Organizational attachment and health

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ABSTRACT

The current study examines whether psychological attachment to an organization is related to employee health. This is an important research question because, while employees' psychological attachment benefits organizational productivity and lowers turnover, it is unclear whether and why such an attachment might benefit employees themselves. Data collected from > 400 studies (N = 230,983) in which nine types of organizational attachment and four types of health outcomes were measured showed that, although different types of organizational attachment were highly correlated, they demonstrated some significantly different relationships with health outcomes. For example, psychological ownership and organization-based self-esteem demonstrated the strongest relationships with employee health, whereas perceived insider status and organizational embeddedness demonstrated the weakest relationships. In addition, variables that captured deep bonds (e.g., organization-based self-esteem) had stronger relationships with health than did those that captured weaker bonds (e.g., person-organization fit). Results underscore the need for more attention to the close relationship between organizational attachment and health in general, and the similarities and differences across various specific types of organizational attachment and health.

Many organizations strive to keep their employees attached (Park & Shaw, 2013; Rousseau, 1998). Having a psychologically attached workforce is important, as those employees are often more satisfied and productive than employees who are less attached (Hunter & Thatcher, 2007; Vandenberg & Lance, 1992). Promoting employee health has also gained worldwide attention (Ganster & Rosen, 2013; Michel, O'Shea, & Hoppe, 2015), because when employees are mentally and physically healthy, organizational productivity is likely to be enhanced (Ford, Cerasoli, Higgins, & Decresare, 2011; Trumble & Pattath, 2013).

These two streams of research, organizational attachment (OA) and health, have developed independently. The goal of this study is to understand the theoretical foundation that underlies the OA-health relationship, test the strength of the overall relationship, and consider similarities and differences across various indicators of OA and health. In doing so, we make three important contributions. First, OA is a key job attitude that sustains motivation and productivity (Harrison, Newman, & Roth, 2006; Meyer, Stanley, Herscovitch, & Topolnitsky, 2002). In turn, managers give greater support to those who are seen to have greater OA, as they are viewed as loyal employees who merit more resources (Shore, Barksdale, & Shore, 1995; Shore, Bommer, & Shore, 2008; Yun, Takeuchi, & Liu, 2007). Although it is established that OA benefits the organization, whether and why OA benefits employees remains elusive. While many studies have included measures of OA and health, the OA-health relationship has been a by-product of studying other relationships rather than a focus. The OA-health relationship is important to examine because over-investment into work has often been associated with undermined health (e.g., Sonnentag & Fritz, 2015). If there is evidence that OA promotes health, it can provide a more balance and accurate view of the relationship between work and health.
Second, many constructs have been examined as specific indicators of OA (Stamper & Masterson, 2002) and of health (Robbins, Ford, & Tetrick, 2012), and the overlap between some of these indicators (e.g., depression and burnout) has also been highlighted (Schoenfeld & Bianchi, 2016). An integrated consideration of these constructs is needed because if they overlap to a large extent, then treating them separately hinders research growth. It is indeed not uncommon that organizational constructs are similar (LePine, Erez, & Johnson, 2002; Morrow, 1983), which in turn impedes theory development, as new theories might be offered for slightly different variables that could in fact be parsimoniously explained by a single framework (Le, Schmidt, Harter, & Lauver, 2010; Singh, 1991). Conversely, if the various indicators of OA and of health are distinct, then a finer-grained approach to understanding the OA-health relationship is warranted. This study contributes to the literature by offering theoretical and empirical evidence on both the similarities and the differences across various OA and health indicators, thereby laying the necessary groundwork for integrating and differentiating subareas of research. Third, this study relies on attachment theory (Bowlby, 1988) to suggest that being attached to the organization can promote employee health. This premise represents an extension of attachment theory, which has largely focused on attachment in interpersonal relationships (e.g., parents and children, husband and wife, teachers and students). Because employees have a tendency to personify their employers (Ashman & Winstanley, 2007; Levinson, 1965), it is likely that the benefits accrued from attachment to people are observable in an employment context, too. As individuals spend much of their time in their jobs (Dutton, Roberts, & Bednar, 2010), the effects of their psychological attachment to the organizations are unlikely to be negligible.

1. Construct Issues

1.1. The Nature of OA

OA is a stabilizing psychological force that ties an individual to an organization (Shapiro, Hom, Shen, & Agarwal, 2016). It represents a perception that one is closely linked or strongly bonded with the organization and that the organization is a core component in the individual's sphere of life (Ashforth & Mael, 1989; Morrow, 2011). Furthermore, it is an organization-targeted attitude that serves an important functional purpose: It frames employees' perceptions of their organizations in positive ways that provide employees with purpose and direction to their jobs. When OA is strong, employees have legitimate reasons to see to it that their organizations do well, which in turn enables them to find meaning in their work and the motivation to work hard on behalf of the organization (Meyer, Becker, & Vandenberghe, 2004; Rosso, Dekas, & Wrzesniewski, 2010). This motivational argument is similar to that of Meyer and Herscovitch (2001), who suggest that, regardless of the form and reason, OA binds an individual to a course of action specified within the terms of the employment relationship.

Below we consider nine types of OA. These constructs can be treated as indicators of OA because they share similarities that reflect the fundamental principles or components of psychological attachments noted above, such as a strong sense of being tied to the target, the belief that the target is an important entity in one's life, and giving meaning to one's behavior (Mikulincer & Shaver, 2007; Pietomonaco, Uchino, & Schetter, 2013). These nine constructs all focus on employees' feelings of being attached to the organization but not on organizational actions toward the employees, as felt attachment is constructed internally through making sense of one's relationship with an external target. For this reason, we excluded constructs like perceived organizational support (Eisenberger, Huntington, Hutchison, & Sowa, 1986).

1.1.1. Organizational commitment

Affective organizational commitment (or organizational commitment hereafter) refers to a sense of belonging to an organization (Meyer et al., 2002; Meyer, Allen, & Gellatly, 1990) and is driven largely by positive emotional feelings about the organization (O'Reilly & Chatman, 1986). It represents a type of OA that broadly captures a “want-to” stay mentality (Meyer et al., 2004), believed to be the result of a high-quality exchange between the organization and the employee (Meyer et al., 2002). This positive, emotion-filled psychological force (Allen & Meyer, 1990) motivates employees to dedicate their energy and time to the employment relationship (Markvits, Ullrich, Van Dick, & Davis, 2008) and buffers negative workplace experiences (Rivkin, Diestel, & Schmidt, 2015). Organizational commitment remains the most commonly studied form of OA (Morrow, 2011).

1.1.2. Organizational trust

Organizational trust is the degree to which employees are willing to become vulnerable to an organization's behavior (Dirks & Ferrin, 2002; McAllister, 1995). Employees with strong organizational trust believe that the future conduct of the organization will be positive (Lewicki, McAllister, & Bies, 1998) and thus are willing to rely on it despite the risk that it might not follow through on its obligations (Colquitt, Scott, & LePine, 2007; Mayer, Davis, & Schoorman, 1995). Due to the risk involved and an acceptance of that risk, a high level of organizational trust motivates efforts that serve the organization's interests (Williams, 2001).

1.1.3. Organizational identification

Organizational identification is the extent to which employees see an organization as part of their identity (Ashforth, Harrison, & Gorley, 2008; Ashforth & Mael, 1989). Employees with strong organizational identification perceive the essence of an organization as self-defining. Organizational identification thus represents a deep-level psychological phenomenon and emerges through a continuous cognitive process of sense-making of positive events pertinent to the organization (Ashforth et al., 2008; Rousseau, 1998).
1.1.4. Person-organization fit
Person-organization fit is the extent to which employees' values are consistent with those of the organization (Cable & DeRue, 2002; Kristof-Brown, Zimmerman, & Johnson, 2005). Although such congruence itself is not a binding force, it provides the psychological basis to develop stronger attachment to the organization (Kim, Aryee, Loi, & Kim, 2013). For instance, when value congruence is high, employees' needs are satisfied, which in turn enhances their positive attitudes toward the organization (Cable & Edwards, 2004).

1.1.5. Organizational embeddedness
Organizational embeddedness is the extent to which employees are enmeshed in their organization (Crossley, Bennett, Jex, & Burnfield, 2007). It consists of three components: fit with the organization, links to people and activities, and sacrifices if they leave (Mitchell, Holtom, Lee, Sablynski, & Erez, 2001). Together, these components keep employees tethered to the organization, especially when fit is strong, links are abundant, and sacrifice is high. Thus, organizational embeddedness overall represents a stable binding force that psychologically ties an employee to the organization.

1.1.6. Organization-based self-esteem
Organization-based self-esteem is the extent to which people believe that they are capable, significant, and worthy organizational members (Pierce, Gardner, Cummings, & Dunham, 1989). It reflects the belief that “I count around here”; when it is high, employees develop a strong sense of competence working for the organization (Pierce & Gardner, 2004). As individuals often have strong self-enhancement needs (Sedikides, 1993; Wells, 2001), such an employment relationship should be satisfying to them, thereby leading to the growth of a solid psychological bond (McAllister & Bigley, 2002; Pierce et al., 1989).

1.1.7. Psychological ownership
Psychological ownership is the degree to which employees feel possessive of an organization (Pierce, Kostova, & Dirks, 2001). This type of OA involves the “It's mine” belief. The explicit focus on possessiveness of the organization is the most distinguishing aspect of psychological ownership (Avey, Avolio, Crossley, & Luthans, 2008; Van Dyne & Pierce, 2004), which creates a deep sense of bonding to the organizations.

1.1.8. Perceived insider status
Perceived insider status is the extent to which employees see themselves as insiders within their organization (Stamper & Masterson, 2002). It involves the feeling that one has earned a personal space and acceptance inside the organization (Chen & Aryee, 2007). Perceived insider status might initially be just a membership perception, but can later become the basis of an employment relationship in which employees feel worthy of staying and of their contributions (Hui, Lee, & Wang, 2015; Wang & Kim, 2013).

1.1.9. Relational psychological contracts
Relational psychological contracts are employee expectations of their obligations and entitlements (Rousseau, 1989, 1995). Relational psychological contracts are said to exist when employees define and interpret their obligations broadly and are willing to further invest into the employment relationship (Conway & Briner, 2002; Lambert, Edwards, & Cable, 2003). Relational psychological contracts, thus, go beyond purely economic terms to include loyalty in exchange for long-term support and growth (Raja, Johns, & Ntalians, 2004).

In brief, the nine aforementioned variables are all indicators of one's OA. Other researchers have also viewed these variables as convergent, further justifying their conceptualization as representations of OA (Cable & DeRue, 2002; Cooper-Hakim & Viswesvaran, 2005; Han, Chiang, McConville, & Chiang, 2015; Knapp, Smith, & Sprinkle, 2014; Masterson & Stamper, 2003; Pierce et al., 2001; Stamper & Masterson, 2002).

1.2. The nature of health outcomes
Health is one's mental and physical well-being (Ford et al., 2011; Pascoe & Richman, 2009). According to the World Health Organization, mental health is a psychological state in which a person realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Put in a simpler way, it is a psychological state in which one functions satisfactory. Physical health, then, is the physical state of a person functioning satisfactorily. In occupational health psychology, two additional variables are used to represent employee health: low levels of job burnout and job strain. These two variables are important indicators of employee health, as there is robust evidence that high levels of these psychological variables severely hinder employees from functioning satisfactorily (Lee & Ashforth, 1996; Sonnentag, Venz, & Casper, 2017).

Job burnout is a response to chronic stress and comprises three specific dimensions (Lee & Ashforth, 1996; Maslach, Schaufeli, & Leiter, 2001). Emotional exhaustion is the degree to which one feels drained and void of energy. Depersonalization (or cynicism) is the extent to which a detached, cynical, and callous response to others and to objects is developed. Reduced sense of accomplishment (or loss of professional efficacy) is the degree to which one lacks a feeling of productivity and achievement and devalues his worth as a professional. Whereas job burnout captures one's diminishing psychological capacity to perform her work role (Halbesleben & Buckley, 2004), job strain is not confined to specific dimensions and is often broadly defined as any negative affective and cognitive state that emerges in response to stressful work (De Croon, Sluiter, Blonk, Broersen, & Frings-Dresen, 2004; Ford et al., 2014), such as
feeling anxious, irritable, or frustrated.

Mental health, physical health, low job burnout, and low job strain are likely to be positively correlated, and we thus treat all four of them as indicators of health. First, the ways stressors and other variables (e.g., OA) induce these health outcomes are likely to be similar (e.g., through resource depletion, through attachment benefits) (Baba, Jamal, & Tourigny, 1998; Pascoe & Richman, 2009; Robbins et al., 2012). Second, it can be argued that work well-being (low levels of job burnout, job strain) is a component of overall well-being. Health is a product of experiences in different life domains (Binder & Ward, 2013). Work constitutes a major sphere of life for most adults (Gini, 1998; Pryor & Davies, 1989). As Dutton et al. (2010) note, “work as a life domain is important for self-construction. Most people will spend large portions of their adult lives at work.” (p. 266). Thus, employees’ overall health can be partially reflected in people's low level of job burnout and job strain, alongside mental and physical health. This broad perspective of health is widely adopted. For instance, Xanthopoulos, Bakker, and Illies (2012) note, “well-being [that is, health] may be used as a general ‘umbrella’ term that encompasses different constructs” (p. 1054). Grant, Christanson, and Price (2007) similarly call for a less restricted, more holistic view on the meaning of employee health.

In addition, mental health and physical health are reciprocally linked. That is, a person with positive mental health has better bodily functioning and fewer health complaints (e.g., stomachache, headache, insomnia, fatigue, muscle pain), and vice versa (Hay, Marshall, Wang, & Sherbourne, 1994). For instance, those who have depression report more physical health complaints (Gates, Petterson, Wingrove, Miller, & Klink, 2016), whereas those with poor physical health report less positive emotions and self-concepts (Folkins & Sime, 1981). Similarly, job burnout and strain might be inseparable in the long run; burnout is a chronic response to highly stressful jobs that create acute psychological strains (Ganster & Schaumbrock, 1991; Halbesleben & Buckley, 2004). Furthermore, health threats (job burnout, job strain) accumulate to build mental and physical health problems, whereas generic mental and physical health problems hamper employees’ capacity to cope with job demands that cause job burnout and strain (Ganster & Rosen, 2013; Kahill, 1988).

2. Hypothesis development

2.1. Theoretical foundation of the relationship between OA and health

To feel attached to a social target is a fundamental need of humans (Baumeister & Leary, 1995). Attachment theory suggests that a close bond with an attachment figure has functional and protective effects on the individual (Bowlby, 1988). Feeling attached provides one psychological shelter, which one can use to shield away fear and hurtful feelings and to look for reassurance (Pietromonaco et al., 2013). Thus, attachment is therapeutic (Mikulincer & Shaver, 2007).

While attachment theory originally focused on attachment figures (e.g., parents) that are more powerful than the focal person (e.g., infants), subsequent research extends its application to include any figure that can provide resources (e.g., spouses, best friends) (Collins & Feeney, 2000; La Guardia, Ryan, Couchman, & Deci, 2000). As such, an organization, as a resource provider, can also be an attachment figure. Indeed, Levinson (1965) notes that employees might personify organizations, especially when the organization controls employees’ resources.

Being attached to an organization should relate to better health. Even though the underlying processes are largely psychological, and thus predominantly enhance mental health, they should have positive effects on one’s physical health, too, as the entire body functionality and immune system is enhanced in the presence of a secured attachment (Luyten, Van Houdenhove, Lemna, Target, & Fonagy, 2013). Conversely, insecure attachment has been linked to higher body-mass index (Hintsanen, Jokela, Pulkkki-Raback, Viikari, & Keltikangas-Jarvinen, 2010) and reporting more inflammation-based illnesses (Puig, Englund, Simpson, & Collins, 2013).

First, Dykas and Cassidy (2011) suggest that those with secure attachment adopt a mental model that draws on their positive attachment-related knowledge to process information in a positive way. Secured individuals are able to remember positive, trust-related events and tend to see and understand the world with a positive mindset that culminates in better health (Mikulincer, 1998). Extending these cognitive benefits to an employment relationship, perhaps employees who feel securely and persistently attached to their organizations might hold more positive mental frames, such as being more upbeat and optimistic at work (Rom & Mikulincer, 2003; Silverman, 1998; Simmons, Nelson, & Quick, 2003).

Second, being attached promotes a more positive self-concept; people who feel securely attached to an attachment figure are more likely to see themselves as individuals of worth and develop a sense of mattering (RaqueBogdan, Erisson, Jackson, Martin, & Byran, 2011). In other words, secure attachment dispels negative beliefs about oneself, as one feels loved by others (Bowlby, 1988). As positive self-concepts can buffer stress, anxiety, and depression, employees who are attached securely and persistently to an organization might report fewer such problems.

Third, another benefit of attachment is that it dispels negative beliefs about others; one anticipates the attachment figure to be supportive in stressful situations (Bowlby, 1988). Confidence in protection, thus, is the key reason why attachment enhances health (Dickstein, 1999; Meuwly, Bodenmann, Bardury, Ditzen, & Heinrichs, 2012). Similarly, OA might promote health because employees anticipate enduring and long-term organization protection in times of need, alleviating their stress, burnout, and personal problems (Feeney, 2000).

Fourth, Bowlby (1988) noted that individuals treat themselves as they were treated by their attachment figures, with a secured attachment leading to better self-treatment. This self-respect mechanism might apply to the employment relationship too. When employees feel compassionately attached to an organization, they might become more compassionate about treating themselves positively, including maintaining good health (Neff & McGhee, 2010).

Finally, a secure attachment fulfills individuals’ socioemotional needs, or the need for approval, esteem, and affiliation (Keller,
For instance, when employees feel safely attached to the firm, they might feel approved by the firm as a recognized organizational member, feel integrated with the firm of which they are proud, and feel protected by the firm. When socioemotional needs are consistently satisfied, individuals' affective well-being is likely to be enhanced (Easterbrooks & Biringer, 2000; Ryan & Frederick, 1997), thereby promoting health.

Empirically, researchers observed that attachment to a partner was associated with greater mental health (Galinha, Oishi, Pereira, Wirtz, & Esteves, 2014) and greater physical health (Joplin, Nelson, & Quick, 1999). Even recalling the mental image of the attachment figure enables individuals to garner positive thoughts and dispel negative thoughts (Selcuk, Zayas, Gunaydin, Hazan, & Kross, 2012). In contrast, insecure attachment is associated with more negative emotions, poorer health, greater maladaptation, and more visits to doctors (Feeney & Ryan, 1994; McWilliams & Bailey, 2010) across infants, children, adolescents, and adults (Hazan & Shaver, 1987).

In sum, on the basis of attachment theory, we predict that greater OA is linked to more positive employee health. Although organizations are not persons, it is the feelings of being attached to and belonging to an entity that generates the health benefits discussed above, such as positive self-evaluation, positive mental frames, positive perceptions of others, and satisfaction of socioemotional needs. Those without OA might be deprived of these attachment benefits. As noted by Baumeister and Leary (1995), “if belongingness is indeed a fundamental need, then, aversive reactions to a loss of belongingness should go beyond negative affect to include some types of pathology” (p. 500). Moreover, these attachment benefits are even more apparent over time; as time progresses, employee bonding becomes stronger and more stable, and the organization becomes a long-term attachment figure.

**H1.** OA positively relates to employee health.

### 2.2. Fine-grained approaches

The nine constructs of OA, though sharing similarities as discussed before, are fundamentally distinctive. First, the bases of attachment are different. For instance, organizational commitment captures a sense of belonging (Mathieu & Zajac, 1990) whereas person-organization fit captures value congruence (Kristof-Brown et al., 2005). Second, some OA constructs largely focus on the past and present experience with the firm; for instance, organizational embeddedness is based on fit, links, and sacrifice accumulated over the course of the employment relationship. Other OA constructs focus on anticipated relationships with the firm; for instance, relational psychological contracts are based on promises and expectations that the organization will be developmental. Third, as explained below, some OA constructs capture a deep bond in which one's self-concept is affected by the firm, whereas other OA constructs capture a psychological bond that does not involve incorporation of one's self-concept.

More specifically, as OA benefits health largely through an attachment mechanism, those OA constructs that characterize a deeper psychological bond should demonstrate greater effects on health. That is, those that signify one’s extended self-concept into the relationship with the organization, including organizational identification, organization-based self-esteem, and psychological ownership should capture deep OA. These three types of OA are based on employees' perceptions that the organization is well integrated with their lives, including their identity (captured by organizational identification; Ashforth et al., 2008; Lee, Park, & Koo, 2015), self-evaluation (captured by organization-based self-esteem; Pierce & Gardner, 2004), and fate (captured by psychological ownership; Pierce et al., 2001). In each of these three types of OA, much is at stake because the well-being of the organization determines the well-being of the employees. Pierce et al. (2001) similarly highlight that those with strong psychological ownership see the organization as part of their identity and self-concept, suggesting that psychological ownership, organizational identification, and organization-based self-esteem all converge to capture a deep form of bonding that entails mental integration of the self and the organization, thereby generating more attachment benefits.

Conversely, several OA constructs capture a relatively weak form of bonding; those OA types that simply tie the individuals to the organizational membership but do not necessarily create any deep-level integration might have weaker attachment benefits. Among the nine OA constructs, organizational embeddedness, person-organization fit, and perceived insider status characterize employees' perceptions that they are somewhat linked to the organization, although the attachment force itself might not really affect their own self-concepts and mental processes. Organizational embeddedness, for example, can be predominantly driven by not wanting to sacrifice the accumulated stakes rather than a deeply held affective bond (Crossley et al., 2007). Similarly, person-organization fit might merely indicate value similarity between employees and the organization (Cable & DeRue, 2002), although that similarity does not necessarily lead to the development of a deep attachment. Perceived insider status represents a membership perception (Stamper & Masterson, 2002), but that membership might or might not resonate strongly with the employees. Thus, these three types of OA should generate weaker attachment benefits. The above discussion leads us to expect that:

**H2.** Deep OA relates to health more strongly than does weak OA.

The various health outcomes we examine (mental health, physical health, low job burnout, low job strain) are also fundamentally distinct. Specifically, mental health and physical health problems can be generated by different stressors (e.g., being undermined mainly creates mental health problems, while bad eating habits mainly creates physical health problems). Thus, treating them as interchangeable is not appropriate in some situations. Job burnout and job strain are also fundamentally distinctive. Job burnout is an accumulated response to job stressors; employees are unlikely to experience this health threat (e.g., diminished sense of accomplishment) in a short period. On the contrary, job strain, such as worries, can emerge in even just a few days. In addition, job burnout captures an avoidance orientation that an employee distances himself from further harm in his job role (Cordes & Dougherty, 1993), while job strain often involves negative activating psychological states such as anxiety, distress, and irritability (Spector, Chen,
Finally, job burnout and strain might contribute to mental and physical health problems over time, but the two are distinct (Toker & Biron, 2012). As overall well-being reflects the well-being in various domains (e.g., work, marital relationships, family lives, personal hobbies, religions etc.; Binder & Ward, 2013; Hsieh, 2016), it can be argued that job burnout and strain is not the same as mental and physical health.

The abovementioned differences among the four health outcomes lead us to expect significant differences in their strength of the relationship with OA constructs. First, low levels of job burnout and strain reflect well-being in the work domain (Ganster & Schaubroeck, 1991; Halbesleben & Buckley, 2004), whereas mental and physical health reflect one’s overall well-being (Ford et al., 2011). A generally accepted tenet in organizational research is that one can expect stronger relationships among phenomena that are at the same level of abstraction (Behson, 2002). As OA emerges from the work domain, it should accordingly have stronger effects on health outcomes that reflect one’s work well-being, including low levels of burnout and strain.

**H3.** OA relates to work-specific health (i.e., low levels of job burnout and job strain) more strongly than to mental and physical health.

In addition, OA represents a psychological construct that should more strongly affect one’s psychological well-being than one’s physical well-being. Even if better psychological well-being ultimately leads to better physical well-being (Gates et al., 2016; Hay et al., 1994), OA’s effects are still likely to be indirect. As OA, low levels of burnout and strain and mental health all capture psychological forces whereas physical health does not, OA should have stronger effects on these health outcomes than on physical health. Thus, we expect that:

**H4.** The relationship between OA and physical health is weaker than is the relationship between OA and mental health aggregated with work-specific health (i.e., low level of job burnout and job strain).

### 3. Method

#### 3.1. Article search

We began our article search by using keywords in 11 business and psychology databases, including EBSCOHost, Emerald, Factiva, JSTOR, Oxford Journals, Proquest, PsycINFO, ScienceDirect, Sage Full-Text Collections, Wiley InterScience, and Digital Dissertation Consortium. To be thorough, we set the search period to cover articles published in the last 50 years (1967–2017). The first set of keywords was pertinent to OA. They include “organizational commitment,” “person-organization fit,” “organization-based self-esteem,” “organizational identification,” “organizational trust,” “job or organizational embeddedness,” “perceived insider status,” “psychological ownership,” “perceived organizational membership,” and “relational psychological contracts.”

The second set of keywords was health-related and included employees’ “mental well-being,” “physical well-being,” “depression,” “psychological distress,” “anxiety,” “illness/sickness/diseases,” “health complaints,” “health symptoms,” “body mass index,” “fatigue,” “burnout,” “emotional exhaustion,” “cynicism,” “depersonalization,” “professional accomplishment,” “negative mood,” “anger,” “hostility,” “job stress,” and “job strain.”

The above keywords were used in each of the aforementioned 11 databases. In addition, in each search, only one keyword was used. The searches identified > 2000 articles. We retained 398 articles that included abstracts that mentioned at least one OA variable and one health variable, and the text provided correlation values. Adopting this exclusion rule increased the likelihood that the retained articles had relevant effect sizes.

Several exclusion criteria were further applied. Six articles that did not operationalize the variables in ways consistent with our study’s conceptualization of OA and health were excluded. Eight articles that measured job stressors, rather than reactions to those stressors, were excluded. Second, six experimental investigations were excluded, as the strength of effect sizes might be dependent upon the strength of researchers’ manipulation. Third, five articles that used student samples were excluded, as these respondents were not actively participating in the labor market to fully experience the effects of OA on health. Fourth, as OA and health are both individual-level phenomena, two articles that examined the relationship at an aggregate level were excluded. Finally, as our focus is on OA, two articles that examined attachment to a profession or to a union were excluded.

The above steps resulted in a total of 364 articles, which contained 401 studies (N = 230,983). There were 21 dissertations. Eleven percent (11%) were published before 2000, 37% between 2000 and 2010, and 52% in 2011 or after. Across studies that provided sample information, the average age was 38 (18–60 years old, SD = 9), 55% were women, 76% were Caucasians, 59% were married, 59% had children, and 65% had at least some college education. The average job and organizational tenure was 8 and 9 years, respectively. A complete list of the studies included in the meta-analysis is available from the authors upon request.

The OA measures, health measures, and internal consistency estimates were coded by the first author. Following Finkelstein, Burke, and Raju (1995), two researchers blind to the purpose of the project were invited to independently code the studies. One researcher coded a random sample of 100 articles (about 25%), whereas the other coded the remaining articles. The coding provided by these two researchers was compared with the original coding conducted by the first author. Overall coding agreement was 95%. Discussion was undertaken to reach an agreement when there were discrepancies.

#### 3.2. Measures

*Organizational commitment* involved measures of affective commitment. Meyer, Allen, and Smith’s (1993) scale was frequently...
used. Measures of organizational trust and identification used the organization as the target. In cases in which researchers measured components of organizational trust, such as affective and cognitive trust, effect sizes were averaged. Robinson and Rousseau’s (1994) scale was commonly adopted. As managers represent the organization (Mayer & Gavrin, 2005), trust in management was also treated as an indicator of organizational trust, following other researchers (e.g., Harvey, Kelloway, & Duncan-Leiper, 2003). Thus, organizational trust in this study broadly captures employees’ trust in either their organizations or managers who act on behalf of the organizations. Mael and Ashforth’s (1992) scale was frequently used to measure organizational identification.

**Person-organization fit** was operationalized with two approaches. Under the objective approach, employees’ values and those of the organization were compared, with greater congruence indicating greater person-organization fit (Dylag, Jaworek, Karwowski, Kozusznik, & Marek, 2013; George & Chattopadhyay, 2005). Under the subjective approach, employees were asked to report the extent to which they felt they fit their organization (Chen & Chiu, 2008), using Cable and DeRue’s (2002) or other scales. Although subjective fit is conceptually distinct from objective fit (Edwards, Cable, Williamson, Lambert, & Shipp, 2006), we combined them here based on Judge and Cable’s (1997) observation that subjective fit mediated the effects of objective fit on outcomes. In other words, these two types of fit tend to converge and overlap.

**Organizational embeddedness** was operationalized with two approaches: objective and subjective. Under the objective approach, embeddedness was operationalized as the average of fit, links, and sacrifice, the three major components of this construct (Mitchell et al., 2001). Under the subjective approach, embeddedness was operationalized as a global feeling of being embedded in an organization (Crossley et al., 2007).

**Organization-based self-esteem** was consistently measured by Pierce et al.’s (1989) scale. Both psychological ownership and perceived insider status were operationalized with established scales as well. Examples of psychological ownership scales include House et al.’s (2008) and Van Dyne and Pierce’s (2004) measures. Perceived insider status is frequently operationalized with Stamper and Masterson’s (2002) scale.

**Relational psychological contracts** were operationalized with two methods. First, some studies measure employees’ orientation toward sustaining a relational psychological contract with their employers, using Raja et al.’s (2004) or Shore, Tetrick, Lynch, and Barksdale’s (2006) scale. Second, some studies measure the extent that employees expect their firms to provide activities that promote long-term relationships with employees, such as training, development opportunities, and personal support (Jamil, Raja, & Darr, 2013; Jing, Xie, & Ning, 2014).

**Job burnout** is typically operationalized by three core components (Lee & Ashforth, 1996; Schaufeli, Leiter, Maslach, & Jackson, 1996), including emotional exhaustion, depersonalization or cynicism, and a sense of reduced personal accomplishment or professional efficacy. Job strain broadly includes various measures of negative affective reactions to work, such as job frustration, job anxiety, negative mood at work, or the absence of positive mood at work. These elements have been included in past studies of job strain (e.g., Beehr, Jex, Stacy, & Murray, 2000) and are consistent with Ford et al.’s (2014) premise that job strain encompasses all negative affective and cognitive states as a result of work.

**Mental health** included mental health issues, such as anxiety (Johnson & Joshi, 2016), depression (Fletcher, 1991), and psychological distress (Barling, Bluen, & Fain, 1987). General mood (mood not limited to the work domain) has also been used as an indicator of mental health (Ng & Feldman, 2014). Physical health was measured by asking respondents to identify somatic symptoms experienced, such as headache, fatigue, pain, muscle strains, insomnia, stomachache, and high blood pressure (Schaubroeck & Fink, 1998; Ten Brummelhuis, Ter Hoeven, De Jong, & Peper, 2013). This variable was meant to be broad and included any physical or bodily health complaints (Lee, Ashford, & Bobko, 1990). Most studies measured groups of symptoms and combined them to represent overall physical health. Only a few studies measured one specific type of physical health problem (e.g., muscle pain; Elst et al., 2014).

### 3.3. Analytical procedures

Correlations were corrected based on Raju, Burke, Normand, and Langlois’s (1991) technique. In the first step, the observed correlations were corrected for measurement error. To that end, the observed correlation between a measure of OA and a measure of health was corrected using the internal reliability estimates reported in the primary studies. In the second step, the observed correlations were corrected for sampling error. To that end, the corrected correlations between OA and health were aggregated across samples so that sample-size weighted mean effect sizes were obtained. We coded all health measures in a positive direction so that the analysis consistently indicates whether greater OA relates to more positive health. In addition, in cases in which more than one relevant effect size was provided in a single study (e.g., a study that reported both organizational commitment and identification or a study that reported both mental and physical health), an average effect size was created to represent that study before it was included in calculation of the overall relationship between OA and health.

As a first step, we determined if aggregating across OA measures and across health measures was reasonable. Table 1 shows the meta-analytical correlations among OA measures. In order to obtain these inter-correlations, an additional 244 articles were gathered. We used keywords that represented the nine OA constructs (e.g., “organizational commitment,” “organizational identification,” and “organizational trust”) in electronic searches and used the same exclusion criteria as before (e.g., excluding experimental studies, excluding student samples) to identify suitable studies. However, for some of the cells in this matrix, empirical studies were not available even after a thorough search. We observed that the sample-size weighted average correlation was 0.65. This effect size is similar to effect sizes observed in other meta-analyses that create higher-order constructs (Harrison et al., 2006; Judge & Bono, 2001). At the same time, as the shared variance (42%) was less than half, it was prudent that we also provided finer-grained results that separated different indicators of OA (e.g., deep vs. week OA).

A similar analysis was performed on different measures of health (low job burnout, low job strain, mental health, and physical
health). Table 2 shows the meta-analytical correlations among these four measures of health. In order to derive these correlations, 155 additional articles were identified, with 61 being from the original pool used in the main analyses. These articles were identified through electronic keyword searches (e.g., “mental health,” “physical health,” “strain,” and “burnout”). We also used the same exclusion criteria as before to identify suitable studies (e.g., excluding experiments). We found that the sample-size weighted average correlation was 0.61. Again, as the shared variance (37%) was less than half, it was prudent that we also provided fine-grained results which treated different indicators of health as separate and meaningful aggregates (e.g., general health vs. work-specific health).

4. Results

Table 3 shows the meta-analyzed correlations. In the Appendix, we provide the meta-analytical correlation between each of the OA constructs and each of the health outcomes, whenever we had at least two primaries studies addressing the same disaggregated relationships.

H1 predicts OA positively relates to health. Across 401 samples (N = 230,983), OA was positively related to health at 0.38 (95% CI = 0.36, 0.40), suggesting that OA was a positive correlate of health. This effect size can be described as strong (Cohen, 1988). To lend further insight into this relationship, we identified 19 studies in which OA was measured prior to health (the time interval ranged from 3 weeks to 3 years). The effect size was 0.25 (95% CI = 0.16, 0.34). Thus, it can be described as moderate in strength. Several specific OA-health relationships demonstrated strong effect sizes, including the relational contracts-mental health (0.52), organizational commitment-low job burnout (0.46), and organizational trust-low job burnout relationships (0.41). These findings support H1.

H2 predicts that deep OA (i.e., organizational identification, organization-based self-esteem, and psychological ownership) relates to health more strongly than does weak OA (i.e., person-organization fit, organizational embeddedness, and perceived insider status). The comparison tests were conducted with the approach adopted by others who performed effect size comparisons in meta-analyses (Steel & Kammeyer-Mueller, 2002; Wright & Bonett, 2002). In this procedure, the moderator in question (e.g., deep vs. weak OA type) was used as an independent variable to predict, in a weighted least squares multiple regression, the corrected correlations. If the

Table 1
Meta-analytical correlations among specific measures of organizational attachment.

<table>
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<tbody>
<tr>
<td>1. OC</td>
<td>-</td>
<td></td>
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<tr>
<td>2. OT</td>
<td>0.57</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(53, 37,403)</td>
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<tr>
<td>3. OI</td>
<td>0.74</td>
<td>0.57</td>
<td>-</td>
<td></td>
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<tr>
<td>(34, 20,341)</td>
<td>(12, 4393)</td>
<td></td>
<td></td>
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<tr>
<td>4. OE</td>
<td>0.76</td>
<td>0.72</td>
<td>0.53</td>
<td>-</td>
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<tr>
<td>(31, 41,655)</td>
<td>(1, 338)</td>
<td>(2, 588)</td>
<td></td>
<td></td>
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<tr>
<td>5. OBSE</td>
<td>0.53</td>
<td>0.52</td>
<td>0.42</td>
<td>0.72</td>
<td>-</td>
</tr>
<tr>
<td>(30, 9778)</td>
<td>(1, 186)</td>
<td>(2, 1089)</td>
<td>(1, 242)</td>
<td></td>
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<tr>
<td>6. POF</td>
<td>0.64</td>
<td>0.81</td>
<td>0.50</td>
<td>0.75</td>
<td>0.52</td>
</tr>
<tr>
<td>(33, 13,890)</td>
<td>(1, 335)</td>
<td>(6, 1612)</td>
<td>(1, 643)</td>
<td>(1, 199)</td>
<td></td>
</tr>
<tr>
<td>7. RPC</td>
<td>0.63</td>
<td>0.28</td>
<td>0.51</td>
<td>0.62</td>
<td>0.52</td>
</tr>
<tr>
<td>(20, 6803)</td>
<td>(3, 530)</td>
<td>(4, 1168)</td>
<td>(4, 2150)</td>
<td>(1, 84)</td>
<td>(1, 314)</td>
</tr>
<tr>
<td>8. POW</td>
<td>0.65</td>
<td>N/A</td>
<td>0.64</td>
<td>N/A</td>
<td>0.64</td>
</tr>
<tr>
<td>(14, 4049)</td>
<td>(1, 347)</td>
<td>(5, 3672)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. PIS</td>
<td>0.57</td>
<td>N/A</td>
<td>0.62</td>
<td>N/A</td>
<td>0.65</td>
</tr>
<tr>
<td>(2, 316)</td>
<td>(1, 347)</td>
<td>(2, 354)</td>
<td>(1, 289)</td>
<td>(1, 347)</td>
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</table>

Note. The first figure in parentheses represents the number of studies cumulated (k). The second figure represents the total sample size (N). OC = organizational commitment; OT = organizational trust; OI = organizational identification; OE = organizational embeddedness; OBSE = organization-based self-esteem; POF = person-organization fit; RPC = relational psychological contracts; POW = psychological ownership; PIS = perceived insider status; N/A = unavailable; ρ = corrected correlation.

Table 2
Meta-analytical correlations among specific measures of health.

<table>
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<tbody>
<tr>
<td>1. Low job burnout</td>
<td>-</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>2. Low job strain</td>
<td>0.49</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(19, 5348)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Mental health</td>
<td>0.54</td>
<td>0.60</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(46, 27,065)</td>
<td>(14, 3070)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Physical health</td>
<td>0.65</td>
<td>0.49</td>
<td>0.63</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>(40, 38,995)</td>
<td>(10, 2182)</td>
<td>(75, 92,788)</td>
<td></td>
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</tbody>
</table>

Note. The first figure in parentheses represents the number of studies cumulated (k). The second figure represents the total sample size (N); ρ = corrected correlation.
moderator was a significant predictor, then it indicates significant between-group differences driven by the moderator.

As shown in Table 3, the average of deep OA (organizational identification, organization-based self-esteem, psychological ownership) was related to health at 0.36 (95% CI = 0.31, 0.41), and was significantly stronger (p < 0.05) than the effect size associated with the average of weak OA (person-organization fit, organizational embeddedness, perceived insider status) on health (0.26, 95% CI = 0.21, 0.31). Post-hoc analyses showed that it was largely the difference in mental health that drove this difference; deep OA, on average, was related to mental health (0.41) more strongly than was weak OA (0.25). Strong and weak OA did not differ in their effects on low job burnout and low job strain. Overall, H2 received support.

H3 predicts that OA relates to low job burnout and job strain as an aggregate more strongly than to mental and physical health as an aggregate. As shown in Table 3, the effect of OA on the average of low job burnout and low job strain (0.41, 95% CI = 0.40, 0.42) was significantly stronger (p < 0.01) than the effect of OA on the average of mental and physical health (0.35, 95% CI = 0.33, 0.37). Post-hoc analyses showed that the difference was driven by organizational embeddedness, OBSE, organizational commitment, and organizational trust. That is, these variables have significantly stronger effects on work-related health (0.30, 0.53, 0.43, and 0.41, respectively) than on general health (0.06, 0.32, 0.36, and 0.26, respectively). H3 was thus supported.

H4 predicts that OA relates to physical health more weakly than to mental health, low job burnout, and low job strain as an aggregate. As shown in Table 3, OA was related to physical health (0.30, 95% CI = 0.26, 0.34), and the magnitude of this effect size was significantly weaker (p < 0.01) than the effect of OA on the average of mental health, low job burnout, and low job strain (0.39, 95% CI = 0.37, 0.41). Post-hoc analyses revealed that the difference was driven by organizational embeddedness, OBSE, organizational commitment, and organizational trust. These variables have significantly weaker effects (p < 0.05) on physical health (−0.06, 0.27, 0.32, and 0.23, respectively) than on the combination of mental health, low job burnout, and low job strain (0.24, 0.47, 0.40, and 0.32, respectively). These results support H4.

5. Discussion

5.1. Implications for theory development

Researchers have studied different types of OA (e.g., Masterson & Stamper, 2003; Meyer et al., 2002; Riketta, 2005), as employees with stronger OA are often more productive and loyal. The benefits of promoting OA, thus, are evident from an organization’s standpoint. From an individual’s standpoint, though, it is unclear why one should develop strong OA, especially when job mobility has become the norm rather than the exception over the last few decades (Arthur & Rousseau, 1996; Briscoe, Henagan, Burton, & Murphy, 2012).

We contribute to the literature by demonstrating that OA is associated with health benefits for individuals. Being attached to an attachment figure has been shown to be therapeutic (Lopez & Brennan, 2000); we extend that premise to the workplace arena and show that, regardless of the specific form, OA was generally related to better employee health, including greater mental and physical well-being and lower job burnout and strain.

This finding also contributes to occupational health psychology by showing that the work domain can significantly promote the health of an individual. This is important, as existing approaches that examine the effects of work on health typically focus on how
overinvestment in the work domain undermines one's health (Ganster & Rosen, 2013; Ganster & Schaubroeck, 1991). Extending that perspective, this study suggests that being attached to an organization is not detrimental to one's health. Guided by attachment theory, this study indeed argues that OA provides many attachment benefits, thereby generating positive effects on employee health.

In addition, this study contributes to the literature by integrating two domains that have been extensively examined using different, but closely related, constructs. First, there are at least nine different types of OA. We provided both theoretical reasons and empirical evidence as to why they are positively correlated but distinctive. While all nine OA types motivate individuals to stay at the organization and work hard, some OA types represent a deeper form of attachment, such as those that assimilate one's self-concept with the organization's entity, whereas others represent weaker types of attachment, such as those that merely tie individuals to the relationship through membership.

Despite these differences, our meta-analytical results still showed that different types of OA were quite strongly correlated (averaged correlation = 0.65), suggesting that it is important for future research to either further distinguish the different OA constructs by comparing their strength of association with other important correlates (like we did here) or provide some integration of the overlapping literature. For instance, the notion of person-organization fit is already incorporated in the construct of organizational embeddedness, and therefore the research on the latter can be legitimately built on the research on the former.

At the same time, we have also presented empirical evidence that deeper OA had generally stronger relationships with health than did weaker OA. Similarly, in the health domain, we have provided both theoretical reasons and empirical evidence that the four indicators examined are inter-related but distinct. For instance, we have shown that OA tended to have weaker effects on physical health than on mental health, as OA represents a psychological, rather than physiological, experience. Researchers are therefore encouraged to provide strong theoretical rationales for their choice of OA or health or both, as we have demonstrated that there are subtle differences between them, manifested in different strengths of association with their correlates.

### 5.2. Implications for future research

The abovementioned findings show to researchers who examined OA that they should consider health as one of the possible study outcomes, in addition to the typical consequences of OA, like job performance and turnover. As individuals who are healthier tend to perform better (Ford et al., 2011), future theories that address OA and job performance should consider the incorporation of health variables as a possible mediating or feedback mechanism.

Second, researchers should probe the differences between different types of OA, and this study has laid the groundwork for that avenue. We have provided theoretical reasons and empirical evidence for why the various indicators of OA converge and diverge. Some more specific comparisons can be conducted in future research, such as the different attachment benefits generated by deep OA (e.g., organization-based self-esteem, psychological ownership) and weak OA (e.g., person-organization fit, organizational embeddedness).

There are three OA constructs that we did not categorize into either deep or weak bonds, including organizational commitment and trust and relational psychological contract. They do not involve integration of self-concepts with the organization, but they are not merely perceptions of membership. Commitment captures a sense of belonging whereas trust and relational psychological contracts are based on positive expectation of future conduct and promises. Their relationship with health was between 0.30 and 0.39. Future research should identify under what conditions the effects of these three types of OA on health can be strengthened. For instance, the effects on negative health might be accentuated when the expectation or promise that is central to trust and relational psychological contract is unmet. The fact that psychological contract breach has robust negative effects on employees' affective well-being (Zhao, Wayne, Glibkowski, & Bravo, 2007) lends credit to such conjecture.

In addition, some of the effect sizes were small. For example, organizational identification as a specific OA type deserves more attention, as it did not have an especially strong relationship with health. As shown in Table 3, its relationship with health (0.31) was the same as that of person-organization fit (0.31), although we have argued that identification represented a deeper form of OA than does person-organization fit. One possible explanation is that, in order to integrate one's identity with that of the organization, one must establish some sort of similarity with the organization, which was captured by person-organization fit. Without this basis, the resulted identity might be fragile.

Moreover, future research into job strain as a specific indicator of health is also needed. For instance, the relationships of low job burnout and low job strain with OA were markedly different (0.45 vs. 0.32, p < 0.05). On the contrary, we observed that OA's relationship with physical health (0.30) was not different from that of low job strain (0.32), despite the argument that OA should affect job strain more strongly, as they are both psychological in nature. These results suggest that the extent to which low job strain overlaps with mental and physical health was perhaps underestimated in the existing research. One possibility is that job strain, as an immediate response to acute job stressors, evokes intense emotional and physiological reactions that become mental and physical health issues over time. In addition, we observed that only four studies focused on one specific physical health symptom (e.g., Elst et al., 2014). It is possible that the OA-health relationship is weaker when a specific health complaint, rather than overall physical health, is measured; for instance, we found that, across the four empirical studies that measured a specific health complaint, the relationship with OA was only 0.03.

Another possible research avenue is to incorporate the positive OA-health relationship into workaholism research. Workaholism has been shown to relate to negative health outcomes (Clark, Michel, Zhdanova, Pui, & Baltes, 2016). Our findings, however, indicate that OA is associated with positive health. The key to understanding these different findings is that workaholism implies an over-investment in work tasks (Ng, Sorensen, & Feldman, 2007), and this investment does not necessarily reflect stronger feelings of being tied to the organization. OA research, on the other hand, focuses more on the positive sense of attachment to an organization and how
it affects employees. Thus, perhaps if researchers focus on the group of workaholics who also feel attached to their organizations (in addition to just to their work), they are more likely to identify the positive outcomes of workaholism.

Finally, future research should also consider operationalizing the attachment benefits we have outlined in this study, as it is important to first understand why being attached to an organization is psychologically and physiologically beneficial and then use that theoretical basis to identify mediating mechanisms. In so doing, the different attachment benefits generated by various types of OA can be identified, which in turn facilitates researchers to compare findings for the OA-outcome relationship across various types of OA.

Several limitations deserve more empirical research as well. First, most of the empirical studies included here adopted cross-sectional designs, and future studies should consider using more longitudinal designs. We did identify a subset of time-lagged studies that measured OA prior to health, and the result showed that OA was associated with greater subsequent health. Future research should design different longitudinal studies to extend this observation.

Second, all of the study variables were self-reported in the original studies; future research should consider using non-self-report measures. Because OA represented employees' subjective feelings of attachments to their own organizations, the use of self-report OA was inevitable. Although objective (physiological) measures of health are desirable, we were not able to identify any OA studies that reported such measures, suggesting a research gap. Third and finally, as our focus was on clarifying the theoretical and empirical nature of the OA-health relationship, we did not examine moderators. However, some groups or cultures might experience the OA-health relationship more strongly, especially those that value attachment and belonging, like collectivists. Future research should therefore explore cross-cultural differences.

5.3. Implications for managerial practice

This study suggests to managers that employees who feel attached to their organization not only are likely to be more productive and loyal, but they are also likely to be healthier. Thus, there are strong reasons to continue to promote employee attachment, as that attachment is likely to benefit both the individual and the organization. We have argued that OA enhances one's well-being largely because it provides many attachment benefits, such as a sense of security and belonging, self-worth, confidence in protection, and satisfaction of socioemotional needs.

Although we have shown to managers that different types of OA have parallel positive effects on health, we have also alerted them to the subtle differences across the nine OA types. These OA types have different substantive bases, with some more likely to affect health strongly whereas others more likely to affect health only mildly. Managers, therefore, are strongly advised to understand the psychological bases of their employees' OA; for instance, if OA is only based on the fact that the employee has been a core member of the organization, perhaps managers should endeavor to cultivate deeper bonds that link employees' self-concepts to the organization.

We also hope to draw managers' attention to employees with weak OA (Beck & Wilson, 2000; Morrow, 2011). In addition to being a turnover risk, these employees are vulnerable to health problems because of the deprivation of attachment benefits. Their poor health might not only affect their own productivity, but also interfere with their coworkers' productivity if their tasks are interdependent. Thus, it is vital that managers identify employees that have weak OA so that corresponding actions addressing the abovementioned management problems (e.g., turnover, declining productivity) can be planned.

6. Conclusion

OA has been a pillar of vocational behavior research; many studies in this area have investigated how to promote employees' attachment to their organizations, which in turn should lower organizational turnover and strengthen organizational productivity. We adopt a different perspective and focus on why and how OA might benefit employees themselves in terms of promoting their health. Data gathered from multiple studies showed that OA had a non-trivial positive relationship with employee health and that the relationship varied across different types of OA and different health outcomes. We hope that these results draw researchers' attention to the fact that OA may be an important precursor of one's good health and that there are both similarities and differences across the existing indicators of OA and health.

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References


