverse industries and domains in NZ. The same invitation and information sheet were shared with them, yielding 6 more participants. This type of recruitment strategy falls under the broader term of *purposeful sampling,* in which a small number of information-rich sources are utilised to collect in-depth information about the research topic (Shaheen et al., 2016).

In total, 16 participants were interviewed for this study. Each interview was transcribed, and coding commenced as soon as possible after the interview was conducted (see Chapter 9 for details of the transcription and coding processes). The first interview generated 22 sub-themes for the research questions. While subsequent interviews added to these sub-themes, after the 14th interview, there were no additional sub-themes. Therefore, considering the diminishing utility of conducting more interviews, only two more interviews were conducted, and data collection was closed for Study 1, resulting in a final sample of 16 managers: 10 from the first (quantitative) phase of research and 6 via personal contacts. Data

collection started on 28th April 2023 and finished on 26th May 2023. On average, interviews lasted for 24 minutes.

10.2.2 Participants' Characteristics

Ten (62%) participants identified as female and 6 (37%) as male. Ten of the participants worked in the public sector, 2 in a private sector organisation, 2 in a registered charity, while the last 2 participants were private business owners. The tenure of participants in their managerial role ranged from 6 months to 20 years. The number of direct reports ranged from 2 to 30 employees. Table 10.1 provides an overview of the participants.

Participant	Gender	Industry/Sector	Experience in current role	No of Subordinates
P01	Female	Registered Charity	1.5 years	5
P02	Female	Registered Charity	10 years	11
P03	Female	Private Sector Organisation	6 months	4
P04	Female	Territorial Local Authority (TLA)	1.5 years	8
P05	Male	Private Business Owner	5 years	17
P06	Female	School	20 years.	30
P07	Female	School	Over 10 years	2
P08	Female	Private Business Owner	13 years	4
P09	Male	Territorial Local Authority (TLA)	6 years	8
P10	Male	Territorial Local Authority (TLA)	1.5 years	5
P11	Female	Government Research Institute	9 years	6
P12	Female	Territorial Local Authority (TLA)	5 years	4
P13	Male	Private Organisation	6 months	3
P14	Male	Tertiary Education	6 months	3
P15	Male	Government Agency	2.5 years	6
P16	Female	Publicly Listed Company	Over 15 years	6

Table 10.1 Study 1 Participant Characteristics

10.3 Findings – Qualitative Study 1

Three topics (outlined as research questions in section 10.1) were explored in the interview: participants' understanding of a healthy workplace (RQ1); the behaviours they perceive as promoting healthy workplaces and what they report doing to support employee wellbeing (RQ2); and participants' views on enablers and barriers to managers' health-promoting behaviours (RQ3).

Analysis indicated that within Topic 1, participants conceptualised a healthy workplace through two key themes: *wellbeing-related aspects* and *work-related aspects*. These themes aligned with two (out of three) of the themes identified in topic 2, which involved exploring managers' perceptions of HPLB and asking them to share their experiences and examples of practices they used to support employee wellbeing. The two intersecting themes were labelled as *wellbeing supportive behaviours* and *job supportive behaviours*, see Table 10.2 below. The third theme that was recognised as managers' HPLB was authentic leadership – described by participants as a strategic necessity for modern workplaces to foster a healthy organisational culture. The following section collectively discusses the themes and sub-themes associated with topics 1 and 2, which are then followed by a discussion of topic 3.

Topic 1: Managers' Conceptualisation of a Healthy Workplace Themes	Topic 2: Managers' Health Promoting Leadership Behaviours (HPLB) Themes	Sub-Themes
Wellbeing-Related Aspects	**Wellbeing Supportive Behaviours**	1. Supporting work-life balance 2. Relationship building beyond work 3. Support for physical mental and emotional wellbeing 4. Exhibiting empathy, support and open communication
Work-Related Aspects	**Work Supportive Behaviours**	1. Assigning Optimum Workload 2. Taking a Development Orientation 3. Role Clarity and Job-related support 4. Employee Empowerment through Autonomy, Participation, and Recognition
	Authentic Leadership	1. Exhibiting Self-Awareness and Self-Control 2. Asking Feedback 3. Maintaining Transparency 4. Modelling Desired Behaviours 5. Building Mutual Trust

Table 10.2 Managers' Perceptions of a Healthy Workplace and their Self-reported HPLB

10.3.1 Topics 1 & 2: Managers' Perceptions of a Healthy Workplace and their Self-reported HPLB

When discussing their perceptions of the characteristics of a healthy workplace, participants also discussed the behaviours that they perceived as important to promote employee wellbeing and that they reported exhibiting at work. The two themes – *wellbeing-related aspects* and *work-related aspects* – associated with managers' conceptualisations of a

healthy workplace and the behaviours they reported using to build healthy work comprised 8 different characteristic features (sub-themes). The w*ellbeing-related aspects* theme included four sub-themes: (1) work-life balance; (2) relationships beyond work; (3) physical, mental and emotional wellbeing; and (4) empathy, support and open communication. The *work-related aspects* theme included four sub-themes: (1) workload; (2) development orientation; (3) role clarity and job-related support, and (4) autonomy, participation, and recognition (see Table 10.2). The two intersecting themes are explained below. This explanation is followed by the third theme specifically associated with managers' HPLB, i.e., authentic leadership behaviours.

Theme 1. Wellbeing-related aspects of a healthy workplace and managers' wellbeing supportive behaviours

Managerial participants described a set of features to describe healthy workplaces and their HPLB, which were categorised under the broad theme of wellbeing-related aspects of a healthy workplace and managers' wellbeing supportive behaviours. This theme included four sub-themes: (1) Supporting work-life balance; (2) Relationship building beyond work; (3) Support for physical, mental, and emotional wellbeing; and (4) Exhibiting empathy, support and open communication. See Figure 10.1 below.

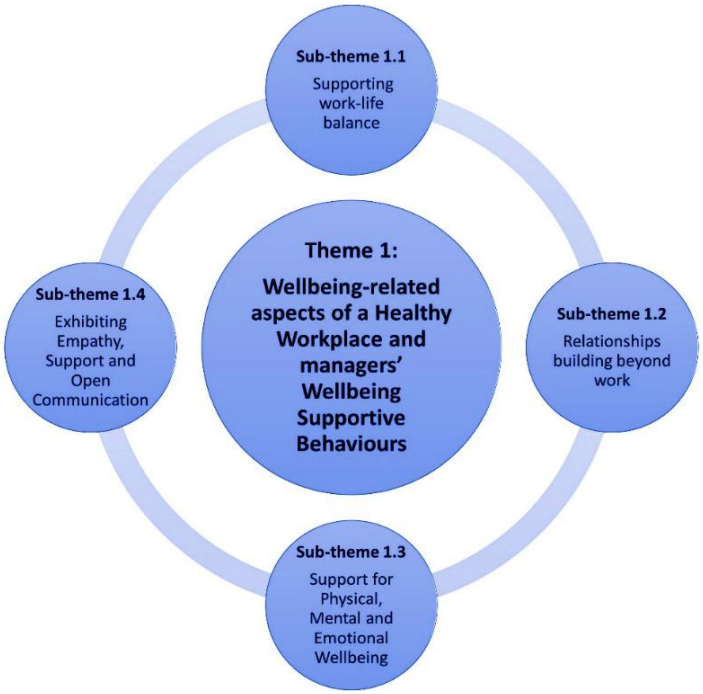


Figure 10.1 Wellbeing-related aspects of a healthy workplace and managers' wellbeing supportive behaviours

Sub-theme 1.1 Supporting work-life balance

More than half of the participants recognised the importance of work-life balance as a characteristic of a healthy workplace. The word balance was used in different ways. Some participants clarified that this meant maintaining boundaries around work so that employees worked within specific hours and did not engage in overtime. This also included having a balanced workload so that employees could balance their personal and work lives. Others explained balance in terms of flexibility, so that employees could start and stop working as per their preferences or needs and were not expected to work inflexible hours, for example, from 9 am to 5 pm. When discussing the flexible working hours of their employees, the following narratives of P01 and P10 illustrate these differences:

> *So being able to stop working on your hours, not being expected to reply outside of that time. (P01)*

My understanding of healthy work is that there needs to be a good balance between private life and work life. (P10)

In line with the importance that they placed on work-life balance for employees, participants explained the ways that they supported their employees' wellbeing. For example, P10 explained that this involved being flexible enough to ensure that people were allowed to take time off if they needed it:

COVID has shown that we all can work from home, in a good manner. And it might not be that you are available 100% during business hours, but I can actually see that some people work earlier in the day or later on in the afternoon, which is fine. (P10)

Part of managers' support for employee flexibility originated from organisational policies, for example, in the form of sick leave or study leave policies. However, managers mostly attributed their support for flexibility to their personal motivation to foster employees' wellbeing. For example, they elaborated that their support for employees' work-life balance was not just about accommodating employees' personal life events, such as caring for a sick child, making medical appointments during work hours, taking study leave, or generally talking about colds, flu, coughs, and sore throats. Rather, it was about holistic wellbeing, which involved pushing their own (managers') boundaries to help employees at work. Examples included supporting employees to deal with challenging situations at home that may be impacting on their focus at work, allowing employees to work flexible hours, doing volunteer work outside of their work, or making temporary changes to their roles.

Participants explained their support for flexibility in terms of a trust-based model of accommodating employees when adjusting work schedules. However, they further explained their expectations from employees in return for flexibility from a transactional lens. They stated that while they wanted employees to feel comfortable in the organisation and

communicate clearly with their manager about their life needs, employees should also understand critical situations and work demands and maintain accountability for work performance. Managers explained their expectation that employees should reciprocate the flexibility provided to them, for example, by working beyond normal work hours when required. The following narrative of a manager exemplifies this expectation:

> *We need to be flexible enough to enable staff to be confident that they can have flexible work time. But the thing is that then at other times, if I put onto them a task that needs to work past five o'clock, they're confident and they're happy to do that, because there's the reward, or there is the ability for them to have some glide time further down the track. (P05)*

Overall, the participants emphasised the importance of understanding employees' commitments outside of work and supporting them for that, for example by offering flexible work hours. At the same time, they clearly explained that such flexibility should be balanced with organisational requirements, ensuring that any flexible arrangements still aligned with organisational goals and operational needs.

Sub-theme 1.2 Relationships building beyond work

Relationship building beyond work was described as another feature of a healthy workplace. Discussion around this aspect involved building good relationships with employees, providing them with *"social opportunities" (P14)*, both formal and informal, where they could share their personal or work-related issues with their managers. Organising regular *"check-ins"* or *"fun activities" (P14)* was also a key part of instigating such opportunities.

When explaining the behavioural aspects of relationship building, participants reported that relationship building with their teams was the most important leadership action they used to promote health and wellbeing. Depending upon their work settings, managers reported engaging in several interconnected behaviours at work, such as regular social catch-ups or checking in with employees about non-work matters. They described these catch-ups as opportunities to build closer, *"more human connections" (P14)* with their team rather than just being work colleagues, which they saw as improving cohesion and social bonds. Participants stated that the main purpose of these catch-ups was to foster open communication, allowing them to learn about their team members, such as their families, children, holiday plans, and general life updates. The following is an example provided by P10:

> *We would normally start with what's going on with the family and everything? And what's the holiday plan? And then, how can we support each other? (P10)*

Managers spoke of two key reasons for these relationship-building activities. Firstly, to build trust-based relationships with their team members. Here, they explained that non-work-related catch-ups or conversations with their team members encouraged employees to trust their managers up to a level where they felt safe and comfortable to vent about anything, whether it was related to work life or home life. Secondly, managers reasoned that open communication with team members allowed them to know their team members at a personal level, which they saw as important to set employees up for success. They explained that this level of familiarity with colleagues enabled them to express care and empathy with openness, as well as to gauge how best to support them. Managers mentioned that, in a post-COVID world where many organisational interactions were online, checking in and connecting with team members remained crucial. They reported achieving this through small gestures of

presence and encouraging social activities, such as organising cultural or social clubs or arranging a lunch out where everyone could meet and discuss life outside of work. One manager exemplified relationship building as:

> *Knocking on the door, saying, hey, I'm just going out to get a coffee. Would anybody like anything? Or does someone want to come for a walk with me? (P12)*

Participants explained that relationship-building activities could include following a fixed protocol on a daily/periodic basis, such as catching up with the team at least once a week for informal discussions around their work, performance or general development. This might be followed by a general catch-up so that employees could share their challenges or happenings in life, which might or might not be part of their work but could impact their work. Other examples included social catch-ups involving connecting over something separate from work, such as going out for coffee or playing cards together, celebrating birthdays, cooking something for the team, or keeping space for some fun activities from time to time in a mutually reinforcing way. The following comment exemplifies one such scenario involving a manager and their team:

> *I try to create good opportunities for my team to just spend time together outside of our work setting… not talking about work, potentially, like meeting up for a coffee during a lunch break and things like that every now and then… just so that they're also able to have quite friendly and positive relationships in that way. (P01)*

Sub-theme 1.3 Support for physical, mental and emotional wellbeing

Participants emphasised the importance of being attentive to physical wellbeing as an essential feature of a healthy workplace. They explained how physical wellbeing could be addressed by working in a peaceful and relaxing environment, where employees were not

exposed to risks or hazards, and where people could work without any risk of harm to their health. Workplace ergonomics, such as having footrests, adjustable chairs, standing desks, an optimum temperature at the workplace, with nice interior decoration and good views from the windows, were also highlighted within this aspect of a healthy workplace. As one participant responded:

> *Taking regular breaks, making sure you get outside get fresh air, good sunlight, mix up tasks. So don't stay sitting in one position the whole time, move around, have a variety of tasks, get regular breaks, to refresh and eat and drink. (P14)*

When describing a healthy workplace, managers from the education and health sectors emphasised the importance of physical health and the safety of teachers and doctors as paramount to their attendance and optimum performance at work because their work required their physical presence. This finding indicates that participants' concern for employees' physical health and safety was sometimes seen as a prerequisite for working and not just a result of giving priority to employee health and wellbeing. These findings indicate that as well as psychosocial aspects of the work environment, participants emphasised that physical health and safety remained important features of a healthy workplace.

Nearly half of the participants mentioned mental and emotional wellbeing as essential features of a healthy workplace. Participants explained that a healthy workplace should provide a psychologically safe work environment, so that employees feel emotionally safe and supported at work. One participant (P09) comprehensively described a healthy workplace via the *te whare tapa whā* (house of four walls) model (Ministry of Health, 2023), a holistic wellbeing model well known in New Zealand. The model likens wellbeing to a house ("whare") where physical well-being, family/community wellbeing, mental well-being, and spiritual well-being comprise the four walls with the idea that if any one component is

deficient, then the entire wellbeing structure will collapse. This finding is consistent with the World Health Organisation's definition of health, where health is described as a complete state of physical, mental, and social wellbeing (Callahan, 1973).

Managers reported that caring for employees' mental and emotional wellbeing was an important health-promoting leadership behaviour. They explained that to do this, they needed to look after their own mental health before promoting it to others. For example, they explained that it was important for managers to model positive mental health by routinely engaging in wellness discussions with their team members and sharing how they (managers) were feeling. In doing so, it was reasoned, this could help create spaces for employees to support their own emotional wellbeing. Managers further expressed that there could be different ways to emphasize the importance of mental health at work and to promote it among their staff, for example by performing small acts such as prayer or *"karakia"(P07)* to seek spiritual guidance before starting work every morning, by giving everyone a chance to express their feelings or decompress from emotionally overwhelming situations at work, or by discussing the wins of the week.

Participants also emphasised the organisational initiatives to upskill employees by providing them with opportunities to use different wellbeing tools and training. For example, one of the managers mentioned:

> *I've got a St. John's certificate in…Mental Health First Aid. I have trained with a company called the Riders and Elephants, and they have a program called The Emotional Culture Deck. We have a Hauora [health and wellbeing] policy where any of the teachers could access counselling, you know, and we would fund that. (P07)*

Participants explained that it was important for them to have regular discussions with employees around mental health and wellbeing, which could involve occasionally touching

base or reflecting on the wellbeing of the team. They explained that having discussions about wellbeing separately from work helped build employees' trust in their managers. Participants reported that they did this at their workplace, and that they believed their employees found it normal to have discussions around these aspects and felt confident that there was no stigma attached to them. As one manager explained:

> *My staff are confident that they could come to me and say, I need help, you know… So yeah, it's something that I think needs to happen as the remover of that stigma around mental health and wellbeing so that people are confident to raise their hand up, ask for help. Get help, because the sooner they get it, the quicker that they can get back to their normal life. (P05)*

Sub-theme 1.4 Exhibiting empathy, support and open communication

Within the wellbeing-related aspects of a healthy workplace, participants emphasised the importance of empathy, support, and open communication. Managers stressed the importance of providing employees a workplace where they felt supported and encouraged, and where everyone was empathetic and helpful, regardless of their position in the hierarchy. They explained that in a healthy workplace, staff should have open communication with each other, and they should be able to discuss personal life events as well as work-related aspects, such as workload or anything that they need assistance with.

Participants explained that empathy**,** support, and open communication were important behavioural dimensions. They described these behaviours as showing *"good old-fashioned human compassion for people" (P13)* and genuinely caring for them regardless of hierarchy. An essential element of being an empathetic and caring manager involved trusting their staff, understanding their needs and showing interest in their wellbeing. Having a trusting relationship was an essential prerequisite for being caring or empathetic, because if

managers were not able to trust their staff, it would be difficult to support them. Participants explained that support involved communicating openly with their team members and solving problems together as well as identifying key factors and signals that indicated stress. This kind of empathetic and trust-based leadership was labelled by one participant (P15) as *"People First Leadership"*. P07 described the importance of trust in these terms:

> *Well, you know, unlimited sick days, and unquestionable, you know, so it's a high trust model, you know, and I think trust…, when you trust your employees, they step into that space, you know. And if they don't, you are questioning their integrity. (P07)*

Listening and being able to take time to talk to people and support them when they needed it was also described as an HPLB. One manager specifically spoke about supporting neurodiverse staff and explained that:

> *Healthy behaviour would be advocating for them, accommodating them, and catering to their individual needs by allowing them to be who they are and preventing bullying at the workplace as long as organisational outcomes are achieved (P06).*

Participants explained that to support employee wellbeing, it was essential to provide enough opportunities to communicate and link employees with relevant resources where they could discuss any issues about their physical, emotional, and mental health. Managers explained that this empathetic relationship involved discussion about personal life events as well as work-related aspects such as workload, or anything that employees needed assistance with. It could be as straightforward as just asking employees how they were feeling. For example, explaining the importance of empathy, a call centre manager (P04) mentioned that it was their practice to allow call centre staff a break for fifteen minutes after every difficult call to go out for a walk or have a discussion with colleagues.

Overall, the wellbeing supportive behaviours reported by participating managers included providing employees with an encouraging environment where they felt connected and cared for. These findings showed that managers' reported that their HPLB could create and strengthen trust-based relationships with employees with the aim of setting them up for success and ensuring that people were at the forefront of business activities while also ensuring that organisational performance was not compromised.

Theme 2. Work-related aspects of a healthy workplace and managers' work supportive behaviours

Participants discussed four work-related features to describe a healthy workplace and their corresponding work supportive behaviours: (1) Assigning optimum workload; (2) Taking a development orientation; (3) Role clarity and job-related support; (4) Empowering employees through autonomy, participation, and recognition. See Figure 10.2 below.

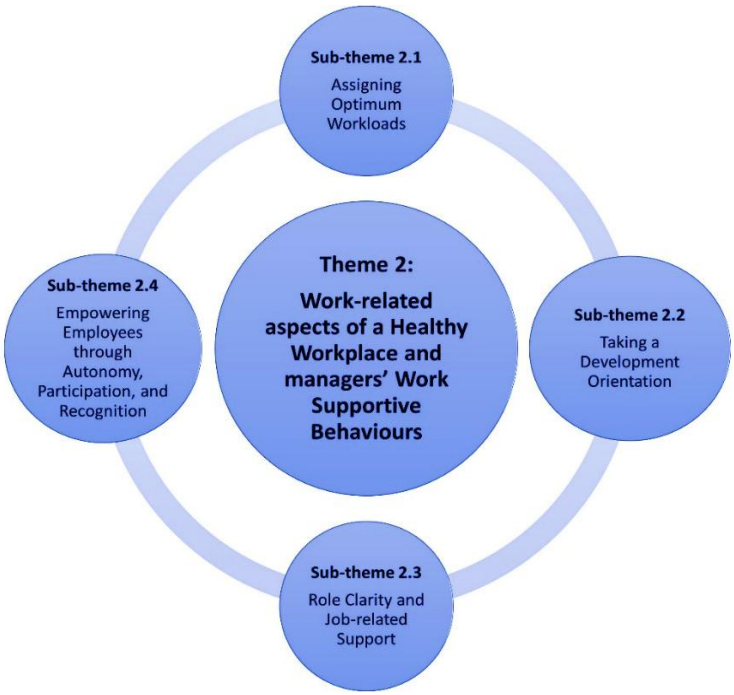


Figure 10.2 Work-related aspects of a healthy workplace and managers' work supportive behaviours

Sub-theme 2.1 Assigning optimum workloads

Focusing specifically on workload, participants explained a healthy workplace as a work environment where people have an optimum level of workload and do not feel unreasonably overstressed or overburdened with tasks. They elaborated that in a healthy work environment, workloads should be checked and monitored by managers for fair and strategic distribution of tasks to prevent burnout and stress. P09 explained the importance of optimum workload as follows:

> *In a healthy workplace, you get a sense of not being overloaded with your work and come in fresh of mind to be able to conduct your work efficiently. (P09)*

Participants explained that managers should have a good awareness of the capacity of their staff and proactively make changes when they believe their employees feel overloaded, so that employees feel well enough to stay at work and come to work with a fresh mind and do their jobs efficiently. Participants explained different ways through which they monitored their team's workload. For example, one manager explained that a big part of being in a leadership role was to act as an *'advocate' (P08)* for their teams and to be able to shelter the team by protecting them from pressure coming from top management or from other teams. They explained that sometimes people cannot stand up for themselves, or they may be facing some challenging situation at home, which might be affecting their performance. In those situations, managers should speak up on behalf of team members and try to lighten the workload without impacting others in the team.

However, not all participants thought in the same way. Participants also added that in healthy workplaces, taking care of employees' workload should not be the sole responsibility of the managers. Instead, employees should be able to say 'no' and self-manage their capacity in order to prevent health issues or difficulty in performing their role.

There's always so much that needs to be done. It's very easy for them to see jobs and say, Oh, I could do that and they're taking on too much. That's not going to be good for them in the long term. So, I encourage them around that to delegate, not to feel responsible for it. because I don't want them to be burnt out. (P02)

Sub-theme 2.2 Taking a development orientation

Participants explained that healthy work should focus on team members' professional growth and development and should challenge people so that they feel fulfilled in their work. They explained it as giving employees a chance for personal development by assigning them tasks that they are comfortable with, i.e., there should not be too much challenge or too little challenge. One participant explained development in terms of pushing boundaries:

Pushing people to the boundaries of their comfort so that they can learn new things, then making sure that, as a manager, you'd be giving people the appropriate training. (P09)

Nearly half of the participants explained that their management philosophies and different behavioural actions were designed to encourage their team members' growth and development. Examples of such behaviour ranged from giving employees growth and networking opportunities to having performance-based catch-ups. Managers further explained their attention to employees' needs and capabilities when assigning tasks to their teams, so that tasks were sufficiently but not excessively challenging. P08 explained their approach towards employee development:

I personally like to grow my people. I'm quite open, and I say, look, we want you for 18 months, and then I want you to grow out of the position. As opposed to always, you know, only just working on their physical, mental wellbeing but also providing them direction towards development. (P08)

Sub-theme 2.3 Role clarity and job-related support

While participants emphasised the importance of challenging tasks, they also highlighted the importance of role clarity and job-related support as a feature of a healthy workplace. Managers explained that, in a healthy workplace, it was important to clarify employees' roles and give them clear instructions and directions to perform their work. They emphasised that clear communication, clarity of goals and purpose, and proper guidelines play a crucial role. They mentioned that this kind of support can take different forms, such as helping people, listening to them, answering their questions, conducting regular meetings to keep realistic expectations, and guiding or coaching employees whenever necessary. Participants acknowledged that where employees lack the necessary knowledge or skills to perform their jobs, managers should help them gain that knowledge and lend a hand as needed. This may involve having daily stand-ups where people talk about the work that needs to be done and working on solving problems together. While explaining their job-supportive behaviour, the following were the narratives of two participants:

> *Giving them clear instructions about my expectations. What our standards are. I'm happy for them to contact me about anything. (P02)*

> *Making sure that our team has clear guidelines of what we do and don't do, so bringing them some clarity. (P08)*

While explaining their behaviours related to fostering growth and development, participants explained the importance of clarifying employees' roles and giving them clear instructions and directions, listening to their team members, and guiding or coaching them. Participants explained that they aim to have clear communication with their teams, convey guidelines, clarify goals, and have regular meetings to keep expectations clear. Managers mentioned that their work-supportive behaviours could take different forms, such as helping

people, answering their questions, and collectively owning work problems. It could also involve working in close proximity to each other to have a sense of being together and managing work pressure in a group rather than as individuals. Participants acknowledged that in instances where employees lacked the necessary knowledge or skills to perform their job, it was up to the manager to help them gain that knowledge and to lend a hand whenever needed. This could involve having daily stand-ups to talk about the work that needed to be done and solving problems together. The following was the response of one participant:

Giving a helping hand whenever people need some help (P10)

Sub-theme 2.4 Empowering employees through autonomy, participation, and recognition

Participants also reported three interconnected dimensions of healthy work autonomy, participation, and recognition. They emphasised that in a healthy workplace, employees need to have autonomy to feel empowered, motivated, and confident. They should be able to raise issues when they come up, and work in an open, supportive and encouraging environment. Conversations with participants emphasised the importance of giving independence and control to employees rather than excessively controlling and supervising their work through intrusive management**.** For example, the following was the narrative of a participant while describing a healthy workplace:

In a healthy workplace, they [employees] feel comfortable and confident and also empowered to, I guess, make changes and raise stuff. (P15)

Managers further emphasised that employees need to be involved in the process of policy making so that they feel like they are heard and supported in bringing ideas, issues and creativity to the table, to collaborate and work together. Emphasising the importance of

participation at work, managers mentioned that they involved employees in the process of policy-making. P16 reported how they did this:

> *Involve them in the process of doing the strategy so that they feel like they have ownership. (P16)*

Explaining further, managers shared that one of their HPLBs was the level of care that they exhibited at work to give independence and control to employees, rather than excessively controlling and supervising their work. Managers mentioned the importance of delegating at least non-critical tasks to their team members and allowing them time, space and appropriate methodology to perform effectively and to support wellbeing, growth and development. Participants also talked about leadership styles while pointing towards the importance of employee participation. For example, one manager said that a good management approach is to lead from the back and remove the roadblocks, which necessarily involves trusting and believing in people as professionals. Another explained that it's important for a good manager to believe in "Servant Leadership" *(P13).* P13 went on to explain this form of leadership:

> *I believe in a style of leadership called Servant Leadership. So [a manager is] down at the bottom, and people you support are above you, so you lift up the people, and then they lift other people up. (P13)*

Managers further explained that another aspect of HPLB was recognition of employees' work so that when employees do something good, they should be acknowledged, praised and encouraged. They shared that their feelings of gratitude, encouragement, motivating use of language, and appreciation for employees' work had a positive impact on employees' interest in their jobs and boosted their morale. They expressed that recognition could take different forms, ranging from simply telling them that they are doing a great job to

acknowledging them publicly for the things that they do. One participant provided a detailed explanation:

> *I try to regularly praise them, if I can. That's good. It's a good old-fashioned people management. I mean, it's just you try to look after people by letting them know when they've done well. I would rather give positive reinforcement rather than negative reinforcement. (P13)*

Theme 3. Authentic leadership as HPLB

While describing the HPLB that they exhibited at work, participants mentioned a set of behaviours that have been categorised under the theme of authentic leadership. Discussions with participants indicated that they viewed manager's authenticity not a fleeting behaviour but as a need to be authentic all the time, even while displaying wellbeing and job-supportive behaviours. Five sub-themes were identified under this HPLB, including (1) Exhibiting self-awareness and self-control; (2) Asking for feedback; (3) Maintaining transparency; (4) Modelling desired behaviours; (5) Mutual trust. See figure 10.3 below.



Figure 10.3 Authentic Leadership as HPLB

Sub-theme 3.1 Exhibiting self-awareness and self-control

Participants explained that an essential aspect of a manager's HPLB was to exhibit "*people-centric leadership" (P15)* and demonstrate a high level of self-awareness**,** i.e., awareness of the influence that their behaviours can have on the wellbeing of subordinates and the general influence that they can have on their team and organisation. Other participants emphasised the importance of self-control for managers and that they should be able to exhibit "relaxed behaviour" (P03) even when dealing with strict deadlines or difficult-to-handle team members. This also involved not being anxious or displaying emotional dysregulation and knowing that how they deal with their team members can affect the team. Thus, they saw it as important to know how to manage their emotions based on situational awareness and to regulate their behaviours accordingly. As P15 explained it:

> *A leader should be self-aware around the influence or the shadow that they can cast on their team or within an organization. (P15)*

Sub-theme 3.2 Asking for feedback

Participants further mentioned that it was equally important for managers to get feedback from their team about how they lead and then adjust their leadership style accordingly. For example, they described it as a personal willingness to be teachable and to adjust as needed. They explained that feedback opportunities from employees can take different forms, such as informal conversations as well as more formal workplace assessments. As one participant explained:

> *I actively ask for feedback from my team about whether I am supporting them well or not. And I do take feedback on board if there's anything they would like me to change over. (P01)*

Sub-theme 3.3 Maintaining transparency

Interview findings indicated another HPLB described by participants that closely aligned with authentic leadership behaviours – maintaining transparency. Participants explained the importance of transparency by sharing that managers must be open and honest, good at showing what is expected, able to have the hard conversations when needed and to have open lines of communication with their team members. They mentioned that for them, communication played a key role, and that they considered it important to share information in a relevant level of detail. This involved keeping employees informed about any policy changes that would have an impact on them. They also added that it was a good practice to maintain transparency to a healthy level so that employees remained confident about what was happening at work, while also feeling cared for. For example, one participant explained:

> *I think a healthy level of transparency is to provide awareness of what's going on, but not so much as to burden your team at the same time. So, if there is a challenge that's being faced at a leadership level that impacts the team, I think it's important to make them aware of it so that they feel a part of it, but not so much to make them feel that stress. (P04)*

Sub-theme 3.4 Modelling desired behaviours

Participants explained that role modelling the behaviours that they expected their staff to exhibit was another important aspect of their HPLB. They explained it as setting an example, demonstrating appropriate behaviour, creating spaces for people to be authentically themselves, not expecting from staff anything that they were not willing to do, and *"practice what you preach kind of behaviour" (P06)*. Participants explained that it may also involve talking about things that managers themselves were struggling with, taking time off when unwell, modelling appropriate boundaries around their work, and demonstrating good health

and safety practice. Participants emphasised that they had a responsibility to model appropriate behaviours because the effect of role models filters throughout the workplace. They stressed that it was their responsibility to take care of their own emotional and mental well-being, because while a workplace can have formal policies, managers need to enact and exemplify them in their role as leaders. For example, P01 and P07 said:

> *It's important for me to stop working at a certain time and not reply out of hours, because I don't want to set that incorrect expectation for other people. (P01)*

> *It starts at the top, and it filters down. And leaders have a responsibility to model it and to embody it, to be able to enable it. So, you can't have a leader who doesn't know how to take care of their own emotional and mental wellbeing. So, you can have all the policies you like, but you should be able to enact and model those as a leader. (P07)*

Sub-theme 3.5 Mutual trust

Discussions with participants indicated that mutual trust between managers and their team members was an essential ingredient of HPLB at work. Participants explained that empathy, support, open communication, and relationship building beyond work were important managerial behaviours that made employees feel understood and supported (see subthemes 1.2 and 1.4 above). However, while specific behaviours were moment-to-moment behaviours, building a trustful relationship involved broader and more consistent demonstrations of reliability, fairness, and integrity, which extended beyond a single interaction. Several participants mentioned the importance of building mutually trusting relationships with subordinates in different ways. One participant explained it as being authentic and being someone who provided high-trust environments, reporting that when managers trust their team members, employees can trust their managers in return. Others

explained that mutually trusting relationships enabled staff to feel confident asking for help, as trust provided psychological safety and confidence in their manager. For example, P05 stated:

> *My staff are confident that they could come to me and say, I need help. (P05)*

Participants also shared different ways through which they built trustful relationships with their team members, such as by spending time with them in the workplace, asking them how they were doing and what concerns they might have, being available to answer questions, and ensuring staff had their managers' contact details. Others explained it as having open relationships with their team up to a level of friendship, so that people felt comfortable sharing their personal challenges, which may or may not be part of their work. Another participant summarised a trustworthy relationship as:

> *You need to make sure that you trust and believe your people as being professionals so that they can do the job even if you're not there. (P09)*

10.3.2 Topic 3: Managers' Perspectives on Enablers and Barriers of their HPLB

To explore the third research question, managers were asked what factors enabled them to engage in health-promoting behaviours at work and any obstacles they had faced. To identify the obstacles, they were asked to recall a time when they tried to promote the wellbeing of their employees, but for some reason they could not do so. The enablers and barriers of managers' HPLB were categorised according to five themes: *organisational factors*, *job-related factors, personal factors, employee-related factors,* and *technological factors* (see Table 10.3).

Topic 3: Enablers and Barriers of Managers' Health-Promoting Behaviours	
Themes	**Sub-Themes**
1. Organisational Factors	1. Organisational policies and values 2. Senior management support 3. Autonomy
2. Job-related Factors	1. Workload 2. Virtual work 3. Lack of managers' training
3. Personal Factors	1. Personal values, preferences, and experiences
4. Employee-related Factors	2. Employee personality 3. Fear of stigma 4. Employee commitment
5. Technological Factors	1. Flexible work tools (e.g., Zoom, Skype)

Table 10.3 Enablers and Barriers of Managers' Health-Promoting Behaviours

Theme 1: Organisational factors

Participants identified three enabling factors at the organisational level to explain their motivation to care for their team members' wellbeing. These included, (1) Organisational policies and values; (2) Senior management support; (3) Autonomy. See Figure 10.4 below

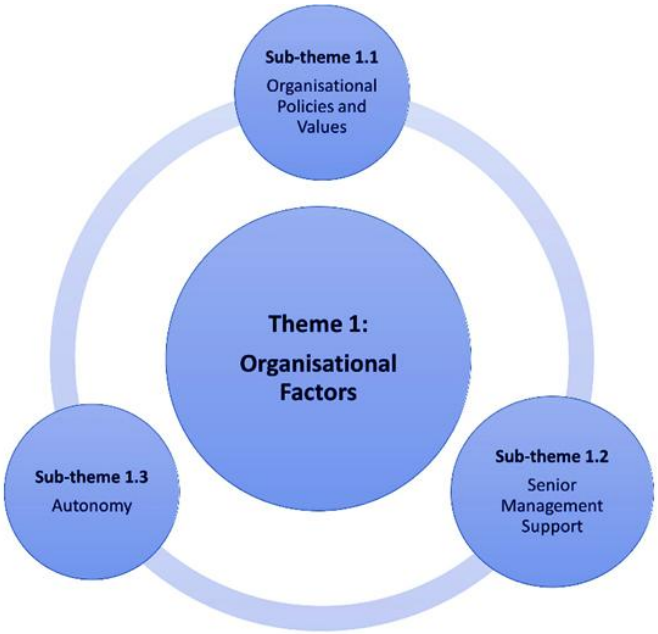


Figure 10.4 Organisational Factors

Sub-theme 1.1 Organisational policies and values

Nearly two-thirds of the participants emphasised that organisational policies and values supported and encouraged them to engage in HPLB. They explained that policies reinforced the strategic direction and signalled the organisation's priority for care of employee wellbeing. P08 explained it as:

> *So, one of our core values here at [organisation name] is hītengitengi. putting people at the heart of what we do. We have a 'te whare tapa whā' model – the overall wellbeing model. (P08)*

Other participants attributed their health-supportive behaviours to robust systems and processes, such as access to trained professionals or people to reach out to or having an extra day off as *"Social Impact Leave" (P12)* for full-time employees to do some voluntary work to contribute to an organisation outside their workplace. The following was the narrative of one of the participants:

I see that the [organization] has signed up with EAP [Employee Assistance Programme] services. So that is something that is quite good (P09)

Participants explained that while the presence of organisational support encouraged them to care for their team's wellbeing, the absence of a supportive organisational culture hindered them from engaging in HPLB. For example, the following was the narrative of a participant:

There's obviously lots of evidence out there about the benefits of reducing working hours on productivity and wellbeing. But there was some sort of traditional old-fashioned views at my workplace that prevented me from doing that, from higher up in the organisation (P01)

Sub-theme 1.2 Senior management support

Participants stated that support from senior levels of management reflected the priority that the workplace placed on the health and wellbeing of employees. They explained that they received information about levels of organisational support for employee wellbeing through discussions in senior management meetings, such as discussions around how people were doing, any support needed, or whether money was required to recognise outstanding work. They further exemplified visible support as the willingness of senior management to support employees' attendance at relevant training, conferences, online seminars, and other professional development opportunities, thereby enhancing their skill set for themselves or their teams. Participants explained that this kind of support was important because it made them feel as if they worked in an *"extended family" (P10)*. Acknowledging the support of senior managers, a participant mentioned:

So, my managers! They facilitate open relationships where I can talk to them about things I'm struggling with and the concerns that I have. And they link me as well to

resources. So, for example, we have access to employee support counselling! They provide things like workshops that staff can attend. So, you know they are resourcing me. And yeah, that's actually, that's another part of my role, linking people who report to me to those resources as well and making them aware. (P02)

While participants explained that support and advice from senior management were important enablers for them to engage in health-promoting behaviours for their team, a few participants emphasised that support needed to be timely to have an impact. They explained that in stressful situations, it was important for senior management to support mid-management, who then, in turn, could support their teams. Such support at multiple levels needed to be timely and focused on resolving issues, and a key to this was that top management needed to listen and understand the issues.

Participants also linked a risk-averse mindset, which tended to prioritise business over wellbeing, as another barrier to health-promoting behaviours. For example, describing her efforts to promote flexibility for her staff during COVID-19, a participant explained that her senior management labelled it as '*unnecessary' (P01),* and in her view, restrictive views of workplace culture prevented her from engaging in HPLB. This finding shows that non-flexible organisational cultures and structural limitations can inhibit managers from engaging in HPLB.

Sub-theme 1.3 Autonomy

Participants further acknowledged that the autonomy given to them by top management was an organisational factor contributing to their ability to support their teams. They explained autonomy in terms of being able to be flexible with their teams, not to be micromanaged, to have the freedom to manage things in the ways that they saw fit, and to be able to try new things and new approaches. However, one participant explained that

autonomy should not only involve managing '*super operational stuff' (P08)* but should include decisions that would have a long-term impact on the team. Overall, autonomy was reported to be a strong motivating factor for managers to care for their staff's wellbeing, as evident in the following response:

> *There is a good level of encouragement that I receive and empowerment from my leader to, you know, make the right decisions and do what I think is right or best. And that makes me feel supported and encouraged, and so it's nice to feed that back down into my team and give them that same level of autonomy. (P04)*

Describing the importance of autonomy, participants explained that top management needed to be aware of when and where to provide autonomy to managers to make staff-related decisions. For example, in busy times, when staff members need to be taken care of, managers need to be able to provide the required support. Participants explained that in large bureaucratic organisations where there is a steep hierarchy, senior management might not understand the priority to care for employees' wellbeing or have the authority to change policy. In those situations, mid-level managers may have to put a lot of effort into convincing top management of their point of view. P08 explained it as:

> *Being able to have a little bit more wiggle room to allow us to get our team, especially through the busy times, because you know, busy time is where I would have less autonomy in that space, and you know, it's also the most important time to have it. (P08)*

Theme 2: Job-related factors

During the discussion, several job aspects were described by participants as factors that had thwarted their ability to promote their team's wellbeing. These included, (1) Workload, (2) Virtual work; and (3) Lack of managers' training. See Figure 10.5 below

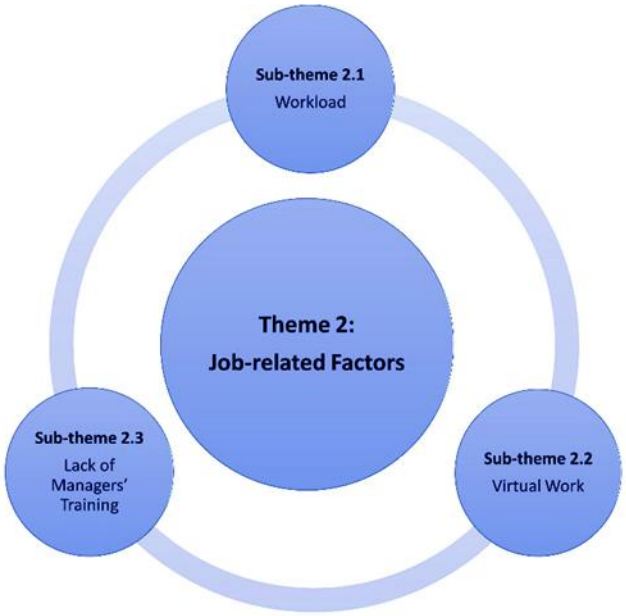


Figure 10.5 Job-related Factors

Sub-theme 2.1 Workload

Half of the managers pointed towards high workload as an obstacle to their efforts to promote employee wellbeing. They explained that due to high workload, they sometimes had to postpone or cancel their own wellbeing-related activities, such as attending a mental health first aid course. They explained that one of the reasons for their inability to prioritise staff wellbeing efforts was the need to deal with other, more urgent things, making them too busy to work on staff wellbeing. At times, they had to deal with tight deadlines, competing priorities or reactive responses to tasks. In this regard, a sense of urgency or a generalised level of work intensity and rising expectations were key reasons reported for not being able to prioritise staff wellbeing. P06 noted:

> *Wellbeing of others is important. But sometimes I think it can get overshadowed with what we have to get done (P06)*

Sub-theme 2.2 Virtual work

While managers mentioned that supporting employees with flexible work options was a necessary step to boost their wellbeing, they also shared that a completely virtual work arrangement could inhibit their capability to care for their team. For example, one participant (P03), whose team worked remotely, mentioned that it can be tricky when employees work from different locations, so managers have to put in more effort to meet in person for example in order to attend social gatherings. Similarly, another manager whose team was dispersed in Auckland and Wellington mentioned:

> *So, I'm much closer to the person here up in Auckland, because I'm there physically with them. But I'm trying to keep a close eye on what's happening with the two in Wellington. It's hard, it's very hard, because the two that work remotely now, I only see them online in meetings and things, but I don't get the chance to really take their temperature (P13).*

Sub-theme 2.3 Lack of managers' training

Lack of management training came up as another factor that participants reported could inhibit their capability to care for their team's well-being. P09 explained that a good technical person might not be an equally good manager, so there was a need to train managers to be managers, which, according to P09, was *'missing in New Zealand'.* P09 explained that organisations need to arrange a formal induction, give managers tools and resources, and support the people who are getting promoted into leadership positions. By taking these steps, organisations could help people who are good in an operational sense, set them up to be successful in managerial positions, and prevent them from being ineffective or '*becoming bullies*' *(P09)* by equipping them with the resources that they would need to support their teams. P11 explained the implications and benefits of managers' training:

But there's no formal induction as a team leader or a team manager. So, you find out about these things kind of by accident rather than being, you know, OK, here is what you need to be doing in this wellbeing space. And here are all the resources for you, like it's usually more that you have an issue and then go searching for help. (P11)

Theme 3: Personal factors

Discussions around enablers and barriers to health-promoting behaviours identified important personal factors related to managers, which were categorised as personal values, preferences, and experiences, as explained below.

Sub-theme 3.1 Personal values, preferences, and experiences

Two different perspectives were held by participants when they explained the importance of a leader's personality in caring for employee wellbeing. Participants from the first school of thought believed that to develop and maintain a positive culture within the team, team leaders should proactively lead wellbeing with their *"people-first" (P15)* attitude, making employees the centre of their focus. They emphasised that it was their responsibility to be proactive and maintain the team's culture, motivation and direction to make everyone's work easier. To achieve this, they emphasised that managers should start with self-awareness and be able to step back and reflect. Participants from this school of thought identified two sources of motivation to care for their staff's wellbeing. First, *personal preference* – such as managers' empathetic nature, personal values or a liking to help people grow, an innate desire to treat people with respect, and to help and empower them. Second, *personal experiences,* which included both their knowledge and experience in the wellbeing field and their personal life experiences, such as working in the wellbeing or mental health space. However, these participants also mentioned that a focus on wellbeing that was driven by personal motivation could change if the person in the role changed, as P01 explained:

Autonomy to make those decisions has good and bad aspects to it. The good is that I've been able to be very flexible with my team and give them lots of support. But the bad is that obviously, no one is telling me to do that. So, someone else could come into my role and could change the way that they do those things, completely. (P01)

Managers from the second school of thought explained that wellbeing initiatives are more durable when they are based on formalised rules and wellbeing policies.

I think it's probably something that should be put down in rules to ensure that all the leadership is doing the same things with their team, so every team member feels supported, whether they're the seniors or juniors. (P06)

Participants who supported the importance of personal traits and values were of the view that policies may serve as a limiting factor or may not make much difference, as people may or may not be aware of the policies, especially new managers. It was generally agreed that, while policies may exist the implementation of those policies ultimately comes down to people. Whether or not policies are in place, participants reported that a great deal depends on managers' traits, how they want to engage or treat people, and how they want to develop and maintain a constructive and positive culture within the team.

Theme 4: Employee-related factors

Participants explained three employee-related factors to explain their perspectives on enablers and barriers of their HPLB. These included (1) Employee personality; (2) Fear of stigma; (3) Employee commitment. See Figure 10.6 below:

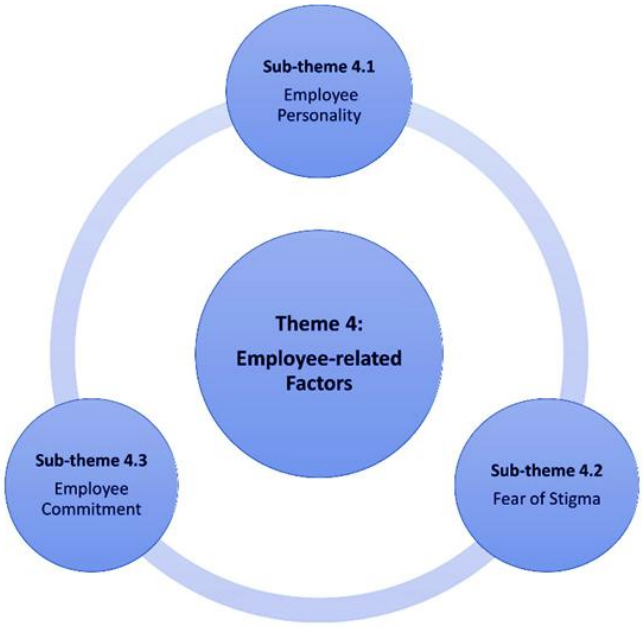


Figure 10.6 Employee-related Factors

Sub-theme 4.1 Employee personality

Personality traits of team members were reported to be an important enabler/barrier of managers' HPLB. For example, a participant (P07) indicated that in a large team, it was often difficult for them to be equally supportive of everyone. The manager explained that they tried to accommodate the personal life challenges of people, but in the instances where employees had behavioural issues, or when people made their wellbeing the organisation's responsibility, engaged in a blaming attitude, or immediately started taking leave in the face of a stressful situation, then it needed to be addressed. The following was a manager's narrative:

> *This is a two-way thing we are here to deliver. When people are saying on occasional basis 'No I can't do this work', this is something, fine. But if this is becoming a habit, we need to wear our management hat. (P10)*

Sub-theme 4.2 Fear of stigma

Managers explained that some people may be suffering from extreme life challenges but may be shy in asking for '*mental health and wellbeing support' (P05)* due to the '*stigma'*

(P05) or external social pressure attached to it. In those cases, managers need to work on the removal of that stigma to encourage people to ask for help when needed, as acknowledged by P05:

> *Sometimes access to the mental health and wellbeing support, you know, it's got such a stigma attached to it. And I think the removal of that stigma is a big thing that needs to happen. (P05)*

Sub-theme 4.3 Employee commitment

While discussing the enablers of their HPLB, participants acknowledged the dedication and commitment of their staff and mentioned that it was employee commitment that motivated them to care for their staff's wellbeing. For example, they were of the view that a great encouragement for them to create a healthy workplace was the '*general commitment from employees' (P03)*. Another participant explained that:

Seeing people coming to work happy every day is quite rewarding, as it helps us to actually retain those people by seeing that they are having a good day at work (P04).

Another participant stated:

> *The biggest support is actually the team themselves, because you kind of see the potential, and you see the great work that they do, and you want to make work a great place for them to exist in. (P11)*

While some participants valued the general commitment and happiness of employees as their motivation for supporting employee wellbeing, others used the words *"retention"* or *"maintaining competent people" (P05),* as their motivation to provide them with flexibility around their work. Participants from small to medium organisations also mentioned the relative ease of making decisions for employees because, unlike large bureaucratic organisations, they did not need to go through complex chains of leadership. This view

showed that more flexibility, less rigidity, and the availability of more discretionary resources, made it relatively easier for managers to implement wellbeing initiatives for their teams.

Theme 5: Technological factors

Participants explained flexible work tools as another enabling factor for them to promote their teams' wellbeing, as explained below:

Sub-theme 5.1 Flexible work tools

Advancements in technology were identified by participants as both enablers and barriers of HPLB. Managers accepted that with technological advancements, it had become easier for them to provide work flexibility to their teams, supporting wellbeing. They explained that *everything has changed (P09),* people have *all the equipment at home* and that they can c*ommunicate through Zoom or through Skype (P05).* However, on the other hand, if appropriate technology was not available (for example, outdated systems), then it limited managers' ability to exhibit HPLB. As P05 explained:

> *We're so connected nowadays that we have the ability to do administrative tasks from a remote location. I can still communicate with suppliers, clients, you know, and staff. So, I think through the use of technology, people have been able to become more flexible with their working arrangements. (P05)*

10.4 Discussion

This qualitative study aimed to explore three questions regarding healthy leadership from the perspective of managers working in New Zealand. These questions include *how managers in New Zealand conceptualise a healthy workplace, which managerial behaviours they consider health-promoting and what they do to promote employee wellbeing, and what*

supports or hinders them in engaging in HPLB for the wellbeing of their team.

The findings extend the existing healthy leadership literature by defining what participating managers perceived as a healthy workplace. The results show that for participants, a healthy workplace comprises *wellbeing-related factors* and *work-related factors*. In contrast to existing models of healthy leadership, which focus on the indirect influence of leaders on employees' health (Eriksson et al., 2010; Jimenez et al., 2017), the present research highlights the direct influence managers can have on the wellbeing of their teams through their supportive behaviours. Specifically, within the analysis, the emergence of physical, mental, and emotional elements closely aligns with the World Health Organisation's definition of health (Callahan, 1973), which promotes a holistic view of health and emphasises the importance of psychological health in addition to physical health. Similarly, managers' linking of different job-related factors to employee wellbeing closely aligns with the existing leadership–wellbeing scholarship (Inceoglu et al., 2018; Nielsen et al., 2008). For example, participants' recognition of the importance of employees having an optimum workload links to the extensive evidence that an optimum workload is essential to enable employees to perform their work efficiently and effectively (Bruggen, 2015). Collectively, these findings show that the concept of healthy leadership combines traditional leadership concepts with the fields of occupational and organisational psychology, workplace health promotion, and human resource management.

This research also makes a novel contribution by exploring which specific behaviours participants considered to be health-promoting and what they reported doing to promote the wellbeing of their teams. Three key types of behaviours were identified, i.e., *wellbeing supportive* and *job-supportive behaviours*, and *authentic leadership behaviours*. Wellbeing and job-supportive leadership behaviours specifically focused on maintaining employee wellbeing and organisational priorities and goals, while authentic leadership behaviours were

seen as more holistic and included role modelling, transparency, and mutual trust. This is in line with the existing authentic leadership literature, which shows that authentic leaders' humanistic values help them promote a work environment where people feel supported (Wong & Cummings, 2009). This study also showed that an essential ingredient to promote employees' health was managers' ability to be aware of and regulate their own behaviours at work, a finding which is consistent with the self-awareness and self-regulation dimensions of the authentic leadership literature (Luthans & Avolio, 2003).

The findings also support previous studies, in which participants reported that their positive psychological capacities helped them to foster high-quality relationships with employees through empathy and care, resulting in greater productivity, better work performance, and mutual trust (Avolio et al., 2004; Luthans & Avolio, 2003). Trustful leader-member relations were seen as an essential characteristic of a healthy workplace by participants in the current study as well as in previous research. Findings indicated that effective leaders build an environment in which people feel safe and secure and have a high level of trust in their leaders (Deon 2021).

The research also contributes to the healthy leadership literature by identifying the enablers and barriers for managers to engage in health-promoting behaviours. Extending the findings of the quantitative part of this research, which showed that perceptions of autonomy support directly relate to PSC perceptions, this qualitative study showed that organisational policies, practices and values have a far-reaching impact on managers' decisions to support their team's wellbeing. Participants emphasised the importance of top management support as an enabler of HPLB. Their view emphasised that although there may be policies and systems in place to support employee wellbeing, when it comes to actual enactment, support from senior management plays a key role. Specifically, the autonomy support they received from top management was reported to directly translate into participants' care for their direct

reports. Previous research has also found that managers show more autonomous motivation for their work when they perceive that top management supports their autonomy (Otis & Pelletier, 2005). A plausible reason could be that line managers are in an influential position to promote a healthy work culture because they can enact the wellbeing priorities of top management to their direct reports via a top-down process. This finding is also supported by Self-Determination Theory, which shows that workplace contextual factors are crucial in motivating or inhibiting an individual's engagement in certain behaviours (Deci et al., 2017). Identification of job-related factors, such as high workload, as barriers to promoting employees' health is also consistent with the Workplace Wellness Report (2021), which shows New Zealand workplaces suffer from high workloads.

Under the theoretical lens of SDT, which shows that variations in individuals' causality orientations (autonomous vs. controlled motivation) account for variations in their behavioural choices, this research also makes a unique contribution by showing that managers' individual factors, such as their self-reported personal values, preferences, and experiences, serve as enablers/barriers of their HPLB. Thus, the research shows that while autonomously regulated behaviours could serve as a basis for managers' intrinsic motivation to care for their subordinates' wellbeing, a lack of managerial motivation could also limit their care for the wellbeing of their team.

This research also provides important insights into HPLB by showing that the enactment of a healthy workplace depends not only on organisational policies or managers' personal preferences but also on external factors, and on employees themselves. For example, technological factors associated with remote working could act as enablers or barriers to managers' health-promoting behaviours, showing the interdependence of organisational and external environmental factors for achieving desired organisational health outcomes. Similarly, participants identified that commitment to wellbeing is a shared responsibility

between managers and employees, which aligns with the concept of employee *self-care* in the existing health-oriented leadership literature (Franke et al., 2014). Wellbeing is a shared responsibility because organisational efforts to provide support and resources to employees cannot be practical if employees are not ready to take responsibility for their own wellbeing.

Theoretically, this qualitative research makes several unique contributions to the healthy leadership literature by conceptualising the dimensions of a healthy workplace, exploring health-promoting leadership behaviours from managers' perspectives and identifying the enablers and barriers of managers' HPLB. Practically, it helps build an understanding of healthy workplaces, managers' health-promoting leadership behaviours, and their interplay with organisational and external environmental factors, which offer opportunities for organisations to design strategies for workplace health promotion.

Together, these qualitative findings extend, refine, and reinforce the proposed HPLB framework by providing a deeper, practice-based understanding of how healthy leadership is enacted by managers in real organisational contexts. First, the findings extend the framework by clarifying how managers conceptualise a healthy workplace, highlighting the integration of wellbeing-related and job-related factors and demonstrating that healthy leadership involves both direct and indirect influences on employee wellbeing. Second, the identification of three categories of health-promoting behaviours, wellbeing-supportive, job-supportive, and authentic leadership behaviours, refines the behavioural dimension of the HPLB model by showing that authentic leadership behaviours such as self-awareness, transparency, and trust-building are central to leaders' ability to promote wellbeing. Third, the qualitative insights reinforce the HPLB framework by illustrating how organisational systems, autonomy support, personal values, and external contextual factors shape leaders' motivation and capacity to engage in HPLB. These findings emphasise that healthy leadership is not solely a function of individual leader behaviour but is shaped by the

dynamic interplay between leaders, organisational structures, and employees' own engagement in wellbeing practices. Collectively, the qualitative results strengthen the theoretical foundation of the HPLB framework and provide a more nuanced understanding of the conditions under which health-promoting leadership can be effectively enacted.

Chapter 11

Phase II Qualitative Study 2 – Perspectives of Non-Managerial Staff

11.1 Introduction to Qualitative Study 2

The quantitative study, conducted with non-managerial staff (Chapter 8), investigated the relationship between non-managers' perceptions of their managers' Health-Promoting Leadership Behaviours and their psychological wellbeing and self-reported performance. The findings indicated that non-managers' perceptions of their managers' destructive leadership behaviours, such as putting excessive quantitative or qualitative workload on their direct reports, did not directly relate to impacting their (non-managers) performance (both in-role performance and extra-role behaviours). Instead, these behaviours influenced their subordinates' performance indirectly by negatively affecting their wellbeing. Similarly, the survey findings showed that non-managers' perceptions of their managers' positive leadership behaviours, such as autonomy, trust, participation, and appreciation, did not directly relate to impacting their (non-managers) performance. Rather, these positive managerial behaviours influenced subordinates' performance indirectly by positively affecting their wellbeing.

While the survey findings showed an important link between non-managers' perceptions of leadership behaviours and their self-reported performance via wellbeing, these findings raised two important questions. Firstly, what specific behaviours did non-managers believe contributed to enhancing their wellbeing and thereby performance? Secondly, how did those leadership behaviours impact wellbeing and performance? To explore these questions, first, it was essential to understand how non-managers define a healthy workplace and which managerial behaviours they identify as health-promoting based on their workplace

experiences. Additionally, it was important to explore which managerial behaviours they perceived as impairing their wellbeing. To complement and enrich the earlier survey findings, the present study aimed to gain a deeper insight into how non-managers perceive their managers' HPLB as influencing their performance and wellbeing. Therefore, the purpose of this second qualitative study with non-managers was to explore the following research questions:

RQ1: How do non-managers understand a healthy workplace, and why do they hold these perspectives?

RQ2: Which managerial behaviours do non-managers consider to be health-promoting, and which thwart their health?

RQ3: How do the health-promoting or health-thwarting behaviours of managers impact the performance and wellbeing of non-managers?

11.2 Method

11.2.1 Sample Size

To conduct this study, the same method was used as described for Qualitative Study 1 (Chapter 10). Of the 302 non-managers who participated in the survey, 35 (11.6%) indicated an interest in being interviewed. An invitation email (Appendix XI) and information sheet (Appendix X) were sent to the potential participants. From these 35 invitations, 7 individuals responded positively (20% response rate). Due to the limited uptake from survey respondents, a supplementary recruitment strategy was also adopted (for details, see section 10.2.1 in Chapter 10). For this, the researcher utilised personal contacts who were working in diverse industries and domains in NZ. The same invitation and information sheet were shared with them, yielding 7 more participants.

The interview process was started, and initial analysis of the first interview with non-managerial staff generated nineteen codes, with subsequent interviews adding to this list; however, the final coded interview generated only five new codes. Therefore, considering the diminishing utility of conducting more interviews, data collection was closed for this study, resulting in a sample size of 14 participants – 7 from the first (quantitative) phase of this research, and 7 from the researchers' personal contacts. Overall, data collection of non-managerial interviews continued for 37 days, from the 20th of July 2023 until the 26th of August 2023, with an average duration of 27 minutes per interview.

11.2.2 Participants' Characteristics

Of the 14 participants, 8 (57%) identified as male, and six (43%) identified as female. In terms of industry sectors, six participants were employed by a territorial local authority (local government), and five worked in tertiary education. The remaining three were employed at an early childhood education centre, a financial institution, and a registered charity. The workplace tenure of these participants ranged from 1.5 years to 21 years (See Table 11.1).

Participant	Gender	Industry/Organisation	Experience
P01	Male	Territorial Local Authority (TLA)	1.5 years
P02	Male	Tertiary Education Institute	21 years
P03	Female	Territorial Local Authority (TLA)	1.5 Years
P04	Male	Territorial Local Authority (TLA)	1.5 Years
P05	Female	Tertiary Education Institute	1.5 years
P06	Male	Early Childhood Organisation	12 years
P07	Female	Territorial Local Authority (TLA)	5 years
P08	Male	Territorial Local Authority (TLA)	1 year 3 months
P09	Male	Tertiary Education Institute	3 years
P10	Male	Financial Institution	1 year
P11	Female	Territorial Local Authority (TLA)	7 years
P12	Male	Tertiary Education Institute	4 years
P13	Female	Registered Charity	2 years
P14	Female	Tertiary Education Institute	1.5 years

Table 11.1 Study 2 Participant Characteristics

The data analysis process was the same for this group as in Qualitative Study 1 and is detailed in Chapter 9.

11.3 Findings

Three topics (section 11.1) were explored in the interview: participants' understanding of a healthy workplace (RQ1); the behaviours of their managers that the participants perceived as health-promoting, and the behaviours that they perceived to thwart their health (RQ2); and the impact of their managers' health-promoting and health impairing behaviours on wellbeing and performance (RQ3).

Within Topic 1, analysis identified that participants conceptualised a healthy workplace through three key themes: *wellbeing-related aspects*, *work-related aspects, and human aspects*. Within Topic 2, analysis identified three themes to explain participants' perceptions of managers' HPLB and behaviours that undermine their wellbeing: *wellbeing-*

supportive behaviours, work-supportive behaviours, and people-oriented behaviours (see Table 11.2). As the themes and sub-themes within these two topics aligned with each other, the following section collectively discusses topics 1 and 2, followed by a discussion of topic 3.

Topic 1: Non-Managers' Conceptualisation of a Healthy Workplace	**Topic 2: Non-Managers' Perceptions of HPLB**	
Themes	**Themes**	**Sub-Themes**
Wellbeing-Related Aspects	**Wellbeing Supportive Behaviours**	1. Wellbeing Support 2. Physical Health and Safety 3. Emotional Safety
Work-Related Aspects	**Work Supportive Behaviours**	1. Optimum Workload 2. Task-related Support 3. Opportunities for Growth and Development 4. Recognition and Appreciation 5. Open Communication, Inclusion, and Listening 6. Autonomy
Human Aspects	**People Oriented Behaviours**	1. Approachability and Responsiveness 2. Relationship Building 3. Trust 4. Authentic Leader-Member Relationship

Table 11.2 Non-managers' Perceptions of a Healthy Workplace and HPLB

11.3.1 Topics 1 and 2: Non-Managers' Perceptions of a Healthy Workplace and Managers' HPLB

The same three themes – *wellbeing-related aspects*, *work-related aspects, and human aspects* – were associated with non-managers' conceptualisation of a healthy workplace,

perceived managers' HPLB, and managers' health-thwarting behaviours. Collectively, these three themes comprised 13 sub-themes, discussed below.

Theme 1. Wellbeing-related aspects of a healthy workplace and wellbeing supportive behaviours

Non-managerial participants described a set of features to describe healthy workplaces and the HPLB of their managers, which were categorised under the broad theme of wellbeing-related aspects. This theme included three sub-themes: (1) Wellbeing support; (2) Physical health and safety; and (3) Emotional safety. See Figure 11.1 below.

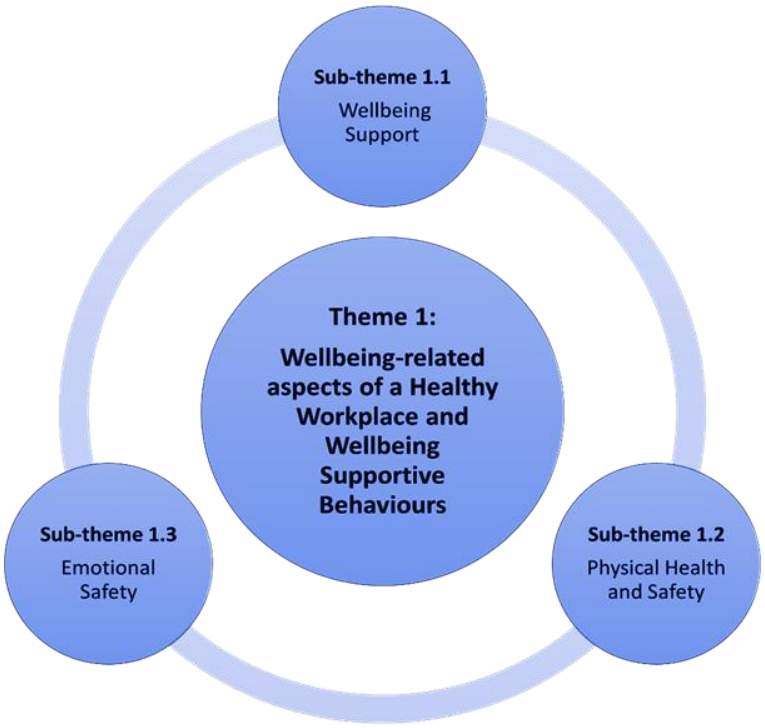


Figure 11.1 Wellbeing-related aspects of a healthy workplace and wellbeing supportive behaviours

Sub-theme 1.1 Wellbeing support

For a healthy workplace, participants described that managers' support for their wellbeing was of the utmost importance. They explained it as *"flexibility in terms of working*

hours and conditions" (P06) to support their family, health or personal needs, without going through complicated administrative processes. Participants also described wellbeing as *"organisations' wrap-around support" (P10),* i.e., the workplace being flexible enough to accommodate employees in difficult or unusual times, such as circumstances that did not fit in the category of sick leave. They further explained that a healthy workplace is one where people love to come every day for reasons that keep them motivated. These reasons ranged from having feelings of personal growth to feelings of pride for their contributions. A participant (P11) summed it up as:

> [A healthy workplace is] *where people actually come to work and leave better than they arrived. So, from a wellbeing perspective, they should be going away being enhanced by their day. (P11)*

Connecting their understanding of a healthy workplace to the wellbeing supportive behaviours of their managers, participants explained that in a healthy workplace, a manager's role is to manage the whole person, not just the working person. They explained these considerate and kind managerial behaviours as a *"family-first attitude" (P11)*, so that when an employees' family members were sick, their manager should understand and provide support. Participants emphasised that managers should enable flexible arrangements such as time off when employees needed to take care of themselves, when not feeling well, or in order to take bereavement leave.

In addition to enabling flexible working arrangements, participants explained that wellbeing support involved offering assistance to people who were going through particularly challenging periods. For example, one participant (P03) explained that, back in 2023, their organisation had psychologists and counsellors available to support people affected by Cyclone Gabrielle in addition to the regular employee assistance programs (EAP). Similarly,

another participant (P10), who was recovering from a hand injury, explained how supportive his organisation had been throughout his recovery period. He acknowledged his managers' understanding of rules and policies and outlined his organisation's continuous support by providing him with the services of an occupational therapist, and overall flexibility while he was returning to work.

Participants emphasised that their organisations did not need to support the wellbeing of team members via extensive or expensive programs. Managers could make employees feel cared for through simple gestures. One participant explained small gestures expressing the element of care as follows:

> *You know, just, "how are you" is also really important? Maybe in the morning, or you know, even in the afternoon. It makes me feel that they care about me, because then it allows me, if I'm concerned with something at home, if my son is sick, for example. I'm allowed to express it. (P12)*

Sub-theme 1.2 Physical health and safety

Describing the features of a healthy workplace, participants emphasised the importance of workplace environmental factors and connected them to the broad area of physical health and safety. For example, they mentioned the importance of an aesthetically pleasing, *"warm and dry" (P06)* work environment, *with lots of natural light" (P03)* as being essential for optimum working. Availability of a "quiet room" to take short breaks from work was another feature of a healthy workplace described by participants. Pointing towards physical safety at the workplace, participants emphasised that the place where they worked should be free of hazards that may cause accidents. As part of caring for employees' physical health and safety, participants explained that organisations should provide some non-salary benefits such as vaccinations and optometrists' visits, as indicators of a commitment to

wellbeing. P02 described non-financial compensation as:

> *A healthy workplace in a physical sense is providing free flu jabs for the field staff, to have eye tests and contact lenses or glasses every 2 years, discounted life insurance, and income protection insurance. (P03)*

Describing the health-promoting behaviours of their managers focused on the physical health and safety of employees, participants emphasised the importance of customised support for people with additional needs at work. They explained that this might involve providing a footrest to all employees and a customised set-up for employees with long-term injuries who needed a particular set-up for health and safety reasons and to minimise their discomfort. Explaining their managers' HPLB, P13 exemplified a fund created by their manager to offer monetary support to employees periodically:

> *It's just like a hundred dollars once every three months, and it was expected that we would spend it on something that we wouldn't otherwise do for ourselves. So it might be like massages, it might be like, I need new shoes, but the sort of things where you like put it off because you can't afford it. (P13)*

Sub-theme 1.3 Emotional safety

Participants explained that a healthy workplace is one where people feel emotionally safe in relation to their personal and professional relationships with managers and colleagues. For example, they clarified that in a healthy work environment, managers should not use *"bully tactics or gender-based prejudice"* (P09) and that they should not be *"racist or sexist"* (P09). They further added that employees should feel safe approaching their managers to share their work-related and even personal problems. One participant (P12) exemplified the caring behaviour of their manager as follows:

I especially now really like my manager. Because she is somebody who will ask me every morning as soon as she sees me: 'How are you? Did you have a good evening yesterday?' So even though maybe she doesn't expect a long answer but that actually makes me feel really happy that she's asking. It's not like she's just saying 'Hi' and just walking away. (P12)

Discussions with participants regarding HPLB indicated that managers can only contribute to their employee's wellbeing when they are empathetic and kind enough to feel for their team members. Participants talked about managers' empathy and understanding as essential elements of a healthy workplace. They explained that the considerate and kind behaviours of their manager allowed them to work flexibly and communicate easily as and when required. Participants expressed gratitude when their manager cared for them as a person, not just as their employee. The following was the narrative of a participant:

If you have a manager who is empathic and makes that their central focus for managing, more in terms of a servant leadership sort of role where they are serving you rather than dictating you what to do. I think those people tend to be the best leaders. (P10)

When discussing empathy, one participant emphasised the importance of managers' assertiveness as an important HPLB. P10 explained that managers should be kind and empathetic, but firm with clear boundaries and expectations, because if empathy is not complemented with appropriate firmness, it could lead to blurred expectations. P10 went on to explain that if a manager is too soft, then people might take advantage, but if a manager is too difficult to work with, then people will change departments or leave the organisation. Thus, according to P10, there needed to be a good balance between empathy and firmness to create a work environment where staff feel emotionally safe and mutually respected.

Theme 2: Work-related aspects of a healthy workplace and work-supportive behaviours

Participants discussed six work-related features to describe a healthy workplace and the corresponding HPLB of managers: (1) An optimum workload; (2) Task-related support; (3) Opportunities for growth and development; (4) Recognition and appreciation; (5) Open communication, inclusion, and listening; (6) Autonomy. See Figure 11.2 below.



Figure 11.2 Work-related aspects of a healthy workplace and work-supportive behaviours

Sub-theme 2.1 Optimum workload

Participants emphasised the importance of an optimum workload as an essential feature of a healthy workplace. They explained that an optimal workload is manageable and matches a person's capacity and resources. Participants also explained that a balanced workload involves management having realistic expectations of employees in terms of both the quantity and quality of tasks, thereby avoiding tension and fostering an environment of trust between managers and employees. P01 explained the optimum workload as:

> [In a healthy workplace] *there should be a balanced workload so that when you go back home, or you go for your weekend, you do not carry any work-related thinking with you* (P01).

Explaining managers' responsibility to ensure that employees were not overloaded with work, participants explained that it was important for managers to be mindful of the work assigned to each team member and, where possible, to optimise the responsibilities of people to make work more flexible. Participants expressed appreciation for managers who were not over-ambitious, and who constantly checked in and took care of workload assignments by not *"bombarding" (P01)* employees with tasks. For example, two participants appreciated their managers as follows:

> [My manager] *checks with me now and then to make sure that the workload that I'm being given isn't too much.* (P05)

> *Well, as far as my manager - she's a very busy person, but I think one of the best things I appreciate about her is that when I have a lot of work being given to me, she always does recognise that and she tries to, where possible, minimise some of the responsibility so that it's more flexible for me. So that's something I really appreciate about her. (P14)*

Sub-theme 2.2 Task-related support

Participants described task-related support as a core component of a healthy workplace. By task-related support, they meant that employees needed to have adequate guidance, resources, and clarity to perform their work efficiently and effectively. They explained that this might include helping employees to prioritise tasks, removing barriers that might be hindering efficient delivery of projects, and providing timely feedback.

Participants acknowledged that the task-related support provided by their managers was an important HPLB, especially when performing a new task, a complicated task or a task performed infrequently. Other circumstances when task-related support was particularly valued involved collaboration with other teams or departments, or when a '*bottleneck'* was encountered in an assigned job. P01 explained

> *If there is a bottleneck in any task that needs to be removed, or when I'm actually in trouble or stuck on some tasks, he* [my manager] *would actually be there to help me. (P01)*

Managerial support was also required for projects that required higher cognitive loads in order for employees to reduce their stress levels and avoid errors, and to encourage participants to seek help in difficult situations rather than hiding problems. P14 described the importance of proper onboarding by sharing her experience of how vital proper guidance had been at the beginning of her new role. Another participant (P10) appreciated his manager's style of dealing with difficult people who could potentially withhold information or complicate the handover process in a diplomatic and considerate way. They explained that their manager's supportive behaviour served as a shield for the team members and allowed them to perform their duties smoothly and to meet deadlines.

Sub-theme 2.3 Opportunities for growth and development

Participants described opportunities for growth and development as an essential feature of a healthy workplace. They explained it as a *"career-led environment" (P12).* Explanations of the opportunities ranged from *"opportunities to learn something new" (P08)* to growing personally and professionally. Participants elaborated that opportunities also involved encouraging employees to keep learning, and, where possible, financially supporting them for their growth and development, for example, by fully paying the costs

associated with courses or workshops or partially reimbursing training costs. They explained that this kind of support was especially important for employees who were early in their careers and who needed to upskill and broaden their knowledge. A participant (P09) explained it as:

> *"If I want to go on some professional development, they* [management] *are willing to let me go, and if they've got the money, they'll pay for it"* (P09)

Explaining managerial HPLB regarding teams' growth and development, one participant (P10) clarified that focusing on the learning and development of the team did not necessarily mean that managers should be highly technical and know everything about their employees' requirements. Managers could ask team members about their expectations for learning opportunities that they would like in order to perform the job well. This support allowed employees to feel that they were working in a career-led environment and developing themselves. For example, a participant explained it as:

> [My manager] *does not deal with the technical aspects of my work, so it's more along the lines of what training would you like? What would you like to learn more about? What has ignited your curiosity? Is there an opportunity within the organisation that you've seen that you would like to move into? (P10)*

Sub-theme 2.4 Recognition and appreciation

Participants emphasised that recognition, appreciation and encouragement were crucial for them at work. They explained it as having a sense of worth in what they were doing, feeling appreciated, and knowing that their efforts would be rewarded or recognised. They reported that managers should encourage employees if they want continued employee engagement. Appreciation could range from formal recognition of achievement to small gestures of verbal praise. Such validation from the organisation helped to counterbalance

work demands and sustain morale for continued performance. A participant (P11) explained appreciation as:

> *Having a sense of worth in what they're doing. Feeling appreciated and just knowing that what they're doing is making a difference.* (P11)

Participants valued encouragement as an important behaviour of their managers that could boost wellbeing, reinforce positive behaviours and positively impact performance. Appreciation and encouragement from managers were seen as essential for employees to remain engaged at work, reduce feelings of invisibility, or counter feelings of performing the job 'mechanically'. They further explained that a work environment where people love to come every day and find meaning and enjoyment in their jobs can enhance performance and create a culture of respect and trust.

One participant (P14) clarified that managers did not need to micromanage employees to be able to recognise their contributions. Meaningful appreciation could be achieved by remaining mindful of employees' efforts and outcomes, finding time to look around, keeping an eye on what was happening with people, then appreciating them for their efforts. P14 expressed a similar sentiment:

> *I think one of the best things about her* [my manager*], regardless of how busy she is, is that she notes everything that has been done by me and even appreciates and recognises the fact that I've been doing all that stuff, whether it is a little thing or a big thing. (P14)*

Sub-theme 2.5 Open communication, inclusion and listening

Participants stated that in a healthy workplace, employees should feel heard and included in day-to-day matters about their role, and that they should have a voice in the workplace. This could be in the form of idea-sharing and exchanging information to building

mutual understanding and offering support when required. Purposeful open communication was essential, and while spontaneous and informal communication was important, more formal, structured and regular meetings were also crucial. For example, P06 emphasised that a planned catch-up would allow employees to be prepared to discuss issues that they wanted to share with their manager. Describing a healthy workplace, P09 explained inclusion and listening as follows:

> *Where you are listened to by management. Where it's not a ticking the box sort of exercise. Where your contribution is valued. Where you are valued as a person, not as just as an employee. (P09)*

Participants emphasised that inclusive practices and open communication were central to a supportive and healthy work environment. When managers were able to communicate transparently and invite questions, employees felt encouraged to voice questions and that they were informed and respected. This also ensured that all team members, regardless of experience and roles, were involved in decisions affecting them. The following was the narrative of P07:

> *When my manager encourages us to speak up and actually listens, it makes me feel as if I have a say in the workplace and my voice matters. (P07)*

Seen from a health-threatening perspective, participants stated that workplaces where managers fail to consider people's opinions, do not keep employees informed, or fail to make people feel a useful part of the team will become detrimental to long-term wellbeing.

Sub-theme 2.6 Autonomy

The final work-related element of a healthy workplace described by participants was autonomy. One of the participants (P14) explained autonomy as having some degree of flexibility, to make decisions or to be able to do things in a way that they liked, rather than

always being told. Others explained that having the freedom to organise their work and make day-to-day decisions without excessive oversight was important for them to feel trusted by their managers. A participant (P11) explained it as follows:

> *I guess they* [non-managers] *should have the autonomy to make the decisions and choices that are within their skill set, you know, so that they're not micromanaged. (P11)*

Describing autonomy as a HPLB, a participant explained that their managers' autonomy-supportive behaviours ensured that they had control over their work, and that employees were able to adjust their approach when they noticed any inefficiencies or improvements in their work. This kind of relationship with their manager made them feel more trusted and valued at work, boosted their sense of competence and encouraged creativity at workplace. The narrative of P14 exemplifies this:

> *My manager guides me to prioritise my tasks based on the timelines and senior management priorities but then leaves it to me how I organise my work, and that freedom makes me comfortable. (P14)*

Theme 3: Human aspects of a healthy workplace and people-oriented behaviours

Non-managerial participants described behaviours and traits of their managers that they considered had a direct impact on non-managers' optimum performance and wellbeing. Four such leadership characteristics were: (1) Approachability and responsiveness; (2) Relationship-building skills; (3) Trust; (4) Authentic leader-member relationships. See Figure 11.3 below:

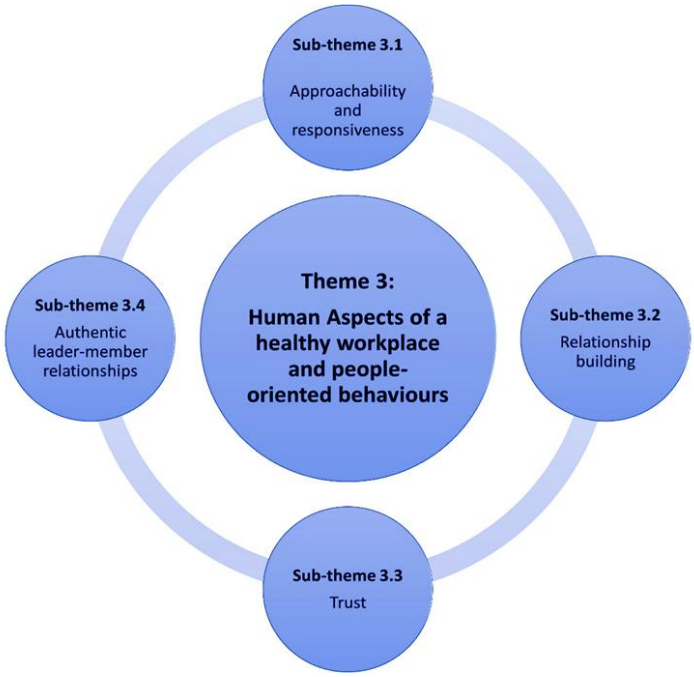


Figure 11.3 Human Aspects of a Healthy Workplace and People-oriented Behaviours

Sub-theme 3.1 Approachability and responsiveness

Managers' approachability and responsiveness were described as important indicators of a healthy workplace. Participants explained that they felt more comfortable in seeking guidance and raising concerns when their managers were accessible and receptive to their needs, listened to them carefully, showed empathy and reduced barriers. For example, a participant mentioned that managers' friendly behaviour allowed him to raise concerns:

> *Unless the manager is, you know, friendly with me, I wouldn't talk about, you know, things that concern me. Because I need to have a little bit of a 'human-like' kind of relationship before I will open up about even work complaints. (P12)*

Participants admired their managers' approachability and responsiveness and saw these as important health-promoting behaviours. For example, one participant (P06) described their manager as inspirational and down-to-earth, so much so that employees felt

comfortable going to her with any issue. Others valued the responsiveness of managers who provided timely feedback. Another participant appreciated the ease of communication with their manager and saw it as an essential element to performing the job well. This type of support ranged from taking time to listen to employees' personal or work-related issues to helping them come up with a solution. The following quote explains how one participant described the availability and ease of communication with the manager.

> *I have great communication with my boss, and I don't think that there has ever been a situation where I felt like she hadn't supported me. I know that if I were in a situation where I was too stressed or felt uncomfortable, I know that I could go to her and she would be able to stand behind me and support me through that. (P05)*

Seen from the perspective of health-thwarting managerial behaviours, participants were clear that managers should not engage in any kind of unprofessional behaviours, such as "*bullying" (P10)*, gossiping, or losing emotional control at the workplace.

Sub-theme 3.2 Relationship building

Participants explained that in a healthy workplace, good managers show interest in employees' lives outside work. This might involve knowing about employees' interests, families or career-related aims to build strong relationships. Participants emphasised that people work in collaboration with each other and rely on others to get information or support to perform well. Having good people around with mutual understanding and supportive relationships was, therefore, paramount to excelling as a team. The following narrative shows how enthusiastic employees can be about their managers:

> *So, my manager is amazing; she is really engaged and knows me as a person, not just as her report. So, she really understands, and she has taken the time to get to know me. (P11)*

Participants further explained that having good relationships with their managers and working in a friendly or comfortable environment meant that any issues could be positively resolved. In a sociable work environment, employees could seek opportunities to improve and learn from each other without being seen as a troublemaker. Overall, having friendly relationships with colleagues was identified as being helpful, accepting each other, and extending respect with patience. P10 explained a friendly work environment at their workplace as:

> *We have quite a friendly environment here, and people are happy to take ownership of their own mistakes and their own shortcomings, so that any issues can be positively resolved and can be seen as opportunities to improve rather than someone being labelled a troublemaker (P10)*

Sub-theme 3.3 Trust

Participants emphasised that trust was a foundation to build and nourish positive relationships with managers and colleagues. P09 explained it as:

> *If you haven't got trust, you haven't got a relationship. (P09)*

Specifically, trustful manager-employee relationships were described as those in which they respected each other, and where employees felt safe, supported and valued in their roles. For example, a participant explained that a healthy workplace was a work environment where managers *"were able to rely on employees" (P12)* with confidence. The following was the narrative of one of the participants:

> *A healthy workplace is based on trust and confidence, where people can trust each other, and no one talks about someone else behind their backs. (P07)*

Participants quoted different types of managerial behaviours that built trust in their managers, as explained in the previous themes. For example, they attributed an appropriate level of autonomy, inclusion, open communication, recognition, and development opportunities as supporting trusting relationships with their managers.

> *I trust my manager because when she says she supports me, she actually does, and that makes me feel safe and supported and do my best work. (P12)*

Emphasising the role of organisations in nurturing strong manager-employee relationships, participants emphasised the need to control managers' turnover, i.e., managers' leaving the organisation too frequently. They explained that controlling turnover was important because it was time-consuming to get to know someone new, know what their skills are, and develop a trusting relationship.

Sub-theme 3.4 Authentic leader-member relationships

Participants emphasised the value of authentic leader-member relationships based on trust and confidence. They explained that leaders' authenticity was about being genuine in their relationships with staff and providing a friendly environment where everyone was able to freely talk and express their opinions. One participant explained that in a healthy workplace, managers should be predictable, behave as per their true selves, and give equal opportunities to their staff members. The following was the narrative of a participant while describing a healthy workplace:

> *Being able to be like authentically myself and having the understanding that the people who are up in the management system are also like honestly themselves. (P13)*

In regard to the HPLB of their managers, participants admired their managers for being genuine, not being aggressive, having a good level of emotional stability, and consistently showing respect for staff. They appreciated managers who showed a real interest

in employees as individuals rather than just colleagues and explained that these kinds of behaviours served as a foundation of trust between them and their managers. They further attributed the authenticity of a leader-employee relationship to talking and listening to each other, conveying expectations clearly to team members, valuing opinions, acknowledging differences, and recognising diverse learning styles. Participants emphasised that open communication was the key to building authentic relationships with managers. These communications included managers and employees getting to know something about each other's personal side and building relationships at a human level, for example, knowing something about background, family, pets, and hobbies to build rapport outside the actual job role. These kinds of authentic, friendly, approachable relationships allowed participants to talk about personal or work-related things that concerned them, and to admit mistakes and seek guidance without fear of being judged by their managers. P02 explained the importance of friendly leader-member relationships:

> *If a manager isn't in a genuinely trusting relationship with their colleagues, then people tend to hold back. Because people need to be comfortable before they start feeling safe and start sharing what's bothering them at work.(P02)*

Overall, participants highlighted that healthy workplace relationships grounded in managers' authentic interactions with their staff, being approachable and communicating openly were the foundation of trust and mutual respect. These relational behaviours were described as essential components in fostering a positive and healthy workplace culture.

11.3.2 Topic 3: Outcomes of Managers' Health-promoting and Health-thwarting Behaviours

Topic 3, represented by RQ3 in Section 11.1, asked participants about how their managers' health-promoting behaviours impacted their work performance and overall

wellbeing. Additionally, participants were asked to think of a time (in their current or previous role) when their manager did something that did not support their wellbeing and the impact that those managerial behaviours had on them. Interviews indicated that managers' HPLB had wide-ranging impacts on employees, from establishing clear expectations to better performance. Similarly, managers' health-impairing behaviours had adverse outcomes ranging from work disengagement to turnover intentions. See Table 11.3 below.

Topic 3: **Outcomes of Managers' Health-Promoting Behaviours**	**Outcomes of Managers' Health-Thwarting Behaviours**
1. Clear Expectations 2. Mutual Cooperativeness 3. Increased Morale 4. Enhanced Commitment 5. Better Performance and Productivity	1. Work Disengagement 2. Lack of Confidence 3. Lack of Trust and Admiration 4. Intention to Leave

Table 11.3 Outcomes of Managers' Health-promoting and Health-thwarting Behaviours

Participants described different positive outcomes associated with their managers' health-promoting behaviours. For example, they explained that working with a manager who was approachable and communicated clearly in a timely manner helped to establish **clear expectations** between them. Working with such managers enabled employees to ask confidently about what was expected of them, without being shy about seeking clarity for their work. Working in a flexible and friendly environment also encouraged people to be **mutually cooperative**, i.e., to support one another and work collaboratively to achieve the shared organisational goals. Participants explained that in a healthy work environment, where people felt supported and valued, they were more willing to help each other, share knowledge and offer support to each other in busy times.

Interview findings showed that **increased morale** was an outcome that people experienced when their manager thanked them for their work or when other stakeholders acknowledged that they were doing a good job. A participant involved in community work explained the power of getting positive feedback from her manager and clients as:

> *I know that I've done really effective work. I keep getting really nice feedback from my manager and the young people I've supported so I know as a person I am valuable and that kind of drives me to be better at what I do. (P13).*

Contrary to this, participants explained that in situations where employees did not receive any recognition for their work or were not given any growth opportunities, they felt undervalued and demotivated, which led to a loss of work engagement. Participants explained work **disengagement** as losing interest in the role and a lack of motivation to go to work. Sharing an example from a previous role, one of the participants explained disengagement as:

> *...I don't think I was looking forward to going to work. (P07)*

A good manager who was perceived to care for their employees' wellbeing enhanced the likelihood of those employees reciprocating by giving their best at work. Participants explained that **enhanced commitment** and **better performance** were the results of their managers' care for their health and wellbeing. Participants appreciated their manager for encouraging them to meet work expectations, which helped them to perform better. They explained that getting positive feedback and appreciation from their manager encouraged them to reciprocate by exhibiting more flexibility and doing more work, even working out of office hours. They reported that they did not mind putting extra effort into an assigned task or working overtime, if required by the assignment, because the appreciation they received was worth it. Similarly, P07 explained that a supportive environment improved their performance

because they wanted to give 100% due to feeling valued at work. P11 explained it as, *"I'm prepared to give the extra as well".* P01 explained their flexibility as follows:

> *For instance, if there is a task that needs to be done before going on the weekend or before going on holidays. I make sure that that has to be done even if there is a bottleneck. So, I prefer to spend more time on the task. Maybe after work hours, to actually finish the task. (P01)*

Linking work motivation to productivity, participants explained that managers' wellbeing supportive behaviours enhanced their motivation, energised them, and helped them focus on work, which enhanced their creativity and productivity. They explained that if an organisation has a work environment where people love to come every day by fostering feelings of growth and pride in their contributions, then organisations "*can get much better work out of them"* (P11).

On the other hand, participants explained that where managers did not encourage their team members or involve them in day-to-day discussions, people would start **losing interest and confidence** in their role and start questioning their capabilities. This kind of management style was also detrimental for managers who would risk **losing the trust** and respect of the team members. A participant (P07) who had felt overburdened with work associated it with a continuous feeling of burnout and eventual resignation. Giving an example of such managers in a previous role, a participant said:

> *…I was questioning myself whether this was the right place for me to work. (P14)*

Overall, participants highlighted that the behaviours of their managers had a direct and meaningful impact on their morale and overall experience at work. Managers' HPLB, such as recognition, appreciation, autonomy, growth opportunities, and flexibility, enabled

employees to feel valued, motivated, and psychologically safe. In contrast, managers' health-impairing behaviours such as micromanagement, unrealistic tasks, or lack of encouragement enhanced uncertainty, leading to lack of work engagement and increased staff **turnover**. Taken together, these findings emphasise how employees process the information regarding managers' intentional, unintentional, or habitual healthy or unhealthy behaviours and how far-reaching the impacts of these managerial behaviours can be for their team members.

11.4 Discussion

This qualitative study aimed to explore three key research questions relating to managers' health-promoting leadership behaviours from the perspective of non-managers working in New Zealand. These questions included *how non-managers understand a healthy workplace, which managerial behaviours they consider to be promoting or thwarting their health, and how those behaviours impact the performance and wellbeing of non-managers.*

The present study contributes to the existing healthy leadership literature by identifying specific leadership behaviours that non-managers see as supporting wellbeing. While existing leadership studies show that different leadership styles influence employee wellbeing (Inceoglu et al., 2018; Liu et al., 2010; Liu et al., 2021), the current study fills the gap in the emerging field of healthy leadership by specifically identifying *wellbeing-related* and *job-related behaviours* that impact employees' wellbeing. Specifically, behaviours such as wellbeing support, fostering physical and emotional safety, managing for optimum workloads, task-related support, opportunities for growth and development, recognition and appreciation, open communication, and autonomy were seen as important by non-managers. This finding shows that healthy leadership is a combination of specific behaviours, expanding on traditional leadership styles that mainly focus on the achievement of organisational goals (Awamleh & Gardner, 1999; Yammarino et al., 1993).

In this study, participants' emphasis on workload optimisation aligned with the findings of qualitative study 1, where managers shared that sometimes they cannot facilitate their teams or prioritise their health and wellbeing because of high workloads. The current study has also contributed to the healthy leadership literature by highlighting management of the *human aspects* of the work environment as an essential set of health-promoting behaviours. Behaviours that supported a healthy workplace included managers' approachability, responsiveness and relationship-building skills which resulted from a trustworthy and authentic leader-member relationship. The existing authentic leadership literature suffers from conceptual ambiguity and a lack of clarity about what authentic leadership can do (Alvesson & Einola, 2019; Lux & Lowe, 2024). Despite a growing interest in the emerging healthy leadership literature, the explicit identification of health-promoting behaviours that are seen as indicating authentic leadership offers a unique contribution to both the authentic and healthy leadership literatures. This finding emphasises the importance of behaviours that reflect an empathetic, human-centric leadership approach that is grounded in trust-based, friendly relationships, rather than a traditional command and control style.

The current study also contributes to the existing leadership literature by emphasising that managers' characteristics can be both health-promoting and health-thwarting. This points towards the crucial role of frontline managers in influencing the wellbeing of their direct reports. Participants' emphasis on the individual characteristics and behaviours of managers indicated that no matter how perfect the organisation's policies are for employees' health and wellbeing, all organisational efforts are ultimately dependent on managers' demonstrated willingness to care for their employees. This finding is also supported by the existing leadership literature, which reinforces the importance of a strong trust-based relationship between managers and their direct reports to ensure employees' psychological safety (Newman et al., 2017).

In line with the existing literature that links employees' wellbeing at work with performance, engagement, morale, and commitment (Dollard & Bakker, 2010; Haddon, 2018; Nielsen et al., 2017; Warr & Nielsen, 2018), participants reported that managers' HPLB supported both their wellbeing and their performance. Self-determination theory also shows that when employees' basic psychological needs (autonomy, feelings of competence, and relatedness) are met, they experience positive outcomes such as better performance and wellbeing (Deci et al., 2017). This indicates that if managers do not realise the importance of their roles for supporting employee wellbeing as well as performance, this could lead to adverse outcomes ranging from shaking employees' self-confidence to reducing trust in management, poor wellbeing and performance and increased intentions to leave.

Theoretically, this qualitative study contributes to the understanding of healthy leadership by identifying specific observable behaviours of frontline managers that are valued by non-managerial staff working in New Zealand workplaces. This moves the existing leadership literature towards a more behaviourally grounded explanation of how managers can influence employee wellbeing, thus bridging the leadership and occupational health psychology literatures and contributing to the field of workplace health promotion.

Practically, the findings offer clear and actionable insights into how the behaviours of managers in frontline positions can be shaped to promote healthy workplaces. These findings show the potential for organisations to invest in the 'human aspects' of the work environment through the promotion of empathetic, trust-based relationships between managers and their direct reports, which support and are supported by the wellbeing culture of the organisation. Embedding health-promoting leadership behaviours at all stages from managers' induction to their ongoing performance evaluations can help foster a work environment where employees feel safe, supported and motivated.

Chapter 12

General Discussion and Conclusion

12.1 Introduction

This thesis explored healthy leadership from the perspectives of managers and non-managers working in New Zealand. The aim of investigating managerial perspectives was to understand *how managers conceptualise a healthy workplace in New Zealand, which behaviours they consider to be health-promoting, what they report doing to support the wellbeing of their teams*, *and to identify the motivators and barriers for them to engage in Health Promoting Leadership Behaviours (HPLB)*. The aim of including non-managers in this research was to contrast *their perception of a healthy workplace, which leadership behaviours they consider health-promoting and how their managers' HPLB impact their performance and wellbeing.*

To explore these questions, this thesis utilised a sequential explanatory mixed-method design in two phases. Phase I comprised two quantitative studies, and Phase II comprised two qualitative studies. Both phases of this research were grounded in the theoretical support of Self-Determination Theory (Deci et al., 2017). Based on previous research that has found that work environments with high Psychosocial Safety Climate (PSC) prioritise employee wellbeing (Peters et al., 2021), Quantitative Study 1 (Chapter 7) explored how managers' perceptions of their work autonomy and authentic leadership related to their perceptions of PSC in their workplaces. Findings from this study indicated that managers' perceived autonomy was strongly related to their perceptions of PSC. Quantitative Study 2 (Chapter 8) examined non-managers' perceptions of the relationship between their managers' HPLB and the non-managers' psychological wellbeing (PWB) and self-reported performance. Study 2

found that perceptions of managers' HPLB were positively related to non-managers' self-reported performance via psychological wellbeing.

Findings from these two quantitative studies were further explored in the Phase II – the Qualitative Phase. Qualitative Study 1 (Chapter 10) explored managers' perspectives on a healthy workplace, their self-reported HPLB, and the enablers and barriers to their engagement in these behaviours. The interview questions asked about perspectives on a healthy workplace and self-reported HPLB separately and these were coded as distinct topics. However, analysis showed that managers discussed same points under both themes, so they were integrated and discussed together.

Findings indicated that managers considered the features of a healthy workplace and their own health-promoting leadership behaviours in terms of *work-related aspects* and *wellbeing-related aspects*. Work-related aspects included managing employee workloads, a development orientation, role clarity and support, and employee empowerment. Wellbeing-related aspects included supporting employees' work-life balance, relationship building, wellbeing support and empathy and communication. In addition, managers considered *authentic leadership* to be part of their HPLB. Regarding the motivators and barriers to their engagement in HPLB, managers identified five categories of factors: *organisational, job-related, personal, employee-related, and technological* factors.

Qualitative Study 2 (Chapter 11) explored non-managers' understanding of a healthy workplace, managerial behaviours that they considered health-promoting, and the outcomes associated with those behaviours. Findings showed that non-managers attributed *wellbeing-related aspects*, *work-related aspects, and human aspects* to their conceptualisation of a healthy workplace. Correspondingly, they described *wellbeing-supportive behaviours* (support, physical and emotional health and safety)*, work-supportive behaviours* (workload,

task support, growth and development, recognition, communication and autonomy), and *people-oriented behaviours* (approachability, relationship building, trust and authentic leadership) as managers' HPLB. Non-managers indicated that their managers' HPLB had wide-ranging impacts on them, such as building *clear expectations, mutual cooperativeness, increased morale and commitment, better performance,* and *productivity*. Similarly, managers' health-impairing behaviours had adverse outcomes on non-managerial employees, ranging from *work disengagement, lack of confidence, trust,* and *admiration,* to *turnover intentions.*

12.2 Perceptions of Healthy Workplaces and HPLB

The findings from this research help develop the conceptualisation of healthy leadership by offering an inclusive, position-specific philosophy of a healthy workplace. After more than a decade of research on healthy leadership, the field lacks clarity about how leaders in frontline managerial positions and non-managerial employees describe a healthy workplace, the extent to which these descriptions align or conflict, and how this might relate to different interpretations of wellbeing initiatives. The qualitative studies of this research extend the healthy leadership literature by exploring the variation in descriptions of a healthy workplace between the two groups of participants. Although managers and non-managers had similarities in their descriptions of healthy workplaces and corresponding leadership behaviours, there were also some key differences.

Managers described their HPLB through a self-referential perspective; in contrast, non-managers described their managers' HPLB based on their experiences. These findings indicate that managers evaluate their leadership behaviours based on what they believe they do, while subordinates assess those behaviours based on their impact. This implies that while it appeared that both groups were discussing the same ideas or expectations when healthy

workplaces and leadership behaviours were discussed, they had different views on the behaviours that promote employee wellbeing at work. Managers tended to emphasise authentic leadership, suggesting that they believed that the source of health promotion is being transparent and genuine at work. Non-managers focused on people-oriented behaviours, indicating that they experienced health promotion through managers' supportive behaviours, such as approachability and ease of communication. This mismatch implies that good intentions are not sufficient, as they might not necessarily lead to positive employee outcomes. For example, while leaders might wish to be authentic and believe that they are acting in this way, their high workloads may affect their ability to notice when employees are experiencing high levels of strain, and their ability to offer timely support, recognition and acknowledgement. This offers a possible explanation for the lack of a significant relationship between leaders' self-reported authentic leadership and their PSC perceptions in quantitative Study 1 of this research (Chapter 7). The differences in how both groups of participants perceived managers' interpersonal behaviours to be health-promoting offer valuable insights and prospects for further research.

The application of Self-Determination Theory (SDT) and PSC theory in this research provides a strong theoretical grounding for both the quantitative and qualitative studies. SDT helps explain how non-managerial employees' fulfilment of basic psychological needs (autonomy, competence, and relatedness) is enabled by managers' health-promoting behaviours and translated into positive wellbeing and performance outcomes (Ryan & Deci, 2000). When employees' needs are met, they experience greater psychological safety which boosts their wellbeing. Positive workplace experiences and enhanced wellbeing motivate employees to undertake better performance at work. This interpretation aligns with previous research linking need fulfilment to enhanced wellbeing and better performance across organisational contexts (Kovjanic et al., 2013).

The finding that managers' HPLB have a positive impact on the wellbeing and performance of their teams, in addition to other positive outcomes, aligns with existing workplace health promotion research, which shows that health promotion at work leads to improved productivity, better performance and long-term wellbeing of followers (International Labour Organization, 2014; Vivarelli & Fenga, 2024). The findings are also consistent with the broader leadership literature which shows that leadership is a process of influencing others to achieve organisational goals (Yukl, 2006). Leaders play a crucial role in shaping working conditions that minimise risk to employees' health, ultimately supporting improved performance and enhanced wellbeing (Milner et al., 2015; Nielsen et al., 2017). Previous leadership studies have shown that a range of positive leadership styles, such as transactional, transformational, charismatic, ethical, and servant leadership, are associated with different employee wellbeing outcomes (Arnold et al., 2007; Hoert et al., 2018; Kranabetter & Niessen, 2017; Kuoppala et al., 2008). This research extends that line of inquiry by identifying the specific leadership behaviours of frontline managers that result in positive employee wellbeing and performance outcomes.

An important finding in quantitative Study 2 (Chapter 8), regarding non-managerial employees' perspectives on job design and their wellbeing, showed that employee wellbeing experiences varied depending on whether they worked on-site or remotely. Survey data showed that nearly a quarter of participants reported working from home between one and three days a week. Of these participants, nearly 80% reported being satisfied with the frequency and quality of interaction with their managers. This implied that remote workers' wellbeing might not be strongly associated with their managers' HPLB because of their less frequent interaction with their managers. In comparison, on-site employees, such as those in health and education, might rely more on their managers' availability, interpersonal styles, and routine supportive behaviours to experience wellbeing. These findings show that

variations in workplace experiences, such as greater self-management or more control over work, might lead employees to experience wellbeing in a non-uniform way across different working groups, indicating that organisations should consider tailoring job design and working conditions for employees based on their needs instead of assuming a one-size fits all approach.

12.3 Factors Supporting HPLB

The research findings also advance understanding of how healthy workplaces are enacted by identifying factors that motivate managers to support employee wellbeing, while also exploring the limitations that they face. The identification of multiple enablers and barriers within and outside the organisation, including organisational, job-related, personal, employee-related, and technological factors, shows that managers do not act in isolation. Instead, they operate within their organisation's hierarchy, which is shaped by structural and relational contextual factors that either support them or hold them back from caring for their teams' wellbeing.

The application of Self-Determination Theory (SDT) in this research supports the idea that managers exhibit health-promoting behaviours at work, depending on the type of motivation and the degree to which they experience the fulfilment of their needs. Managers who reported being autonomously motivated to care for their teams' wellbeing engaged in more HPLB, such as supporting employees' work-life balance, showing appreciation for their work, and providing opportunities for growth and development. In contrast, managers who felt they worked under pressure and experienced a controlled form of motivation demonstrated limited support for their teams. In addition, the extent to which managers' need for autonomy was met was related to their ability to enact a healthy workplace. These variations in the support provided by organisations to managers resulted in differences in

their engagement in desired behaviours, providing a strong theoretical grounding for this research.

With this theoretical framework, Chapter 7 (Quantitative Study 1) demonstrated that managers' perceived autonomy was an important antecedent for them to make a positive evaluation of organisational PSC. This finding was supported by SDT, which states that the fulfilment of the need for autonomy is a fundamental requirement for individuals to exhibit required positive workplace behaviours. A meta-analytic review by Slemp et al. (2018) also showed that people who work in autonomy-supportive environments and can work in a self-directed way make a positive evaluation of their work environment. Similarly, in this study, managers who experienced that their work environment supported their autonomy made a positive evaluation of the psychosocial safety climate of their organisation.

In addition to autonomy, the qualitative study findings (Chapter 10) strongly emphasised *organisational support* and *managers' job design* as important motivating factors for managers to exhibit health-promoting behaviours. Supportive organisational cultures accompanied by written policies, established processes, and senior management backing for frontline managers helped them to enact a healthy workplace. Supportive organisations with an adequate level of autonomy can free up managers' psychological capacity to behave empathically towards their teams. This finding was also supported by SDT, which proposes that people thrive when their basic psychological needs are met. In contrast, when organisational support was limited or absent, and managers lacked autonomy to perform their day-to-day jobs, they found it difficult to support their teams because of the strain or pressure they felt in maintaining their focus on achieving organisational goals.

The other two key factors identified in this study were the differences in *managers' personal preferences* regarding employee wellbeing and *employees' personal preferences* to

be taken care of. The findings showed that while organisational policies and practices might serve as a starting point to create a healthy workplace, the ultimate implementation of those policies depends upon the extent to which managers embrace those policies at the team level and the extent to which employees care for their own wellbeing. Managers who preferred collaboration and relationship-building were more likely to engage in HPLB because they personally exhibited empathy and valued employee wellbeing, as compared to those managers who believed that employee wellbeing was the sole responsibility of the organisation and did not need active support of managers. Under the theoretical lens of SDT, the former class of managers were more autonomously motivated to support employee wellbeing compared to the later who exhibited more controlled motivation. Deci et al. (2017) described this situation as reflecting variations in individuals' causality orientations. This research also showed that variations in the intrinsic vs extrinsic motivations of managers explained variations in their health-promoting behaviours.

Finally, the findings from qualitative Study 1 (Chapter 10) indicated that *technological factors* could serve as important enablers and barriers for managers to care for employee wellbeing. On the one hand, technology can provide managers with more visibility of their employees' workload patterns and activities through constant communication, thereby enabling them to identify early indicators of employee strain and to offer timely support. On the other hand, technology can also be a barrier to promote employee wellbeing by contributing to more strain on employees. For example, the culture of being always available and expectations for rapid communication might diminish employee wellbeing. These findings showed that technology is not simply good or bad, rather, its impact depends on how it is integrated into daily routines, which in turn influences how effectively it contributes to the achievement of organisational goals and boosts employee wellbeing.

Understanding the motivations and constraints of managers' HPLB in this research helps explain why healthy leadership initiatives could be inconsistent within and across organisations. Rudolph et al. (2020) emphasised in their review of the need to explore the genesis of healthy leadership behaviours. Clarifying what encourages managers to engage in health-promoting behaviours and, more importantly, what inhibits their capacity to care for employee wellbeing, fills an important gap in the existing wellbeing and leadership literatures. At present, these two literatures mostly explore the wellbeing-related outcomes and managers' personal characteristics and traits associated with healthy leadership, while largely ignoring upstream and downstream factors that affect leader behaviour (Chen & Wu, 2023; Franke et al., 2014; Hoert et al., 2018; Kaluza et al., 2021). It is important to recognise that managers work under competing pressures such as performance targets and resource constraints, which may inhibit them from engaging in HPLB or building PSC, and that wellbeing initiatives may or may not be perceived as meeting employee needs.

This multi-level perspective also fills a persistent gap in the healthy leadership literature by emphasising that both contextual factors and personal motivations can enhance or diminish organisational efforts to enact a healthy workplace. This contribution offers rich insights for the management, leadership, and occupational health psychology literatures in general, and healthy leadership scholarship in particular. The findings suggest that enacting healthy workplaces requires a dual focus, i.e., nurturing an organisational culture that provides the necessary structural support for managers, in addition to building managers' capacity by accounting for differences in their individual motivations, while ensuring wellbeing initiatives are seen as relevant. Without understanding and addressing managers' motivations and limitations, and employees' needs, senior management can place unrealistic expectations on frontline managers to promote employee wellbeing.

This research highlights an additional compelling insight for both the leadership and followership literature – the identification of non-managers' attitudes, beliefs, and behaviours about their wellbeing as an important factor in shaping managers' attitudes towards their subordinates' wellbeing. This finding challenges the traditional unidirectional nature of leadership studies, which shows that influence flows from leaders to followers. Shamir (2007) criticises the way that most of the leadership literature overlooks reciprocal and bottom-up dynamics through which followers shape leaders' behaviours. The present research shows that when non-managers place a high value on their own health, and demonstrate proactive wellbeing behaviours, they signal to managers that managers should also prioritise wellbeing and model HPLB. Conversely, when non-managers deprioritise their health, they indicate that wellbeing is less important for them. These findings imply that the key to the enactment of healthy workplaces is understanding the relational and dynamic nature of the leader-member relationship, which is established through shared expectations. Finally, workplaces need to integrate the appropriate technological advancements into everyday work practices as a critical determinant of whether they enable or undermine managers' capability to promote employee wellbeing.

12.4 Implications and Future Directions

12.4.1 Theoretical Implications

Theoretically, this research makes several important contributions to the leadership literature in general and the healthy leadership in particular. First, by examining both managers' and non-managers' perspectives, this research offers two distinct lenses on how workers in New Zealand conceptualise healthy workplaces. This approach also extends the healthy leadership literature by identifying specific health-promoting behaviours through the

lens of two groups of informants offering unique perspectives on how HPLB are experienced and interpreted by followers, rather than solely relying on a leader-centric perspective.

Secondly, this research advances healthy leadership theory by identifying both precursors and limiting factors to frontline managers' engagement in HPLB. Specifically, the importance of organisational support integrates with PSC theory and also extends it. Existing PSC research shows that high PSC environments are built through top management's commitment to workers' psychological health and safety (Dollard & Karasek, 2010). PSC research also suggests that PSC acts as a precursor to the creation of a psychosocially safe work environment for employees (Dollard & Bakker, 2010), but far less attention has been paid to the factors that shape strong PSC perceptions. In this research, the identification of autonomy as a strong predictor of positive PSC perceptions contributed directly to the PSC literature. By demonstrating that managers' autonomy is a meaningful antecedent of PSC, this study also makes a contribution to the healthy leadership literature by emphasising the importance of strong PSC to developing a healthy workplace. The present research also extends PSC theory by identifying that organisational support is not sufficient on its own unless it is complemented by personal willingness of managers to support their teams' wellbeing in addition to workers' own prioritisation for their wellbeing. This highlights the contextual and relational nature of healthy leadership, where frontline managers' ability to engage in HPLB is shaped not only by organisational policies and structure and their working conditions, but also by their motivations to foster a wellbeing supportive work environment, and employees' willingness to prioritise their own wellbeing.

Third, the New Zealand context adds to the international body of evidence supporting PSC theory and the importance of HPLB and work wellbeing, while offering an opportunity to replicate this research in other cultural settings which might offer new insights. Even replication of this study in New Zealand might offer new insights because data collection was

conducted immediately after COVID-19, when people were still navigating disrupted work routines. The timing of this study may have meant there was a heightened awareness among respondents about healthy workplaces and how managers and workplaces can support employees' wellbeing. Replicating this research both within and outside New Zealand would help confirm these insights and gain new perspectives in the post-pandemic world of work.

Fourth, using SDT as a theoretical lens offered a valuable way to explore healthy leadership. SDT's focus on basic psychological needs and different types of motivations helped understand individuals' engagement in work-related behaviours and offered a structured way to understand why people engage in certain behaviours and the work and wellbeing-related outcomes associated with those behaviours.

Finally, the qualitative studies provide unique insights that warrant explicit consideration. Together, the qualitative studies conducted for this research yielded several insights that extend beyond widely acknowledged aspects of good leadership and workplace wellbeing, which offer unique contributions to the development of the HPLB framework. While participants emphasised familiar elements such as support, autonomy, trust, and workload management, the qualitative findings indicate how these behaviours are understood, enacted, and experienced in practice, highlighting nuances not captured in existing leadership models. Importantly, this thesis provided two distinct perspectives on healthy leadership and HPLB: managers' accounts of the behaviours they believed promoted wellbeing, and non-managers' accounts of the behaviours they actually experienced as health-promoting or health-thwarting. This dual-lens approach offers a unique contribution by demonstrating areas of alignment and divergence between leaders' intentions and employees' lived experiences. Together, these perspectives show that healthy leadership is a behavioural, relational, and context-dependent construct shaped by specific observable actions, leaders' self-regulation and authenticity, organisational systems, personal values, and employees' own engagement in

wellbeing practices. These insights refine the HPLB framework by grounding it in the lived realities of both managers and employees, clarifying the behavioural indicators of health-promoting leadership, and highlighting the contextual enablers and barriers that determine whether such behaviours can be sustained in real workplaces.

12.4.2 Practical Implications

This research offers several implications for practitioners seeking to strengthen healthy leadership and create healthier workplaces. The research findings relating to the description of a healthy workplace and corresponding identification of *work-related and wellbeing-related aspects* can help guide organisational leadership regarding the behaviours and conditions for the enactment of a healthy workplace and the wellbeing of employees. The strong emphasis placed by participants on the *human aspects* (leader-member relations) as important pillars of a healthy workplace suggests that organisations should focus on training their managers and boosting their relationship-building skills and interpersonal capabilities. A recent study shows that compassionate and prosocial empathetic behaviours of leaders lead to better employee outcomes, such as trust, bonding, wellbeing, and performance (Raina, 2022), reinforcing the value of investing in these relational skills.

A constant emphasis by participating managers on the importance of supportive organisational policies as enablers/barriers of their HPLB reinforces that organisations need to invest in the development and enactment of health-supportive policies to establish a strong PSC in the organisation. This effort would encourage and make it easier for managers to support their teams' wellbeing by reducing bureaucratic barriers to making wellbeing-supportive decisions for their team members. Reducing bureaucratic barriers and empowering managers to make timely wellbeing-related decisions would strengthen the organisation's PSC and make it easier for managers to support their teams effectively.

The finding that autonomy was a strong predictor of managers' PSC perceptions and an important enabler/barrier of HPLB offers direct practical implications. Organisations need to ensure that managers have an adequate level of autonomy and decision-making authority so that they perceive the organisational climate as psychosocially safe and supportive of decisions they make for the wellbeing of their team. This finding also showed that an autonomy-supportive work environment was not only a catalyst for making a positive evaluation of organisational climate but also removed barriers to enacting healthy workplaces. Practically, this finding shows that policies alone cannot yield desired outcomes unless they are paired with a job design that grants managers genuine discretion and decision-making authority, a supportive organisational climate, and a clear process to care for employee wellbeing.

Similarly, the importance given to technological factors as an enabler/barrier of managers' HPLB shows the need to invest in relevant technology and skills within the workforce. Equipping managers and employees with required up-to-date technology can reduce strain and facilitate employees to perform their tasks efficiently and efficiently. Technology that enables people to work flexibly fulfils their need for autonomy within SDT and can also free up capacity for managers to engage in wellbeing supportive behaviours and enable them to tailor their support for people working in diverse work contexts.

The important role of managers' personal values, preferences and beliefs as enablers/barriers of their HPLB indicates that there may sometimes be a need for interventions to boost managers' wellbeing-related knowledge and leadership development. Leadership development programs should focus on the benefits of employee wellbeing not only for individuals but also for the achievement of organisational goals, and should train leaders to exhibit behaviours that foster employee wellbeing. Such programs can help

managers recognise that their personal views towards employee wellbeing shape their leadership behaviours and can help them exhibit HPLB at work.

The high level of satisfaction reported by remotely working employees with the frequency and quality of interaction with their managers showed that these employees might not rely too heavily on their managers to experience wellbeing. A probable reason could be that they might not readily observe their managers' health-promoting behaviours, except when they directly affect them. Conversely, managers who do not have frequent in-person interaction with their team-mates might need to take extra steps to show that they indeed support their team's wellbeing. This finding shows that remotely working employees' wellbeing might not necessarily be strongly related to their managers' HPLB because of their less frequent interaction with their managers. Contrary to this, employees who work in person in their workplaces, such as participants in the Health and Education sectors, are likely to engage in frequent interactions with managers and colleagues. These roles can be emotionally demanding and cognitively draining; therefore, employees might need more support from their employers to boost their wellbeing. Thus, examining sector-specific differences in employee wellbeing and the reasons associated with those differences could be another area to explore.

12.5 Directions for Future Research

This research offers several opportunities for future studies. First, exploring the two distinct perspectives of managers' and non-managers' on healthy workplaces and managers' HPLB challenges the leader-centric view of many leadership studies. Findings showed that employee-centred models of leadership based on followers' experiences at work should be used to gauge leadership effectiveness, instead of relying on leaders' self-concepts.

Specifically, an extension of this study by matching manager-non-manager dyads could further strengthen the understanding of healthy workplaces and HPLB.

Second, this research used SDT's motivational mechanism to explore how managers' intrinsic motivation enabled them to engage in HPLB, and the need fulfilment mechanism to explain how non-managers' perceptions of their managers' HPLB led to better performance and wellbeing outcomes. Based on the strong theoretical framework offered by SDT, this research proposed that SDT could be used in future studies to explore how qualitatively different *types* (rather than amounts) of motivation (on the motivational continuum of SDT) influence leaders' and followers' engagement in other behaviours at work.

Third, previous PSC research has identified that PSC serves as a foundation for creating a favourable work environment, and there is a need to explore the precursors of a strong PSC (Dollard & Bakker, 2010). The identification of managers' autonomy as a strong predictor of PSC in this research offers potential for future studies to explore additional factors. Investigating organisational, relational, or individual factors such as job characteristics, ease of communication across organisational hierarchies, leadership styles, and individual values and motivations could provide a deeper understanding of how PSC is shaped and sustained over a period of time in workplaces. Exploration of PSC with these lenses could offer potential points of intervention to strengthen PSC in support of a healthy workplace.

Fourth, the study found that engagement in HPLB was not the sole responsibility of managers; it also depended upon the extent to which employees were ready to care for their own wellbeing. Non-managers' attitudes towards their health appeared to be an important factor in enacting healthy workplaces. This finding links to the existing relational leadership literature, which focuses on the importance of a strong leader-member relationship (Graen &

Uhl-Bien, 1995). This offers an opportunity for future studies to explore healthy leadership from a Leader-Member Exchange perspective (Graen & Uhl-Bien, 1995) to see why different situations require different types of exchange relationships and how leaders can/should behave in those situations to yield positive outcomes. Future studies could explore the relationship between the importance given by followers to their wellbeing and leaders' health-promoting behaviours to enrich the healthy leadership literature. Investigating the role of followers in shaping managers' other workplace behaviours could be a worthy extension to general leadership scholarship as well.

Finally, the cross-sectional nature of the surveys conducted with both groups of participants offers another opportunity for future studies to undertake a longitudinal approach to identify how managers' HPLB could influence employees in the long run. A longitudinal approach could help gain insights regarding the cumulative effect of managers' HPLB as working conditions evolve.

12.6 Conclusion

Workplace health promotion programs emphasise that a key to developing a healthy workplace is the proper organisation of work (Semmer, 2006; Shain & Kramer, 2004). Work-related outcomes are related to what employees and managers bring with them to the workplace and how workplaces shape their experiences through organising the physical and psychosocial aspects of work. Existing leadership research emphasises that organisational leaders can influence employees' health and well-being by altering the working conditions for them or designing policies and practices with an aim to positively influence their psychological health (Milner et al., 2015; Nielsen, 2017). However, several fundamental issues remain unexplored, for example, how leaders and non-managerial staff envisage a healthy workplace; the specific leadership behaviours that are seen as health-promoting; the

drivers and barriers for managers to engage in health-promoting leadership behaviours, and how those behaviours impact their teams' wellbeing and performance.

The current research presented a response to these questions by utilising the Self-Determination Theory (Deci et al., 2017) and PSC theory (Dollard & Karasek, 2010). The research showed that healthy leadership is a human-centric management approach enabled by organisational support and grounded in authentic reciprocal relationships between managers and non-managerial employees. In this model, managers attend to the work- and non-work-related needs of people through self-motivated, authentic, people-oriented behaviours backed by organisational support, and employees reciprocate by performing at their best and taking shared responsibility for their health, yielding positive work and life outcomes. Importantly, the research showed that managers' autonomy was a significant predictor of their PSC perceptions, which, in turn, shaped their health-promoting behaviours. This also highlighted the importance of supportive organisational structures for the enactment of safe and health-focused workplaces.

Overall, the conceptualisation of healthy work and HPLB that was developed in this research aligns with the ILO's Decent Work agenda, which focuses on social protection and rights of people at work and is an integral element of the 2030 Agenda for Sustainable Development Goal (SDG) Goal 8, and the ILO's aim to promote occupational health (International Labour Organization, 2015). The research, therefore, contributes to the global movement of creating safe, supportive, and healthy workplaces. The research findings offer significant insights for theory, intervention research and organisations in designing a work environment that enhances employee wellbeing and business success.

References

Aboulafia, M., Adams, F., Adams, M. M., Adams, R. M., Addis, L., Allard, J. W., Allison, D., Alston, W. P., Ameriks, K., Anderson, C. A., Anderson, D. L., Anderson, L., Ariew, R., Armstrong, D., Arnold, D. G., Ashworth, E. J., Atherton, M., Attfield, R., Aune, B., . . . Zupko, J. A. (2015). Contributors. In R. Audi (Ed.), *The Cambridge Dictionary of Philosophy* (3rd ed., pp. ix-xxx). Cambridge University Press. https://www.cambridge.org/core/product/3B6502323391A2FFF2A930A9DD23BA89

Afzali, A., Motahari, A. A., & Hatami-Shirkouhi, L. (2014). Investigating the influence of perceived organizational support, psychological empowerment and organizational learning on job performance: An empirical investigation. *Technical Gazette*, *21*(3), 623-629.

Agote, L., Aramburu, N., & Lines, R. (2016). Authentic leadership perception, trust in the leader, and followers' emotions in organizational change processes. *The Journal of Applied Behavioral Science*, *52*(1), 35-63.

Aguinis, H., Cascio, W. F., & Ramani, R. S. (2017). Science's reproducibility and replicability crisis: International business is not immune. *Journal of International Business Studies*, *48*, 653-663.

Aguinis, H., Ramani, R. S., & Alabduljader, N. (2018). What you see is what you get? Enhancing methodological transparency in management research. *Academy of Management Annals*, *12*(1), 83-110.

Alfes, K., Shantz, A., & Truss, C. (2012). The link between perceived HRM practices, performance and well-being: The moderating effect of trust in the employer. *Human Resource Management Journal*, *22*(4), 409-427.

Alilyyani, B., Wong, C. A., & Cummings, G. (2018). Antecedents, mediators, and outcomes of authentic leadership in healthcare: A systematic review. *International Journal of Nursing Studies*, *83*, 34-64.

Alqarni, S., Hamsan, H., Rasdi, R. M., & Rahman, H. A. (2023). A systematic literature review on job performance in diverse organizations from 2010 to 2023. *International Journal of Academic Research in Business and Social Sciences*, *13*(18), 203-216.

Altman, D. G., & Bland, J. M. (1995). Statistics notes: The normal distribution. *BMJ*, *310*(6975), 298. https://doi.org/https://doi.org/10.1136/bmj.310.6975.298

Alvesson, M. (1996). Leadership studies: From procedure and abstraction to reflexivity and situation. *The Leadership Quarterly*, *7*(4), 455-485. https://doi.org/https://doi.org/10.1016/S1048-9843(96)90002-8

Alvesson, M., & Einola, K. (2019). Warning for excessive positivity: Authentic leadership and other traps in leadership studies. *The Leadership Quarterly*, *30*(4), 383-395. https://doi.org/https://doi.org/10.1016/j.leaqua.2019.04.001

Alvesson, M., & Einola, K. (2022). The gaslighting of authentic leadership 2.0. *Leadership*, *18*(6), 814-831. https://doi.org/https://doi.org/10.1177/17427150221125271

Amoadu, M., Agyare, D. F., Doe, P. F., & Abraham, S. A. (2025). Examining the impact of psychosocial safety climate on working conditions, well-being and safety of healthcare providers: a scoping review. *BMC Health Services Research*, *25*(1), 90.

Anderson, J. C., & Gerbing, D. W. (1988). Structural equation modeling in practice: A review and recommended two-step approach. *Psychological Bulletin*, *103*(3), 411. https://doi.org/https://doi.org/10.1037/0033-2909.103.3.411

Andreassen, C. S., Hetland, J., & Pallesen, S. (2010). The relationship between 'workaholism', basic needs satisfaction at work and personality. *European Journal of Personality*, *24*(1), 3-17.

Andrews, F. M., & Withey, S. B. (1976). *Social Indicators of well-being: Americans' perceptions of life quality*. Springer.

Antonakis, J., Avolio, B. J., & Sivasubramaniam, N. (2003). Context and leadership: An examination of the nine-factor full-range leadership theory using the Multifactor Leadership Questionnaire. *The Leadership Quarterly*, *14*(3), 261-295. https://doi.org/10.1016/S1048-9843(03)00030-4

Aristoteles, & Ostwald, M. (1962). *Nicomachean ethics*. Prentice Hall.

Arnold, K. A. (2017). Transformational leadership and employee psychological well-being: A review and directions for future research. *Journal of Occupational Health Psychology*, *22*(3), 381-393. https://doi.org/https://doi.org/10.1037/ocp0000062

Arnold, K. A., Turner, N., Barling, J., Kelloway, E. K., & McKee, M. C. (2007). Transformational leadership and psychological well-being: The mediating role of meaningful work. *Journal of Occupational Health Psychology*, *12*(3), 193-203. https://doi.org/10.1037/1076-8998.12.3.193

Auerbach, C., & Silverstein, L. B. (2003). *Qualitative data: An introduction to coding and analysis*. NewYork University Press.

Avery, G. C. (2003). *Understanding leadership: Paradigms and cases*. Sage.

Avolio, B. J. (1999). *Full leadership development: Building the vital forces in organizations*. Sage Publications.

Avolio, B. J., & Bass, B. M. (2004). *Multifactor Leadership Questionnaire. Manual and Sampler Set (3rd ed.)*. Redwood City, CA: Mindgarden. https://doi.org/10.1207/s1532754xjprr1602_2

Avolio, B. J., & Gardner, W. L. (2005). Authentic leadership development: Getting to the root of positive forms of leadership. *The Leadership Quarterly*, *16*(3), 315-338. https://doi.org/https://doi.org/10.1016/j.leaqua.2005.03.001

Avolio, B. J., Gardner, W. L., Walumbwa, F. O., Luthans, F., & May, D. R. (2004). Unlocking the mask: A look at the process by which authentic leaders impact follower attitudes and behaviors. *The Leadership Quarterly*, *15*(6), 801-823. https://doi.org/https://doi.org/10.1016/j.leaqua.2004.09.003

Avolio, B. J., Walumbwa, F. O., & Weber, T. J. (2009). Leadership: Current theories, research, and future directions. *Annual Review of Psychology*, *60*(1), 421-449. https://doi.org/https://doi.org/10.1146/annurev.psych.60.110707.163621

Awamleh, R., & Gardner, W. L. (1999). Perceptions of leader charisma and effectiveness: The effects of vision content, delivery, and organizational performance. *The Leadership Quarterly*, *10*(3), 345-373. https://doi.org/https://doi.org/10.1016/S1048-9843(99)00022-3

Baard, P. P., Deci, E. L., & Ryan, R. M. (2004). Intrinsic Need Satisfaction: A Motivational Basis of Performance and Weil-Being in Two Work Settings1. *Journal of Applied Social Psychology*, *34*(10), 2045-2068. https://doi.org/10.1111/j.1559-1816.2004.tb02690.x

Babalola, S. S. (2016). The effect of leadership style, job satisfaction and employee-supervisor relationship on job performance and organizational commitment. *Journal of Applied Business Research*, *32*(3), 935-946.

Babatunde, O., & Emem, I. (2015). The impact of leadership style on employee's performance in an organization. *Public Policy and Administration Research*, *5*(1), 193-206.

Bagozzi, R. P., & Fornell, C. (1982). Theoretical concepts, measurements and meaning. In *A second generation of multivariate analysis: Measurement and evaluation*. Praeger.

Baker, S. E., & Edwards, R. (2012). How many qualitative interviews is enough? Expert voices and early career reflections on sampling and cases in qualitative research. In: National Centre for Research Methods.

Bakker, A. B., & Demerouti, E. (2007). The job demands-resources model: State of the art. *Journal of Managerial Psychology*, *22*(3), 309-328.

Bamford, M., Wong, C. A., & Laschinger, H. (2013). The influence of authentic leadership and areas of worklife on work engagement of registered nurses. *Journal of Nursing Management*, *21*(3), 529-540.

Barber, J. D. (2009). *The presidential character: Predicting performance in the White House* (4th ed.). Routledge. https://doi.org/https://doi.org/10.4324/9781351223706

Barbuto, J. E. (2005). Motivation and Transactional, Charismatic, and Transformational Leadership: A Test of Antecedents. *Journal of Leadership & Organizational Studies*, *11*(4), 26-40. https://doi.org/10.1177/107179190501100403

Barling, J., & Frone, M. R. (2017). If only my leader would just do something! Passive leadership undermines employee well-being through role stressors and psychological resource depletion. *Stress and Health*, *33*(3), 211-222.

Barling, J., Weber, T., & Kelloway, E. K. (1996). Effects of transformational leadership training on attitudinal and financial outcomes: A field experiment. *Journal of Applied Psychology*, *81*(6), 827-832. https://doi.org/10.1037/0021-9010.81.6.827

Barrett, L., Plotnikoff, R. C., Raine, K., & Anderson, D. (2005). Development of measures of organizational leadership for health promotion. *Health Education & Behavior*, *32*(2), 195-207.

Bass, B. M. (1999). Two decades of research and development in transformational leadership. *European Journal of Work and Organizational Psychology*, *8*(1), 9-32. https://doi.org/10.1080/135943299398410

Bass, B. M., & Avolio, B. J. (1994). *Improving organizational effectiveness through transformational leadership*. Sage.

Bass, B. M., Avolio, B. J., Jung, D. I., & Berson, Y. (2003). Predicting unit performance by assessing transformational and transactional leadership. *Journal of Applied Psychology*, *88*(2), 207.

Bass, B. M., & Bass, R. (2009). *The Bass handbook of leadership: Theory, research, and managerial applications* (4th ed.). New York: Free Press.

Bass, B. M., & Steidlmeier, P. (1999). Ethics, character, and authentic transformational leadership behavior. *The Leadership Quarterly*, *10*(2), 181-217.

Bass, B. M., & Stogdill, R. M. (1990). *Bass & Stogdill's handbook of leadership: Theory, research, and managerial applications* (3rd ed.). Simon and Schuster.

Baumgartner, H., & Steenkamp, J.-B. E. (2001). Response styles in marketing research: A cross-national investigation. *Journal of Marketing Research*, *38*(2), 143-156.

Bentham, J. (1781). *An introduction to the principles of morals and legislation*. McMaster University Archive for the History of Economic Thought.

Bentler, P. M. (1990). Comparative fit indexes in structural models. *Psychological Bulletin*, *107*(2), 238.

Berg, J. M., Wrzesniewski, A., & Dutton, J. E. (2010). Perceiving and responding to challenges in job crafting at different ranks: When proactivity requires adaptivity. *Journal of Organizational Behavior*, *31*(2-3), 158-186.

Biesta, G. (2010). Pragmatism and the philosophical foundations of mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *Sage handbook of mixed methods in social and behavioral research* (Vol. 2, pp. 95-118).

Biswas, A., Begum, M., Van Eerd, D., Smith, P. M., & Gignac, M. A. (2021). Organizational perspectives on how to successfully integrate health promotion activities into

occupational health and safety. *Journal of Occupational and Environmental Medicine*, *63*(4), 270-284.

Blau, P. (2017). *Exchange and power in social life* (1st ed.). Routledge. https://doi.org/https://doi.org/10.4324/9780203792643

Boğan, E., & Dedeoğlu, B. B. (2017). The effects of perceived behavioral integrity of supervisors on employee outcomes: Moderating effects of tenure. *Journal of Hospitality Marketing & Management*, *26*(5), 511-531.

Borman, W. C., & Motowidlo, S. (1993). Expanding the criterion domain to include elements of contextual performance. In N. Sctunitt & W. C. Borman (Eds.), *Personality Selection* (pp. 71-98). San Francisco: Jossey-Bass.

Bourke, L., & Geldens, P. M. (2007). Subjective wellbeing and its meaning for young people in a rural Australian center. *Social Indicators Research*, *82*, 165-187.

Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research*, *8*(1), 137-152.

Bowers, D. G., & Seashore, S. E. (1966). Predicting organizational effectiveness with a four-factor theory of leadership. *Administrative Science Quarterly*, 238-263.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Bradburn, N. M. (1969). The structure of psychological well-being.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2012). *Thematic analysis*. American Psychological Association.

Brayfield, A. H., & Crockett, W. H. (1955). Employee attitudes and employee performance. *Psychological Bulletin*, *52*(5), 396.

Brinkmann, S., & Kvale, S. (2018). *Doing interviews* (Vol. 2). Sage.

Bronkhorst, B. (2015). Behaving safely under pressure: The effects of job demands, resources, and safety climate on employee physical and psychosocial safety behavior. *Journal of Safety Research*, *55*, 63-72.

Brown, M. E., Treviño, L. K., & Harrison, D. A. (2005). Ethical leadership: A social learning perspective for construct development and testing. *Organizational Behavior and Human Decision Processes*, *97*(2), 117-134. https://doi.org/10.1016/j.obhdp.2005.03.002

Brown, T. A. (2015). *Confirmatory Factor Analysis for Applied Research* (2nd ed.). Guilford Press.

Browne, M. W., & Cudeck, R. (1992). Alternative ways of assessing model fit. *Sociological Methods & Research*, *21*(2), 230-258.

Bruggen, A. (2015). An empirical investigation of the relationship between workload and performance. *Management Decision*, *53*(10), 2377-2389.

Burke, C. S., Sims, D. E., Lazzara, E. H., & Salas, E. (2007). Trust in leadership: A multi-level review and integration. *The Leadership Quarterly*, *18*(6), 606-632.

Burns, J. M. (1978). *Leadership*. Harper & Row.

Burrell, G., & Morgan, G. (2017). *Sociological paradigms and organisational analysis: Elements of the sociology of corporate life* (1st ed.). Routledge.

Burton, J. (2010). *WHO healthy workplace framework and model: Background and supporting literature and practices*. World Health Organization.

Byrne, D., Gouaux, C., Griffitt, W., Lamberth, J., Murakawa, N., Prasad, M., Prasad, A., & Ramirez III, M. (1971). The ubiquitous relationship: Attitude similarity and attraction: A cross-cultural study. *Human Relations*, *24*(3), 201-207.

Callahan, D. (1973). The WHO definition of'health'. *Hastings Center Studies*, *1*(3), 77-87.

Campbell, A., Converse, P. E., & Rodgers, W. L. (1976). *The quality of American life: Perceptions, evaluations, and satisfactions*. Russell Sage Foundation.

Campbell, J. P., McCloy, R. A., Oppler, S. H., & Sager, C. E. (1993). A theory of performance. In N. Schmitt & W. C. Borman (Eds.), *Personnel selection in organizations* (Vol. 3570, pp. 35-70). Jossey-Bass Publishers, San Francisco, CA.

Campbell, J. P., & Wiernik, B. M. (2015). The modeling and assessment of work performance. *Annual Review of Organizational Psychology and Organizational Behavior*, *2*(1), 47-74. https://doi-org.ezproxy.massey.ac.nz/10.1146/annurev-orgpsych-032414-111427

Carlquist, E., Ulleberg, P., Delle Fave, A., Nafstad, H. E., & Blakar, R. M. (2017). Everyday understandings of happiness, good life, and satisfaction: Three different facets of well-being. *Applied Research in Quality of Life*, *12*, 481-505.

Carlsen, B., & Glenton, C. (2011). What about N? A methodological study of sample-size reporting in focus group studies. *BMC Medical Research Methodology*, *11*(1), 1-10.

Carlyle, T. (1841). *On heroes, hero-worship, and the heroic in history* (Vol. 1). London: James Fraser.

Cavana, R., Delahaye, B., & Sekeran, U. (2001). *Applied business research: Qualitative and quantitative methods*. John Wiley & Sons.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Aanalysis*. Sage.

Chen, F., & Wu, Q. L. (2023). Health-oriented leadership communication matters: a trickle-down model to enhance employees' health and well-being during turbulent times. *Corporate Communications: An International Journal*, *29*(3), 384-404.

Christmann, G. B. (2009). Expert interviews on the telephone: A difficult undertaking. In *Interviewing experts* (pp. 157-183). Springer.

Chughtai, A., Byrne, M., & Flood, B. (2015). Linking ethical leadership to employee well-being: The role of trust in supervisor. *Journal of Business Ethics*, *128*(3), 653-663.

Ciulla, J. B. (1995). Leadership ethics: Mapping the territory. *Business Ethics Quarterly*, 5-28.

Clapp-Smith, R., Vogelgesang, G. R., & Avey, J. B. (2009). Authentic leadership and positive psychological capital: The mediating role of trust at the group level of analysis. *Journal of Leadership & Organizational Studies*, *15*(3), 227-240.

Collier, J. E. (2020). *Applied structural equation modeling using AMOS: Basic to advanced techniques*. Routledge.

Collinson, D. (2011). Critical leadership studies. *The Sage handbook of leadership*, 181-194.

Conger, J. A. (1989). *The charismatic leader: Behind the mystique of exceptional leadership*. San Francisco, CA: Jossey-Bass.

Conger, J. A. (1999). Charismatic and transformational leadership in organizations: An insider's perspective on these developing streams of research. *The Leadership Quarterly*, *10*(2), 145-179.

Conger, J. A., & Kanungo, R. N. (1987). Toward a behavioral theory of charismatic leadership in organizational settings. *Academy of Management Review*, *12*(4), 637-647.

Conger, J. A., & Kanungo, R. N. (1988). Behavioral dimensions of charismatic leadership. In *Charismatic leadership: The elusive factor in organizational effectiveness.* (pp. 78-97). Jossey-Bass.

Cooper, C. D., Scandura, T. A., & Schriesheim, C. A. (2005). Looking forward but learning from our past: Potential challenges to developing authentic leadership theory and authentic leaders. *The Leadership Quarterly*, *16*(3), 475-493.

Copeland, M. K. (2014). The emerging significance of values based leadership: A literature review. *International Journal of Leadership Studies*, *8*(2), 105.

Cox, T., Griffiths, A., Barlowe, C., Randall, R., Thomson, L., & Rial-Gonzalez, E. (2000). Organisational interventions for work stress A risk management approach. *HSE Contract Research Report*.

Coyle, I. R., Sleeman, S. D., & Adams, N. (1995). Safety climate. *Journal of Safety Research*, *26*(4), 247-254.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Creswell, J. W., Plano Clark, V., Gutmann, M. L., & Hanson, W. E. (2003). An expanded typology for classifying mixed methods research into designs. *A. Tashakkori y C. Teddlie, Handbook of Mixed Methods in Social and Behavioral Research*, 209-240.

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Crum, A. J., Salovey, P., & Achor, S. (2013). Rethinking stress: the role of mindsets in determining the stress response. *Journal of Personality and Social Psychology*, *104*(4), 716.

Cunliffe, A. L. (2003). Reflexive inquiry in organizational research: Questions and possibilities. *Human Relations*, *56*(8), 983-1003.

Czerwiński, S. K., & Atroszko, P. A. (2023). A solution for factorial validity testing of three-item scales: An example of tau-equivalent strict measurement invariance of three-item loneliness scale. *Current Psychology*, *42*(2), 1652-1664.

Dalal, R. S., Baysinger, M., Brummel, B. J., & LeBreton, J. M. (2012). The relative importance of employee engagement, other job attitudes, and trait affect as predictors of job performance. *Journal of Applied Social Psychology*, *42*, E295-E325.

Daly, K. J. (2007). *Qualitative methods for family studies and human development*. Sage.

Daniels, K., & Harris, C. (2000). Work, psychological well-being and performance. *Occupational Medicine*, *50*(5), 304-309.

Dansereau Jr, F., Graen, G., & Haga, W. J. (1975). A vertical dyad linkage approach to leadership within formal organizations: A longitudinal investigation of the role making process. *Organizational Behavior and Human Performance*, *13*(1), 46-78.

Darko, T. O. (2020). Leaders' behaviour as a determinant of employee performance in Ghana: The mediating role of employee engagement. *Public Organization Review*, *20*(3), 597-611.

Day, D. V., Fleenor, J. W., Atwater, L. E., Sturm, R. E., & McKee, R. A. (2014). Advances in leader and leadership development: A review of 25 years of research and theory. *The Leadership Quarterly*, *25*(1), 63-82.

Daykin, N. (1998). Workplace health promotion: Benefit or burden to low-paid workers. *Critical Public Health*, *8*(2), 153-166.

De Cooman, R., Stynen, D., Van den Broeck, A., Sels, L., & De Witte, H. (2013). How job characteristics relate to need satisfaction and autonomous motivation: Implications for work effort. *Journal of Applied Social Psychology*, *43*(6), 1342-1352.

De Jonge, J., & Schaufeli, W. B. (1998). Job characteristics and employee well-being: a test of Warr's Vitamin Model in health care workers using structural equation modelling. *Journal of Organizational Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior*, *19*(4), 387-407.

Deci, E. L., Connell, J. P., & Ryan, R. M. (1989). Self-determination in a work organization. *Journal of Applied Psychology*, *74*(4), 580.

Deci, E. L., Koestner, R., & Ryan, R. M. (1999). A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation. *Psychological Bulletin*, *125*(6), 627.

Deci, E. L., Olafsen, A. H., & Ryan, R. M. (2017). Self-determination theory in work organizations: The state of a science. *Annual Review of Organizational Psychology and Organizational Behavior*, *4*, 19-43.

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum Press. https://doi.org/http://dx.doi.org/10.1007/978-1-4899-2271-7

Deci, E. L., & Ryan, R. M. (2000). The" what" and" why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, *11*(4), 227-268.

Deci, E. L., Ryan, R. M., Gagné, M., Leone, D. R., Usunov, J., & Kornazheva, B. P. (2001). Need satisfaction, motivation, and well-being in the work organizations of a former eastern bloc country: A cross-cultural study of self-determination. *Personality and Social Psychology Bulletin*, *27*(8), 930-942.

DeJoy, D. M., & Wilson, M. G. (2003). Organizational health promotion: broadening the horizon of workplace health promotion. *American Journal of Health Promotion*, *17*(5), 337-341.

Della, L. J., DeJoy, D. M., Goetzel, R. Z., Ozminkowski, R. J., & Wilson, M. G. (2008). Assessing management support for worksite health promotion: psychometric analysis of the leading by example (LBE) instrument. *American Journal of Health Promotion*, *22*(5), 359-367.

Delle, F. A., Brdar, I., Freire, T., Vella-Brodrick, D., & Wissing, M. P. (2011). The eudaimonic and hedonic components of happiness: Qualitative and quantitative findings. *Social Indicators Research*, *100*, 185-207.

Dellve, L., & Eriksson, A. (2017). Health-promoting managerial work: A theoretical framework for a leadership program that supports knowledge and capability to craft sustainable work practices in daily practice and during organizational change. *Societies*, *7*(2), 12.

Demerouti, E., & Bakker, A. B. (2011). The job demands-resources model: Challenges for future research. *SA Journal of Industrial Psychology*, *37*(2), 01-09. https://doi.org/10.4102/ sajip.v37i2.974

Denzin, N. K., & Lincoln, Y. S. (2000). *Handbook of qualitative research* (Second ed.). Thousand Oaks, Calif. : Sage Publications.

Diamantidis, A. D., & Chatzoglou, P. (2019). Factors affecting employee performance: an empirical approach. *International Journal of Productivity and Performance Management*, *68*(1), 171-193.

DiCicco, B. B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, *40*(4), 314-321. https://doi.org/https://doi.org/10.1111/j.1365-2929.2006.02418.x

Dickson-Swift, V., Fox, C., Marshall, K., Welch, N., & Willis, J. (2014). What really improves employee health and wellbeing. *International Journal of Workplace Health Management*, *7*(3), 138-155. https://doi.org/10.1108/ijwhm-10-2012-0026

Diener. (1984). Subjective well-being. *Psychological Bulletin*, *95*(3), 542-575. https://doi.org/10.1037/0033-2909.95.3.542

Diener, E., Diener, M., & Diener, C. (1995). Factors predicting the subjective well-being of nations. *Journal of Personality and Social Psychology*, *69*(5), 851.

Diener, E., Lucas, R. E., & Scollon, C. N. (2006). Beyond the hedonic treadmill: revising the adaptation theory of well-being. *American Psychologist*, *61*(4), 305.

Diener, E., Napa-Scollon, C., Oishi, S., Dzokoto, V., & Suh, E. (2000). Positivity and the construction of life satisfaction judgments: Global happiness is not the sum of its parts. *Journal of Happiness Studies*, *1*(2), 159-176. https://doi.org/10.1023/A:1010031813405

Diener, E., Sapyta, J. J., & Suh, E. (1998). Subjective well-being is essential to well-being. *Psychological Inquiry*, *9*(1), 33-37.

Diener, E., Suh, E., & Oishi, S. (1997). Recent findings on subjective well-being. *Indian Journal of Clinical Psychology*, *24*, 25-41.

Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, *125*(2), 276.

Diener, R. B., Kashdan, T. B., & King, L. A. (2009). Two traditions of happiness research, not two distinct types of happiness. *The Journal of Positive Psychology*, *4*(3), 208-211. https://doi.org/10.1080/17439760902844400

Dirks, K. T., & Ferrin, D. L. (2002). Trust in leadership: meta-analytic findings and implications for research and practice. *Journal of Applied Psychology*, *87*(4), 611.

Dollard, M. F., & Bakker, A. B. (2010). Psychosocial safety climate as a precursor to conducive work environments, psychological health problems, and employee engagement. *Journal of Occupational and Organizational Psychology*, *83*(3), 579-599. https://doi.org/10.1348/096317909x470690

Dollard, M. F., Dormann, C., Tuckey, M. R., & Escartín, J. (2017). Psychosocial safety climate (PSC) and enacted PSC for workplace bullying and psychological health problem reduction. *European Journal of Work and Organizational Psychology*, *26*(6), 844-857.

Dollard, M. F., & Karasek, R. A. (2010). Building psychosocial safety climate: Evaluation of a socially coordinated PAR risk management stress prevention study. In

Contemporary occupational health psychology: Global perspectives on research and practice, Vol 1. (pp. 208-233). Wiley Blackwell. https://doi.org/10.1002/9780470661550.ch11

Dollard, M. F., Opie, T., Lenthall, S., Wakerman, J., Knight, S., Dunn, S., Rickard, G., & MacLeod, M. (2012). Psychosocial safety climate as an antecedent of work characteristics and psychological strain: A multilevel model. *Work & Stress*, *26*(4), 385-404. https://doi.org/10.1080/02678373.2012.734154

Ducki, A. (2000). *Diagnose gesundheitsförderlicher Arbeit: eine Gesamtstrategie zur betrieblichen Gesundheitsanalyse* (Vol. 25). vdf Hochschulverlag AG.

Dunkl, A., Jiménez, P., Šarotar Žižek, S., Milfelner, B., & Kallus, W. K. (2015). Similarities and differences of health-promoting leadership and transformational leadership. *Naše gospodarstvo/Our economy*, *61*(4), 3-13. https://doi.org/10.1515/ngoe-2015-0013

Dvir, T., Eden, D., Avolio, B. J., & Shamir, B. (2002). Impact of transformational leadership on follower development and performance: A field experiment. *Academy of Management Journal*, *45*(4), 735-744.

Dziuban, C. D., & Shirkey, E. C. (1977). Sampling Adequacy and the Semantic Differential.

Eberz, S., & Herbert Antoni, C. (2016). The Systemic Salutogenic Interaction Modell (SSIM)–a holistic approach for explanation and development of health-promoting interactions between leaders and employees. *Gruppe. Interaktion. Organisation. Zeitschrift für Angewandte Organisationspsychologie (GIO)*, *47*, 265-273.

Edú-Valsania, S., Moriano, J. A., & Molero, F. (2016). Authentic leadership and employee knowledge sharing behavior: Mediation of the innovation climate and workgroup identification. *Leadership & Organization Development Journal*, *37*(4), 487-506.

Eekhout, I., De Vet, H. C., Twisk, J. W., Brand, J. P., de Boer, M. R., & Heymans, M. W. (2014). Missing data in a multi-item instrument were best handled by multiple imputation at the item score level. *Journal of Clinical Epidemiology*, *67*(3), 335-342.

Eichhorn, B. R. (2014). Common method variance techniques. *Cleveland State University, Department of Operations & Supply Chain Management. Cleveland, OH: SAS Institute Inc*, *1*(11).

Eng, J., Moy, F., & Bulgiba, A. (2016). Impact of a workplace health promotion program on employees' blood pressure in a public university. *PLoS One*, *11*(2), e0148307. https://doi.org/10.1371/journal.pone.0148307

Erickson, R. J. (1995). The importance of authenticity for self and society. *Symbolic Interaction*, *18*(2), 121-144. https://doi.org/10.1525/si.1995.18.2.121

Eriksson, A. (2011). Health-promoting leadership. *Socialmedicinsk Tidskrift*, *88*(6), 573.

Eriksson, A., Axelsson, R., & Axelsson, S. B. (2011). Health promoting leadership - different views of the concept. *Work*, *40*(1), 75-84. https://doi.org/10.3233/WOR-2011-1208

Eriksson, A., Axelsson, R., & Bihari Axelsson, S. (2010). Development of health promoting leadership – experiences of a training programme. *Health Education*, *110*(2), 109-124. https://doi.org/10.1108/09654281011022441

Eriksson, A., Axelsson, S. B., & Axelsson, R. (2012). Collaboration in workplace health promotion–a case study. *International Journal of Workplace Health Management*, *5*(3), 181-193.

Eriksson, A., Jansson, B., Haglund, B. J., & Axelsson, R. (2008). Leadership, organization and health at work: a case study of a Swedish industrial company. *Health Promotion International*, *23*(2), 127-133.

European Network for Workplace Health Promotion. (2007). *The Luxembourg declaration on workplace health promotion in European Union*. Luxembourg

Eva, N., Robin, M., Sendjaya, S., Van Dierendonck, D., & Liden, R. C. (2019). Servant leadership: A systematic review and call for future research. *The Leadership Quarterly*, *30*(1), 111-132.

Fattore, T., Mason, J., & Watson, E. (2007). Children's conceptualisation (s) of their well-being. *Social Indicators Research*, *80*, 5-29.

Fernet, C., Austin, S., & Vallerand, R. J. (2012). The effects of work motivation on employee exhaustion and commitment: An extension of the JD-R model. *Work & Stress*, *26*(3), 213-229.

Fernet, C., Gagné, M., & Austin, S. (2010). When does quality of relationships with coworkers predict burnout over time? The moderating role of work motivation. *Journal of Organizational Behavior*, *31*(8), 1163-1180.

Fernet, C., Trépanier, S.-G., Austin, S., Gagné, M., & Forest, J. (2015). Transformational leadership and optimal functioning at work: On the mediating role of employees' perceived job characteristics and motivation. *Work & Stress*, *29*(1), 11-31.

Fiedler, F. E. (1967). *A theory of leadership effectiveness.* New York: McGraw-Hill.

Field, A. (2018). *Discovering Statistics Using- IBM SPSS Statistics* (5th ed.). Sage Publications Ltd.

Fisher, C. D. (2002). Antecedents and consequences of real-time affective reactions at work. *Motivation and Emotion*, *26*, 3-30.

Fisher, C. D. (2010). Happiness at work. *International Journal of Management Reviews*, *12*(4), 384-412.

Fishwick, D., Carroll, C., McGregor, M., Drury, M., Webster, J., Bradshaw, L., Rick, J., & Leaviss, J. (2013). Smoking cessation in the workplace. *Occupational Medicine*, *63*(8), 526-536.

Fleishman, E. A. (1953a). The description of supervisory behavior. *Journal of Applied Psychology*, *37*(1), 1.

Fleishman, E. A. (1953b). The measurement of leadership attitudes in industry. *Journal of Applied Psychology*, *37*(3), 153.

Foo, M.-D., Uy, M. A., & Baron, R. A. (2009). How do feelings influence effort? An empirical study of entrepreneurs' affect and venture effort. *Journal of Applied Psychology*, *94*(4), 1086.

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*, *25*(10), 1229-1245.

Franke, F., & Felfe, J. (2011a). Diagnose gesundheitsförderlicher Führung–Das Instrument „Health-oriented Leadership ". *Fehlzeiten-Report 2011: Führung und Gesundheit: Zahlen, Daten, Analysen aus allen Branchen der Wirtschaft*, 3-13.

Franke, F., & Felfe, J. (2011b). How does transformational leadership impact employees' psychological strain? *Leadership*, *7*(3), 295-316. https://doi.org/10.1177/1742715011407387

Franke, F., Felfe, J., & Pundt, A. (2014). The impact of health-oriented leadership on follower health: Development and test of a new instrument measuring health-promoting leadership. *German Journal of Human Resource Management*, *28*(1-2), 139-161.

Gagné, M., & Deci, E. L. (2005). Self-determination theory and work motivation. *Journal of Organizational Behavior*, *26*(4), 331-362.

Gagné, M., Senecal, C. B., & Koestner, R. (1997). Proximal job characteristics, feelings of empowerment, and intrinsic motivation: A multidimensional model 1. *Journal of Applied Social Psychology*, *27*(14), 1222-1240.

Gardner, W. L., Avolio, B. J., Luthans, F., May, D. R., & Walumbwa, F. (2005). “Can you see the real me?” A self-based model of authentic leader and follower development. *The Leadership Quarterly*, *16*(3), 343-372.

Gardner, W. L., Cogliser, C. C., Davis, K. M., & Dickens, M. P. (2011). Authentic leadership: A review of the literature and research agenda. *The Leadership Quarterly*, *22*(6), 1120-1145.

Gardner, W. L., Karam, E. P., Alvesson, M., & Einola, K. (2021). Authentic leadership theory: The case for and against. *The Leadership Quarterly*, *32*(6), 101495.

Gardner, W. L., & McCauley, K. D. (2022). The gaslighting of authentic leadership. *Leadership*, *18*(6), 801-813.

Gefen, D., & Straub, D. W. (1997). Gender differences in the perception and use of e-mail: An extension to the technology acceptance model. *MIS Quarterly*, *21*(4), 389-400. https://doi.org/https://doi.org/10.2307/249720

Gerstner, C. R., & Day, D. V. (1997). Meta-Analytic review of leader–member exchange theory: Correlates and construct issues. *Journal of Applied Psychology*, *82*(6), 827.

Ghasemi, A., & Zahediasl, S. (2012). Normality tests for statistical analysis: a guide for non-statisticians. *International Journal of Endocrinology and Metabolism*, *10*(2), 486.

Gilbreath, B., & Benson, P. G. (2004). The contribution of supervisor behaviour to employee psychological well-being. *Work & Stress*, *18*(3), 255-266. https://doi.org/10.1080/02678370412331317499

Gillespie, N. (2003). *Measuring trust in working relationships: The behavioral trust inventory*. Melbourne Business School.

Gillespie, N. A., & Mann, L. (2004). Transformational leadership and shared values: The building blocks of trust. *Journal of Managerial Psychology*.

Gillet, N., Fouquereau, E., Forest, J., Brunault, P., & Colombat, P. (2012). The impact of organizational factors on psychological needs and their relations with well-being. *Journal of Business and Psychology*, *27*, 437-450.

Goetzel, R. Z. (2005). Examining the value of integrating occupational health and safety and health promotion programs in the workplace. *NIOSH Report Contract No. 211-2004-M*, *9393*.

Goetzel, R. Z., Ozminkowski, R. J., Bowen, J., & Tabrizi, M. J. (2008). Employer integration of health promotion and health protection programs. *International Journal of Workplace Health Management*.

Goodin, R. E., & Klingemann, H.-D. (1998). *A New Handbook of Political Science*. Oxford University Press.

Gouldner, A. W. (1960). The norm of reciprocity: A preliminary statement. *American Sociological Review*, 161-178.

Gowin, E. B. (1919). *Developing executive ability.* New York: The Ronald Press Company.

Graen, G. B., & Uhl-Bien, M. (1995). Relationship-based approach to leadership: Development of leader-member exchange (LMX) theory of leadership over 25 years: Applying a multi-level multi-domain perspective. *The Leadership Quarterly*, *6*(2), 219-247.

Grant, A. M. (2008). The significance of task significance: Job performance effects, relational mechanisms, and boundary conditions. *Journal of Applied Psychology*, *93*(1), 108.

Grant, A. M., Christianson, M. K., & Price, R. H. (2007). Happiness, health, or relationships? Managerial practices and employee well-being tradeoffs. *Academy of Management Perspectives*, *21*(3), 51-63.

Green, L. W. (1991). Health promotion planning. *Mountain View*, *24*.

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis*, *11*(3), 255-274.

Greenleaf, R. K. (2013). *Servant leadership: A journey into the nature of legitimate power and greatness*. Paulist press.

Griffin, M. A., Neal, A., & Parker, S. K. (2007). A new model of work role performance: Positive behavior in uncertain and interdependent contexts. *Academy of Management Journal*, *50*(2), 327-347.

Guba, E. G., & Lincoln, Y. S. (1994). Competing Paradigms in Qualitative Research. *Handbook of Qualitative Research*, *2*(163-194), 105.

Guest, D. E. (2017). Human resource management and employee well-being: Towards a new analytic framework. *Human Resource Management Journal*, *27*(1), 22-38.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59-82.

Gurin, G., Veroff, J., & Feld, S. (1992). *Americans View Their Mental Health, 1957* Inter-university Consortium for Political and Social Research [distributor]. https://doi.org/10.3886/ICPSR03503.v1

Gurt, J., Schwennen, C., & Elke, G. (2011). Health-specific leadership: Is there an association between leader consideration for the health of employees and their strain and well-being? *Work & Stress*, *25*(2), 108-127. https://doi.org/10.1080/02678373.2011.595947

Hackman, J. R., & Oldham, G. R. (1976). Motivation through the design of work: Test of a theory. *Organizational Behavior and Human Performance*, *16*(2), 250-279.

Haddon, J. (2018). The impact of employees' well-being on performance in the workplace. *Strategic HR Review*, *17*(2), 72-75.

Hair, J. F., Black, W. C., Babin, B. J., & Anderson, R. E. (2013). *Multivariate Data Analysis*. Pearson Education Limited. https://books.google.co.nz/books?id=VvXZnQEACAAJ

Hall, G. B., Dollard, M. F., & Coward, J. (2010). Psychosocial safety climate: Development of the PSC-12. *International Journal of Stress Management*, *17*(4), 353-383. https://doi.org/10.1037/a0021320

Hanson, A. (2004). Hälsopromotion i arbetslivet (Health promotion in working life). *Lund: Studentlitteratur*, 107-131.

Harms, P. D., Credé, M., Tynan, M., Leon, M., & Jeung, W. (2017). Leadership and stress: A meta-analytic review. *The Leadership Quarterly*, *28*(1), 178-194.

Harter, S. (2002). Authenticity. In *Handbook of Positive Psychology* (pp. 382-394). Oxford University Press.

Hasin, H., Hussain, W. S., Nordin, E., Jamil, A., & Johari, Y. C. (2023). The Impact of Workload, Management Factors, and Job Insecurity on Employee Well-Being: A Review of Recent Research.

Hassan, A., & Ahmed, F. (2011). Authentic leadership, trust and work engagement. *International Journal of Human and Social Sciences*, *6*(3), 164-170.

Havermans, B. M., Boot, C. R., Houtman, I. L., Brouwers, E. P., Anema, J. R., & Van Der Beek, A. J. (2017). The role of autonomy and social support in the relation between psychosocial safety climate and stress in health care workers. *BMC Public Health*, *17*(1), 558.

Health and Safety at Work Strategy. (2018-2028). New Zealand: New Zealand Government Retrieved from https://www.mbie.govt.nz/assets/69361d5a98/health-safety-at-work-strategy-2018-2028.pdf

Hendriks, M., Burger, M., Rijsenbilt, A., Pleeging, E., & Commandeur, H. (2020). Virtuous leadership: a source of employee well-being and trust. *Management Research Review*.

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, *292*, 114523.

Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2017). Code saturation versus meaning saturation: how many interviews are enough? *Qualitative Health Research*, *27*(4), 591-608.

Hentrich, S., Zimber, A., Garbade, S. F., Gregersen, S., Nienhaus, A., & Petermann, F. (2017). Relationships between transformational leadership and health: The mediating role of perceived job demands and occupational self-efficacy. *International Journal of Stress Management*, *24*(1), 34.

Herbert, S. L. (2005). A comprehensive literature review and critical anaylsis of servant leadership theory.

Hersey, P., & Blanchard, K. H. (1974). So you want to know your leadership style? *Training & Development Journal*.

Hersey, R. B. (2015). *Workers' Emotions in Shop and Home: A Study of Individual Workers from the Psychological and Physiological Stand-point*. University of Pennsylvania Press.

Herzberg, F., Mausner, B., & Snyderman, B. B. (1959). The Motivation to Work, 2nd Edn New York. *NY: John Wiley & Sons*.

Hmieleski, K. M., Cole, M. S., & Baron, R. A. (2012). Shared authentic leadership and new venture performance. *Journal of Management*, *38*(5), 1476-1499.

Hobfoll, S. E. (2001). The influence of culture, community, and the nested-self in the stress process: Advancing conservation of resources theory. *Applied Psychology*, *50*(3), 337-421.

Hoert, J., Herd, A. M., & Hambrick, M. (2018). The Role of Leadership Support for Health Promotion in Employee Wellness Program Participation, Perceived Job Stress, and

Health Behaviors. *American Journal of Health Promotion*, *32*(4), 1054-1061. https://doi.org/10.1177/0890117116677798

Holte, A., Barry, M., Bekkhus, M., & Trommsdorff, G. (2014). Psychology of child well-being. In F. C. A. Ben-Arieh, I. Frønes, & J. E. Korbin (Ed.), *Handbook of child well-being: Theories, methods and policies in global perspective.* (pp. 555-631). Netherlands: Springer. .

Hooper, D., Coughlan, J., & Mullen, M. (2008). Structural equation modelling: Guidelines for determining model fit. *Electron Journal of Business Research Methods 6*(1), 53–60.

Horstmann, D. (2018). Enhancing employee self-care. *European Journal of Health Psychology*.

House, R. J. (1971). A path goal theory of leader effectiveness. *Administrative Science Quarterly*, 321-339.

House, R. J., & Howell, J. M. (1992). Personality and charismatic leadership. *The Leadership Quarterly*, *3*(2), 81-108.

Howell, J. M., & Avolio, B. J. (1993). Transformational leadership, transactional leadership, locus of control, and support for innovation: Key predictors of consolidated-business-unit performance. *Journal of Applied Psychology*, *78*(6), 891-902. https://doi.org/10.1037/0021-9010.78.6.891

Hsieh, C.-C., & Wang, D.-S. (2015). Does supervisor-perceived authentic leadership influence employee work engagement through employee-perceived authentic leadership and employee trust? *The International Journal of Human Resource Management*, *26*(18), 2329-2348.

Hu, L. t., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: A Multidisciplinary Journal*, *6*(1), 1-55.

Hu, Q., Dollard, M. F., & Taris, T. W. (2022). Organizational context matters: Psychosocial safety climate as a precursor to team and individual motivational functioning. *Safety Science*, *145*, 105524.

Humphrey, S. E., Nahrgang, J. D., & Morgeson, F. P. (2007). Integrating motivational, social, and contextual work design features: a meta-analytic summary and theoretical extension of the work design literature. *Journal of Applied Psychology*, *92*(5), 1332.

Idris, M. A., Dollard, M. F., Coward, J., & Dormann, C. (2012). Psychosocial safety climate: Conceptual distinctiveness and effect on job demands and worker psychological health. *Safety Science*, *50*(1), 19-28.

Ilies, R., Morgeson, F. P., & Nahrgang, J. D. (2005). Authentic leadership and eudaemonic well-being: Understanding leader–follower outcomes. *The Leadership Quarterly*, *16*(3), 373-394.

Inceoglu, I., Thomas, G., Chu, C., Plans, D., & Gerbasi, A. (2018). Leadership behavior and employee well-being: An integrated review and a future research agenda. *The Leadership Quarterly*, *29*(1), 179-202. https://doi.org/10.1016/j.leaqua.2017.12.006

Inglehart, R. (1990). *Culture shift in advanced industrial society*. Princeton University Press.

International Labour Organization. (2014). *Improving health in the workplace: ILO's framework for action*. Retrieved from https://www.ilo.org/safework/info/publications/WCMS_329350/lang--en/index.htm

International Labour Organization. (2015). *Decent work*. Switzerland Retrieved from https://www.ilo.org/global/topics/decent-work/lang--en/index.htm

Jackson, B., & Parry, K. (2018). *A very short, fairly interesting and reasonably cheap book about studying leadership*. Sage Publications.

Jackson, D. L., Gillaspy Jr, J. A., & Purc-Stephenson, R. (2009). Reporting practices in confirmatory factor analysis: an overview and some recommendations. *Psychological Methods*, *14*(1), 6.

Jeurissen, T., & Nyklíček, I. (2001). Testing the vitamin model of job stress in Dutch health care workers. *Work & Stress*, *15*(3), 254-264.

Jiang, J. Y. (2014). Leader–member relationship and burnout: The moderating role of leader integrity. *Management and Organization Review*, *10*(2), 223-247.

Jimenez, P., Bregenzer, A., Kallus, K. W., Fruhwirth, B., & Wagner-Hartl, V. (2017). Enhancing resources at the workplace with health-promoting leadership. *International Journal Environmental Research and Public Health*, *14*(10). https://doi.org/10.3390/ijerph14101264

Jiménez, P., Winkler, B., & Bregenzer, A. (2017). Developing Sustainable Workplaces with Leadership: Feedback about Organizational Working Conditions to Support Leaders in Health-Promoting Behavior. *Sustainability*, *9*(11). https://doi.org/10.3390/su9111944

Jiménez, P., Winkler, B., & Dunkl, A. (2016). Creating a healthy working environment with leadership: the concept of health-promoting leadership. *The International Journal of Human Resource Management*, *28*(17), 2430-2448. https://doi.org/10.1080/09585192.2015.1137609

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a Definition of Mixed Methods Research. *Journal of Mixed Methods Research*, *1*(2), 112-133. https://doi.org/10.1177/1558689806298224

Jöreskog, K. G., Sörbom, D., Magidson, J., & Cooley, W. W. (1979). *Advances in factor analysis and structural equation models* (J. Magidson, Ed.). University Press of America. https://lccn.loc.gov/84013116

Judge, T. A., Piccolo, R. F., & Ilies, R. (2004). The forgotten ones? The validity of consideration and initiating structure in leadership research. *Journal of Applied Psychology*, *89*(1), 36.

Jung, D. I., & Avolio, B. J. (2000). Opening the black box: An experimental investigation of the mediating effects of trust and value congruence on transformational and transactional leadership. *Journal of Organizational Behavior*, *21*(8), 949-964.

Kahneman, D., Diener, E., & Schwarz, N. (1999). *Well-being: Foundations of hedonic psychology*. Russell Sage Foundation.

Kalshoven, K., Den Hartog, D. N., & De Hoogh, A. H. B. (2011). Ethical leadership at work questionnaire (ELW): Development and validation of a multidimensional measure. *The Leadership Quarterly*, *22*(1), 51-69. https://doi.org/10.1016/j.leaqua.2010.12.007

Kaluza, A. J., Schuh, S. C., Kern, M., Xin, K., & Van Dick, R. (2018). The importance of organizational health climate for employee health: A multilevel cascading model. Academy of Management Proceedings,

Kaluza, A. J., Weber, F., van Dick, R., & Junker, N. M. (2021). When and how health-oriented leadership relates to employee well-being—The role of expectations, self-care, and LMX. *Journal of Applied Social Psychology*, *51*(4), 404-424. https://doi.org/10.1111/jasp.12744

Kapp, E. A. (2012). The influence of supervisor leadership practices and perceived group safety climate on employee safety performance. *Safety Science*, *50*(4), 1119-1124.

Karanika-Murray, M., Bartholomew, K. J., Williams, G. A., & Cox, T. (2015). Leader-Member Exchange across two hierarchical levels of leadership: concurrent influences

on work characteristics and employee psychological health. *Work & Stress*, *29*(1), 57-74.

Karasek, R. A. (1979). Job demands, job decision latitude, and mental strain: Implications for job redesign. *Administrative Science Quarterly*, 285-308.

Karatepe, O., Kilic, H., & Isiksel, B. (2008). An examination of the selected antecedents and outcomes of work-family conflict and family-work conflict in frontline service jobs. *Services Marketing Quarterly*, *29*(4), 1-24. https://doi.org/10.1080/15332960802218620

Kartz, D., & Kahn, R. (1978). The social psychology of organizing. *Wiley, New York*.

Kashdan, T. B., Biswas-Diener, R., & King, L. A. (2008). Reconsidering happiness: The costs of distinguishing between hedonics and eudaimonia. *The Journal of Positive Psychology*, *3*(4), 219-233.

Katz, D., Maccoby, N., & Morse, N. C. (1950). *Productivity, supervision, and morale in an office situation.* Ann Arbor, Mich., Institute for Social Research, University of Michigan.

Kelloway, E. K., Sivanathan, N., Francis, L., & Barling, J. (2005). Poor leadership. In *Handbook of work stress* (pp. 89-112). SAGE Publications, Inc.

Kelloway, E. K., Weigand, H., McKee, M. C., & Das, H. (2013). Positive leadership and employee well-being. *Journal of Leadership & Organizational Studies*, *20*(1), 107-117.

Kernis, M. H., & Goldman, B. M. (2005). From thought and experience to behavior and interpersonal relationships: A multicomponent conceptualization of authenticity. *On building, defending and regulating the self: A psychological perspective. Psychology Press*, 31-52.

Kernis, M. H., & Goldman, B. M. (2006). A multicomponent conceptualization of authenticity: Theory and research. In *Advances in experimental social psychology, Vol 38.* (pp. 283-357). Elsevier Academic Press. https://doi.org/10.1016/S0065-2601(06)38006-9

Ketokivi, M., & Mantere, S. (2010). Two strategies for inductive reasoning in organizational research. *Academy of Management Review*, *35*(2), 315-333.

Kiersch, C. E., & Byrne, Z. S. (2015). Is being authentic being fair? Multilevel examination of authentic leadership, justice, and employee outcomes. *Journal of Leadership & Organizational Studies*, *22*(3), 292-303.

Kim, H. (2014). Transformational leadership, organizational clan culture, organizational affective commitment, and organizational citizenship behavior: A case of South Korea's public sector. *Public Organization Review*, *14*, 397-417.

Kim, M. (2018). The effects of authentic leadership on employees' well-being and the role of relational cohesion. *Leadership*, 193-210. https://doi.org/10.5772/intechopen.76427

Kim, P. C., Diener, E., Tamir, M., Scollon, C., & Diener, M. (2005). Integrating the diverse definitions of happiness: A time-sequential framework of subjective well-being. *Journal of Happiness Studies*, *6*, 261-300.

Kline, R. B. (2015). *Principles and practice of structural equation modeling*. Guilford publications.

Koch, T. (1994). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing*, *19*(5), 976-986.

Koopmans, L., Bernaards, C. M., Hildebrandt, V. H., Schaufeli, W. B., de Vet Henrica, C., & Van Der Beek, A. J. (2011). Conceptual frameworks of individual work performance: A systematic review. *Journal of Occupational and Environmental Medicine*, *53*(8), 856-866.

Kovjanic, S., Schuh, S. C., & Jonas, K. (2013). Transformational leadership and performance: An experimental investigation of the mediating effects of basic needs satisfaction and work engagement. *Journal of Occupational and Organizational Psychology*, *86*(4), 543-555.

Kranabetter, C., & Niessen, C. (2017). Managers as role models for health: Moderators of the relationship of transformational leadership with employee exhaustion and cynicism. *Journal of Occupational Health Psychology*, *22*(4), 492-502. https://doi.org/10.1037/ocp0000044

Krosgaard, M. A., Brodt, S. E., & Whitener, E. M. (2002). Trust in the face of conflict: The role of managerial trustworthy behavior and organizational context. *Journal of Applied Psychology*, *87*(2), 312.

Kuoppala, J., Lamminpaa, A., Liira, J., & Vainio, H. (2008). Leadership, job well-being, and health effects--a systematic review and a meta-analysis. *Journal of Occupational and Environmental Medicine*, *50*(8), 904-915. https://doi.org/10.1097/JOM.0b013e31817e918d

Laloo, E., Coman, R., Hanley, N., & Bakand, S. (2023). The impact of leadership on the psychosocial safety climate of organizations: A scoping review of the international literature. *International Journal of Occupational Safety and Health*, *13*(2), 258-271.

Land, K. C., & Spilerman, S. (1975). Social indicator models. An overview. . In K. C. Land; & S. Spilerman; (Eds.), *Social indicator models.* (pp. 5-35). Russell Sage Foundation.

Lau, D. C., Liu, J., & Fu, P. P. (2007). Feeling trusted by business leaders in China: Antecedents and the mediating role of value congruence. *Asia Pacific Journal of Management*, *24*(3), 321-340.

Lavoie-Tremblay, M., Fernet, C., Lavigne, G. L., & Austin, S. (2016). Transformational and abusive leadership practices: impacts on novice nurses, quality of care and intention to leave. *Journal of Advanced Nursing*, *72*(3), 582-592.

Lawler, E. E., & Porter, L. W. (1967). The effect of performance on job satisfaction. *Industrial Relations*.

Lawson, C., Latsis, J. S., & Martins, N. (2013). *Contributions to social ontology*. Routledge.

Ledford, G. E. (1999). Comment: Happiness and productivity revisited. *Journal of Organizational Behavior*, 25-30.

Leroy, H., Palanski, M. E., & Simons, T. (2012). Authentic leadership and behavioral integrity as drivers of follower commitment and performance. *Journal of Business Ethics*, *107*, 255-264.

Lewin, K., Lippitt, R., & White, R. K. (1939). Patterns of aggressive behavior in experimentally created "social climates". *The Journal of Social Psychology*, *10*(2), 269-299.

Lim, B.-C., & Ployhart, R. E. (2004). Transformational Leadership: Relations to the Five-Factor Model and Team Performance in Typical and Maximum Contexts. *Journal of Applied Psychology*, *89*(4), 610-621. https://doi.org/10.1037/0021-9010.89.4.610

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Newberry Park.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. *The Sage Handbook of Qualitative Research*, *4*(2), 97-128.

Liu, J., Siu, O. L., & Shi, K. (2010). Transformational leadership and employee well-being: The mediating role of trust in the leader and self-efficacy. *Applied Psychology*, *59*(3), 454-479.

Liu, L., Zhang, C., & Fang, C.-C. (2021). Effects of health-promoting leadership, employee health on employee engagement: employability as moderating variable. *International Journal of Workplace Health Management*, *15*(1), 1-18.

Liu, S.-m., Liao, J.-q., & Wei, H. (2015). Authentic leadership and whistleblowing: Mediating roles of psychological safety and personal identification. *Journal of Business Ethics*, *131*(1), 107-119.

Liu, Y., Fuller, B., Hester, K., Bennett, R. J., & Dickerson, M. S. (2018). Linking authentic leadership to subordinate behaviors. *Leadership & Organization Development Journal*, *39*(2), 218-233.

Ljungblad, C., Granström, F., Dellve, L., & Åkerlind, I. (2014). Workplace health promotion and working conditions as determinants of employee health. *International Journal of Workplace Health Management*, *7*(2), 89-104. https://doi.org/10.1108/ijwhm-02-2013-0003

Loewe, N., Bagherzadeh, M., Araya-Castillo, L., Thieme, C., & Batista-Foguet, J. M. (2014). Life domain satisfactions as predictors of overall life satisfaction among workers: Evidence from Chile. *Social Indicators Research*, *118*(1), 71-86.

Loh, M. Y., Dollard, M. F., McLinton, S. S., & Tuckey, M. R. (2021). How psychosocial safety climate (PSC) gets stronger over time: A first look at leadership and climate strength. *Journal of Occupational Health Psychology*, *26*(6), 522.

Loh, M. Y., Idris, M. A., Dollard, M. F., & Isahak, M. (2018). Psychosocial safety climate as a moderator of the moderators: Contextualizing JDR models and emotional demands effects. *Journal of Occupational and Organizational Psychology*, *91*(3), 620-644.

Lopez-Martin, E., & Topa, G. (2019). Organizational culture and job demands and resources: Their impact on employees' wellbeing in a multivariate multilevel model. *International Journal of Environmental Research and Public Health*, *16*(17), 3006.

Lopez, I., Delgado-Bello, C., Veas-Gonzalez, I., & Villar, M. (2025). Impact of transformational and laissez-faire leadership styles on performance, job satisfaction, and turnover intention: A case study of educational organizations in Chile. *Problems and Perspectives in Management*, *23*(1), 729.

Lowe, K. B., Kroeck, K. G., & Sivasubramaniam, N. (1996). Effectiveness correlates of transformational and transactional leadership: A meta-analytic review of the MLQ literature. *The Leadership Quarterly*, *7*(3), 385-425.

Lowin, A., & Craig, J. R. (1968). The influence of level of performance on managerial style: An experimental object-lesson in the ambiguity of correlational data. *Organizational Behavior and Human Performance*, *3*(4), 440-458.

Lucas, R. E., Diener, E., & Suh, E. (1996). Discriminant validity of well-being measures. *Journal of Personality and Social Psychology*, *71*(3), 616-628. https://doi.org/10.1037/0022-3514.71.3.616

Lucas;, R. E., Diener;, E., & Suh;, E. (1996). Discriminant validity of well-being measures. *Journal of Personality and Social Psychology*, *71*(3), 616.

Lundqvist, D., Wallo, A., & Reineholm, C. (2023). Leadership and well-being of employees in the Nordic countries: A literature review. *Work: A Journal of Prevention, Assessment & Rehabilitation*, *74*(4), 1331-1352. https://doi.org/https://doi.org/10.3233/WOR-210063

Luthans, F. (2002). The need for and meaning of positive organizational behavior. *Journal of Organizational Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior*, *23*(6), 695-706.

Luthans, F., & Avolio, B. J. (2003). Authentic leadership development. *Positive Organizational Scholarship*, *241*, 258.

Lux, A. A., & Lowe, K. B. (2024). Authentic leadership: 20-Year review editorial. *Journal of Management & Organization*, *30*(6), 1634-1641.

MacCallum, R. C., Browne, M. W., & Sugawara, H. M. (1996). Power analysis and determination of sample size for covariance structure modeling. *Psychological Methods*, *1*(2), 130.

Mache, S., Jensen, S., Linnig, S., Jahn, R., Steudtner, M., Ochsmann, E., & Preuß, G. (2015). Do overweight workers profit by workplace health promotion, more than their normal-weight peers? Evaluation of a worksite intervention. *Journal of Occupational Medicine and Toxicology*, *10*(1), 1-12.

MacKenzie, S. B., & Podsakoff, P. M. (2012). Common method bias in marketing: Causes, mechanisms, and procedural remedies. *Journal of Retailing*, *88*(4), 542-555.

MacKenzie, S. B., Podsakoff, P. M., & Rich, G. A. (2001). Transformational and transactional leadership and salesperson performance. *Journal of the Academy of Marketing Science*, *29*, 115-134.

Marshall, B., Cardon, P., Poddar, A., & Fontenot, R. (2013). Does sample size matter in qualitative research?: A review of qualitative interviews in IS research. *Journal of Computer Information Systems*, *54*(1), 11-22. https://doi.org/10.1080/08874417.2013.11645667

Maslach, C., & Leiter, M. P. (2008). Early predictors of job burnout and engagement. *Journal of Applied Psychology*, *93*(3), 498.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum Qualitative Sozialforschung Forum: Qualitative Social Research*, *11*(3). https://doi.org/10.17169/fqs-11.3.1428

Maximo, N., Stander, M. W., & Coxen, L. (2019). Authentic leadership and work engagement: The indirect effects of psychological safety and trust in supervisors. *SA Journal of Industrial Psychology*, *45*(1), 1-11.

Mayer, R. C., Davis, J. H., & Schoorman, F. D. (1995). An integrative model of organizational trust. *Academy of Management Review*, *20*(3), 709-734.

McLinton, S. S., Dollard, M. F., & Tuckey, M. R. (2018). New perspectives on psychosocial safety climate in healthcare: A mixed methods approach. *Safety Science*, *109*, 236-245.

Megeirhi, H., Kilic, H., Avci, T., Afsar, B., & Abubakar, A. M. (2018). Does team psychological capital moderate the relationship between authentic leadership and negative outcomes: an investigation in the hospitality industry. *Economic research-Ekonomska istraživanja*, *31*(1), 927-945.

Mertens, D. M. (2019). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods*. Sage Publications.

Millette, V., & Gagné, M. (2008). Designing volunteers' tasks to maximize motivation, satisfaction and performance: The impact of job characteristics on volunteer engagement. *Motivation and Emotion*, *32*, 11-22.

Milner, K., Greyling, M., Goetzel, R., Da Silva, R., Kolbe-Alexander, T., Patel, D., Nossel, C., & Beckowski, M. (2015). The relationship between leadership support, workplace health promotion and employee wellbeing in South Africa. *Health Promotion International*, *30*(3), 514-522. https://doi.org/10.1093/heapro/dat064

Ministry of Business Innovation and Employment. (2019). *Defining small business. Recommendations of the New Zealand small business council for the minister of small business*. Retrieved from https://www.mbie.govt.nz/assets/defining-small-business.pdf

Ministry of Health. (2023). *Te Whare Tapa Whā model of Māori health*. New Zealand Retrieved from https://www.health.govt.nz/maori-health/maori-health-models/te-whare-tapa-wha

Minnis, S. E., & Callahan, J. L. (2010). Servant leadership in question: A critical review of power within servant leadership. *HRD Research and Practice across Europe*, 1-20.

Mitchell, A. (2018). A review of mixed methods, pragmatism and abduction techniques. *The Electronic Journal of Business Research Methods*, *16*(3), 103-116. www.ejbrm.com

Montano, D., Reeske, A., Franke, F., & Hüffmeier, J. (2017). Leadership, followers' mental health and job performance in organizations: A comprehensive meta-analysis from an occupational health perspective. *Journal of Organizational Behavior*, *38*(3), 327-350. https://doi.org/10.1002/job.2124

Morgan, D. L. (2007). Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research*, *1*(1), 48-76.

Morgeson, F. P., Delaney-Klinger, K., & Hemingway, M. A. (2005). The importance of job autonomy, cognitive ability, and job-related skill for predicting role breadth and job performance. *Journal of Applied Psychology*, *90*(2), 399.

Morgeson, F. P., & Humphrey, S. E. (2006). The Work Design Questionnaire (WDQ): developing and validating a comprehensive measure for assessing job design and the nature of work. *Journal of Applied Psychology*, *91*(6), 1321.

Morse, J. M. (1995). The significance of saturation. In (Vol. 5, pp. 147-149): Sage Publications Sage CA: Thousand Oaks, CA.

Motowidlo, S. J., & Van Scotter, J. R. (1994). Evidence that task performance should be distinguished from contextual performance. *Journal of Applied Psychology*, *79*(4), 475.

Muntz, J., Dormann, C., & Kronenwett, M. (2019). Supervisors' relational transparency moderates effects among employees' illegitimate tasks and job dissatisfaction: A four-wave panel study. *European Journal of Work and Organizational Psychology*, *28*(4), 485-497.

Murray, M. K., Bartholomew, K. J., Williams, G. A., & Cox, T. (2015). Leader-Member Exchange across two hierarchical levels of leadership: concurrent influences on work characteristics and employee psychological health. *Work & Stress*, *29*(1), 57-74. https://doi.org/10.1080/02678373.2014.1003994

Navarro, D., Montserrat, C., Malo, S., Gonzàlez, M., Casas, F., & Crous, G. (2017). Subjective well-being: What do adolescents say? *Child & Family Social Work*, *22*(1), 175-184.

Nestel, D., Hui, J., Kunkler, K., Scerbo, M. W., & Calhoun, A. W. (2019). *Healthcare Simulation Research*. Springer.

Newman, A., Donohue, R., & Eva, N. (2017). Psychological safety: A systematic review of the literature. *Human Resource Management Review*, *27*(3), 521-535.

Nielsen, K. (2017). Leaders can make or break an intervention–but are they the villains of the piece? *Leading to Occupational Health and Safety: How Leadership Behaviours Impact Organizational Safety and Wellbeing: How Leadership Behaviours Impact Organizational Safety and Wellbeing*, 197-210.

Nielsen, K., Nielsen, M. B., Ogbonnaya, C., Känsälä, M., Saari, E., & Isaksson, K. (2017). Workplace resources to improve both employee well-being and performance: A systematic review and meta-analysis. *Work & Stress*, *31*(2), 101-120.

Nielsen, K., Randall, R., Yarker, J., & Brenner, S.-O. (2008). The effects of transformational leadership on followers' perceived work characteristics and psychological well-being:

A longitudinal study. *Work & Stress*, *22*(1), 16-32. https://doi.org/10.1080/02678370801979430

Nielsen, M. B., Eid, J., Mearns, K., & Larsson, G. (2013). Authentic leadership and its relationship with risk perception and safety climate. *Leadership & Organization Development Journal*, *34*(4), 308-325.

Nix, G. A., Ryan, R. M., Manly, J. B., & Deci, E. L. (1999). Revitalization through self-regulation: The effects of autonomous and controlled motivation on happiness and vitality. *Journal of Experimental Social Psychology*, *35*(3), 266-284.

Noblet, A., & LaMontagne, A. (2006). The role of workplace health promotion in addressing job stress. *Health Promotion International*, *21*(4), 346-353. https://doi.org/10.1093/heapro/dal029

Noblet, A. J., & Rodwell, J. J. (2010). Workplace health promotion. *Occupational Health Psychology*, *157*, 193.

Northouse, P. G. (2021). *Leadership: Theory and practice*. Sage Publications.

Novicevic, M., Harvey, M., Buckley, M., Brown, J., & Evans, R. (2006). Authenticity in executive behavior: theorizing leadership on Barnard's foundations. *Journal of Leadership and Organizational Studies*, *13*(1), 64-76.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847.

NZ. Government. (2023). *Government Contact Details*. Retrieved from https://www.govt.nz/organisations/mail-merge/

O'Reilly, C. A., & Chatman, J. (1986). Organizational commitment and psychological attachment: The effects of compliance, identification, and internalization on prosocial behavior. *Journal of Applied Psychology*, *71*(3), 492.

O’Donnell, M. (2002). Preface. In J. S. H. Michael P. O'Donnell (Ed.), *Health promotion in the workplace.* (3rd ed.). Delmar Publishers.

O’Reilly, M., & Parker, N. (2013). ‘Unsatisfactory Saturation’: a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research*, *13*(2), 190-197.

Oates, J. (2015). Use of Skype in interviews: The impact of the medium in a study of mental health nurses. *Nurse Researcher*, *22*(4).

Ogbonnaya, C., & Valizade, D. (2018). High performance work practices, employee outcomes and organizational performance: a 2-1-2 multilevel mediation analysis. *The International Journal of Human Resource Management*, *29*(2), 239-259.

Oishi, S., Diener, E., Lucas, R. E., & Suh, E. M. (2009). Cross-cultural variations in predictors of life satisfaction: Perspectives from needs and values. *Culture and well-being: The collected works of Ed Diener*, 109-127.

Okoye, P., & Ezejiofor, R. A. (2013). The effect of human resources development on organizational productivity. *International Journal of Academic Research in Business and Social Sciences*, *3*(10), 250.

Onwuegbuzie, A. J., Johnson, R. B., & Collins, K. M. (2009). Call for mixed analysis: A philosophical framework for combining qualitative and quantitative approaches. *International Journal of Multiple Research Approaches*, *3*(2), 114-139.

Organ, D. W., & Paine, J. B. (1999). A new kind of performance for industrial and organizational psychology: Recent contributions to the study of organizational citizenship behavior.

Oswald, A. J., Proto, E., & Sgroi, D. (2015). Happiness and productivity. *Journal of Labor Economics*, *33*(4), 789-822.

Otis, N., & Pelletier, L. G. (2005). A motivational model of daily hassles, physical symptoms, and future work intentions among police officers 1. *Journal of Applied Social Psychology*, *35*(10), 2193-2214.

Oxford English Dictionary. (2024). well-being, n. In *Oxford English Dictionary*.

Page, K. M., & Vella, B. D. A. (2009). The 'what','why'and 'how'of employee well-being: A new model. *Social Indicators Research*, *90*, 441-458.

Parker, S. K. (1998). Enhancing role breadth self-efficacy: the roles of job enrichment and other organizational interventions. *Journal of Applied Psychology*, *83*(6), 835.

Parker, S. K., Williams, H. M., & Turner, N. (2006). Modeling the antecedents of proactive behavior at work. *Journal of Applied Psychology*, *91*(3), 636.

Pavot, W., & Diener, E. (2008). The satisfaction with life scale and the emerging construct of life satisfaction. *The Journal of Positive Psychology*, *3*(2), 137-152. https://doi.org/10.1080/17439760701756946

Pawirosumarto, S., Sarjana, P. K., & Muchtar, M. (2017). Factors affecting employee performance of PT. Kiyokuni Indonesia. *International Journal of Law and Management*, *59*(4), 602-614.

Peters, S. E., Grogan, H., Henderson, G. M., López Gómez, M. A., Martínez Maldonado, M., Silva Sanhueza, I., & Dennerlein, J. T. (2021). Working conditions influencing drivers' safety and well-being in the transportation industry:"on board" program. *International Journal of Environmental Research and Public Health*, *18*(19), 10173.

Peus, C., Wesche, J. S., Streicher, B., Braun, S., & Frey, D. (2012). Authentic leadership: An empirical test of its antecedents, consequences, and mediating mechanisms. *Journal of Business Ethics*, *107*, 331-348.

Piccolo, R. F., & Colquitt, J. A. (2006). Transformational leadership and job behaviors: The mediating role of core job characteristics. *Academy of Management Journal*, *49*(2), 327-340.

Platania, S., Morando, M., Caruso, A., & Scuderi, V. E. (2022). The effect of psychosocial safety climate on engagement and psychological distress: A multilevel study on the healthcare sector. *Safety*, *8*(3), 62. https://doi.org/10.3390/safety8030062

Podsakoff, N. P., Whiting, S. W., Podsakoff, P. M., & Blume, B. D. (2009). Individual-and organizational-level consequences of organizational citizenship behaviors: A meta-analysis. *Journal of Applied Psychology*, *94*(1), 122.

Podsakoff, P. M., MacKenzie, S. B., Lee, J.-Y., & Podsakoff, N. P. (2003). Common method biases in behavioral research: a critical review of the literature and recommended remedies. *Journal of Applied Psychology*, *88*(5), 879.

Podsakoff, P. M., MacKenzie, S. B., & Podsakoff, N. P. (2012). Sources of method bias in social science research and recommendations on how to control it. *Annual Review of Psychology*, *63*, 539-569.

Preacher, K. J., & Hayes, A. F. (2008). Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behavior Research Methods*, *40*(3), 879-891.

Raina, R. (2022). Moving crisis to opportunities: A corporate perspective on the impact of compassionate empathic behaviour on the well-being of employees. *International Journal of Global Business and Competitiveness*, *17*(2), 239-255.

Reichers, A. E., & Schneider, B. (1990). Climate and culture: An evolution of constructs. *Organizational Climate and Culture*, *1*, 5-39.

Reiter, S., Stewart, G., & Bruce, C. (2011). A strategy for delayed research method selection: Deciding between grounded theory and phenomenology. *Electronic Journal of Business Research Methods*, *9*(1), 35-46.

Richardson, H. A., Simmering, M. J., & Sturman, M. C. (2009). A tale of three perspectives: Examining post hoc statistical techniques for detection and correction of common method variance. *Organizational Research Methods*, *12*(4), 762-800.

Richer, S. F., Blanchard, C., & Vallerand, R. J. (2002). A motivational model of work turnover. *Journal of Applied Social Psychology*, *32*(10), 2089-2113.

Rockmann, K. W., & Vough, H. C. (2023). Using quotes to present claims: practices for the writing stages of qualitative research. *Organizational Research Methods*, 10944281231210558.

Rode, J. C. (2004). Job satisfaction and life satisfaction revisited: A longitudinal test of an integrated model. *Human Relations*, *57*(9), 1205.

Roskin, M. G., Cord, R. L., Medeiros, J. A., & Jones, W. S. (2012). *Political Science: An Introduction* (12th ed.). Pearson.

Rudolph, C. W., Murphy, L. D., & Zacher, H. (2020). A systematic review and critique of research on "healthy leadership". *The Leadership Quarterly*, *31*(1). https://doi.org/10.1016/j.leaqua.2019.101335

Russell, B. (1930). The Conquest of Happiness (Liveright, New York, NY). *Original work published*.

Ryan, R. M. (1982). Control and information in the intrapersonal sphere: An extension of cognitive evaluation theory. *Journal of Personality and Social Psychology*, *43*(3), 450.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*(1), 68-78.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology*, *52*(1), 141-166.

Ryan, R. M., Duineveld, J. J., Di Domenico, S. I., Ryan, W. S., Steward, B. A., & Bradshaw, E. L. (2022). We know this much is (meta-analytically) true: A meta-review of meta-analytic findings evaluating self-determination theory. *Psychological Bulletin*, *148*(11-12), 813.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, *57*(6), 1069.

Ryff, C. D. (1995). Psychological well-being in adult life. *Current Directions in Psychological Science*, *4*(4), 99-104. https://doi.org/10.1111/1467-8721.ep10772395

Ryff, C. D., Boylan, J. M., & Kirsch, J. A. (2021). Eudaimonic and hedonic well-being: An integrative perspective with linkages to sociodemographic factors and health. In *Measuring well-being: Interdisciplinary perspectives from the social sciences and the humanities.* (pp. 92-135). Oxford University Press. https://doi.org/10.1093/oso/9780197512531.003.0005

Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, *69*(4), 719.

Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry*, *9*(1), 1-28.

Ryff, C. D., & Singer, B. H. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of Happiness Studies*, *9*(1), 13-39.

Samad, A., Muchiri, M., & Shahid, S. (2021). Investigating leadership and employee well-being in higher education. *Personnel Review*, *ahead-of-print*(ahead-of-print). https://doi.org/10.1108/pr-05-2020-0340

Santa Maria, A., Wolter, C., Gusy, B., Kleiber, D., & Renneberg, B. (2019). The Impact of Health-Oriented Leadership on Police Officers' Physical Health, Burnout, Depression and Well-Being. *Policing: A Journal of Policy and Practice*, *13*(2), 186-200. https://doi.org/10.1093/police/pay067

Sarwar, G., Cavaliere, L. P. L., Ammar, K., & Afzal, F. U. (2021). The impact of servant leadership on employee performance. *International Journal of Management (IJM)*, *12*(5), 165-173.

Saunders, M. N. K., Lewis, P., & Thornhill, A. (2019). *Research Methods For Business Students* (Eighth ed.). Pearson.

Schafer, J. L., & Graham, J. W. (2002). Missing data: our view of the state of the art. *Psychological Methods*, *7*(2), 147.

Schreiber, J. B., Nora, A., Stage, F. K., Barlow, E. A., & King, J. (2006). Reporting structural equation modeling and confirmatory factor analysis results: A review. *The Journal of Educational Research*, *99*(6), 323-338.

Schriesheim, C., & Kerr, S. (1974). Psychometric properties of the Ohio State leadership scales. *Psychological Bulletin*, *81*(11), 756.

Schruijer, S. G., & Vansina, L. S. (2002). Leader, leadership and leading: From individual characteristics to relating in context. *Journal of Organizational Behavior*, 869-874.

Schulman, M. (2002). How we become moral: The sources of moral motivation. In C. R. Synder & S. J. Lopez (Eds.), *Handbook of Positive Psychology* (pp. 499-512). Oxford University Press.

Schwarz, G., Newman, A., Cooper, B., & Eva, N. (2016). Servant leadership and follower job performance: The mediating effect of public service motivation. *Public Administration*, *94*(4), 1025-1041.

Segbenya, M., & Okorley, E. N. A. (2022). Effect of teleworking on working conditions of workers: A post-COVID-19 lockdown evaluation. *Human Behavior and Emerging Technologies*, *2022*.

Semmer, N. K. (2006). Job stress interventions and organization of work. *Scandinavian Journal of Work, Environment & Health*, *32*(6), 515-527. https://doi.org/doi.org/10.5271/sjweh.1056

Sender, G., Nobre, G. C., Armagan, S., & Fleck, D. (2021). In search of the Holy Grail: A 20-year systematic review of the happy-productive worker thesis. *International Journal of Organizational Analysis*, *29*(5), 1199-1224.

Sendjaya, S. (2015). Personal and organizational excellence through servant leadership. *Australia: Springer International Publishing Switzerland*.

Seo, M. G., Bartunek, J. M., & Barrett, L. F. (2010). The role of affective experience in work motivation: Test of a conceptual model. *Journal of Organizational Behavior*, *31*(7), 951-968.

Shaheen, M., Gupta, R., & Kumar, Y. (2016). Exploring dimensions of teachers' OCB from stakeholder's perspective: A study in India. *The Qualitative Report*, *21*(6), 1095.

Shain, M., & Kramer, D. M. (2004). Health promotion in the workplace: Framing the concept; reviewing the evidence. *Occupational and Environmental Medicine*, *61*(7), 643-648, 585. https://doi.org/10.1136/oem.2004.013193

Shamir, B. (2007). From passive recipients to active co-producers: Followers' roles in the leadership process. *Follower-centered perspectives on leadership: A tribute to the memory of James R. Meindl*, 9-39.

Shamir, B., House, R. J., & Arthur, M. B. (1993). The motivational effects of charismatic leadership: A self-concept based theory. *Organization Science*, *4*(4), 577-594.

Shartle, C. L. (1979). Early years of the Ohio State University leadership studies. *Journal of Management*, *5*(2), 127-134.

Shee, P. Y., Dollard, M. F., & Idris, M. A. (2025). How psychosocial safety climate affects employee well-being via basic psychological needs: A longitudinal multilevel moderated mediation study. *Journal of Applied Psychology*.

Sheer, V. C. (2015). "Exchange lost" in leader–member exchange theory and research: A critique and a reconceptualization. *Leadership*, *11*(2), 213-229.

Shirey, M. R. (2009). Authentic leadership, organizational culture, and healthy work environments. *Critical Care Nursing Quarterly*, *32*(3), 189-198.

Siegrist, J. (1996). Adverse health effects of high-effort/low-reward conditions. *Journal of Occupational Health Psychology*, *1*(1), 27.

Sinclair, A. (2005). *Doing leadership differently: Gender, power and sexuality in a changing business culture*. Melbourne University Publishing.

Skakon, J., Nielsen, K., Borg, V., & Guzman, J. (2010). Are leaders' well-being, behaviours and style associated with the affective well-being of their employees? A systematic review of three decades of research. *Work & Stress*, *24*(2), 107-139. https://doi.org/10.1080/02678373.2010.495262

Skiba, T., & Wildman, J. L. (2019). Uncertainty reducer, exchange deepener, or self-determination enhancer? Feeling trust versus feeling trusted in supervisor-subordinate relationships. *Journal of Business and Psychology*, *34*(2), 219-235.

Slemp, G. R., Kern, M. L., Patrick, K. J., & Ryan, R. M. (2018). Leader autonomy support in the workplace: A meta-analytic review. *Motivation and Emotion*, *42*(5), 706-724.

Small Business Council NZ. (2019). *Defining Small Business Recommendations of the New Zealand Small Business Council for the Minister of Small Business*. Retrieved from https://www.mbie.govt.nz/assets/defining-small-business.pdf

Smith, H. L., & Krueger, L. M. (1933). A brief summary of literature on leadership. *Bulletin of the School of Education, Indiana University.*, *9*(4), 3-80.

Sonnentag, S., & Frese, M. (2003). Stress in organizations. In *Handbook of psychology: Industrial and organizational psychology, Vol. 12.* (pp. 453-491). John Wiley & Sons, Inc. https://doi.org/10.1002/0471264385.wei1218

Soper, D. (2023). *Free Statistics Calculators*. https://www.danielsoper.com/statcalc/default.aspx

Sorensen, G., Barbeau, E., Hunt, M. K., & Emmons, K. (2004). Reducing social disparities in tobacco use: a social-contextual model for reducing tobacco use among blue-collar workers. *American Journal of Public Health*, *94*(2), 230-239.

Sosik, J. J., & Godshalk, V. M. (2000). Leadership styles, mentoring functions received, and job-related stress: A conceptual model and preliminary study. *Journal of Organizational Behavior*, *21*(4), 365-390. https://doi.org/10.1002/(SICI)1099-1379(200006)21:4<365::AID-JOB14>3.0.CO;2-H

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*(10), 1372-1380.

Staw, B. M., Sutton, R. I., & Pelled, L. H. (1994). Employee positive emotion and favorable outcomes at the workplace. *Organization Science*, *5*(1), 51-71.

Stogdill, R. M. (1948). Personal factors associated with leadership: A survey of the literature. *The Journal of Psychology*, *25*(1), 35-71.

Stordeur, S., D'hoore, W., & Vandenberghe, C. (2001). Leadership, organizational stress, and emotional exhaustion among hospital nursing staff. *Journal of Advanced Nursing*, *35*(4), 533-542.

Tabakhnick, B., & Fidell, L. S. (2007). Using multivariate statistics. In: Boston: Allyn & Boco.

Tafvelin, S., Armelius, K., & Westerberg, K. (2011). Toward Understanding the Direct and Indirect Effects of Transformational Leadership on Well-Being. *Journal of Leadership & Organizational Studies*, *18*(4), 480-492. https://doi.org/10.1177/1548051811418342

Tamminen, K. A., & Poucher, Z. A. (2020). Research Philosophies. In *The Routledge International Encyclopedia of Sport and Exercise Psychology* (pp. 535-549). Routledge. https://doi.org/10.4324/9781315187259-39

Tariq, A., Bukhari, S. M. I., & Adil, A. (2021). Perceived organizational support as the moderator between psychosocial safety climate and organizational citizenship behaviour among nurses. *Foundation University Journal of Psychology*, *5*(2).

Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches* (Vol. 46). Sage Publications Inc.

Tatarkiewicz, W. (1976). Analysis of happiness. The Hague, the Netherlands: Martinus Nijhoff. *Diener, E.(1984). Subjective well-being. Psychological Bulletin*, *95*(3), 558.

Taussig, F. W., & Joslyn, C. S. (1932). *American business leaders: a study in social origins and social stratification.* Macmillan Company, New York.

Taylor, C., Dollard, M. F., Clark, A., Dormann, C., & Bakker, A. B. (2019). Psychosocial safety climate as a factor in organisational resilience: Implications for worker psychological health, resilience, and engagement. In *Psychosocial safety climate: A new work stress theory* (pp. 199-228). Springer.

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*. Sage.

Terglav, K., Ruzzier, M. K., & Kaše, R. (2016). Internal branding process: Exploring the role of mediators in top management's leadership–commitment relationship. *International Journal of Hospitality Management*, *54*, 1-11.

Thomas, C. H., & Lankau, M. J. (2009). Preventing burnout: The effects of LMX and mentoring on socialization, role stress, and burnout. *Human Resource Management: Published in Cooperation with the School of Business Administration, The University of Michigan and in alliance with the Society of Human Resources Management*, *48*(3), 417-432.

Thompson, N., & Livingston, W. (2018). Promoting Well-Being. *Illness, Crisis & Loss*, *26*(2), 98-110. https://doi.org/10.1177/1054137316643445

Topp, C. W., Ostergaard, S. D., Sondergaard, S., & Bech, P. (2015). The who-5 well-being index: A systematic review of the literature. *Psychotherapy and Psychosomatics*, *84*(3), 167-176. https://doi.org/10.1159/000376585

Tourish, D. (2019). *Management studies in crisis: Fraud, deception and meaningless research*. Cambridge University Press.

Trépanier, S.-G., Fernet, C., & Austin, S. (2012). Social and motivational antecedents of perceptions of transformational leadership: A self-determination theory perspective. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement*, *44*(4), 272.

Tsang, E. W. (2016). *The philosophy of management research* (1st ed.). Routledge. https://doi.org/10.4324/9781315463216

Tucker, L. R., & Lewis, C. (1973). A reliability coefficient for maximum likelihood factor analysis. *Psychometrika*, *38*(1), 1-10.

Turgut, S., Schlachter, S., Michel, A., & Sonntag, K. (2019). Antecedents of Health-Promoting Leadership and Workload as Moderator. *Journal of Leadership & Organizational Studies*, *27*(2), 203-214. https://doi.org/10.1177/1548051819848988

Umbrella Wellbeing NZ. (2023). *Navigating workload and wellbeing in Aotearoa New Zealand: Umbrella wellbeing report May 2023.* https://umbrella.org.nz/umbrellawellbeingreport/

Van den Broeck, A., Ferris, D. L., Chang, C.-H., & Rosen, C. C. (2016). A review of self-determination theory's basic psychological needs at work. *Journal of Management*, *42*(5), 1195-1229.

Van den Broeck, A., Vansteenkiste, M., De Witte, H., & Lens, W. (2008). Explaining the relationships between job characteristics, burnout, and engagement: The role of basic psychological need satisfaction. *Work & Stress*, *22*(3), 277-294.

Van Dierendonck, D. (2011). Servant leadership: A review and synthesis. *Journal of Management*, *37*(4), 1228-1261.

van Dierendonck, D., Haynes, C., Borrill, C., & Stride, C. (2004). Leadership behavior and subordinate well-being. *Journal of Occupational Health Psychology*, *9*(2), 165-175. https://doi.org/10.1037/1076-8998.9.2.165

Vandenberg, R. J., Park, K.-O., DeJoy, D. M., Wilson, M. G., & Shannon Griffin-Blake, C. (2002). The healthy work organization model: Expanding the view of individual health and well being in the workplace. In *Historical and current perspectives on stress and health* (pp. 57-115). Emerald Group Publishing Limited.

Vander Elst, T., Van den Broeck, A., De Witte, H., & De Cuyper, N. (2012). The mediating role of frustration of psychological needs in the relationship between job insecurity and work-related well-being. *Work & Stress*, *26*(3), 252-271.

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, *18*, 1-18.

Veer, E., Golf-Papez, M., & Zahrai, K. (2019). Using the Socio-Ecological Model as an Holistic Approach to Behavioural Change. In *Macro-Social Marketing Insights* (pp. 54-71). Routledge.

Vincent-Höper, S., & Stein, M. (2019). The role of leaders in designing employees' work characteristics: validation of the health-and development-promoting leadership behavior questionnaire. *Frontiers in Psychology*, *10*, 1049. https://doi.org/10.3389/fpsyg.2019.01049

Vincent, S. (2012). Analysis tool for leadership behavior that is conducive to health and development: A validation study. *Zeitschrift für Arbeitswissenschaft*, *66*, 41-60. https://doi.org/10.1007/BF03373859

Viswanathan, M. (2005). *Measurement error and research design*. Sage.

Vivarelli, S., & Fenga, C. (2024). Workplace health promotion program: An integrated intervention to promote well-being among healthcare workers. *Public Health Toxicology*, *4*(3), 1-8.

Vroom, V. H., & Yetton, P. W. (1973). *Leadership and decision-making* (Vol. 110). University of Pittsburgh Press.

Wallander, J. L., & Koot, H. M. (2016). Quality of life in children: A critical examination of concepts, approaches, issues, and future directions. *Clinical Psychology Review*, *45*, 131-143.

Walumbwa, F. O., Avolio, B. J., Gardner, W. L., Wernsing, T. S., & Peterson, S. J. (2008). Authentic leadership: Development and validation of a theory-based measure. *Journal of Management*, *34*(1), 89-126.

Wang, H., Law, K. S., Hackett, R. D., Wang, D., & Chen, Z. X. (2005). Leader-member exchange as a mediator of the relationship between transformational leadership and followers' performance and organizational citizenship behavior. *Academy of Management Journal*, *48*(3), 420-432.

Warr, P. (2008). Environmental "vitamins", personal judgments, work values, and happiness. In *The Oxford Handbook of Organizational Well Being* (1 ed., pp. 57-85). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199211913.003.0004

Warr, P. (2011). *Work, happiness, and unhappiness* (1 ed.). Psychology Press. https://doi.org/10.4324/9780203936856

Warr, P. (2012). How to think about and measure psychological well-being. In *Research methods in occupational health psychology* (pp. 76-90). Routledge.

Warr, P., & Nielsen, K. (2018). Wellbeing and work performance. *Handbook of Well-being*, 1-22.

Waterman, A. S. (1993). Two conceptions of happiness: Contrasts of personal expressiveness (eudaimonia) and hedonic enjoyment. *Journal of Personality and Social Psychology*, *64*(4), 678.

Weber, M., & Eisenstadt, S. N. (1969). *Max Weber on Charisma and Institution Building: Selected Papers*. Chicago : University of Chicago Press.

Wei, F., Li, Y., Zhang, Y., & Liu, S. (2018). The interactive effect of authentic leadership and leader competency on followers' job performance: The mediating role of work engagement. *Journal of Business Ethics*, *153*(3), 763-773.

Western, S. (2019). Leadership: A critical text. In (3rd ed., pp. 456). SAGE Publications Ltd.

Whatmore, L., Cartwright, S., & Cooper, C. (1999). Evaluation of a stress management program in the public sector. In *MAJ Kompier, & CL Cooper, Preventing stress, improving productivity: European case studies in the workplace*. Routledge.

WHO. (1986). Ottawa Charter for Health Promotion. First International Conference on Health Promotion,

Williams, C. (2007). Research methods. *Journal of Business & Economics Research (JBER)*, *5*(3).

Williams, G. C., Halvari, H., Niemiec, C. P., Sørebø, Ø., Olafsen, A. H., & Westbye, C. (2014). Managerial support for basic psychological needs, somatic symptom burden and work-related correlates: A self-determination theory perspective. *Work & Stress*, *28*(4), 404-419.

Williams, L. J., & Anderson, S. E. (1991). Job satisfaction and organizational commitment as predictors of organizational citizenship and in-role behaviors. *Journal of Management*, *17*(3), 601-617.

Wilson, W. R. (1967). Correlates of avowed happiness. *Psychological Bulletin*, *67*(4), 294.

Wolff, J. (2023). *An introduction to political philosophy*. Oxford University Press.

Wolor, C. W., Ardiansyah, A., Rofaida, R., Nurkhin, A., & Rababah, M. A. (2022). Impact of toxic leadership on employee performance. *Health psychology research*, *10*(4).

Wong, C., & Cummings, G. (2009). Authentic leadership: a new theory for nursing or back to basics? *Journal of Health Organization and Management*, *23*(5), 522-538. https://doi.org/10.1108/14777260910984014

Wong, C. A., & Laschinger, H. K. (2013). Authentic leadership, performance, and job satisfaction: the mediating role of empowerment. *Journal of Advanced Nursing*, *69*(4), 947-959. https://doi.org/10.1111/j.1365-2648.2012.06089.x

Wong, C. A., Spence Laschinger, H. K., & Cummings, G. G. (2010). Authentic leadership and nurses' voice behaviour and perceptions of care quality. *Journal of Nursing Management*, *18*(8), 889-900.

Workplace Wellness Report. (2021). *Workplace Wellness Report 2021*. https://www.businessnz.org.nz/resources/surveys-and-statistics/wellness-in-the-workplace-survey/Southern-Cross-Health-Insurance-BusinessNZ-Workplace-Wellness-Report-2021.pdf

WorkSafe. (2021). *Work-related health*. New Zealand: New Zealand Government Retrieved from https://data.worksafe.govt.nz/editorial/work_related_health

World Health Organization. (1946). *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference*. New York Retrieved from https://www.who.int/about/governance/constitution

Wright, B. E., Hassan, S., & Park, J. (2016). Does a public service ethic encourage ethical behaviour? Public service motivation, ethical leadership and the willingness to report ethical problems. *Public Administration*, *94*(3), 647-663.

Wright, T. A., & Cropanzano, R. (2000). Psychological well-being and job satisfaction as predictors of job performance. *Journal of Occupational Health Psychology*, *5*(1), 84.

Wright, T. A., & Staw, B. M. (1999). Further thoughts on the happy–productive worker. *Journal of Organizational Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior*, *20*(1), 31-34.

Wu, T.-C., Chen, C.-H., & Li, C.-C. (2008). A correlation among safety leadership, safety climate and safety performance. *Journal of Loss Prevention in the Process Industries*, *21*(3), 307-318.

Wyatt, S., & Fraser, J. (1925). *Studies in repetitive work with special reference to rest-pauses*. Industrial Fatigue Research Board. Great Britain.

Yammarino, F. J., Spangler, W. D., & Bass, B. M. (1993). Transformational leadership and performance: A longitudinal investigation. *The Leadership Quarterly*, *4*(1), 81-102.

Yao, L., Li, P., & Wildy, H. (2021). Health-Promoting Leadership: Concept, Measurement, and Research Framework. *Frontiers in Psychology*, *12*, 602333. https://doi.org/10.3389/fpsyg.2021.602333

Yarker, J., Lewis, R., & Donaldson-Feilder, E. (2008). *Management competencies for preventing and reducing stress at work: identifying the management behaviours necessary to implement the management standards: phase two*. Goldsmiths, University of London.

Yasin Ghadi, M., Fernando, M., & Caputi, P. (2013). Transformational leadership and work engagement: The mediating effect of meaning in work. *Leadership & Organization Development Journal*, *34*(6), 532-550.

Yavaş, A. (2016). Sectoral differences in the perception of toxic leadership. *Procedia-Social and Behavioral Sciences*, *229*, 267-276. https://doi.org/10.1016/j.sbspro.2016.07.137

Yukl, G. (1993). A retrospective on Robert House's "1976 theory of charismatic leadership" and recent revisions. *The Leadership Quarterly*, *4*(3-4), 367-373.

Yukl, G. A., & Van Fleet, D. D. (1982). Cross-situational, multimethod research on military leader effectiveness. *Organizational Behavior and Human Performance*, *30*(1), 87-108.

Zadow, A., Dollard, M. F., Parker, L., & Storey, K. (2019). Psychosocial safety climate: a review of the evidence. In *Psychosocial safety climate: A new work stress theory* (pp. 31-75).

Zhang, B., & Morris, J. L. (2014). High-performance work systems and organizational performance: testing the mediation role of employee outcomes using evidence from PR China. *The International Journal of Human Resource Management*, *25*(1), 68-90.

Zohar, D. (1980). Safety climate in industrial organizations: theoretical and applied implications. *Journal of Applied Psychology*, *65*(1), 96.

Zohar, D. (2002). The effects of leadership dimensions, safety climate, and assigned priorities on minor injuries in work groups. *Journal of Organizational Behavior*, *23*(1), 75-92.

Zohar, D., & Luria, G. (2005). A multilevel model of safety climate: cross-level relationships between organization and group-level climates. *Journal of Applied Psychology*, *90*(4), 616.

Appendices

Appendix I: Full Ethics Approval Letter for Quantitative Studies

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

5/09/2022

Dear: Mubshra Sattar

Re: Ethics Application - SOB 22/12 - Understanding the drivers of supervisors' health-promoting behaviours through the development of a multi-level model

Thank you for the above application that was considered by the Massey University Human Ethics Committee: Southern B at their meeting held on 14 April 2022.

On behalf of the Committee, I am pleased to advise you that on 5 August 2022 the ethics of your application were approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely



Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 951 6841; 06 95106840
E humanethics@massey.ac.nz; animalethics@massey.ac.nz; gtc@massey.ac.nz

Appendix II: Invitation Email to Organisations for Quantitative Studies

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

MASSEY BUSINESS SCHOOL
TE KURA WHAI PAKIHI

School of Management | Te Kāhui Kahurangi
Private Bag 102904, North Shore Mail Centre, Auckland 0745 T: +64 9 414 0800
Private Bag 11 222, Manawatu Mail Centre, Palmerston North 4442 T: +64 6 356 9099
http://management.massey.ac.nz

Dear members of HR department,

Subject: Invitation for employees to participate in survey

My name is Mubshra Sattar, and I am a Ph.D. student at Massey University, New Zealand. I am conducting research to explore the contextual and motivational factors that drive supervisors to care for their subordinates' health and wellbeing. I am particularly interested in understanding the extent to which supervisors' (a) perceptions of the organizational Psychosocial Safety Climate, (b) perceived work autonomy, and (c) authenticity relate to their motivation to engage in health promoting behaviours. My research also examines the impact of these behaviours on subordinates' wellbeing and performance outcomes and the role of resulting subordinate trust in making supervisors persistently engage in these behaviours.

To explore these linkages, I would like to invite the employees of your organization to an online survey to seek their views about study variables. Participation in this survey can provide your organization important insights and opportunities for wellbeing initiatives for your staff.

You are requested to kindly circulate the information about this survey to the employees (at all levels) who are working in their current role for at least six months. Employees can access the survey through this link which should not take more than 10 minutes to complete. The survey is anonymous and participation in the survey is completely voluntary. Participants can quit the survey at any time. Information received through the survey will be safely stored and will be used only for the present research. No personal/identifying information will be asked at any stage of the research and confidentiality of the acquired data will be ensured at all costs.

At the end of the study, if your organization would like a summary of the findings, you can contact me, and I will send you out a copy. In addition, I can also present and discuss research findings via a Zoom seminar.

If you have any questions about this survey or would like further information, please contact:

- Mubshra Sattar (Principal Researcher): mubshra.sattar.1@uni.massey.ac.nz
- Prof. Bevan Catley (Primary Supervisor): b.e.catley@massey.ac.nz

Thank you for considering the participation of your employees in this survey.

Yours sincerely
Mubshra Sattar
School of Management, Massey University

This template is to be used only for the purposes of Postgraduate Student research

MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND
MASSEY BUSINESS SCHOOL
School of Management | Te Kāhui Kahurangi
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Private Bag 11 222, Manawatu Mail Centre, Palmerston North 4442 T: +64 6 356 9099
http://management.massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 22/12. If you have any concerns about the conduct of this research, please contact Dr Gerald Harrison, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83570, email humanethicsouthb@massey.ac.nz.

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Appendix III: Information Sheet for Participants – Quantitative Studies

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

MASSEY BUSINESS SCHOOL
TE KURA WHAI PAKIHI

School of Management | Te Kāhui Kahurangi
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Understanding the drivers of supervisors' health-promoting behaviours through the development of a multi-level model

INFORMATION SHEET FOR PARTICIPANTS

My name is Mubshra Sattar, and I am conducting this study as part of my Ph.D. thesis. I am interested in exploring the contextual and motivational factors that drive supervisors to care for their subordinates' health and wellbeing. I am particularly interested in understanding the extent to which supervisors' (a) perceptions of the organizational Psychosocial Safety Climate, (b) perceived work autonomy, and (c) authenticity relate to their motivation to engage in health promoting behaviours. The research further examines the impact of these behaviours on subordinates' wellbeing and performance outcomes and the role of resulting subordinate trust in making supervisors persistently engage in these behaviours.

I am undertaking an online survey that will take approximately 15 minutes to complete. You can participate in this survey if you have been working in your current role for at least six months. The survey is anonymous and participation in the survey is completely voluntary. No information that could identify participants will be asked. All data will be aggregated and no individual identifying information will be contained in the thesis.

Information collected from the survey will be stored on a secure computer and will only be used for this research project. Only my supervisors and I will have access to the data. The data will be analysed to examine participants' perceptions of the study variables to find relationships among them.

At the end of the study, if you would like a summary of the findings, you can contact me, and I will send you a copy.

Your Rights

You are under no obligation to accept this invitation.

If you decide to participate, you have the right to:

- Decline to answer any question.
- Withdraw from the study at any time before the submission of your responses.
- Ask any questions about the study at any time during participation.
- Be given access to a summary of the project findings when it is concluded.

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Please contact me via email at mubshra.sattar.1@uni.massey.ac.nz or Prof. Bevan Catley (my supervisor) at b.e.catley@massey.ac.nz if you have any questions about the project.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 22/12. If you have any concerns about the conduct of this research, please contact Dr Gerald Harrison, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83570, email humanethicsouthb@massey.ac.nz.

This template is to be used only for the purposes of Postgraduate Student research

Appendix IV: Participants' Demographics (Quantitative Studies 1 and 2)

Demographic Information							
		Total		**Non-managers**		**Managers**	
		n	**%**	***n***	**%**	***n***	**%**
Gender	Male	120	22.1	65	21.9	55	24.6
	Female	390	71.8	224	75.4	166	74.1
	Gender Diverse	11	2	8	2.7	3	1.3
	Missing	22	4.1				
Age	25 or under	40	7.4	36	12.1	4	1.8
	26 to 34	101	18.6	67	22.6	34	15.2
	35 to 54	242	44.6	123	41.4	119	53.1
	55 to 64	120	22.1	58	19.5	62	27.7
	65 and over	18	3.3	13	4.4	5	2.2
	Missing	22	4.1				
Contract Type	Permanent	454	83.6	235	79.1	219	96.5
	Fixed Term	54	9.9	49	16.5	5	2.2
	Casual	5	0.9	5	1.7	0	0
	Contractor	3	0.6	2	0.7	1	0.4
	Other	8	1.5	6	2	2	0.9
	Missing	19	3.5				
Work Hours	0 to 39 hours	203	37.4	147	49.7	56	24.7
	40 to 45 hours	233	42.9	119	40.2	114	50.2
	Above 45 hours	87	16	30	10.1	57	25.1
	Missing	20	3.7				
Industry	Transport, Postal & Warehousing	13	2.4	6	2	7	3.2
	Public administration and safety	65	12	38	12.9	27	12.3
	Professional, Scientific and Technical Services	30	5.5	14	4.7	16	7.3
	Information Media and Telecommunications	8	1.5	4	1.4	4	1.8
	Electricity, Gas, Water and Waste Services	5	0.9	4	1.4	1	0.5
	Construction	8	1.5	2	0.7	6	2.7
	Agriculture, Forestry and Fishing	6	1.1	3	1	3	1.4
	Health Care and Social Assistance	54	9.9	30	10.2	24	10.9
	Retail Trade	5	0.9	4	1.4	1	0.5
	Education and Training	249	45.9	143	48.5	106	48.2
	Manufacturing	6	1.1	5	1.7	1	0.5
	Other	66	12.2	42	14.2	24	10.9
	Missing	28	5.2				

Appendix V: Permission Letter to use Authentic Leadership Questionnaire

Permission for Mubshra Sattar to reproduce 1 copy within three years of January 20, 2022

Authentic Leadership Questionnaire Instrument and Scoring Guide

English

by Bruce J. Avolio, William L. Gardner, & Fred O. Walumbwa

Research Permission

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www.mindgarden.com

IMPORTANT NOTE

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The above-named person has made a license purchase from Mind Garden, Inc. and has permission to administer the following copyrighted instrument up to that quantity purchased:

Authentic Leadership Questionnaire

The four sample items only from this instrument as specified below may be included in your thesis or dissertation. Any other use must receive prior written permission from Mind Garden. The entire instrument may not be included or reproduced at any time in any other published material. Please understand that disclosing more than we have authorized will compromise the integrity and value of the test.

Citation of the instrument must include the applicable copyright statement listed below. Sample Items:

As a leader I….

say exactly what I mean
demonstrate beliefs that are consistent with actions
solicit views that challenge my deeply held
positions seek feedback to improve interactions
with others

My leader….

says exactly what he or she means
demonstrates beliefs that are consistent actions solicits
views that challenge his or her deeply held positions
seeks feedback to improve interactions with others

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Sincerely,



Robert Most
Mind Garden, Inc.
www.mindgarden.com

Appendix VI: CFA Fit Statistics for Constructs of Study 1 (Phase I)

Measures	χ2/df	GFI	CFI	TLI	SRMR	RMSEA
Authentic Leadership (16 items)	3.83	0.83	0.79	0.76	0.07	0.11
Authentic Leadership (13 items)	1.91	0.93	0.96	0.94	0.05	0.06
Autonomy	2.77	0.95	0.98	0.97	0.02	0.09
Trust	2.25	0.95	0.97	0.96	0.05	0.07
PSC	2.44	0.94	0.98	0.97	0.03	0.08

The value of chi-square statistics (χ2/df = Chi-square/degree of freedom) ranges between 2 and 5 (Hooper et al., 2008).

Values of GFI = Goodness of Fit Index, CFI = Comparative Fit Index, TLI = Tucker–Lewis index range between 0 and 1; values > 0.9 are adequate and values ≥ 0.95 represent a good fit (Schreiber et al., 2006).

NFI is sensitive to sample size therefore, it is not reported as a goodness of fit measure (Hooper et al., 2008). CFI, which is a revised form of NFI, was used instead because it takes into account the sample size and performs well even when the sample size is small (Tabakhnick & Fidell, 2007).

Value for SRMR = Standardized Root Mean square Residual range between 0 and 0.8, representing adequate fit (Hu & Bentler, 1999).

Fit values for RMSEA (Root Mean Square Error of Approximation) indicate a very close approximate fit if the value falls between 0.00 to 0.05 (Hu & Bentler, 1999), a good data fit if values are between 0.06 to 0.08, a moderate data fit for the values between 0.08 to 0.10 and a poor fit for values > 0.1 (MacCallum et al., 1996).

Appendix VII: CFA Fit Statistics for Constructs of Study 2 (Phase I)

Measures	$\chi 2/df$	GFI	CFI	TLI	SRMR	RMSEA
Healthy Leadership	2.11	0.83	0.94	0.93	0.05	0.06
PWB	3.46	0.98	0.99	0.98	0.02	0.09
Performance	2.90	0.98	0.96	0.93	0.04	0.08

The value of chi-square statistics ($\chi 2/df$ = Chi-square/degree of freedom) ranges between 2 and 5 (Hooper et al., 2008).

Values of GFI = Goodness of Fit Index, CFI = Comparative Fit Index, TLI = Tucker–Lewis index range between 0 and 1; values > 0.9 are adequate and values ≥ 0.95 represent a good fit (Schreiber et al., 2006).

NFI is sensitive to sample size therefore, it is not reported as a goodness of fit measure (Hooper et al., 2008). CFI, which is a revised form of NFI, was used instead because it takes into account the sample size and performs well even when the sample size is small (Tabakhnick & Fidell, 2007).

Value for SRMR = Standardized Root Mean square Residual range between 0 and 0.8, representing adequate fit (Hu & Bentler, 1999).

Fit values for RMSEA (Root Mean Square Error of Approximation) indicate a very close approximate fit if the value falls between 0.00 to 0.05 (Hu & Bentler, 1999), a good data fit if values are between 0.06 to 0.08, a moderate data fit for the values between 0.08 to 0.10 and a poor fit for values > 0.1 (MacCallum et al., 1996).

Appendix VIII: Low Risk Notification – Qualitative Studies

MASSEY UNIVERSITY
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UNIVERSITY OF NEW ZEALAND

26/03/2023

Dear: Mubshra Sattar

Re: Low Risk Notification - 4000027076 - Understanding the drivers of supervisors' health promoting leadership behaviours.

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our database for inclusion in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please contact a Research Ethics Administrator.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 3569099 ext 85271, email humanethics@massey.ac.nz."

Please note, if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to complete the application form again, answering "yes" to the publication question to provide more information for one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely



Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 951 6841; 06 95106840
E humanethics@massey.ac.nz; animalethics@massey.ac.nz; gtc@massey.ac.nz

Appendix IX: Invitation Email for Managerial Participants – Qualitative Study 1

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Private Bag 11 222, Manawatu Mail Centre, Palmerston North 4442 T: +64 6 356 9099
http://management.massey.ac.nz

Subject: Invitation to participate in Interview

Many thanks for participating in my survey on health-promoting leadership behaviours last year. You expressed your interest in the follow-up interview phase.

I am pleased to invite you to participate in a Zoom interview (approximately 25 to 40 minutes), which will explore the factors that motivate supervisors to engage in health promoting behaviours and outcomes associated with those behaviours. This study will have wide reaching benefits and may provide organizations important insights and opportunities for wellbeing initiatives for their staff that may lead to enhanced wellbeing and better work performance.

Please read the attached information sheet carefully before deciding whether or not to participate. Once you have done this, would you please email your intention to participate via a return email. Your decision to participate in this study is purely voluntary and your confidentiality will be maintained. If you decide to participate, I thank you. If you decide not to take part, there will be no disadvantage to you of any kind and I thank you for considering my request.

At the end of the study, if you would like a summary of the findings, you can contact me, and I will send you out a copy.

If you have any questions about this study or would like further information, please contact:

- Mubshra Sattar (Principal Researcher): mubshra.sattar.1@uni.massey.ac.nz
- Prof. Bevan Catley (Primary Supervisor): b.e.catley@massey.ac.nz

Thank you for your time and consideration, and for your help with this research study.

Yours sincerely
Mubshra Sattar
School of Management, Massey University

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named in this document is responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 3569099 ext 85271, email humanethics@massey.ac.nz

Appendix X: Information Sheet for Participants – Qualitative Studies

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http://management.massey.ac.nz

Understanding the drivers of supervisors' health-promoting leadership behaviours.

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this research. My name is Mubshra Sattar, and I am conducting this study as part of my Ph.D. thesis. This research is conducted across two phases. The first phase was a survey you recently participated in, while the second phase is a follow-up interview. Interviews will be conducted with a group of managers and an unrelated group of non-managers from a different organization. The purpose of the interviews with managers is to explore what drives them to engage in health promoting behaviours at work. The interviews with non-supervisors will explore the impact of managers' health promoting behaviours on their work and wellbeing related outcomes. The interviews will also explore which supervisor behaviours are seen as most important by their staff.

The interviews will be audio taped and transcribed. Information collected from the interview will be stored on a secure computer and will only be used for this research project. Only my supervisors and I will have access to the data. At the end of the project any identifying information will be destroyed immediately. However, as required by the University's research policy, any de-identified raw data on which the results of the project depend will be retained in secure storage for at least five years, after which it will be destroyed. Research outputs in the form of a thesis or publications will not identify any individuals or any participating organizations.

Your Rights:

You are under no obligation to accept this invitation.
If you decide to participate, you have the right to:

- Decline to answer any particular questions(s) if you feel hesitant or uncomfortable to answer because semi-structured interviews could involve some questions which have not been determined in advance but will depend on the way in which the interview develops.
- Withdraw from the interview at any time.
- Ask any questions about the study at any time during participation.
- Get a summary of the project findings when it is concluded by contacting me, and I will send you a copy of the findings.

Please contact me at mubshra.sattar.1@uni.massey.ac.nz or Prof. Bevan Catley (my supervisor) at b.e.catley@massey.ac.nz if you have any questions about the project.

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named in this document is responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 3569099 ext 85271, email humanethics@massey.ac.nz

Appendix XI: Invitation Email for Non-Managerial Participants – Qualitative Study 2

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Private Bag 11 222, Manawatu Mail Centre, Palmerston North 4442 T: +64 6 356 9099
http://management.massey.ac.nz

Subject: Invitation to participate in Interview

Many thanks for participating in my survey on health-promoting leadership behaviours last year. You expressed your interest in the follow-up interview phase.

I would like to invite you to participate in a Zoom/Teams interview to explore how you see healthy leadership at your workplace. The interview will take between 20-40 minutes. Participation is voluntary and confidential; no information which could identify participants will be released.

Please read the attached information sheet carefully before deciding whether to participate. If you would like to take part, please email me on mubshra.sattar.1@uni.massey.ac.nz. If you do not want to take part, there will be no disadvantage to you of any kind and I thank you for considering my request.

At the end of the study, if you would like a summary of the findings, you can contact me, and I will send you out a copy.

If you have any questions about this study or would like further information, please contact:

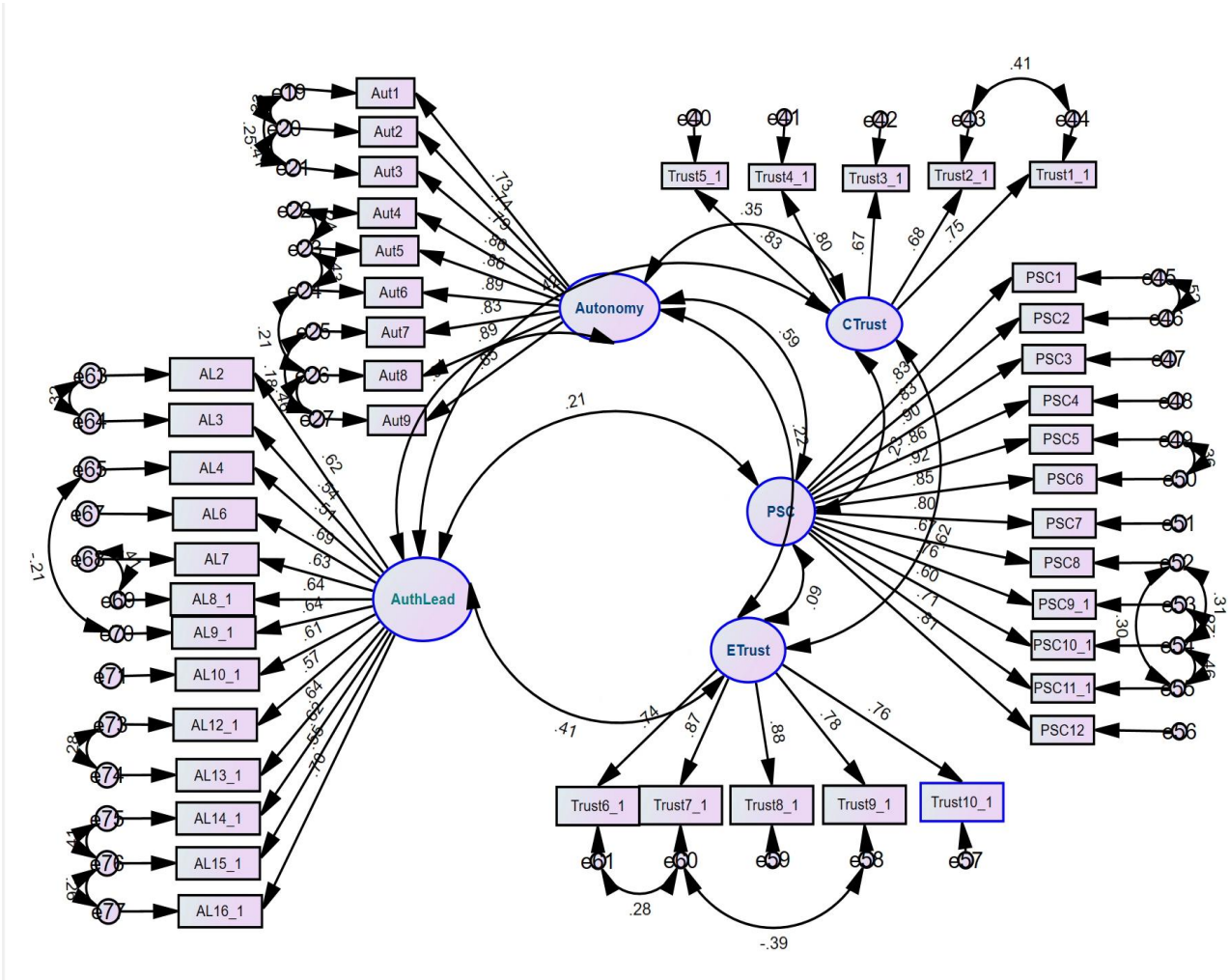
- Mubshra Sattar (Principal Researcher): mubshra.sattar.1@uni.massey.ac.nz
- Prof. Bevan Catley (Primary Supervisor): b.e.catley@massey.ac.nz

Thank you for your time and consideration, and for your help with this research study.

Yours sincerely
Mubshra Sattar
School of Management, Massey University

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named in this document is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 3569099 ext 85271, email humanethics@massey.ac.nz

Appendix XII: CFA diagram of the measurement model-Study 1



Appendix XIII: CFA diagram of the measurement model-Study 2

