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Short Communication

Relationships among perceived psychological growth, resilience and burnout in physicians



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ABSTRACT

The purpose of this study was to examine the relationships between perceived growth as a physician (i.e., positive psychological changes experienced as a result of the professional experience) and burnout after controlling for the effects of perceived family support, dispositional resilience, age, and marital status among physicians. Physicians ($n = 289$) rated perceived support from family and completed the short form of the Posttraumatic Growth Inventory, the Resilience Scale, and Maslach Burnout Inventory. Results of hierarchical regression analyses revealed that the addition of perceived growth significantly improved prediction of resilience and perceived family support for burnout, showing that higher growth, resilience, and family support all were associated with lower levels of burnout. Moreover, the effects of growth on depersonalization, a domain of burnout, were stronger for physicians who perceived a lower level of family support, whereas the effects of growth on personal accomplishment, another domain of burnout, were stronger for physicians who showed a lower level of dispositional resilience. Current results have clinical implications for understanding protective factors for burnout, that is, a sense of personal growth may be a key factor for physicians who may be less resilient or may not perceive strong family support.

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1. Introduction

Physician burnout has received considerable attention for the past decade (e.g., Houkes, Winants, & Twellaar, 2008, for review). Numerous studies have attempted to identify a parsimonious set of predictors that can explain burnout variation among physicians. Such predictors include personality characteristics, work environmental stressors, and work-home interaction. Since burnout affects not only physicians' wellbeing but also their patients' satisfaction and the quality of medical care they provide (e.g., Passalacqua & Segrin, 2012), it is critical to further investigate the determinants of physician burnout.

This study focuses on the role of perceived psychological growth that may occur as a result of physicians' professional experiences. Psychological growth resulting from trauma is referred to as *posttraumatic growth* (PTG; Tedeschi & Calhoun, 1996). As the number of studies of PTG increases, it has become clear that PTG can occur not only in survivors who experience a trauma, but also in healthcare personnel as a result of their professional experiences (e.g., Arnold, Calhoun, Tedeschi, & Cann, 2005). Previous research, although limited, has revealed that burnout is negatively associ-

ated with growth (Gibbons, Murphy, & Joseph, 2011), supporting the PTG model (e.g., Tedeschi & Calhoun, 2004). The question remains as to how perceived growth contributes to burnout, over and above the factors that have been shown to predict burnout.

Resilience is a personality attribute that has been investigated as a predictor for burnout (e.g., García & Calvo, 2012). Resilience moderates the negative effects of stress and promotes the ability to "bounce back" following adversity (Wagnild & Young, 1993). Thus, it is expected to serve as a protective factor for burnout. Previous studies have mostly supported this notion (e.g., García & Calvo, 2012). In addition, the role of perceived family support in burnout (e.g., Dekel, Mandl, & Solomon, 2011) also has been identified; as such, it is necessary to control for these variables when examining the unique contributions of perceived growth to burnout.

The purpose of this study is to investigate the relationships between perceived growth and burnout after controlling for the known predictors (i.e., resilience and perceived family support), and the demographic variables (i.e., age and marital status). Specifically, it is hypothesized that, if a physician endorses a high level of resiliency, whether he or she perceives personal growth will not play a significant role in burnout, due to the well-established protective role of resiliency. However, if a physician does not endorse a high level of resiliency, then the significant role of personal growth will emerge. Similarly, if a physician perceives greater

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family support, he or she will not be likely to develop burnout, regardless of the level of growth. However, if a physician perceives lower level of family support, then the significant role of growth may be observed, assuming that not all physicians have to experience growth to prevent burnout.

The current study, derived from the PTG model (Tedeschi & Calhoun, 2004), tests these hypotheses by examining each of the burnout domains, separately. Three distinct domains have been identified (e.g., Maslach, Jackson, & Leiter, 1996). *Emotional exhaustion* refers to a depletion of one's emotional resources and the feeling that one has nothing left to give to others at a psychological level. *Depersonalization* is an attempt to put distance between oneself and service recipients by becoming indifferent. *Reduced personal accomplishment* occurs when employees gain no professional satisfaction from their occupation. Because little research has been conducted to test the relationships between burnout and personal growth, specific hypotheses were not formulated regarding the role of personal growth in each of these burnout domains; however, the patterns of growth moderation may vary among the three burnout domains, since previous studies have revealed the distinct nature of these different domains (e.g., Glasberg, Eriksson, & Norberg, 2007).

2. Methods

2.1. Participants and procedure

The sample consisted of 289 physicians (119 female, 157 male, 13 did not report), ranging in age from 24 to 74 ($M = 35.79$, $SD = 11.01$). More than half classified themselves as Caucasian (56.4%, 17.6% for Asian or Pacific Islander, 12.1% for other, and 13.8% did not report). Seventy-four percent were married. The breakdown of medical specialty was: 19.0% for internal medicine, 17.6% for family medicine, 11.4% for radiology, 42.7% for other, and 9.3% did not report. Sixty-eight percent were residents, 30% were attending, and 2% were fellows.

The participants were recruited via mail. A total of 839 research packets were mailed, and 290 were returned. One research packet was excluded due to the same response being given for every answer. The response rate was 34.45%. All surveys were conducted anonymously. The study was approved by the institutional review board from three teaching hospitals in the Midwestern United States.

2.2. Measures

2.2.1. Demographics

Demographic variables such as age, gender, and ethnicity were collected. Perceived family support was measured using a single item, "How would you rate the quality of your family support?" with the response format on a 10-point scale, 1 (*poor*) to 10 (*excellent*).

2.2.2. Perceived psychological growth

Perceived psychological growth was assessed by using the 10-item short form of the PTG Inventory (PTGI; Tedeschi & Calhoun, 1996; PTGI-SF: Cann et al., 2010). The original PTGI-SF asks participants to indicate the degree to which each change occurred in their lives as a result of crisis. The current study modified the instructions and asked the participants to indicate the degree to which each change occurred as a result of their professional experience as a physician. Each item was rated from 1 (*strongly disagree*) to 5 (*strongly agree*). The Cronbach's alpha in this sample was .85.

2.2.3. Burnout

Burnout was measured with the Maslach Burnout Inventory (Maslach et al., 1996). Each item was rated from 0 (*never*) to 6 (*every day*) by indicating the degree to which a person experienced 22 different job-related feelings. The internal consistency for each factor in this sample was .89 for *Emotional Exhaustion*, .75 for *Depersonalization*, and .79 for *Personal Accomplishment*.

2.2.4. Resilience

Dispositional resilience was assessed by the 14-item Resilience Scale (Wagnild & Young, 1993). Each item was rated on a 7-point scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The internal consistency in this sample was .94.

3. Results

First, zero-order correlations were obtained (Table 1). Perceived growth was negatively correlated with *emotional exhaustion* ($r = -.34$, $p < .01$) and *depersonalization* ($r = -.36$, $p < .01$) and positively correlated with *personal accomplishment* ($r = .33$, $p < .01$), which is in line with the prediction.

A series of hierarchical regression analyses were performed. The demographic variables were entered first. Marital status was entered using dummy coding (married = 1, not married = 0). The known predictors (i.e., resilience and perceived family support) were entered second. Growth was entered third. Two interactions (i.e., growth \times resilience, growth \times family support) were entered fourth. All predictors were linearly transformed to reduce the multicollinearity problems. The results are presented in Table 2. Significance of the predictors was set at $p < .01$ to reduce experiment-wise type I error.

The final model explained 17% of the variance for *emotional exhaustion*, $F(7, 242) = 7.30$, $p < .001$. Addition of the growth factor improved prediction (R^2 change = .09, $p < .001$) in Step 3. In the resulting Step 4, the only significant predictor was perceived growth ($\beta = -.30$, $p < .001$). Higher growth was associated with lower levels of *emotional exhaustion*.

The final model explained 23% of the variance for *depersonalization*, $F(7, 238) = 10.04$, $p < .001$. Addition of growth improved prediction (R^2 change = .08, $p < .001$) in Step 3. Furthermore, addition of interaction terms improved prediction (R^2 change = .03,

Table 1
Descriptive statistics and zero-order correlations among study variables.

Variables	<i>M</i> (<i>SD</i>)	Possible score range	1	2	3	4	5
1. Growth	36.16 (6.22)	10–50					
2. Resilience	80.79 (11.24)	14–98	.22**				
3. Family support	8.84 (1.77)	1–10	.08	.12*			
4. Emotional exhaustion	19.72 (10.42)	0–54	-.34**	-.24**	-.20**		
5. Depersonalization	7.65 (5.67)	0–30	-.36**	-.24**	-.22**	.58**	
6. Personal accomplishment	37.90 (7.23)	0–48	.33**	.43**	.11	-.22**	-.26**

* $p < .05$.

** $p < .01$.

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