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ARTICLE

Healthy for some but not for all: The moderating role of BMI on perceived health climate–insomnia relationship

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Abstract

This study examines the mediated relationship between perceived health climate and insomnia via exhaustion, and whether the mediation effect is weaker for individuals with higher body mass index (BMI). Results from multi-wave field data revealed that perceived health climate negatively predicted insomnia through reduced exhaustion. Moreover, the mediation effect was weaker among people with higher BMI (obese individuals) than people with lower BMI (non-obese individuals). This study expands our understanding of the workplace health climate and its unintended consequences for obese individuals. Also, it encourages practitioners to develop health climate promotion programmes that intend to reduce employee exhaustion first prior to specific behavioural changes and takes into account individual differences.

KEYWORDS

BMI, burnout, exhaustion, health climate, insomnia, sleep

INTRODUCTION

Among all the benefits that employers typically offer to employees in the United States, healthcare is arguably one of the most important. According to national statistics, healthcare takes up the largest percentage among non-wages/salary compensation costs (Bureau of Labor Statistics, 2020). On average, an employee health insurance plan with family coverage costs $20,576, with employers shouldering about 70% of the cost (Kaiser Family Foundation, 2019). Furthermore, healthcare costs have been on a steady rise over the years, increasing about 5% per year on average since 2013. As such, employers are increasingly incentivized to develop initiatives with the hope of increasing their workforce wellness and controlling healthcare costs. One important factor to improve employees' health and well-being can be having a strong *workplace health climate*. Conventional wisdom and existing organizational science literature suggest that workplace health climate, defined as employees' perceptions of organizational and managerial support for employees' physical and psychological well-being (Ribisl & Reischl, 1993), is related to

Practitioner Points

- We recommend practitioners create and implement health climate promotion programmes that focus on reducing psychological strain while also encouraging positive behavioural health outcomes.
- Organizations may generate more individually tailored health climate promotion programmes to maximize their full benefits.
- To minimize unexpected consequences toward high body mass index individuals, practitioners should focus on ways to ensure that positive health climates are inclusive and interpreted as respectful of all employees, regardless of their individual condition.

positive personal health and work outcomes (Katz et al., 2019; Schulz et al., 2017). Past research suggests that perceived health climate not only predicts health behaviours themselves, but also a range of positive health outcomes such as lower fatigue, lower burnout and more healthy days (Zweber et al., 2016).

However, is workplace health climate beneficial for all employees? Existing research and practice largely focus on the positive effects of workplace health climate on employee health, but little is known regarding who is most likely to experience the benefits of a strong health climate and the potential downsides for some workers. Employees can vary considerably in their own physical health and lifestyle, and some may actually view a strong positive health climate as more stressful than supportive, with little actual benefit for their own well-being. Organizational support theory suggests that when employees perceive that their organizations value their contributions and care about their well-being, this perceived supportiveness fulfils employee socio-emotional needs and contributes to their own well-being (Eisenberger et al., 1986; Kurtessis et al., 2017). Perceived health climate can serve as a sign of support toward employees, but this may not be as well-received among those whose lifestyles and behaviours are not aligned with the perceived climate of the organization. This may especially be the case for those who do not fall within the 'ideal normal' range of health, such as obese individuals.

Being overweight represents one of the most visible, prominent and stigmatized types of ill-health in the workplace (Puhl & Heuer, 2010; Roehling et al., 2007; Shapiro et al., 2007), and overweight workers may be particularly sensitive to workplace health climate. The factors contributing to being overweight are complex, ranging from controllable factors such as lifestyle choices to less controllable factors such as family history, metabolic disorders and other types of chronic illnesses (Brisbois et al., 2012; Kopelman, 2000). Unfortunately, despite the myriad of factors behind body weight, heavy or overweight individuals are often seen as entirely responsible for their condition, which is perceived to result from their lack of willpower and sense of responsibility (Crandall & Eschleman, 2003; Weiner, 1995). Unsurprisingly, a growing body of evidence suggests that overweight individuals suffer negative perceptions and treatment in employment settings (King et al., 2006; Roehling et al., 2007), which, in turn, can negatively predict physical and psychological health (Jones et al., 2016; Pascoe & Smart Richman, 2009). As organizations increasingly emphasize and value employee health, we argue that overweight employees may perceive such climate as a lack of support toward their lifestyle and body appearance, which, in turn, may induce stress and undermine their health, the very thing organizations are trying to promote.

Using multi-wave field data from working adults, this study examines the perceived health climate impacts on one key health indicator: sleep (which is operationalized as insomnia in this study). Sleep has been repeatedly shown to be an important health indicator (Knudsen et al., 2007; Linton, 2004). However, past research on health climate rarely focuses on this health outcome. We focus on insomnia, the understudied health outcome in the workplace health climate literature, as our outcome of interest to further expand the empirical evidence of workplace health climate in employee health. Drawing from social exchange and organizational support theories, we propose that perceived health climate is related to sleep quality through reducing psychological strain, but that this relationship is attenuated by

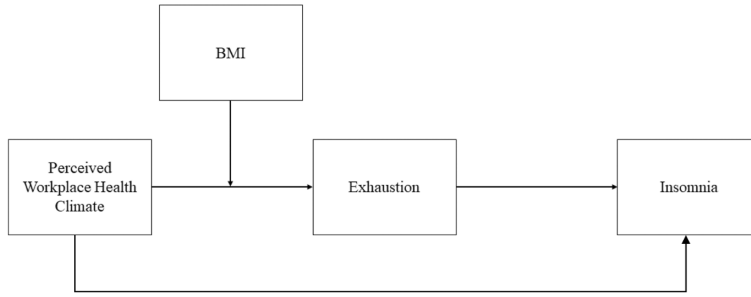

FIGURE 1 A conceptual model.

individual body weight, operationalized as body mass index (BMI; see Figure 1). In doing so, our paper makes two major contributions. First, by integrating the health climate literature with work on discrimination against obese individuals, our paper challenges the implicit assumption that workplace health climate is usually positive for employees by considering those who may not fit into the conventional notion of 'healthy'. Drawing from social exchange and organizational support theories, we argue that health climate, despite its positive intent, may not yield the desired effects for employees whose body weight does not align with what is valued in the workplace. Thus, a positive health climate may fail to communicate to high-BMI employees that the organization values and cares about them. Secondly, our study contributes to the small but growing body of literature on body weight in the workplace. Though a growing body of research suggests that weight discrimination is present in employment settings (e.g. hiring), much less is known about the intrapersonal experience of employees who are overweight despite its prevalence. Altogether, our paper sheds new light into the nuanced effects of workplace health climate and experiences of obese individuals in navigating seemingly positive workplace environments.

THEORETICAL FRAMEWORK AND HYPOTHESIS DEVELOPMENT

Perceived workplace health climate

Due to both business bottom-line and humanitarian reasons, organizations have increasingly devoted attention to ensure employee health and well-being over the past few decades. Accordingly, a growing body of research focusing on workplace health climate, which is defined as employees' perception of active support from organizations for their physical and psychological well-being (Zweber et al., 2016), has emerged. To date, this body of work strongly suggests that poor health is related to lower productivity and higher absenteeism (Cartwright & Cooper, 2014; Danna & Griffin, 1999) and can incur productivity loss and increased healthcare costs at the organizational level. Drawing from a total worker health perspective, health climate takes safety climate, which focuses on preventing workplace hazards and injuries, one step further by focusing on health promotion and protection to advance overall employee well-being (Center for Disease Control and Prevention, n.d.; Zohar & Luria, 2005). This is consistent with the definition of health as 'a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity' (World Health Organization, 1948). Therefore, beyond physical harm prevention, workplace health climate focuses on individual health behaviours (e.g. having a balanced diet, exercising) as well as other workplace characteristics that have health implications (e.g. job stress). One important thing to note is that while the traditional study of organizational climate emphasizes the aggregated perceptions (i.e. averaging perceptions of group members), research has also examined individual *perceived* climate (i.e. individual members' perceptions of the collective climate; Jones & James, 1979), which represents the individual's interpretation of the organizational context. For the purpose of this study, we are focusing on *perceived* health climate because we theorize that individuals'

interpretations of their organization's attitude toward employee health is a more proximal predictor to their experience.

One theoretical framework to explain effects of health climate is social exchange theory, which suggests that health is part of the psychological contract formed between employees and employers under a strong workplace health climate, and employees are likely to conform and reciprocate their workplace's care and concern for health with increased effort to maintain and improve their personal health, which can, in turn, relates to more positive health outcomes (Blau, 1964; Sonnentag & Pundt, 2015; Zweber et al., 2016). Extending this notion, health climate can also be conceptualized as a form of organizational support, through which organizations demonstrate their concern for employees for not only their performance and bottom-line, but also for their health and well-being. When organizations show they care about employee well-being, this is a sign of support from the organization (Eisenberger et al., 1986; Eisenberger & Stinglhamber, 2011). A high level of organizational support toward employee health can serve as a job resource and may reduce employee stress and its subsequent negative effects (Demerouti et al., 2001; Ilies et al., 2010). Indeed, empirical evidence has largely supported this by finding employees' perceptions of health climate directly predict employees' health behaviours (e.g. exercising regularly) as well as health outcomes (e.g. increased general health, lower depression, better sleep quality; Katz et al., 2019; Schulz et al., 2017).

Perceived health climate and sleep

One critical outcome that can result from perceiving a high level of health climate is improved sleep quality, which is operationalized as reduced insomnia in this study. While past health climate research has examined its effects on employee health and well-being, sleep has received less attention despite it being one of the most important health indicators. Past research suggests that sleep is often relegated to lower importance by both employees and organizations alike when employees try to juggle various work and non-work responsibilities (Barnes et al., 2016), despite the negative organizational implications of poor sleep quality such as reduced performance, increased work withdrawal, and increased accidents and injuries (Barnes, 2012; Brossoit et al., 2019; Litwiller et al., 2017). Because sleep is such a key indicator of health, we reason that it is likely one facet of employee health that organizations high in health climate will encourage.

Research has indicated that a high level of health climate suggests that, similar to performance, employee health-related behaviours are part of the range of desirable behaviours endorsed by the organization (Sonnentag & Pundt, 2015). Under a strong health climate, managers may serve as role models by observing health practices and encourage employees to partake in both work and non-work wellness promotion activities, thus reinforcing the value of health within the organization (Kaluza et al., 2018). Drawing from the social exchange framework, employees are likely to conform and reciprocate by following their managers' examples and caring for their own health in ways that should ultimately improve their sleep quality. Health behaviours such as a balanced diet, exercise and a regular sleep regimen are typically associated with sleep health (Kelley & Kelley, 2017; Zuraikat et al., 2021), so perceiving high levels of health climate will likely result in better sleep quality by encouraging behaviours that tend to increase sleep quality. Beyond encouraging health behaviours, health climate can also promote positive health outcomes. For instance, managers may pay more attention to employees' job stress and be more active in reducing their job demands because they recognize the role of work in employee's well-being, which can be perceived as a form of support (Franke et al., 2014). As a result of such support, employees are likely to experience lower job stress from their work, which can result in better sleep quality (Knudsen et al., 2007). Indeed, past research has found that health climate can not only facilitate employee health behaviours, but also health outcomes such as lower fatigue and better appetite (Ribisl & Reischl, 1993; Sonnentag & Pundt, 2015; Zweber et al., 2016), all of which can facilitate better sleep quality. Therefore, we propose that:

Hypothesis 1. Perceived workplace health climate is negatively related to insomnia.

Mediating role of exhaustion

Whereas there should be a direct relationship between perceived health climate and insomnia due to the positive effect of employees perceiving support from their organizations, we also suggest that perceived health climate contributes to more positive sleep outcomes by reducing employee exhaustion. Exhaustion is conceptualized as the stress dimension of burnout, when individuals experience a lack of energy and feel like their emotional resources are depleted (Maslach & Jackson, 1981). Previous studies have shown that job resources (which health climate is one of) tend to lower exhaustion (Van Ruysseveldt et al., 2011). In addition, stress research has demonstrated that lower exhaustion is related to fewer sleep problems (Brand et al., 2010). Particularly, compared to other dimensions of burnout such as cynicism and diminished sense of personal accomplishment, exhaustion is more strongly predicted by work and social factors such as job control and social support. Because this paper aims to examine how perceived health climate protects against exhaustion and in turn improves sleep quality, we focus on reduced exhaustion as an explanatory mechanism in the negative relationship between perceived health climate and insomnia.

As explained above, perceived health climate can be interpreted as a form of social support from the organization. When employees perceive that their workplace prioritizes the health of employees, this means that employees believe that people in their organization value and care about their well-being. Research and theory suggest that when people believe others around them care about them, people experience reduced levels of stress and improved well-being (Cohen & Wills, 1985). This may occur because supportive environments facilitate more positive affective experiences and recognize employees' self-worth (Ford et al., 2018; Kurtessis et al., 2017). Indeed, research has found that strong organizational health climate is related to lower employee emotional exhaustion because their leaders are likely to adapt a health mindset and express support for their subordinates' well-being (Kaluza et al., 2018).

Furthermore, we reason that employees are likely to respond to a positive health climate by engaging in stress reduction and other self-care behaviours. For instance, employees may utilize coping strategies to better manage their stress or engage in job crafting to reduce conflicting demands from their work. Indeed, past research has found that a supportive climate facilitates safety performance (Liu et al., 2019; Mearns & Reader, 2008), as employees who perceive that their organizations care for their well-being conform and reciprocate by complying with safety guidelines. The same can be argued for health climate, wherein positive health climates reduce employee strain by encouraging more self-care and stress reduction. Indeed, recent research suggests that when organizational support and supervisory support are high, employees are more likely to participate in wellness programmes at work, which can, in turn, lead to more positive health outcomes (Smidt et al., 2021).

Research strongly suggests that job stress and strain, in turn, play an important role in sleep (Linton et al., 2015; Van Laethem et al., 2017). Individuals who suffer high stress are likely to ruminate and are also more likely to develop anxiety and depression symptoms (Demsky et al., 2019; Hakanen & Schaufeli, 2012), all of which negatively impact sleep. Conversely, when individuals experience lower stress, either through organizational or through individual interventions, they are also likely to have better sleep (Crain et al., 2014). Therefore, we reason that in addition to facilitating higher sleep quality because it is a form of support, perceived health climate is also likely to have an indirect effect on sleep quality through reduction of stress outcomes such as exhaustion. Employees are likely to experience lower levels of exhaustion due to reduction of stress when they perceive a positive health climate; this decreased exhaustion should, in turn, predict better sleep quality. We propose that:

> **Hypothesis 2.** Exhaustion mediates the negative relationship between perceived workplace health climate and insomnia.

Moderating role of BMI

While perceiving high levels of workplace support for health and wellness can lead to lower exhaustion and, indirectly, better sleep outcomes for employees, such benefits may not be shared by those who do not fit under the conventional standard of health. One example of those who are considered unhealthy is obese individuals, whose body weight is often highly stigmatized in society across work and non-work settings. Stigma theory has long suggested that individuals with stigmatizing characteristics are devalued and seen as having 'flaw in character' (Goffman, 1963). This is further extended by the attribution framework of stigma, which proposes that characteristics are more stigmatized if they are high in visibility (i.e. the degree to which individuals' stigmatizing characteristic can be readily perceivable) and controllability (i.e. the degree to which individuals are responsible for their condition; Jones et al., 1984). Unfortunately, body weight falls under both of those criteria, as it is difficult to hide and it is seen as highly controllable and under one's own responsibility (Crocker et al., 1993; Weiner et al., 1988). This makes obesity one of the most noxious and unyielding stigma in our society (Crandall & Martinez, 1996).

Even though perceived health climate may reduce exhaustion by insinuating to employees that the organization is concerned with their health and well-being, these benefits may not extend to *all* employees, depending on the degree to which employees actually interpret the climate as indicating that the organization values and cares about them. Organizational support theory suggests that a high degree of perceived support may facilitate employee well-being because it fulfils employees' socio-emotional needs for esteem, affiliation and emotional support (Eisenberger & Stinglhamber, 2011). To the extent that these needs are met, perceived support can reduce employee stress and strain outcomes (Baran et al., 2012). Unfortunately, because being overweight is often perceived as an indicator of ill-health and disregard for one's own health, we contend that obese individuals may actually perceive a strong health climate as indicating a *lack* of support from the organization.

Specifically, workplace health climate focuses on individual health behaviours and outcomes (Zweber et al., 2016). Therefore, those who perceive a strong health climate are likely encouraged to be more health conscious and participate in activities that facilitate their well-being. While this emphasis can be viewed as positive by many, overweight employees may not view it as positively because their lifestyle and/or body appearance may not align with what is valued in an organization with a strong positive health climate. As mentioned before, a growing body of research has suggested that weight is a heavily stigmatized characteristic in the workplace (King et al., 2006, 2016), and overweight employees are often likely to be aware of the stigmatized nature of their body weight and its associated stereotypes (Frey & Tropp, 2006; King et al., 2008). As a result, individuals with stigmatized identities often engage in meta-perceiving behaviours to gauge other people's perceptions of them, especially when in an evaluative setting (Kaplan et al., 2009). The workplace is one evaluative setting where the need to engage in meta-perceiving behaviours can be heightened, and so we reason that overweight employees may perceive a strong health climate as an indicator that their body weight is not what is valued and accepted within the organization, and feel that their stigma is made more salient. Consistent with that, research on identity-based meta-perceptions found that stigma salience can negatively related to the well-being of those who carry the stigma (Grutterink & Meister, 2022; Swim et al., 2009). Unsurprisingly, overweight individuals often report higher levels of stress-related emotions due to an increased awareness of the stigma (Major et al., 2012).

Furthermore, previous research has suggested stigmatized individuals are not only often aware of others' perceptions, but also engage in identity management behaviours to minimize the negative impact of their stigma (Clair et al., 2005). As overweight employees are cognizant of the negative perceptions against their condition, they may also actively try to manage others' impressions so that they can remain in good standing within the organization, such as working extra hours to assert their competence or downplaying their weight by dressing in looser clothing. All of these efforts can come at the cost of increasing exhaustion. Therefore, we reason that perceived health climate is experienced as a

form of support only for those who are within the normal range of body weight, and its effects on lowering exhaustion are weaker for those who are obese. We propose:

> **Hypothesis 3.** BMI moderates the relationship between perceived workplace health climate and exhaustion, such that higher BMI attenuates the negative relationship between perceived workplace health climate and exhaustion.

The moderating role of BMI in the relationship between perceived workplace health climate and exhaustion should have implications for employees' sleep quality. As described above, because overweight employees may not view themselves as in alignment with the health ideal encouraged by their organization, they may not interpret health climate as a form of organizational support. Rather, they may perceive that the social stigma of their body weight is made salient and as a result, are not able to reap the benefits of a high perceived health climate that other non-overweight employees may enjoy. In other words, the positive effect of health climate on sleep outcome through reduced exhaustion is likely weaker for overweight individuals. Therefore, we propose that:

> **Hypothesis 4.** BMI moderates the indirect effects of perceived workplace health climate on insomnia via exhaustion, such that the indirect effect is weaker when BMI is higher.

To test those proposed hypotheses, we collected time-lagged data to reduce mood effects and other spurious effects (Podsakoff et al., 2003). Also, we selected 1-week intervals between waves because 1-week intervals seem long enough for employees to experience the negative effects of exhaustion on noticeable problematic sleep symptoms such as insomnia and short enough to demonstrate meaningful relationships between the study variables without significant participant attrition issues.

METHOD

Participants and procedures

To test our hypotheses, we collected three-wave data through Qualtrics online panels. Researchers have shown that online panel data are comparable to traditional data in psychometric properties, and acceptable to examine applied research questions (Walter et al., 2019). All participants were between 18 and 65 years old, worked in the United States, worked at least 30 hours per week, and worked with other individuals. At Wave 1, a total of 1062 workers participated in the study. Among them, 52.4% were female, 84.7% were White, the mean age was 46.70 years ($SD = 11.46$) and 69.9% earned at least a Bachelor's degree. One week after the first survey completion, participants were invited to take the second survey. A total of 615 returned and completed the second survey. Out of 615 participants, 49.3% were female, 84.2% were White, the mean age was 47.93 years ($SD = 11.05$) and 70% earned at least a Bachelor's degree. Again, 1 week after participants took the second survey, they were invited to complete the last survey. A total of 417 took the final survey. Among those participants, 48.0% were female, 85.6% were White, the mean age was 48.27 ($SD = 11.11$) and 68.3% earned at least a Bachelor's degree. Participants worked in various industries including education (12.5%), healthcare/medical (9.9%), government/military (6.8%) and finance/bank/insurance (6.2%). To examine participant attrition biases, we performed a series of one-way analyses of variance (ANOVA) and tested mean differences across three groups: (1) employees who took all three surveys ($N = 417$), (2) employees who took the first and the second surveys ($N = 197$) and (3) employees who took only the first survey ($N = 448$). Results showed that race [$F(2, 1059) = .93$, $p = .40$] and education [$F(2, 1059) = .27$, $p = .76$] did not differ across the three groups. However, gender [$F(2, 1059) = 3.26$, $p < .05$] and age [$F(2, 1059) = 9.38$, $p < .01$] were significantly different. Thus, we included gender and age as control variables in the main analysis.

Measures

We collected employee height, weight and demographic information at Wave 1; health climate and psychological strain information at Wave 2; and insomnia information at Wave 3.

BMI

BMI was calculated based on employee height (in inches) and weight (in pounds) information. To be specific, we followed the CDC BMI calculation formula: weight (lb)/[height (in)]$^2 \times 703$ (Centers for Disease Control and Prevention, 2014).

Perceived workplace health climate ($\alpha = .79$)

Perceived workplace health climate was measured with the five items developed by Basen-Engquist et al. (1998). A sample item is 'My supervisor encourages me to make changes to improve my health'. All five items were measured based on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

Exhaustion ($\alpha = .83$)

Exhaustion was measured with the four negatively worded items from the Oldenburg Burnout Inventory (OLBI; Demerouti et al., 2010). A sample item is 'After my work, I usually feel worn out and weary'. All four items were assessed based on a 5-point Likert scale that ranged from 1 (strongly disagree) to 5 (strongly agree) and higher scores indicate more exhaustion.

Insomnia ($\alpha = .83$)

Insomnia was examined with the four items developed by Jenkins et al. (1996). A sample item is 'Had trouble falling asleep'. All four items were assessed based on a 5-point Likert scale ranging from 1 (to a very small extent) to 5 (to a very large extent).

RESULTS

Means, standard deviations and correlations are presented in Table 1.

TABLE 1 Means, standard deviations, and correlations ($N = 417–1062$).

Variables	Mean	*SD*	1	2	3	4	5	6
1. Age	46.70	11.46						
2. Gender	1.53	.50	−.20**					
3. BMI	28.83	6.92	.18**	−.19**				
4. Perceived health climate	2.54	.81	−.01	.03	−.03			
5. Exhaustion	2.97	.89	−.18**	.14**	.09*	−.15**		
6. Insomnia	2.02	.87	−.11*	.14**	.04	−.07	.38**	

Note: For the gender variable, man was coded as 1 and woman was coded as 2. *$p < .05$. **$p < .01$.

A confirmatory factor analysis

We performed a confirmatory factor analysis to check the factor structures of the included variables on Mplus 7.4. Specifically, we used Full Information Maximum Likelihood estimation and tested a three-factor model, including perceived workplace health climate, exhaustion and insomnia factors. Results showed acceptable model fit, $\chi^2(62) = 300.748$, $p < .01$, CFI = .913, RMSEA = .079.

A moderated mediation analysis

We performed a moderated mediation analysis with a bootstrapping approach on Mplus 7.4. using ML estimation. In addition, we included gender and age as control variables based on the ANOVA results and previous studies suggesting that gender and age are important factors in BMI and mental health research (Bookwala & Boyar, 2008; Peter et al., 2015). The model fit was good, $\chi^2(2) = 1.987$, $p = .37$, CFI = 1.00, RMSEA = .00. Specific results are shown in Figure 2. First, contrary to H1, perceived workplace health climate did not predict insomnia ($b = -.020$; $p = .670$) independent of exhaustion. However, perceived workplace health climate negatively predicted exhaustion ($b = -.540$, $p = .005$), and exhaustion positively predicted insomnia ($b = .352$, $p < .001$). Exhaustion mediated the relationship between perceived workplace health climate and insomnia ($b = -.190$, $p = .010$), supporting H2. Consistent with H3, BMI significantly moderated the relationship between perceived workplace health climate and exhaustion ($b = .426$, $p = .045$), such that the relationship was stronger when BMI was lower (lower BMI: $b = -.632$, $p = .008$, higher BMI: $b = -.448$, $p = .002$). In other words, people with lower BMI (non-obese people) experienced lower exhaustion when they perceived a stronger workplace health climate than did people with higher BMI. The specific moderation pattern is presented in Figure 3. Note that the relationships for higher BMI and lower BMI were significantly different ($b = .184$, $p = .047$). Lastly, consistent with H4, we found that BMI significantly moderated the indirect effect of perceived workplace health climate on insomnia via exhaustion.

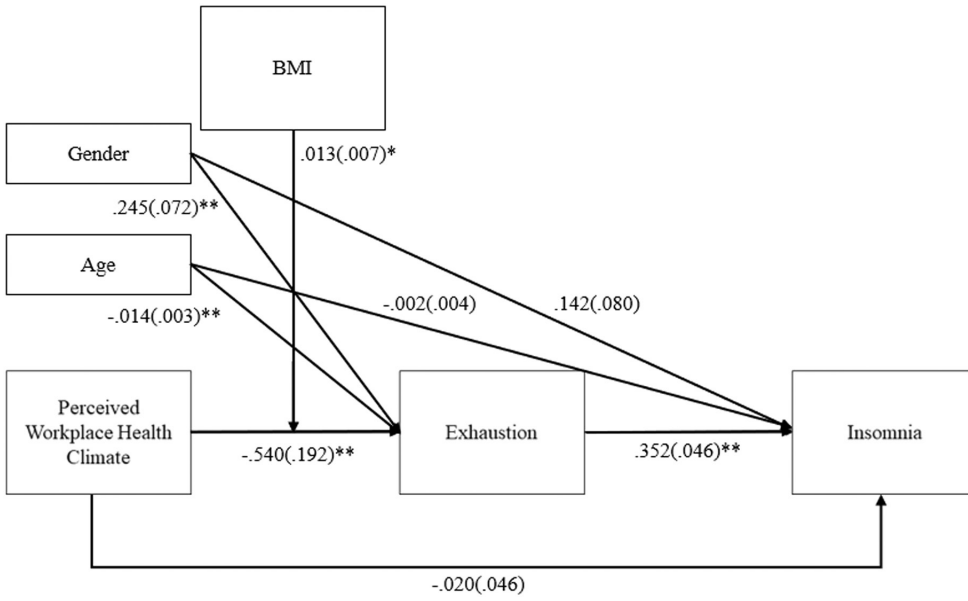

FIGURE 2 A moderated mediation model including gender and age as control variables. *Note*: All values are unstandardized coefficients. The values in parentheses are standard errors. For the gender variable, man was coded as 1 and woman was coded as 2. *$p < .05$. **$p < .01$. $N = 417–1062$.

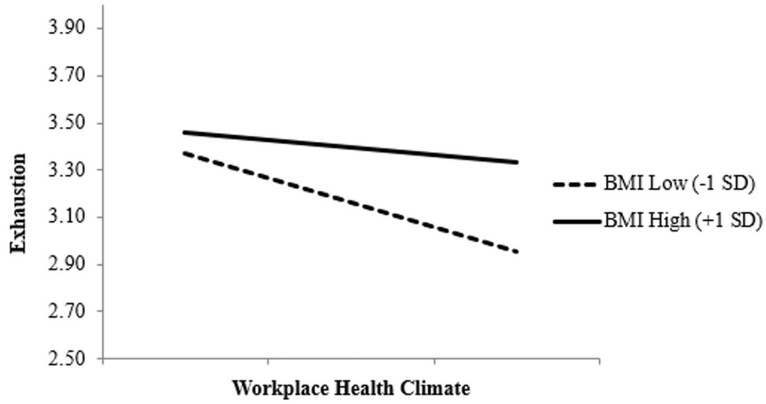

FIGURE 3 A moderation effect.

Specifically, the mediation effect was stronger among people with lower BMI (non-obese people; lower BMI: $b = -.223$, $p = .014$) than people with higher BMI (obese people; higher BMI: $b = -.158$, $p = .006$). Also, the two mediation effects between higher BMI and lower BMI individuals were marginally significantly different ($b = .065$, $p = .060$).[1]

DISCUSSION

This study examines the relationship between perceived workplace health climate and insomnia. Specifically, it proposes that perceived health climate is negatively related to insomnia via reducing exhaustion, and the mediation path is weaker for individuals higher in BMI. Results largely supported our model. First, perceived workplace health climate negatively predicted insomnia through reduced exhaustion. This finding is consistent with previous research showing that health climate is related to better psychological health and positive behavioural health outcomes (Kurtessis et al., 2017). It appears that when employees believe their organization values their health, this signals the organization's concern for the employee's well-being and is associated with lower levels of employee exhaustion and better sleep quality. Furthermore, our findings build on previous research showing that psychological strain, specifically exhaustion, is significantly related to insomnia (Van Laethem et al., 2017). Interestingly, workplace health climate did not directly predict insomnia. This suggests that health climate is related to better sleep quality as a positive behavioural health outcome through its relationship with reduced employee exhaustion.

In addition, results demonstrated that BMI moderated the relationship between workplace health climate and exhaustion, and it also moderated the indirect relationship between perceived workplace health climate and insomnia via exhaustion, such that the mediation effect was weaker among people with higher BMI (obese employees) than those with lower BMI (non-obese employees). The findings suggest that not everyone experiences lower exhaustion when in a positive workplace health climate. Because of the stigma attached to body weight, high-BMI workers may not interpret health climate as a signal that their organization values and respects them. Instead, they may view strong health climates as less supportive and more threatening, thus weakening the strain reduction effect that is typically associated with positive health climates. Such findings are important as previous studies have generally assumed that a health-promoting climate is beneficial for everyone. Here, our findings suggest that the

[1]Note that the two mediation effects between higher BMI and lower BMI individuals were significantly different with a Sobel approach ($b = .065$, $p = .034$).

effects of perceived workplace health climate may be interpreted differently across workers depending on the degree to which those workers align with the perceived climate.

Still, it was notable that, even for high-BMI employees, the relationships between perceived health climate and exhaustion and insomnia were still negative, albeit less so than for low-BMI workers. Thus, it does not appear that perceived health climate is negatively related to obese employees' psychological well-being and health. Rather, the relationship is less positive, which is still consistent with our overall theorizing of BMI as a moderator.

Implications

Our study provides important theoretical implications. First, this study expands on the existing health climate literature by suggesting that the relationships between health climate and health outcomes are more nuanced than what the current literature suggests. While health climate should theoretically have direct positive effects on sleep by encouraging and supporting positive health behaviours and outcomes, the effects of health climate on sleep quality may instead occur through lower levels of strain. This suggests the important role that stress may play in explaining the effects of health climate on sleep quality.

Moreover, we incorporate research on organizational support in a health climate context to explain unintended consequences of workplace health climate on exhaustion and insomnia among obese employees. Our results suggest that the positive effects of workplace health climate may not be universal; instead, some individuals may receive more health benefits from workplace health climate than others. This means that obese employees do not experience the benefits of positive health climates for sleep because they may perceive positive health climates as less supportive and inclusive and even threatening to their self-worth. To date, climate theory has focused more on the general, universal effects of climate on the workforce, placing less emphasis on individual factors that influence whether employees feel included and valued as part of that climate (Schneider et al., 1998; Zohar, 2014). With the current findings, our study suggests that individual employee characteristics should be incorporated in climate theory to better understand the complex effects of workplace climates. This is particularly true for theory on health climate, which may not be experienced as positively among some employees with stigmatized health conditions. This can also help elucidate why positive health climates may have less positive effects on the health and well-being of individuals with higher BMI levels, with consequences for sleep quality.

Lastly, our study expands on existing literature on body weight in the workplace that mostly focuses on perceivers' perspectives by examining one aspect of overweight employees' experience: health. As stigma involves both interpersonal and intrapersonal processes (Goffman, 1963), understanding targets' experiences is crucial to gain a more comprehensive picture of the effects of stigmatized social identities. In addition, extant research has largely focused on the effects of diversity climate on stigmatized individuals' experiences and outcomes (McKay et al., 2007, 2008), but for health-related stigmatized conditions, it may also be helpful to examine other facets of organizational climate, such as health climate to provide further insights into the contextual factors that may signal inclusivity (or lack thereof) to target employees.

Regarding practical implications, our study suggests that workplace health climate itself may not instantly and directly promote behavioural health outcomes such as better sleep. Rather, health climates may promote better sleep through exhaustion reduction. Thus, we recommend practitioners create and implement health climate promotion programmes that focus on reducing psychological strain while also encouraging positive behavioural health outcomes. This focus on psychological strain consequences of health climate is particularly important given this study's finding that high-BMI employees did not experience the same positive effects of workplace health climate as low-BMI employees experienced. Practitioners are encouraged to develop health climate promotion programmes considering how different individuals may interpret these programmes. Specifically, organizations may generate more individually tailored health climate promotion programmes to maximize their full benefits. Furthermore,

to minimize unexpected consequences towards high-BMI individuals, practitioners should focus on ways to ensure that positive health climates are inclusive and interpreted as respectful of all employees, regardless of their individual condition. Organizations may find it useful to inform workers that weight alone, while highly visible, is not necessarily a good indicator of healthy behaviour or overall health in general. Such efforts may help to ensure that positive health climates reduce employee strain while promoting positive behavioural health outcomes.

Limitations and future research directions

Despite its important implications, this study also has several limitations. First, this study reveals that there may be some unintended negative consequences for obese people in the health-promoting climate. However, with this study, it is unclear whether the negative consequences were yielded due to internalized individual misfit perceptions or subtle discrimination incidents as punishments for not meeting the norms in the workplace. To advance our current understanding and enrich the findings, we strongly recommend future researchers measure people's perceptions on fit versus misfit with their workplace health climate and workplace discrimination incidents and uncover a specific cause of the negative consequences for obese individuals. Second, data were collected using a subjective self-report method rather than more objective measures, specifically for insomnia and BMI. Although insomnia and BMI data are usually gathered using a self-report method (Syrek et al., 2017), they are not entirely free from possible reporting errors. We recommend future researchers gather sleep data and BMI data with objective measures (Buxton et al., 2016) and examine our research questions again. Third, the majority of participants were highly educated and White, which limits the generalizability of the results. The findings need to be replicated with more diverse participant data. Fourth, we measured workplace health climate at the individual level focusing on employee perceptions rather than at the organizational level. Future researchers may want to gather more objective workplace health climate data at the organizational level and examine whether the results are still replicated. Fifth, we chose BMI as an indicator to identify obese individuals based on previous studies (Finkelstein et al., 2010); however, BMI alone may not be the best indicator of obesity (Adab et al., 2018). We recommend future researchers collect other indicators of obesity such as waist-to-hip ratio and waist circumference (Song et al., 2013) as well as BMI, and examine whether the results are replicated. Lastly, we used time-lagged data. We encourage future researchers to collect longitudinal data and demonstrate the directionality between the study variables.

As this study demonstrated, there may be other unintended consequences of promoting a healthy climate in the workplace for certain individuals. We advise future researchers to continuously investigate various work, family and health outcomes in relation to workplace health climate and whether the outcomes vary depending on individuals' characteristics. With this line of work, researchers and practitioners can expand their understanding of workplace health climate and its consequences, and successfully develop and implement effective health climate promotion programmes in consideration of individual differences. Another future research direction is to explore how the different health climate perceptions among workers in the same workplace influence people's psychological health and behavioural health outcomes. Even if employees work in the same workplace, they may have quite different perceptions of workplace climate. The more different the perceptions are, the more confusion people would experience, possibly leading to negative psychological and behavioural health consequences. We encourage researchers to examine what causes workers in the same workplace to have different workplace health climate perceptions and how the different perceptions affect employee health outcomes.

Finally, although the results were replicated even after controlling for gender, gender may be a relevant factor to consider more explicitly in future research. In fact, gender was a significant predictor of exhaustion in our study. Future researchers should gather qualitative data, examine how men and women interpret the same perceived workplace climate differently, and explore whether men and

women engage in the different thought processes when they experience lower exhaustion from having a workplace health climate.

CONCLUSION

Despite the importance of employee health from both humanitarian and business bottom-line perspectives, workplace health climate remains understudied in the organizational sciences. The limited extant research suggests that workplace health climate largely leads to positive health outcomes, but such benefits may not be equally shared by all. Drawing on social exchange and organizational support theories and research on organizational support, we argued and found that workplace health climate facilitates higher sleep quality through reduction of exhaustion, but only for those who are within a 'healthy' range of body weight. Considering the prevalence of obesity or otherwise heavy body weight, and the complex range of factors contributing to the condition, organizations need to be more mindful with their approach to employee health so that all, not just some, can reap the benefit of supportive health climates.

AUTHOR CONTRIBUTIONS

Seulki "Rachel" Jang contributed to the research idea generation. Also, Seulki "Rachel" Jang contributed to data collection and analysis. The initial draft of the manuscript was written by the Seulki "Rachel" Jang and Ho Kwan Cheung. Michael Ford revised and strengthened the manuscript. All authors read and approved the final manuscript.

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The authors have no relevant financial or non-financial interests to disclose.

DATA AVAILABILITY STATEMENT

The authors elect to not share data.

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REFERENCES

Adab, P., Pallan, M., & Whincup, P. H. (2018). Is BMI the best measure of obesity? *British Medical Journal (Clinical Research Edition)*, *360*, k1274. https://doi.org/10.1136/bmj.k1274

Baran, B. E., Shanock, L. R., & Miller, L. R. (2012). Advancing organizational support theory into the twenty-first century world of work. *Journal of Business and Psychology*, *27*, 123–147.

Barnes, C. M. (2012). Working in our sleep: Sleep and self-regulation in organizations. *Organizational Psychology Review*, *2*(3), 234–257.

Barnes, C. M., Jiang, K., & Lepak, D. P. (2016). Sabotaging the benefits of our own human capital: Work unit characteristics and sleep. *Journal of Applied Psychology*, *101*(2), 209–221.

Basen-Engquist, K., Hudmon, K. S., Tripp, M., & Chamberlain, R. (1998). Worksite health and safety climate: Scale development and effects of a health promotion intervention. *Preventive Medicine*, *27*(1), 111–119.

Blau, P. (1964). *Exchange and power in social life*. Wiley.

Bookwala, J., & Boyar, J. (2008). Gender, excessive body weight, and psychological well-being in adulthood. *Psychology of Women Quarterly*, *32*(2), 188–195.

Brand, S., Beck, J., Hatzinger, M., Harbaugh, A., Ruch, W., & Holsboer-Trachsler, E. (2010). Associations between satisfaction with life, burnout-related emotional and physical exhaustion, and sleep complaints. *The World Journal of Biological Psychiatry*, *11*(5), 744–754.

Brisbois, T. D., Farmer, A. P., & McCargar, L. J. (2012). Early markers of adult obesity: A review. *Obesity Reviews*, *13*(4), 347–367.

Brossoit, R. M., Crain, T. L., Leslie, J. J., Hammer, L. B., Truxillo, D. M., & Bodner, T. E. (2019). The effects of sleep on workplace cognitive failure and safety. *Journal of Occupational Health Psychology*, *24*(4), 411–422.

Bureau of Labor Statistics. (2020). Medical care premiums in the United States, March 2020. https://www.bls.gov/ncs/ebs/factsheet/medical-care-premiums-in-the-united-states.htm

Buxton, O. M., Lee, S., Beverly, C., Berkman, L. F., Moen, P., Kelly, E. L., Hammer, L. B., & Almeida, D. M. (2016). Work-family conflict and employee sleep: Evidence from IT workers in the work, family and health study. *Sleep*, *39*(10), 1911–1918.

Cartwright, S., & Cooper, C. L. (2014). Towards organizational health: Stress, positive organizational behavior, and employee well-being. In G. F. Bauer & O. Hämmig (Eds.), *Bridging occupational, organizational and public health: A transdisciplinary approach* (pp. 29–42). Springer Science and Business Media.

Centers for Disease Control and Prevention (2014). April 16. Retrieved from http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html

Center for Disease Control and Prevention. Calculating BMI Using the English System. https://www.cdc.gov/nccdphp/dnpao/growthcharts/training/bmiage/page5_2.html

Clair, J. A., Beatty, J. E., & Maclean, T. L. (2005). Out of sight but not out of mind: Managing invisible social identities in the workplace. *Academy of Management Review*, *30*(1), 78–95.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, *98*(2), 310–357.

Crain, T. L., Hammer, L. B., Bodner, T., Kossek, E. E., Moen, P., Lilienthal, R., & Buxton, O. M. (2014). Work–family conflict, family-supportive supervisor behaviors (FSSB), and sleep outcomes. *Journal of Occupational Health Psychology*, *19*(2), 155–167.

Crandall, C. S., & Eshleman, A. (2003). A justification-suppression model of the expression and experience of prejudice. *Psychological Bulletin*, *129*(3), 414–446. https://doi.org/10.1037/0033-2909.129.3.414

Crandall, C. S., & Martinez, R. (1996). Culture, ideology, and antifat attitudes. *Personality and Social Psychology Bulletin*, *22*(11), 1165–1176.

Crocker, J., Cornwell, B., & Major, B. (1993). The stigma of overweight: Affective consequences of attributional ambiguity. *Journal of Personality and Social Psychology*, *64*(1), 60–70.

Danna, K., & Griffin, R. W. (1999). Health and well-being in the workplace: A review and synthesis of the literature. *Journal of Management*, *25*(3), 357–384.

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands-resources model of burnout. *Journal of Applied Psychology*, *86*(3), 499–612.

Demerouti, E., Mostert, K., & Bakker, A. B. (2010). Burnout and work engagement: a thorough investigation of the independency of both constructs. *Journal of Occupational Health Psychology*, *15*(3), 209.

Demsky, C. A., Fritz, C., Hammer, L. B., & Black, A. E. (2019). Workplace incivility and employee sleep: The role of rumination and recovery experiences. *Journal of Occupational Health Psychology*, *24*(2), 228–240.

Eisenberger, R., Huntington, R., Hutchison, S., & Sowa, D. (1986). Perceived organizational support. *Journal of Applied Psychology*, *71*(3), 500–507.

Eisenberger, R., & Stinglhamber, F. (2011). *Perceived organizational support: Fostering enthusiastic and productive employees*. American Psychological Association.

Finkelstein, E. A., daCosta DiBonaventura, M., Burgess, S. M., & Hale, B. C. (2010). The costs of obesity in the workplace. *Journal of Occupational and Environmental Medicine*, 971–976.

Ford, M. T., Wang, Y., Jin, J., & Eisenberger, R. (2018). Chronic and episodic anger and gratitude toward the organization: Relationships with organizational and supervisor supportiveness and extrarole behavior. *Journal of Occupational Health Psychology*, *23*, 175–187.

Franke, F., Felfe, J., & Pundt, A. (2014). The impact of health-oriented leadership on follower health: Development and test of a new instrument measuring health-promoting leadership. *German Journal of Human Resource Management*, *28*(1–2), 139–161.

Frey, F. E., & Tropp, L. R. (2006). Being seen as individuals versus as group members: Extending research on metaperception to intergroup contexts. *Personality and Social Psychology Review*, *10*(3), 265–280.

Goffman, E. (1963). *Stigma: The management of spoiled identity*. Penguin.

Grutterink, H., & Meister, A. (2022). Thinking of you thinking of me: An integrative review of meta-perception in the workplace. *Journal of Organizational Behavior*, *43*(2), 327–341.

Hakanen, J. J., & Schaufeli, W. B. (2012). Do burnout and work engagement predict depressive symptoms and life satisfaction? A three-wave seven-year prospective study. *Journal of Affective Disorders*, *141*(2–3), 415–424.

Ilies, R., Dimotakis, N., & Watson, D. (2010). Mood, blood pressure, and heart rate at work: An experience-sampling study. *Journal of Occupational Health Psychology*, *15*(2), 120–130.

Jenkins, C. D., Jono, R. T., & Stanton, B. A. (1996). Predicting completeness of symptom relief after major heart surgery. *Behavioral Medicine*, *22*(2), 45–57.

Jones, A. P., & James, L. R. (1979). Psychological climate: Dimensions and relationships of individual and aggregated work environment perceptions. *Organizational Behavior and Human Performance*, *23*(2), 201–250.

Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Menec & Perry 453 social stigmas: The psychology of marked relationships*. Freeman.

Jones, K. P., Peddie, C. I., Gilrane, V. L., King, E. B., & Gray, A. L. (2016). Not so subtle: A meta-analytic investigation of the correlates of subtle and overt discrimination. *Journal of Management*, *42*(6), 1588–1613.

Kaiser Family Foundation. (2019). Employee health benefits: 2019 summary. https://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2019

Kaluza, A. J., Schuh, S. C., Kern, M., Xin, K., & Van Dick, R. (2018). The importance of organizational health climate for employee health: A multilevel cascading model. In *Academy of management proceedings* (Vol. *2018*, No. 1, p. 11709). Academy of Management.

Kaplan, S. A., Santuzzi, A. M., & Ruscher, J. B. (2009). Elaborative metaperceptions in outcome-dependent situations: The diluted relationship between default self-perceptions and metaperceptions. *Social Cognition*, *27*(4), 601–614.

Katz, A. S., Pronk, N. P., McLellan, D., Dennerlein, J., & Katz, J. N. (2019). Perceived workplace health and safety climates: Associations with worker outcomes and productivity. *American Journal of Preventive Medicine*, *57*(4), 487–494.

Kelley, G. A., & Kelley, K. S. (2017). Exercise and sleep: A systematic review of previous meta-analyses. *Journal of Evidence-Based Medicine*, *10*(1), 26–36.

King, E. B., Kaplan, S., & Zaccaro, S. (2008). Metaperceptions in diverse work groups: Intrapersonal perspectives and intra-group processes. In *Diversity and groups* (Vol. *11*, pp. 109–141). Emerald Group Publishing Limited.

King, E. B., Rogelberg, S. G., Hebl, M. R., Braddy, P. W., Shanock, L. R., Doerer, S. C., & McDowell-Larsen, S. (2016). Waistlines and ratings of executives: Does executive status overcome obesity stigma? *Human Resource Management*, *55*(2), 283–300.

King, E. B., Shapiro, J. R., Hebl, M. R., Singletary, S. L., & Turner, S. (2006). The stigma of obesity in customer service: A mechanism for remediation and bottom-line consequences of interpersonal discrimination. *Journal of Applied Psychology*, *91*(3), 579–593.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2007). Job stress and poor sleep quality: Data from an American sample of full-time workers. *Social Science & Medicine*, *64*(10), 1997–2007.

Kopelman, P. G. (2000). Obesity as a medical problem. *Nature*, *404*(6778), 635–643.

Kurtessis, J. N., Eisenberger, R., Ford, M. T., Buffardi, L. C., Stewart, K. A., & Adis, C. S. (2017). Perceived organizational support: A meta-analytic evaluation of organizational support theory. *Journal of Management*, *43*(6), 1854–1884.

Linton, S. J. (2004). Does work stress predict insomnia? A prospective study. *British Journal of Health Psychology*, *9*(2), 127–136.

Linton, S. J., Kecklund, G., Franklin, K. A., Leissner, L. C., Sivertsen, B., Lindberg, E., Lindberg, E., Svensson, A. C., Hansson, S. O., Sundin, Ö., Hetta, J., Björkelund, C., & Hall, C. (2015). The effect of the work environment on future sleep disturbances: A systematic review. *Sleep Medicine Reviews*, *23*, 10–19.

Litwiller, B., Snyder, L. A., Taylor, W. D., & Steele, L. M. (2017). The relationship between sleep and work: A meta-analysis. *Journal of Applied Psychology*, *102*(4), 682–699.

Liu, Y., Ye, L., & Guo, M. (2019). The influence of occupational calling on safety performance among train drivers: The role of work engagement and perceived organizational support. *Safety Science*, *120*, 374–382.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, *2*(2), 99–113.

Major, B., Eliezer, D., & Rieck, H. (2012). The psychological weight of weight stigma. *Social Psychological and Personality Science*, *3*(6), 651–658.

McKay, P. F., Avery, D. R., & Morris, M. A. (2008). Mean racial-ethnic differences in employee sales performance: The moderating role of diversity climate. *Personnel Psychology*, *61*(2), 349–374.

McKay, P. F., Avery, D. R., Tonidandel, S., Morris, M. A., Hernandez, M., & Hebl, M. R. (2007). Racial differences in employee retention: Are diversity climate perceptions the key? *Personnel Psychology*, *60*(1), 35–62.

Mearns, K. J., & Reader, T. (2008). Organizational support and safety outcomes: An un-investigated relationship? *Safety Science*, *46*(3), 388–397.

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin*, *135*(4), 531–554.

Peter, R. S., Mayer, B., Concin, H., & Nagel, G. (2015). The effect of age on the shape of the BMI–mortality relation and BMI associated with minimum all-cause mortality in a large Austrian cohort. *International Journal of Obesity*, *39*(3), 530–534.

Podsakoff, P. M., MacKenzie, S. B., Lee, J. Y., & Podsakoff, N. P. (2003). Common method biases in behavioral research: A critical review of the literature and recommended remedies. *Journal of Applied Psychology*, *88*(5), 879–903.

Puhl, R. M., & Heuer, C. A. (2010). Obesity stigma: Important considerations for public health. *American Journal of Public Health*, *100*(6), 1019–1028.

Ribisl, K. M., & Reischl, T. M. (1993). Measuring the climate for health at organizations. Development of the worksite health climate scales. *Journal of Occupational Medicine*, *35*(8), 812–824.

Roehling, M. V., Roehling, P. V., & Pichler, S. (2007). The relationship between body weight and perceived weight-related employment discrimination: The role of sex and race. *Journal of Vocational Behavior*, *71*(2), 300–318.
Schneider, B., White, S. S., & Paul, M. C. (1998). Linking service climate and customer perceptions of service quality: Tests of a causal model. *Journal of Applied Psychology*, *83*(2), 150–163.
Schulz, H., Zacher, H., & Lippke, S. (2017). The importance of team health climate for health-related outcomes of white-collar workers. *Frontiers in Psychology*, *8*, 74.
Shapiro, J. R., King, E. B., & Quinones, M. A. (2007). Expectations of obese trainees: How stigmatized trainee characteristics influence training effectiveness. *Journal of Applied Psychology*, *92*(1), 239–249.
Smidt, M. N., Jimmieson, N. L., & Bradley, L. M. (2021). Predicting employee participation in, and satisfaction with, wellness programs: The role of employee, supervisor, and organizational support. *Journal of Occupational and Environmental Medicine*, *63*(12), 1005–1018.
Song, X., Jousilahti, P., Stehouwer, C. D. A., Söderberg, S., Onat, A., Laatikainen, T., Yudkin, J. S., Dankner, R., Morris, R., Tuomilehto, J., Qiao, Q., & for the DECODE Study Group. (2013). Comparison of various surrogate obesity indicators as predictors of cardiovascular mortality in four European populations. *European Journal of Clinical Nutrition*, *67*, 1298–1302. https://doi.org/10.1038/ejcn.2013.203
Sonnentag, S., & Pundt, A. (2015). Organisational health behavior climate: Organisations can encourage healthy eating and physical exercise. *Applied Psychology*, *65*(2), 259–286.
Swim, J. K., Johnston, K., & Pearson, N. B. (2009). Daily experiences with heterosexism: Relations between heterosexist hassles and psychological well-being. *Journal of Social and Clinical Psychology*, *28*(5), 597–629.
Syrek, C. J., Weigelt, O., Peifer, C., & Antoni, C. H. (2017). Zeigarnik's sleepless nights: How unfinished tasks at the end of the week impair employee sleep on the weekend through rumination. *Journal of Occupational Health Psychology*, *22*(2), 225–238.
Van Laethem, M., Beckers, D. G., Dijksterhuis, A., & Geurts, S. A. (2017). Stress, fatigue, and sleep quality leading up to and following a stressful life event. *Stress and Health*, *33*(4), 459–469.
Van Ruysseveldt, J., Verboon, P., & Smulders, P. (2011). Job resources and emotional exhaustion: The mediating role of learning opportunities. *Work and Stress*, *25*(3), 205–223.
Walter, S. L., Seibert, S. E., Goering, D., & O'Boyle, E. H. (2019). A tale of two sample sources: Do results from online panel data and conventional data converge? *Journal of Business and Psychology*, *34*, 425–452.
Weiner, B. (1995). *Judgments of responsibility: A foundation for a theory of social conduct*. Guilford Press.
Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology*, *55*(5), 738–748.
World Health Organization. (1948). *World Health Organization Constitution*. https://www.who.int/about/governance/constitution
Zohar, D. (2014). Safety climate: Conceptualization, measurement, and improvement. In B. Schneider & K. M. Barbera (Eds.), *The Oxford handbook of organizational climate and culture* (pp. 317–334). Oxford university Press.
Zohar, D., & Luria, G. (2005). A multilevel model of safety climate: Cross-level relationships between organization and group-level climates. *Journal of Applied Psychology*, *90*(4), 616–628.
Zuraikat, F. M., Wood, R. A., Barragán, R., & St-Onge, M. P. (2021). Sleep and diet: Mounting evidence of a cyclical relationship. *Annual Review of Nutrition*, *41*, 309–332.
Zweber, Z. M., Henning, R. A., & Magley, V. J. (2016). A practical scale for multi-faceted organizational health climate assessment. *Journal of Occupational Health Psychology*, *21*(2), 250–259.

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