The Organization and the Injured Worker

Mary M. Hogan

Each year many accidents occur at the workplace and cause injuries to employees. Although many accidents result in only minor injuries, 1.8 million disabling work injuries occurred in the United States in 1988, according to National Safety Council (1989) estimates. (Disabling injuries are defined as those injuries that cause death, permanent disability, or temporary total disability beyond the day of the accident.) This is a rate of 1.6 per 100 workers. Workers with disabling injuries, those who require medical care or are temporarily or permanently unable to work, become part of a complex and sometimes frustrating system that affects their health, health care, employment status, financial status, and occupational choice. Such frustration is likely to impede recovery, interfere with return to work, reduce satisfaction and motivation on the job, and increase litigious action.

A model presented here examines the treatment of a worker by the worker's employer organization after a work injury has occurred, and the resulting employee satisfaction with such treatment. The impact of the organization, rather than characteristics of the individual employee,

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Address correspondence and requests for reprints to Mary M. Hogan, R.N., M.S., Lecturer, School of Nursing, University of Michigan, 400 N. Ingalls, Ann Arbor, MI 48109-0482. This article, submitted to *Medical Care Review* on September 4, 1990, was revised and accepted for publication on March 25, 1991.

is the focus. The model contributes to improved understanding of the interaction of organizational members (e.g., management, other employees) with injured workers and the judgments made by injured workers regarding that interaction.

BACKGROUND

Workers' compensation entitles an injured worker to medical care and disability payments, although specific entitlements vary under each state's compensation laws and regulations. These regulations may require that an employee see a physician selected by the employer. Disability benefits are usually two-thirds to three-fourths of the employee's usual wage. Some employees are ultimately unable to return to their usual occupation. Workers' compensation laws, employer involvement in health care, rehabilitation professionals, attorneys, and personal situational factors may all interact, resulting in conflicts (Isernhagen 1988b). Employers want to limit the time lost from work; employees want to ensure that they are well before they return to work.

Recently, attention has turned to starting up or strengthening employer programs and services that will enhance recovery and return to work for disabled workers (Pati 1985; Galvin 1986; Tate, Habeck, and Schwartz 1986; Tate, Munrowd, and Habeck 1987). Such programs may include early rehabilitation, modification of jobs, and other activities to promote early return to work. Little is known, however, about what these organizational programs or services accomplish. Assertions by business groups (Carbine and Schwartz 1987), health professionals (Isernhagen 1988a), and others (Galvin 1986) that post-injury practices should be modified are made with little reference to results of evaluation or to theoretical arguments. The interpersonal dynamics of working with injured workers in this potentially adversarial situation remain largely unknown.

Factors considered to influence a return to work include the type of injury, medical care received, residual physical impairments, and individual social and psychological characteristics (see, for example, Hirschfeld and Behan 1963, 1967; Behan and Hirschfeld 1963; Tuck 1983; Hanson-Mayer 1984; Eaton 1979; Burgel 1986; Brewin, Robson, and Shapiro 1983; and Weighill 1983). Research has focused primarily on the individual and his or her medical, psychological, and social situation. The result has been a focus on individual level variables and their effect on return to work, costs, or amount of time lost from work. Nonetheless, when workers are injured, factors in addition to personal characteristics, the physical injury itself, and physical recovery from that

injury contribute to outcomes. For example, Yelin, Nevitt, and Epstein (1980) found that several social aspects of work, control over the pace of work, and self-employment, contributed to employment of the disabled. Nagi (1976) has demonstrated that job modifications contributed to maintenance of employment among the disabled. Habeck, Leahy, and Hunt (1988), in a study conducted in Michigan, have found that organizational factors—management climate and culture, safety practices and prevention of accidents, and disability prevention and management—were related to workers' compensation claim rates.

I argue for careful consideration of the ways in which organizational supports provided to injured workers affect their satisfaction and recovery. The model is presented briefly and the concepts are discussed in more detail. Related literature on social support, attribution, and satisfaction with health care is applied to this particular problem. Relationships among segments of the model are proposed. Finally, issues raised by the model and implications for research and practice are considered.

ORGANIZATIONAL SUPPORTS AND EMPLOYEE SATISFACTION WITH THE WORK INJURY EPISODE: A MODEL

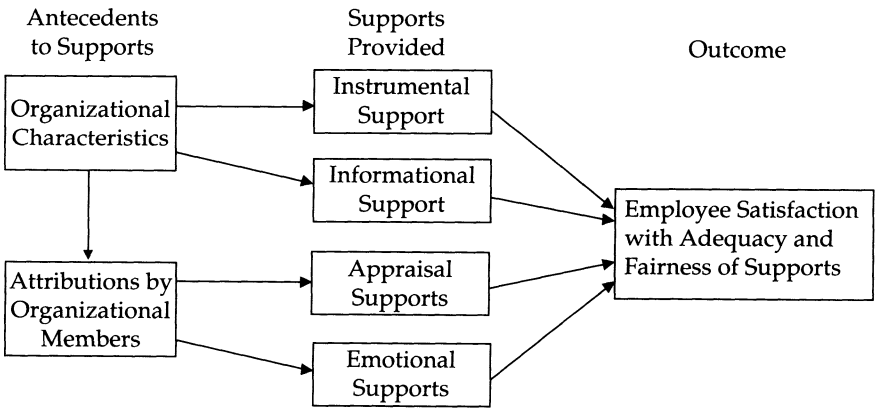
The model depicted in Figure 1 traces the influence of the supports and services provided to an injured worker on that worker's satisfaction with treatment during the work injury episode. In this article a work injury episode refers to the time from occurrence of the injury through recovery—when the worker returns to usual and full employment or to employment at an alternative job. If the injured person is not able to work, the definition is more problematic; "recovery" in this case means that the person has recovered to some extent and a decision is reached that he or she cannot work. A worker's satisfaction with treatment after a work injury is simply a judgment regarding the types and amount of support provided after a work injury and may incorporate perceptions of the outcomes—health and return to work. Instrumental and informational supports depend primarily on overall organizational factors, such as the employer's size, commitment to employees, and type of industry; hence, these supports are expected to be applied similarly to all employees in any one organization according to written or unwritten policies, rules, or customs. Attributions made by individual organizational members influence the provision of emotional and appraisal supports. Attributions regarding the injured employee's responsibility for the

problem (the injury) and attributions regarding the employee's responsibility for the solution (recovery and return to work) are both important. These attributions, in turn, may be influenced by beliefs about the cause of the accident, the severity of the injury, previous experience with this particular employee, and previous experience with other, similar workers. Therefore, interpersonal support is expected to vary in its application because attributions may differ.

EMPLOYEE SATISFACTION WITH A WORK INJURY EPISODE

In this model, the outcome of interest is employee satisfaction with treatment by the employer organization during a work injury episode. This outcome will be referred to as "employee satisfaction with a work injury episode," or as "satisfaction." The model posits that employee satisfaction overall depends on satisfaction with supports and interpersonal interactions, on initial recovery, and on other outcomes, such as level of regained health, return to work, and the compensation settlement. Some supports are provided through the interaction of people in the organization with the injured worker, and some supports, such as income maintenance and other benefits, are provided by the organization as a whole—that is, no organizational member "delivers" the service.

FIGURE 1: Employee Satisfaction with a Work Injury Episode



Employee satisfaction with the work injury episode is based on the person's judgments or evaluations of the adequacy and fairness of these services and supports toward meeting his or her needs and wants, rather than simply the amounts and types of support provided. Other variables will also influence the employee's satisfaction with treatment after a work injury, for example, prior feelings of satisfaction with the job, and with co-workers and the organization. Satisfaction with and commitment to the employer organization will be important influences on the judgments employees make about the treatment they receive. If the employee has always been satisfied with the work and plans to remain with the employer, events may tend to be interpreted in a manner that reinforces prior beliefs. For a dissatisfied worker, the treatment following a work injury, even if it is very positive, cannot solve all of the issues related to dissatisfaction with work. Thus, general satisfaction with the employer may influence the judgments of satisfaction with the work injury episode. However, the model emphasizes those events that occur after an injury. It suggests that supports, if appropriate, can enhance rather than diminish satisfaction with a work injury episode, regardless of the initial level of satisfaction with the employer.

Organizational researchers have studied employee satisfaction with jobs, and health services researchers have studied consumer satisfaction with medical care. Job satisfaction is believed to influence motivation (Herzberg, Mausner, and Snyderman 1959), attendance (Steers and Rhodes 1978), and productivity (Blumberg and Pringle 1982). Health services researchers have focused on consumer satisfaction with health care in general (Ware, Davies-Avery, and Stewart 1978; Hall and Dornan 1988); with specific services, most frequently some aspect of physician services (Hall, Roter, and Katz 1988); and with episodes of care (Lochman 1983). A great deal of research has been published on patient satisfaction with aspects of care (for several reviews, see Hall and Dornan 1988; Hall, Roter, and Katz 1988; or Cleary and McNeil 1988). It seems remarkable that little consideration has been given to worker satisfaction with this health care event, the worker injury episode, which occurs within the context of the workplace. Rather, most attention has been directed toward reducing time off work and controlling costs for workers' compensation cases (Victor 1987). Understanding employee satisfaction or dissatisfaction with a work injury episode is also essential to developing services and supports that are effective both in returning workers to employment and in promoting employees' satisfaction with their treatment experience.

Why should interest exist in the employee's satisfaction or dissatisfaction with treatment? There are several reasons:

1. Satisfaction is important because of humanitarian considerations and social expectations (Calnan 1988).
2. Satisfaction may lead to increased compliance with medical care and improved chances of fuller recovery (Cleary and McNeil 1988).
3. Satisfaction is a measure of quality of care and of the quality of interpersonal interactions in health care (Donabedian 1980; Davies and Ware 1988; Steffen 1988).
4. Satisfaction or dissatisfaction with a critical work event may influence the employee's overall view of the organization.

Humanitarian reasons are important because society *expects* satisfaction to be an outcome. Satisfaction implies that a person has been treated well, with fairness and with consideration of that person's values and needs, particularly during a therapeutic process over which he or she may have limited control. In addition, satisfaction with health care is believed to improve the patient's interactions with health care providers, to improve compliance with treatment, and ultimately to improve the physical outcome (Calnan 1988; Cleary and McNeil 1988). A satisfied employee/patient is more likely to participate actively in treatment as it proceeds.

Satisfaction with health care is believed to be one measure of its quality. Steffen (1988) has argued that the health care consumer's values and goals should be incorporated, in addition to provider judgments of outcome, in judging the quality and the outcomes of health care. Donabedian (1980) has concluded that client satisfaction "is of fundamental importance as a measure of the quality of care because it gives information on the provider's success at meeting those client's values and expectations which are matters on which the client is the ultimate authority" (p. 25). Davies and Ware (1988) reviewed data on consumers' ratings of the technical and interpersonal aspects of care and concluded that the opinions of consumers regarding quality were important both for judging interpersonal aspects of care and for contributing information on the technical quality of care.

Does a work injury episode affect the employees' views of the organization? Eisenberger et al. (1986) suggest that employees make inferences about the support of an organization toward them based on "various aspects of an employee's treatment by the organization" (p. 501). In an empirical study they found that perceived organizational support was associated with reduced absenteeism. Injury on the job, especially minor injury, is not rare. However, an injury that requires medical treatment or results in lost time is a relatively unusual occur-

rence for any one employee and will stand out in the worker's mind. The injured worker's views of the organization are likely to be influenced by organizational representatives during this episode. In addition, workers who observe how the injured are treated may modify their perceptions of the organization.

How do people judge whether or not they are satisfied? Davies and Ware (1988) make a useful distinction between ratings; the evaluations or judgments of quality (such as, "I was treated the best I could have been"); and reports, or consumers' recounting of objective events that occurred (such as, "I was sent to one of the orthopedic physicians in town and was seen by him within 15 minutes"). Workers will observe the way they are treated and will judge that against their expectations regarding the adequacy of the services available, given their needs and their perceptions of fairness or equity. They will consider whether or not the services seemed to provide what they needed. Important aspects might include competent medical care, adequate temporary income, help in retraining, or assistance in returning to the job. Employees may also wonder if they are being treated fairly and impartially: for example, would another employee with a similar problem be treated the same, better, or worse. An employee will judge his or her own treatment against the treatment received by others or believed to be received by others.

An example of informational support will be used to illustrate an injured employee's judgments and beliefs in this regard. After reporting an injury on the job, an injured worker receives information verbally about the amount of disability payments, the date the payments will begin, and the method of getting the checks to the worker. The worker also receives a written booklet reinforcing the same information. These constitute the objective events that the worker observes. These objective events are weighed against the worker's beliefs regarding what should have been done and beliefs about what other workers would be receiving in similar circumstances. The worker may feel that the information is adequate. Perhaps another worker believes that the reason why the check is a particular amount should be provided. This latter worker is dissatisfied because the information is not offered, contributing to lower satisfaction with the work injury episode.

The judgments by the injured worker about the adequacy and fairness of the objective events that occur, given that worker's expectations, determine satisfaction with the work injury episode. As a result, individuals with different expectations may express unequal degrees of satisfaction with the same level of reported occurrences of services and support.

ORGANIZATIONAL SERVICES AND SUPPORTS AFTER A WORK INJURY

Organizational supports are those actions taken through organizational procedures and by organizational actors to, for, or with the injured worker for the purpose of enhancing recovery and return to work or to provide help during the time the employee is unable to work.

In each organization there is some response, even if unplanned, to an injured employee. Co-workers and supervisors may gather round and offer assistance. The injured person may receive on-site care by the company physician or nurse, or may be referred to a local physician or emergency room. After the immediate care is provided, the worker may meet with someone (by telephone or in person) to arrange for a workers' compensation claim to be filed and, if the injured person will remain off work, for disability payments to begin. Supervisors may call to check on the employee's status and to inquire about the employee's well-being. Co-workers may convey sympathy to the injured person, or apathy, or even anger, grumbling about the additional work load because of the missing worker. Contacts may recur periodically to ensure that the employee is recovering or possibly to arrange for return to work in a modified job. Special therapy and exercise programs may be arranged at the work setting to assist the employee in recovery. All of these activities are considered organizational supports but, obviously, some of them may be considered negative by the injured individual.

Organizational rules, procedures, or customs give structure to the organizational supports that are applied when someone is injured. The supports appear to the worker to be "delivered" by organizational members—persons acting on behalf of the organization, such as nurses, supervisors, co-workers, and those employees who handle the workers' compensation paperwork. I use concepts from social support literature to describe organizational support, although the concept here is restricted to the supports and services provided by organizations and, through their members, to work-injured employees.

I have found it useful to organize these organizational supports and services according to the four broad classes of social support as characterized by House (1981): instrumental support, informational support, appraisal support, and emotional support. Examples specifically related to a work injury are used to illustrate House's definitions of these general types. *Instrumental support* for a work-injured employee refers to those behaviors that directly help the person in need, such as rides to the doctor, disability payments, or medical care. *Informational support* means providing information that an injured employee needs or can use

in managing problems. This can include telling the employee when to expect the first disability payment, how much the payment will be, or where the employee can get prescriptions filled. *Appraisal support* is the provision of information (but not emotional support) that can be used for self-evaluation. An explanation to the injured worker that other workers with similar injuries remained off work for an average of four weeks constitutes appraisal support, because this information can be used by the worker in assessing his or her own situation. *Emotional supports* are acts that show caring, empathy, trust, love, or similar attributes. Emotional support is provided when supervisors or co-workers contact injured employees to express concern about their condition or to express the sentiment that they are missed at work.

The instrumental, informational, appraisal, and emotional supports provided by an organization (e.g., money, job modifications) and by individuals in the organization (contact from co-workers, personnel in benefits, etc.) during a work injury episode may include those listed in Table 1. Supports and interactions with an injured worker are classified into these categories, although these supports and interactions are not necessarily pure types, as House (1981) has pointed out. For exam-

TABLE 1: Examples of Organizational Supports after a Work Injury

Informational	*Instrumental*	*Emotional*	*Appraisal*
Providing information about worker's compensation benefits	Worker's compensation disability payments	Contacts by supervisors or co-workers to find out the employee's progress	Providing information about the usual course of illness for similar injuries
Providing information about appropriate health care, where to get prescriptions, supplies	Physical therapy	General expressions of concern	
Providing information on when benefits will begin and the amount that may be expected	Medical treatments, drugs, etc.		
	Modified work		

ple, providing information about benefits—when they begin and what the amount will be (informational support)—may be done in a manner that connotes emotional support. There may be a mixed interaction during which medical care (instrumental support) and expressions of concern and empathy about the employee and about the employee's family situation (emotional support) occur during the same visit with an occupational physician.

Organizational supports and services include not only the resources provided by individual persons but also those resources made available by the organization and not specifically tied to any support-providing person. The latter include, for example, workers' compensation disability payments and the availability of light-duty work. Sources of social support related to work include family and friends, supervisors, co-workers (Caplan, Cobb, French, et al. 1975; Fusilier, Ganster, and Mayes 1986; Karasek, Triantis, and Chaudry 1982), and extra-organizational supports (Kaufmann and Beehr 1986). The work support network for an injured employee consists of co-workers and supervisors, who are known to the employee, and other organizational members, such as workers' compensation administrators and clerks, medical department personnel, and staff in personnel or benefits offices, who may be unfamiliar to the worker. Shumaker and Brownell (1984) explain that support from these formal or professional sources—and support from strangers—may contribute to social support in important ways, because formal providers and strangers do not require "repayment" of supports.

Brief and Motowidlo (1986) make the distinction between helping behaviors that are a part of the organizational role or job and those that represent "extra-role" behavior. Some organizational members provide support or perform helping behaviors toward an injured worker because it is an expected part of their job. One example is the company nurse, who provides direct nursing care, gives information, makes periodic contact with the employee to determine progress, and provides emotional support during the recovery period. In some organizations, supervisors may be expected to contact the employee periodically as part of their job role, while other supervisors may do this even when it is not expected within the usual procedures of that organization (extra-role). The difference between role and extra-role helping behavior may be important both for the actual provision of support and for the employee's perception of the types and amount of support provided by different organizational members. When an employee expects helping behavior as part of the role and the help is not forthcoming, the employee will be disappointed. If support or help is not part of the role, when, for in-

stance, a supervisor calls just to see how an employee is recovering, the employee may be especially pleased by this support beyond expectation.

Shumaker and Brownell (1984) consider the congruence of the perceptions of the support provider and the support recipient regarding whether an action is helpful, neutral, or harmful. Not all exchanges are perceived as helpful and supportive by both the provider and the recipient. A recipient may perceive the help or support offered as harmful rather than supportive; on the other hand, the recipient may perceive an activity as helpful and supportive, while the provider may intend the exchange to be neutral or harmful; or the parties may both perceive the exchange to be helpful. For example, a company nurse may call an injured employee at home to find out if physical therapy is progressing well. The purpose is to arrange another therapist if necessary. The provider considers the interchange positive and supportive. The employee, on the other hand, may feel that the nurse is just checking up—calling to make sure the employee is really at home ill—and accordingly may judge the interchange negatively. An identical exchange representing different intentions and perceptions can occur: the intent of the provider may be to check up on the employee, but the employee may perceive the interaction as supportive. Because adversarial situations commonly arise after a work injury, this possible lack of congruence in perception is important to understanding an employee's dissatisfaction with organizational "supports," which the employee may see in fact as negative or harmful.

To sum up, organizational supports provided after a work injury are those acts of assistance provided by an organization and by organizational members to an injured worker. As mentioned earlier, these supports may be instrumental, informational, appraisal, or emotional, and sometimes one action or behavior may reflect more than one type of support. The sources of support may include supervisors and co-workers, or more formal suppliers of support such as nurses and personnel officers. Some supports such as income maintenance are provided by the organization and not through an individual organizational member. Supports, services, or behaviors may have either positive or negative intent and outcomes, and the perceptions of the injured employee and the supplier of support regarding intent may or may not be congruent.

ATTRIBUTIONS ABOUT THE INDIVIDUAL— HOW THEY AFFECT THE SUPPORTS PROVIDED

This model proposes that emotional and appraisal supports are less concrete than instrumental and informational supports, and are more

likely to vary according to the attributions that individual organizational actors make about the injured employee. Factors that may contribute to these attributions in the case of a work injury include:

1. Attributions regarding the cause and the solution to the problem, in this case the injury and sequelae (Brickman, Rabinowitz, Karuza, et al. 1982);
2. The severity of the injury (Walster 1966);
3. Whether the injury is obvious (for example, a fractured arm in a cast) or not apparent (for example, muscle strain to the back);
4. Previous experiences with this employee;
5. Previous experience with other, similar employees; and/or
6. Previous experience with other similar injuries.

Attribution is a process individuals use to make sense of the world. People observe a behavior and, in the search for its meaning or explanation, make attributions or determinations about its causes and also about the characteristics of the individuals who exhibit that behavior. As Kelley (1967) puts it, attribution is the "process of inferring or perceiving the dispositional properties of entities in the environment" (p. 193). "Dispositional properties," as Kelley calls them, are the stable characteristics of an object or person. People attempt to fix blame or responsibility for the way things are and for the reasons things happen in order to understand and to feel in control of themselves and the environment. For example, individuals might ask some of these questions about a situation or event: to what extent is it the result of luck or fate, or of ability or the lack of it? is it internally or externally caused? is it an intentional or unintentional phenomenon? is it a temporary or permanent condition? Attribution literature has focused both on attributions about the self (Weiner 1986) and on attributions about others (Sadow 1983; Walster 1966).

Heider (1958), in an early work on attribution, suggests that the layperson, whom he terms the "naive psychologist," will adjust reactions to a person who fails (or is lacking) according to whether that person lacks the ability (cannot do it) or the effort (does not try to do it). According to Heider, if the person is believed to lack ability, we may help the person succeed: by simplifying the task, by reducing obstacles, or by providing training or other aids that will improve the person's ability to meet the environmental demand. However, if the person is believed to lack effort, we will not expect the person to use such assistance and therefore will not bother to provide help. Heider proposes that attribu-

tions of ability and effort affect ways in which the observer responds. Ickes and Kidd (1976) have considered attribution and particularly its influence on "helping" behavior, and they have incorporated the observer's attributions about the observer's own success ("To what do I attribute my own success or lack of success?"). They conclude that more help will be given when dependency is attributed to an unintentional lack of ability (what they term "internal unintentional") rather than to an intentional lack of effort ("internal intentional"). In other words, maximum help is provided when the helper feels able to succeed and judges that the other person lacks ability. Alternatively, helping is minimized when helpers believe that their success is due to their own effort and that the other person has not demonstrated any effort. As they put it, "Helping another person makes the most 'sense' when the potential helper is asked to do something for the other which the potential helper is capable of doing, but which the other cannot do for himself" (Ickes and Kidd 1976, 129).

Some attribution studies have shown that the more severe the consequences of an accident, the more likely the victim will be perceived to have contributed to the cause of the accident (Sadow 1983; Walster 1966). However, Burger's (1981) review and other work (e.g., Shaver 1970) have shown that increasing the assignment of responsibility for an accident in light of its increased level of severity does not always occur. One explanation for this is what Shaver (1970) terms defensive attribution. According to the defensive-attribution explanation, the more similar the subject is to the perpetrator of the accident the less likely he or she is to alter judgments of responsibility when the severity of the accident is increased.

Bulman and Wortman (1977) summarize the rationale that may underlie the results of studies of attribution and severity. The "just world hypothesis" explanation is that people tend to assign more responsibility to the victim of a serious accident because of the importance of believing that terrible things happen for some good reason, and that people therefore deserve what happens to them. Walster (1966) suggests that when an accident is relatively severe, it becomes more important (than for a minor accident) that a person be able to assign responsibility to someone or some thing. This makes the person more comfortable in thinking that he or she can control or prevent a serious accident. Alternatively, a reason for people to avoid blaming another person is to avoid self-blame for future accidents that could happen to themselves (Shaver 1970). This is the so-called defensive attribution. This rationale is expected to apply to those situations in which the person is likely to feel vulnerable.

Brickman, Rabinowitz, Karuza, et al. (1982) developed four models

of helping and coping that concern ways in which people decide the kind of help that is suitable in certain situations (Figure 2). The four models—the moral, medical, compensatory, and enlightenment models—revolve around attributions of responsibility for the cause of a problem and attributions of responsibility for the solution by the observer or the potential help giver. In the case of the work-injured employee, attributions about the accident and injury are considered the problem, and attributions about recovery are considered the solution.

In the moral model people are considered to be responsible for a problem and for its solution. This view implies that the person's primary deficit is a lack of effort and that helping consists of exhorting the person to self-help. In the medical model people are held responsible neither for their problems nor for the solutions. In this case, individuals are expected to accept their situation and to try to get well with the aid of experts. The inability to solve the problem themselves makes them reliant upon experts for the solutions. The enlightenment model applies when people are held responsible for their problems but are not held responsible for the solutions. In this model, people must accept responsibility for their current situation and must rely on a usually external source of discipline and authority in order to control the problems they have. It is called the enlightenment model because the person needs to be "enlightened" to the realization that he or she is the cause of the problem. In the compensatory model, people are not held responsible for the problem but are held responsible for solutions. In the compensatory model a person is expected to use individual effort and to be

FIGURE 2: Brickman's (1982) Models of Helping Behavior Based on Attribution of Responsibility for the Problem and the Solution

		Attribution of Responsibility for Problems	
		YES	NO
Attribution of Responsibility for the Solution	YES	Moral	Compensatory
	NO	Enlightenment	Medical

especially assertive in order to overcome handicaps or environmental obstacles. The helper in this case provides resources or opportunities that are not currently available to that person (Brickman, Rabinowitz, Karuza, et al. 1982).

As a specific application of Brickman's models, I suggest that the helper, in this case an organizational member, modifies helping actions based on beliefs about the problem and the solution. Was the injury externally caused or did the employee contribute to it in some way? Is the employee doing everything possible to recover? How do organizational members view employees who do not recover according to schedule? Are these employees regarded with negative attributions—as malingerers, neurotics, or troublemakers? Are they considered unable to overcome the injury? According to Brickman's typology, the "model" that fits, in the eyes of the organizational member, will guide his or her behavior toward the injured worker.

According to Olson and Ross (1985), attribution literature in general provides few clues regarding the effect of attributions of observers on their behaviors toward a person. It has been shown, however, that helping behavior and the intention to help are related to attributions. In general, less help is given in situations in which the person is blamed more for his situation (Weiner 1980; Reisenzein 1986; Barnes, Ickes, and Kidd 1979). In addition, the emotional reaction to the situation (such as pity, anger, or sympathy) and the attributions made in that context have been shown to influence helping (Meyer and Mulherin 1980; Weiner 1980; Reisenzein 1986; Weiner, Perry, and Magnusson 1988).

In a series of studies, Weiner (1980) demonstrated that attributions of causation influenced help-giving behavior. Study participants had more negative emotional reactions and gave less help in situations where the need was caused by factors internal to the person and controllable by the person. Attribution to uncontrollable factors, either internal or external, led to more positive feelings and more help-giving intentions.

Schwartz and Fleishman (1978) proposed that if people have weak or nonexistent norms related to an issue, they will provide more help when the need is viewed as legitimate. However, those with strong personal norms will be guided by those norms without accounting for the legitimacy of the needs. In a study of welfare recipients, those with neutral norms gave more help when the need was due to factors beyond the needy person's control, while those with strong norms did not vary their help based on legitimacy of need.

Attributions about the injured employee by organizational members are expected to influence their behavior toward the employee. In the injured worker model presented in this article, organizational mem-

bers modify the application of supports, particularly emotional and appraisal supports, according to attributions about the employee. Based on the literature, injured workers who are seen as contributing to their own injuries are likely to be afforded fewer supports by organizational members, except by those organizational members who have strong norms about helping or not helping. This group will tend either to help or not based on their norms. Personal and professional background as well as organizational culture may serve to influence the norms for helping.

ATTRIBUTIONS IN WORKERS' COMPENSATION, MEDICAL, AND REHABILITATION LITERATURE

Vocational rehabilitation literature and the medical literature on workers' compensation imply attributions of employee blame for the work injury and responsibility for recovery from it. The literature suggests that a not uncommon view, even among professionals, is that the individual is primarily at fault for failure to recover, either because of deliberate malingering or perhaps through a lack of rugged individualism or an inability to overcome adversity. Such ideas may be even more prevalent among the laypeople who deal with injured workers within organizations.

Modlin (1986) traced the development of the medical perceptions of the industrially injured, which, he believed, were based on the physiologic orientations of the medical profession. Accident victims were seen as either those with "legitimate injuries and claims" or "those with disability out of proportion to the tissue damage they had sustained" (Modlin 1986, 264). Several articles published in the 1960s by the psychiatrists Behan and Hirschfeld (Behan and Hirschfeld 1963; Hirschfeld and Behan 1963, 1967), based on a study of 300 injured workers who had been referred to them for evaluation for workers' compensation litigation, concluded that the injuries were related to psychological processes. The resulting injuries provided a solution to life problems, and the identification and treatment of the underlying personality disorders became the focus of care (Hirschfeld and Behan 1967). In another early work on accidents, Hersey (1936) described emotional factors and their contribution to accidents. This literature was influential in bringing needed attention to the psychological aspects of the problems of accidents and recovery in addition to the physiologic and environmental considerations. However, the focus was almost exclusively on the individual.

The vocational rehabilitation literature has provided evidence of similar views: that injured persons are primarily responsible for their

recovery. Stubbins and Albee (1984) describe the "clinical" model—in their view the predominant model in actual vocational rehabilitation practice—in which the client in vocational rehabilitation is viewed as similar to someone with a disease. Individual assessment, treatment, and counseling are used to correct the deficit in the individual and employment is expected to follow. Stubbins and Albee maintain that blaming the victim is inherent in this clinical model. An alternative model that they describe, the ecological model, sees the disabled person as a victim of social and economic forces in addition to individual characteristics. They point out that, for the most part, the disabled person sees the problem as a social and political (external) one, whereas vocational rehabilitation professionals define the problem as one of individual motivation and adaptation (internal), and therefore attempt to solve the problem at the person level.

Both the medical and vocational rehabilitation literature have focused on identifying and modifying individual health and personal characteristics to enhance recovery (although attention has begun to shift to the environmental factors that influence recovery). The model presented here is an attempt to delineate mechanisms through which an organization, through its members, can influence the level of satisfaction and recovery of an injured employee.

ORGANIZATIONAL CHARACTERISTICS

It is reasonable to suggest that organizational characteristics affect the provision of services and supports to injured workers. Organizational characteristics should be particularly influential in providing informational and instrumental supports. Informational and instrumental services or supports are organized and structured on an organizational level, and are expected to be applied similarly to all employees in the organization who are injured and who have similar injuries. For example, all of the injured employees in one organization who require medical care are likely to receive services from the same clinic(s) or physician(s) (instrumental support). Similar informational support—information about disability payments and available benefits, and procedures for keeping the employer informed of medical progress—are provided to most injured employees. However, differences among organizations are expected—differences that depend on:

1. Organizational size, which may influence the availability of resources, experience with injured workers, and flexibility with regard to individuals;

2. Organizational commitment to human resources;
3. Location of the functions related to injured employees within the organization, which may in part reflect organizational commitment; and
4. Aspects of organizational culture.

Size of the organization is important for several reasons. For example, size influences the amount of experience with injured workers. In very small organizations, because of limited experience in dealing with disabling injuries, the approach may be disorganized, and less structured services may be available to an injured employee. On the other hand, this may result in an individualized approach that the employee finds satisfying. Employees themselves also may view large versus small organizations quite differently—that is, their perception of the organization as an entity that offers support may be different in a large organization versus a small one.

Flexibility with regard to providing support to individuals is influenced by size of the organization and by the organizational culture. Do written or standard procedures exist for handling injured workers? Specific procedures to follow for sending employees for medical care, setting up benefits, and requiring evaluation for return to work are likely to make it relatively easy to provide basic helpful services for recovery. Indeed, the lack of rules and procedures may lead to failure to provide basic supports in potentially appropriate situations.

Are individual organizational actors able to bend or modify the rules and usual practices in a particular situation? If rules must be kept to the letter, the standardization of procedures that results may lead to fairness, efficiency, and a sense that all has been done. The trade-off may be that individuals with particular problems or situations will have difficulty getting their needs met. An example of this problem is the difficulty of placing workers in modified and alternative positions because of seniority or transfer rules and procedures. In many situations organizational procedures and guidelines can be shifted to some extent at the discretion of an organizational member. Flexibility of procedures may allow for attention to a particular injured worker's specific situation. As an example, flexibility may be used to arrange for an unusual work schedule for an employee, who, for example, can work only mornings and not at all on Wednesdays, when the usual procedure is to work a full schedule or not at all. Flexibility toward procedures, on the other hand, enables a person acting on behalf of the employer to fail to provide a service, that might otherwise be provided, to an injured worker if this employer representative considers the worker undeserving for some rea-

son. A company employee may "forget" to mention to an injured worker that selecting his or her own treating physician is an available option when the injured worker is viewed as a malingerer. Flexibility therefore cuts both ways—alternatively allowing for meeting or failing to meet employee needs.

Commitment toward human resources is another element that is important in the treatment of injured workers. If workers are considered long-term employees, efforts to maintain the injured worker and to bring the worker back to the job will be valued. If workers are considered easy to replace and interchangeable, the long-term investment in that employee will be less, resulting in less effort to bring the worker back to the job. Related to this is the availability of competent replacement workers in the geographic region or for the particular occupational classification or rank.

Organizational culture also shapes responses to an injured worker. Galvin (1986), in his review of issues and programs relating to employers and disability management and rehabilitation, proposed that a proactive program rather than a hands-off approach would be most effective in returning disabled workers to the job. According to Galvin, aspects of culture are critical to disability prevention, management, and rehabilitation. He suggests that the following elements are important for successful disability management: commitment to humanization of the workplace, supported by top management; a caring response to disability or illness; and employee trust in the corporation.

Schein (1984, 1990) points out that levels of culture include the observable artifacts, the values, and the underlying assumptions in the organization. Assumptions are often unquestioned and participants may not be aware of them. The underlying assumptions and values inherent in the organizational culture affect the development of rules and policies as well as their implementation, thereby affecting formal organizational support systems. These underlying assumptions also may influence an individual organizational member's attributions about an injured worker and behavior toward the worker. If the underlying cultural assumption is that people are personally responsible for their successes and failures, then employees may tend to believe an individual to be responsible for his or her accident and ability to recover. This would lead to supports that enhance the injured worker's ability to help himself. Another organization may have values and beliefs akin to family: "We all take care of each other here." In this situation, one would expect more interpersonal emotional support and instrumental support. These examples illustrate how culture may influence both structured organizational procedures for injured workers and an organizational member's attribution and behavior toward an injured worker.

Location of the functions relating to injured workers, such as medical care, recordkeeping, accident investigation, and identification of altered jobs, may reside within one department or several. Are worker's compensation issues considered a safety department function, a part of human resources, or the responsibility of the medical department? The functions are possibly divided among these areas. The Brickman, Rabinowitz, Karuza, et al. (1982) findings suggest that various programs, institutions, or professions may have a usual "model" orientation and that different orientations influence the kind of help provided. For example, in the medical model the person is not held responsible for solutions, and thus expert help is provided to resolve the problem. In this way, the types of supports provided by a particular organization may be influenced by the "model" orientation held by the departments that carry out functions related to injured workers. This parallels the notion of subcultures in different departments, as described by Deal and Kennedy (1982). Each departmental culture, because of its organizational function, may embody somewhat different values and assumptions. These, in turn, influence the behavior of individual department members.

IMPLICATIONS

What are the implications of the model? The proposed relationships are tentative, but the possibilities for further understanding of the conflicts surrounding work injuries are intriguing. Research suggested by this analysis includes:

1. Investigation of the meaning of satisfaction with the work injury episode and the types of supports most meaningful to workers;
2. Delineation of attributions (and the reasons for them) made by individual organizational members about injured workers;
3. Consideration of the impact of attributions made by organizational members about injured workers on their behavior toward the workers, and the emotional and appraisal support provided; and
4. Determination of the relationship between the characteristics of organizations and the types of informational and instrumental supports provided.

There are also implications for practice. Those who work with injured workers and those responsible for designing programs to handle work injuries should consider these issues. Consideration of the potential effect of organizational characteristics and attributions by individuals on the

types of supports provided to an injured employee is indicated. Employee satisfaction is a concern. The possible influences on employee satisfaction with the work injury episode can be examined and attended to.

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