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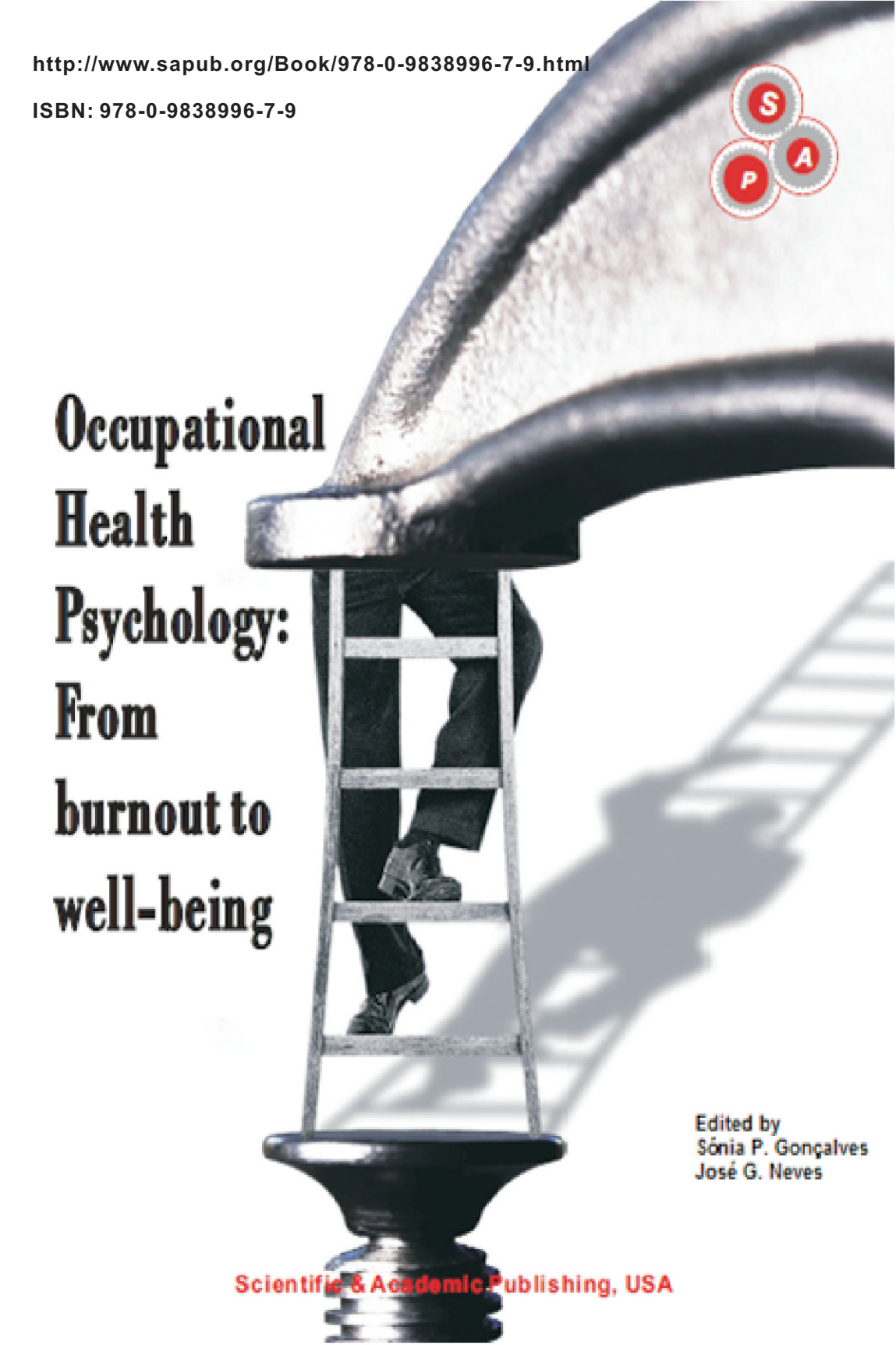

Occupational Health Psychology: From burnout to well-being

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Chapter

Bulding Organizational Trust: A Study in Small and Medium-Sized Enterprises

6

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Abstract The current study aims to contribute to our understanding of the relationship between healthy organizational practices and organizational trust. It is based on the *HEalthy & Resilient Organizations Model* (Salanova, Llorens, Cifre, & Martínez, 2012) and examines 726 employees nested within 72 teams from 12 small and medium-sized enterprises using data aggregated at the work-unit level. Linear multiple regression analyses revealed that, as expected, healthy organizational practices explained a significant amount of the variance of organizational trust. Specifically, communication and skills development are positively related to organizational trust ($p < .05$). Unexpectedly, however, psychosocial health was negatively related to organizational trust ($p < .05$). Theoretical and practical contributions based on the *HEalthy & Resilient Organizations Model* are discussed.

Keywords Healthy Organization, Organizational Practices, Organizational Trust

1. Introduction

Global economic conditions, faster changes in the labor market, and the social and economic crisis are making it increasingly more important to promote positive experiences in organizations, such as organizational trust, which is understood as "employees' willingness at being vulnerable to the actions of their organizations, whose behavior and actions they cannot control" (Lin, 2010, p. 517). In this sense, previous research agrees that organizational trust is pivotal, useful in organizational activities, and a source of sustainable competitive advantage (Andersen, 2005; Barney & Hansen, 1994). Specifically, organizational trust is important in enhancing working life and organizational effectiveness (Dirks & Ferrin, 2001; Kiffin-Petersen &

Cordey, 2003; Mayer & Gavin, 2005), and it has received substantial attention in the management and social science literature (Wong, Ngo, & Wong, 2003).

Despite its relevance, few studies have focused on trust at the team level, especially when groups play a crucial role in enabling contemporary organizations to achieve organizational goals (Tan & Lim, 2010; Wilson, Dejoy, Vandenberg, Richardson, & McGrath, 2004), as well as to increase efficiency and competitiveness (Hodson, 1997), productivity (Salanova, Llorens, Cifre, Martínez, & Schaufeli, 2003), and health (Wilson, Dejoy, Vandenberg, Richardson, & McGrath, 2004). Moreover, as far as we know, no previous research has focused on the antecedents of organizational trust, such as the Human Resources Management practices perceived by teams, which are two key elements (i.e., healthy organizational practices and organizational trust) that define healthy and resilient organizations (Salanova, 2008, 2009). In the current study we go one step further by studying the relationship among specific healthy organizational practices and organizational trust in a higher-order level of analyses (i.e., teams), that is, using data aggregated at the work-unit level based on the *HEalthy & Resilient Organizations (HERO) Model* (Salanova, Llorens, Cifre, & Martínez, 2012).

Nowadays organizations differ not only in the investment they make in the health, resilience and motivation of employees (and teams), but also in the structure and the management of the work processes implemented (e.g., organizational practices) and in healthy outcomes oriented toward achieving incomes and excellence for society (Landsbergis, 2003; Wilson et al., 2004). These organizations are healthy and resilient organizations, since the focus on health and resilience is based not only on individuals (i.e., employees) but also on teams and on the organization as a whole. There is evidence in favor of the idea that HEROs are those which are resilient when it comes to coping with economic and financial crises and important changes, and thus become stronger than unhealthy organizations (Cooper & Cartwright, 1994). In a similar way, Salanova (2008, p. 185) defines

HEROs as "those that make systematic, planned and proactive efforts in order to improve employees' and organizational health through Healthy Organizational Practices related to improving the job characteristics at three levels: (1) task level (e.g., task redesign in order to improve autonomy, feedback); (2) social environmental level (e.g., bidirectional communication in order to improve social relationships); and (3) organizational level (e.g., organizational practices in order to improve health, mobbing prevention)".

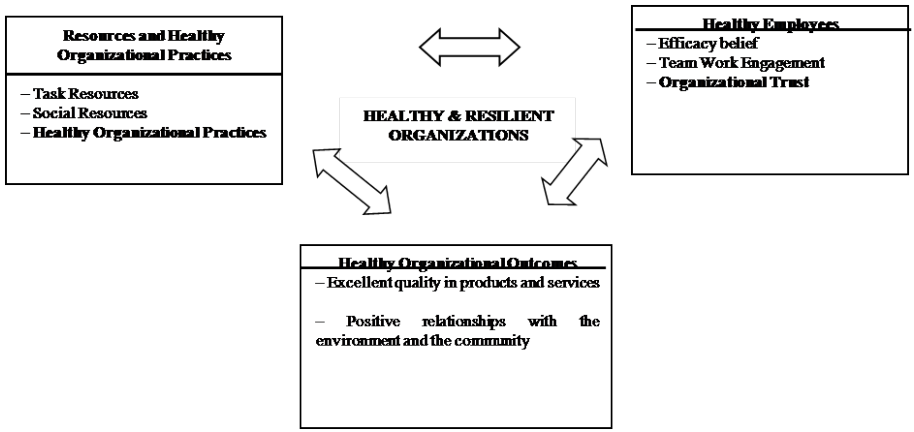

Figure 1. HEalthy & Resilient Organizational Model (*HERO Model*)

Based on theoretical premises about healthy and resilient organizations, the HERO Model is a heuristic theoretical model that makes it possible to integrate results about healthy and resilient organizations based on empirical and theoretically-based evidence from research on job stress, human resources management (HRM), organizational behavior, and positive occupational health psychology. According to this model, a healthy resilient organization refers to a combination of three main and interrelated components: (1) resources and healthy organizational practices (e.g., job resources, healthy organizational practices); (2) healthy employees (e.g., trust, work engagement); and (3) healthy organizational outcomes (e.g., performance) (Salanova et al., 2012). One particular aspect of the model

is that all dimensions included within it are tested at the collective level. Since this model is considered a heuristic model, it is not possible to test the whole model together and this must be done instead by looking at specific relationships among certain key elements. Consequently, in the present study, we focus on two specific components of the HERO Model: (1) resources and healthy organizational practices (e.g., healthy organizational practices), and (2) healthy employees (e.g., organizational trust) tested at the team level (see Figure 1).

1.1. Healthy Organizational Practices

Healthy Organizational Practices are a key component in the HERO Model and one of the elements included in the resources (task and social resources) and healthy organizational practices. They are also part of the organizational practices that are developed by HRM in order to achieve organizational goals (Wright & McMahan, 1992), as well as to increase the psychological and financial health at the staff, team and organizational level (see Salanova et al., 2012). Although there are two key elements in resources and healthy organizational practices, in the present study we focus on just one of them: organizational practices, which are defined as "the pattern of planned human resource deployments and activities intended to enable an organization to achieve its goals" (Wright & McMahan, 1992, p. 298).

The reason for focusing on organizational practices is that they are highly relevant in organizations; in fact, organizations which attempt to implement organizational practices display more positive experiences in employees (and teams) (e.g., organizational trust; Bruhn, 2001; Tremblay, Cloutier, Simard, Chênevert, & Vandenberghe, 2010) and healthy outputs such as organizational commitment (Mayers & Smith, 2000) and organizational performance (Bacon & Hoque, 2005). All in all, organizational practices enhance the appeal of the organization and help it to be perceived as a great place to work (Carlsen, 2008) and, consequently, they should be included in business strategy (Budhwar & Debrah, 2001).

Recent research based on the European Project ERCOVA (2004) shows that there are considered to be eight main practices from HRM based on Corporate Social Responsibility (CSR): work-family balance, mobbing prevention, skills development, career development, psychosocial health, perceived equity, communication, and corporate social responsibility (Salanova et al., 2012). These studies provide evidence that these organizational practices can have a positive impact on employees' well-being. Specifically, in a sample of 710 employees nested in 84 groups from 14 small and medium-sized enterprises (SMEs) results show that, in general terms, organizational practices (in which healthy organizational practices as well as job and social resources were considered) had a positive impact on employees' health (i.e., collective efficacy, engagement, and resilience), which in turn had a positive impact on healthy outcomes (i.e., performance, commitment, and excellent results) (Salanova et al., 2012). Overall, the few studies that have been conducted on the topic offer different results as regards which organizational practices exert the greatest effects on employees' psychological health and well-being. We agree with Fredrickson and Dutton (2008), who showed that the positive impact of healthy organizational practices on employees' health only occurs when workers perceive that those practices are being implemented in the organization correctly, that is, when employees trust their organization.

1.2. Organizational Trust

Organizational trust is considered one of the key elements in the HERO Model. Specifically, it is a psychological construct included within the category of "healthy employees". "Healthy employees" refers to employees with positive psychological resources (e.g., organizational trust, self-efficacy, mental and emotional competence, organizational-based self-esteem, optimism, hope, resilience), which are positively related to well-being (e.g., work engagement) (e.g., Lorente, Salanova, Martínez, & Schaufeli, 2008; Luthans, Youssef, & Avolio, 2007).

As mentioned above, we consider organizational trust to mean "employees' willingness at being vulnerable to the actions of their organizations, whose behavior and actions they cannot control" (Lin, 2010, p. 517). In this sense, healthy resilient organizations need to look at how to build organizational trust based on different antecedents (e.g., healthy organizational practices). Different scholars have shown that in order to increase trust in an organization, investment in healthy organizational practices is needed (Bruhn, 2001; Fredrickson & Dutton, 2008; Mone & London, 2010; Tan & Lim, 2009). Furthermore, there is evidence that employees trust their supervisor and top managers if they perceive justice in the organizational practices and decisions (Dirks & Ferrin, 2002). However, very little research has attempted to identify the factors that explain organizational trust at the team level of analysis. Our idea is based on the positive relationship between healthy organizational practices and trust. The rationale is that employees perceive that the organizations implement resources in order to care for their well-being.

Despite the relevance of HRM in order to enhance organizational trust, research has focused only on the individual level of analysis. And as mentioned earlier, Wilson et al. (2004) proposed that it is necessary to move to collective levels of analysis, especially since teams are the basic work structure in modern organizations. Consequently, one of the innovations of the present study is the fact that healthy organizational practices and organizational trust are considered at the team level of analysis.

1.3. The Aim of this Study

Based on previous research, the objective of our study is to test (for the first time) the role played by healthy organizational practices in organizational trust by aggregating data at the team level. At this point, we expect healthy organizational practices to be positively related with organizational trust when perceptions from employees have been aggregated at the team level of analyses.

2. Method

2.1. Sample and Procedure

The sample consisted of 726 employees (response rate was 60%) nested in 72 work units from 12 SMEs. Of these employees, 54% belonged to the service and 43% to the industry sub-sectors. Additionally, 53% were women and 76% had permanent work contracts. The average tenure in their current job was 4.5 years (*SD* = 3.5), 10 years working in the same company (*SD* = 7.67) and 14 years working in general (*SD* = 10.42). Finally, work units had an average of 7 team members each (mean = 10.07, *SD* = 8.62).

Once agreed in their participation, enterprises provided their employees with information regarding the project by different means (e.g., meetings, bulletin board, intranet). Also researchers conducted information meetings to further explain the project to employees and supervisors. Participants completed a self-report questionnaire regarding their work-units. We use the work-unit definition by George (1990), according to which a work-unit is an entity consisting of a group of workers who work together under the same supervisor and share collective responsibility for performance outcomes. The questionnaire was distributed to the different team members in the company by the researchers themselves and took approximately 30 minutes to be filled in. In order to prevent bias, only workers with more than six months of organizational tenure were considered for the analyses. According to Feldman (1988), the accommodation period that the new worker needs to settle into his or her job and the organization is three or four months (i.e., the encounter stage). Confidentiality and anonymity of the answers were guaranteed.

2.2. Measures

Healthy Organizational Practices were assessed by 9 items included in the HERO questionnaire (Salanova et al., 2012), which, as mentioned above, considers eight practices: work-family balance (1 item; *'In the*

last year, mechanisms and practices have been introduced in this organization in order to facilitate work-family balance and the private lives of its employees'), mobbing prevention (1 item; '*In the last year, mechanisms and practices have been introduced in this organization in order to prevent mobbing at work*), skills development (1 item; '*In the last year, mechanisms and practices have been introduced in this organization in order to facilitate the development of workers' skills*'), career development (1 item; '*In the last year, mechanisms and practices have been introduced in this organization in order to facilitate workers' career development'*), psychosocial health (1 item; '*In the last year, mechanisms and practices have been introduced in this organization in order to ensure well-being and quality of life at work'*), perceived equity (1 item; '*In the last year, mechanisms and practices have been introduced in this organization in order to ensure that workers receive rewards'),* organizational communication (2 items; '*In the last year, mechanisms and practices have been introduced in this organization in order to facilitate communication from management to workers'*; '*In the last year, mechanisms and practices have been introduced in this organization in order to ensure that information about the organizational goals is given to everyone who needs to know about them*'), and corporate social responsibility (1 item; '*In the last year, mechanisms and practices have been introduced in this organization in order to ensure issues concerning corporate social responsibility are dealt with*'). Internal consistencies for the scale reached the cut-off point of .70 (alpha = .89) (Nunnally & Bernstein, 1994). Respondents answered using a 7-point Likert-type scale ranging from 0 'never' to 6 'always'. In order to lead respondents' attention from the individual level to the team level, all the variables focused on team perceptions by aggregating data at the work-unit level.

Organizational Trust was assessed by 8 items based on Huff and Kelly's (2003) scale and McAllister's (1995) scale that were included in the HERO questionnaire (Salanova et al., 2012). An example of the items is: '*In this organization, subordinates have a great deal of trust in*

their managers'. Again, internal consistencies for scale reached the cut-off point of .70 (alpha = .86) (Nunnally & Bernstein, 1994). Respondents answered using a 7-point Likert-type scale ranging from 0 'totally disagree' to 6 'totally agree'. Again, in order to lead respondents' attention from the individual level to the team level, all the items focused on team perceptions so that they could be aggregated at the team level.

2.3. Data Analyses

Firstly, we calculated internal consistencies (Cronbach's α) for individual data using the PASW 18.0 software application. Secondly, Harman's single factor test (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003) was computed for the variables in the study in order to test for bias due to common method variance, also using individual data. Thirdly, since the variables in the study (i.e., healthy organizational practices, organizational trust) were measured at the team level, we computed agreement at the team level for each scale (for the procedure used to aggregate, see Chen, Mathieu, & Bliese, 2004). To do so, we used a consistency-based approach by computing Intraclass Correlation Coefficients (ICC_1 and ICC_2) (Bliese, 2000; Glick, 1985) using PASW 18.0. Thus, it was concluded that team agreement existed when ICC_1 and ICC_2 were higher than .12 and .60, respectively (Bliese, 2000; Glick, 1985). Different Analyses of Variance (ANOVA) were also computed in order to ascertain whether there was any statistically significant between-group discrimination for the average scales. Fourthly, we computed descriptive statistics and intercorrelations among the scales by means of data aggregated at the team level. Finally, PASW 18.0 was used to implement a Linear Multiple Regression Analysis using the *Forced Entry* method (Field, 2005) in order to determine the relationships among healthy organizational practices and organizational trust using data aggregated at the work-unit level. This method is recommended as the best method when all the predictors are forced into the model simultaneously (Berntson & Marklum, 2007; Field, 2005). Furthermore, it makes it possible to determine the proportion of

common variance between different variables through the coefficient of determination (R^2; Everitt, 2002). All healthy organizational practices were introduced in one step in order to ascertain the relationship between healthy organizational practices and organizational trust.

3. Results

3.1. Aggregation and Descriptive Analyses

First, the results of Harman's single factor test (Podsakoff et al., 2003), which were obtained from an individual database (N = 726), reveal a bad fit to the data [$\chi2(35) = 475.273$, $p = .000$, RMSEA = .132, CFI = .858, NFI = .849, TLI = .817, IFI = .858, AIC = 515.273]. In order to avoid the problems related to the use of Harman's single factor test (see Podsakoff et al., 2003), we compared the results of one latent factor with those obtained using multiple latent factors. Results show a significantly lower fit of the model with one single factor when compared to the model with multiple latent factors [Delta $\chi2(1) = 107.733$, $p < .001$]. Consequently, the common method variance can be considered not to be a serious deficiency in this dataset.

Table 1 shows the means, standard deviations and intercorrelations of all the study variables aggregated at the work-unit level (N = 72) using PASW 19.0. Since the variables in the study arise from the shared perceptions of team members, a reference-shift consensus model was applied (Chen et al., 2004). Based on the data aggregated at the work-unit level (N = 72), the ICC_1 and ICC_2 indices ranged from .13 to .37 and from .62 to .85 for the variables in the study, respectively. Thus, aggregation results lend support to the conclusion that within-group agreement in the study's work-units is sufficient to aggregate unit members' perceptions to the work-unit level (Chen et al., 2004). Only one exception was found: for the perceived equity strategy, agreement was not reached. Consequently, this specific healthy organizational practice was not considered in the analyses that followed.

Table 1. Means (M), standard deviations (SD) and intercorrelations by aggregating data (N = 72)

Variables	M	SD	1	2	3	4	5	6	7	8	9
1. Work-Family Balance	2.77	1.36	-								
2. Mobbing Prevention	2.39	1.26	.74***	-							
3. Skills Development	3.51	1.09	.51***	.58***	-						
4. Career Development	2.47	1.03	.18	.23*	.69***	-					
5. Psychosocial Health	3.37	1.19	.72***	.70***	.71***	.45***	-				
6. Perceived Equity	2.02	.94	.18	.22*	.52***	.70***	.38**	-			
7. Communication	2.84	1.20	.65***	.62***	.40**	.29**	.57***	34**	-		
8. CSR	3.34	1.21	.65***	.43***	.57***	.50***	.59***	.39**	58***	-	
9. Organizational Trust	3.54	.84	.50***	.52***	.48***	.34**	.39***	.33**	.62***	55***	-

Notes: ***$p < .001$; **$p < .01$; *$p < .05$.

We also ran a one-way ANOVA to test whether there was statistically significant between-group discrimination among employees in the average variables. Results for the variables in the study ranged from 2.63 to 5.78 ($p < .001$). Consequently, there is a significant degree of between-group discrimination, and the validity of using aggregated data on healthy organizational practices and organizational trust was supported.

Finally, intercorrelations among healthy organizational practices and organizational trust by aggregating data at the work-unit level (N = 72) shows that, as expected, variables correlate positively and significantly

to each other (77%), with values ranging from .22 to .74 ($p < .001$). Unexpectedly, the intercorrelations between three healthy organizational practices (work-family balance with career development and perceived equity) were non-significant.

3.2. Linear Multiple Regression Analyses

For the Linear Multiple Regression Analyses we used the aggregate database (N = 72), which means that the scales aggregated at the work-unit level for healthy organizational practices and organizational trust were considered in the analyses. Specifically, healthy organizational practices comprise seven indicators: work-family balance, mobbing prevention, skill development, career development, psychosocial health, organizational communication, and corporate social responsibility. Finally, organizational trust comprises one indicator.

Table 2 shows the results of the two Linear Multiple Regression Analyses conducted by means of the forced method in order to test the relationship of each healthy organizational practice with organizational trust by aggregating data at the work-unit level. The findings of these analyses indicate that healthy organizational practices are related to organizational trust when the variables are tested at the aggregate level of analysis. A revision of the regression weights reveals that, as expected, healthy organizational practices have a positive and significant relationship with organizational trust. More specifically, only communication and skills development are positively related to organizational trust ($\beta = .39$, $p < .05$ and $\beta = .32$, $p < .05$, respectively). It is interesting to note that healthy organizational practices explain 44% of the variance of organizational trust ($R^2 = 44$, $p < .001$). The rest of the healthy organizational practices (i.e., work-family balance, mobbing prevention, career development and corporate social responsibility) do not show significant relationships with organizational trust.

Finally, it is important to note that one unexpected relationship was obtained between the psychosocial health practice and organizational trust. Particularly, the psychosocial health practice is significantly and

negatively related to organizational trust (β = -.43, $p < .05$).

All in all, these results provide evidence for the following findings: (1) in general, healthy organizational practices are related to organizational trust; and (2) organizational trust is specifically related to communication and skills development practices. Furthermore, a non-expected result was also obtained, that is, the psychosocial health practice is negatively related to organizational trust.

Table 2. Linear Regression Analyses by aggregating data (N = 72)

Practices	B	*SE B*	*β*
1. Work-Family Balance	.013	.144	.021
2. Mobbing Prevention	.180	.110	.27
3. Skills Development	.243	.135	.32**
4. Career Development	.0001	.136	.00
5. Psychosocial Health	-.302	.119	-.43**
7. Communication	.275	..94	.39**
8. CSR	.18	.104	.25
$R^2 = .51$			
$\Delta R^2 = .44$			

Notes: **p < .01

4. Discussion

The aim of our study was to evaluate, for the first time, the relationship between healthy organizational practices and organizational trust by aggregating data at the team level. Specifically, we tested the role of healthy organizational practices in organizational trust by considering the aggregate perceptions from team members in SMEs. We hypothesized that healthy organizational practices were positively related to organizational trust when data were aggregated at the team level. In particular, we expected SMEs with HRM focused on

work-family balance, mobbing prevention, skills development, career development, psychosocial health, perceived equity, communication and corporate social responsibility to be positively related to trusted employees in organizations when data are aggregated at the team level.

The current study contributes to our understanding of the relationship between two of the elements of the HERO Model, that is, resources and healthy organizational practices (healthy organizational practices) and healthy employees (i.e., organizational trust) using data aggregated at the work-unit level. In a sample of 726 employees nested within 72 work units from 12 SMEs, we tested the relationship among healthy organizational practices (8 practices) and organizational trust at the team level included in the HERO questionnaire (Salanova et al., 2012). Items were aggregated for teams using the ICC_1 and ICC_2 indices. Only the strategy of perceived equity failed to acquire enough consistency in order to be aggregated. Consequently, this strategy was deleted from the analyses that followed. This result should be interpreted as meaning that the employees have varying degrees of equity. That is, each employee interprets the same actions implemented by the organization in different ways according his or her individual expectations (Kickul, Gyndry, & Posig, 2005). The different individual expectations make it difficult for there to be an agreement regarding the practices implemented by the organization at team level.

Results of the Linear Multiple Regression Analyses with data aggregated at the work-unit level of analysis revealed that, generally, the healthy organizational practices explain 44% of the variance in organizational trust. Overall, results show that organizational trust is positively related to two of the seven practices, i.e., communication and skills development practices. It seems than the rest of the healthy organizational practices have no relationship with organizational trust. Contrary to expectations, psychosocial health showed a negative relationship with organizational trust. Maybe this finding offers evidence in favor of an artifactual result, since the intercorrelation among psychosocial health and organizational trust was positive and

significant.

Taken as a whole, results are in line with previous research, in which the key role of communication practice in increasing organizational trust was observed (Peña & Del Valle, 2009; Salanova, 2008). On the one hand, teams must be well informed and share the organizational goals, mission and values. On the other hand, communication channels and processes should be nurtured if the organization is interested in promoting organizational trust (Wilson et al., 2004). Opportunities for skills development also have an impact on organizational trust since work units perceive the fact that the organizations carry out specific actions to improve their skills. Consequently, this is reflected in positive contributions to the organization (Fredrickson & Dutton, 2008) and in the increase in the appeal of the organization (Carlsen, 2008). Overall, the results from the present study offer evidence in favor of the need to include these HRM practices in the business strategy (Budhwar & Debra, 2001) in order to give employees a sense of support and trust in the organization (Tremblay et al., 2010).

However, in the present study we go a step further, since the relationship between healthy organizational practices and organizational trust has been considered at the team level. In this respect, we can assume that the group level of analysis is suitable for testing organizational trust as well as healthy organizational practices. The team's perception of the construct of organizational trust, and not only the individual ones, is needed to know about organizational phenomena such as organizational trust, since groups are the essence of work nowadays. Secondly, and addressing the healthy organizational practices, in the present study we use data aggregated at the team level of analysis since we consider sharing the perceptions of employees working in teams to be decisive to be able to perceive the practices implemented by the organizations and their quality. Moreover, we assume that in this process of perception and evaluation of the quality of the practices implemented by the organization, supervisors and the internal functioning of teams play a key role.

In fact, it seems that only when teams perceive that healthy practices are being implemented in the organization, in terms of communication and skills development, does organizational trust increase. We can conclude that organizations must invest in HRM (especially in communication and skills development) if they are interested in generating organizational trust among teams. Thus, results lend support to our hypothesis and we can say that the objective of the study has been reached.

4.1. Limitations and Further Research

The present study has several different limitations. The first one is that the data were obtained by self-report instruments. However, aggregate rather than individual perceptions of teams have been considered for healthy organizational practices and organizational trust. Consequently, the use of these data aggregated at the team level of analysis enabled us to minimize the common method variance bias. Secondly, a convenience sample is used in the present study. However, it is wide sample, including different team groups from different enterprises which belong to different economic sectors. Another limitation is that we used team perceptions on organizational phenomena (i.e., healthy organizational practices and organizational trust) and a further step in the research should consider the aggregation of data at the organizational level. However, as mentioned before, we consider the group level of analysis to be suitable for testing organizational trust as well as healthy organizational practices. A future step in the study should be to test the relationship between healthy organizational practices and organizational trust (aggregated at the organizational level) on other employee health variables (e.g., team work engagement aggregated at the team level) and healthy organizational outcomes (e.g., work-unit productivity measured by the supervisor's opinion). This could be carried out using multilevel analyses by exploring cross-level effects and interactions between the organizational and team levels. This would allow the HERO Model to be tested taking into account the relationship between the three key

elements (i.e., resources and healthy organizational practices, healthy employees, and healthy outcomes) at different levels of analysis. Furthermore, it should be interesting to test this model using multiple organizations (not only SMEs) in cross-cultural and longitudinal studies in order to explore the existence of positive spirals over time. According to the HERO Model, the three elements (i.e., resources and healthy organizational practices, healthy employees, and healthy outcomes) are assumed to be related to each other over time by a gain spiral.

4.2. Theoretical and Practical Implications

The present study shows some implications for future research and practice. At the theoretical level, the present study extends the body of knowledge about the relationship between healthy organizational practices and organizational trust tested by data aggregated at the work-unit level in SMEs. The positive relationship among specific healthy organizational practices (i.e., communication and skills development practices) lends support to the HERO Model (Salanova et al., 2012) because it analyzes the relationship proposed by the model between resources and healthy organizational practices (i.e., healthy organizational practices) and healthy employees (i.e., organizational trust) at a high level of analysis (i.e., teams).

From a practical point of view, results can be used by HRM in order to foster and develop organizational trust in their teams. Organizations should be alerted of the relevance of investing in two key practices, i.e., organizational communication and skills development practices, in order to promote organizational trust. Investment in these practices should be interpreted by teams as a sign that the organization is concerned about its employees, and consequently organizational trust in the organization will be enhanced.

This study has allowed the relationship between HRM and organizational trust in teams to be made explicit by aggregating data. Specific healthy organizational practices are positively related to organizational trust, thus lending support to the premises of the HERO

Model from the team-level analysis. This study provides evidence of the relevance of the quality but not the quantity of the practices implemented, and of the specific role of healthy organizational practices. In this respect, organizational communication and skills development should be implemented in order to enhance organizational trust.

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