



CONTRIBUTIONS OF PSYCHOLOGICAL DETACHMENT FROM WORK AND PERCEIVED ORGANIZATIONAL SUPPORT IN WORK-LIFE BALANCE AMONG HEALTH WORKERS

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Abstract

As work-life balance increasingly becomes crucial for employee wellbeing, research light is also being beamed on possible correlates and predictors of the construct. Using a cross-sectional design, this study examined psychological detachment and perceived organizational support as predictors of work-life balance. Two hundred and fifty healthcare workers selected through convenience sampling from two hospitals in Enugu State Nigeria participated in the study. Psychological Detachment Scale, Perceived Organizational Support Scale and Work-life Balance Scale were used for data collection. Work life balance was conceptualized as having three dimensions-work interference with personal life, personal life interference with work and work/personal life enhancement. Data was analysed using multiple regression. Psychological detachment from work predicted both personal life interference with work and work personal life enhancement. It was found that perceived organizational support did not predict any of the work-life balance dimensions. It was suggested that the link between organizational support and work-life balance among health workers needs further investigation.

Keywords: Health workers, healthcare management, psychological detachment, perceived organisational support, work-life balance.

The healthcare sector in Nigeria is experiencing lots of challenges. For instance, demographic changes, patient expectations and rights, reforms, a health workforce shortage, inadequate equipment and facilities, high cost and rise in demand for health services are few examples of challenges that have plagued this sector. These challenges have led to difficulties in the work environment and a decline in staff satisfaction (Ahmad & Oranye, 2010), which often results in dissatisfaction among the health care recipients and stress/low quality of life experiences on the health care workers themselves, thereby increasing the imbalance between work and life. To improve aspects of the healthcare sector, knowledge of the employees' wellbeing and the ways in which they strive to strike a balance between work and non-work domains will be of great importance. But much more, assessing how healthy and happy health workers themselves are, would go a long way to promote a healthier society. The present study investigates a quality of life domain - the work-life balance (WLB) of health care workers as influenced by their levels of psychological detachment from work and perceived organizational support from their health organizations. Working in the healthcare setting is among the most demanding jobs in Nigeria. Often, health workers are called from their comfort to undertake unplanned tasks and engage in tasks that disrupt their planned involvement in social activities. As a result, the balance between work and other areas of life is tilted more towards work. Worse still, health workers have engaged incessantly in industrial actions within the past few years because of the failure of the Nigerian government to meet up with agreements that should enhance their wellbeing.

Aycan, Eskin and Yavuz (2007) opined that all systems in social life are dependent on one another (and thus disequilibrium and damage to one system will be accompanied by a ripple effect on other systems). In response to this, social and health scientists have suggested that the best approach would be to balance all areas of social life (work inclusive). However, this is often not very possible as people get too busy working and neglect other meaningful areas of life such as family. For the health worker, creating a balance becomes increasingly difficult because they are involved in the business of saving other lives and may often more than necessary have to undergo extra work hours, get involved in complex work environments and perform extra duties that may compromise this balance between work and life. Health work in itself requires the availability of workers on a twenty-four hour basis. Though measures and systems such as shift working and rostering have been put in place to ensure that workers do not burn out completely, it often comes along with additional hardships for health workers in rural and complex environments.

WLB has been explained in differing terms by experts to be the extent to which an individual's effectiveness and satisfaction in work and family roles are compatible with the individual's life priorities (Greenhaus & Allen, 2006); the accomplishment of role-related expectations that are negotiated and shared between an individual, and his/ her role partners in the work and family domains (Grzywacz & Carlson, 2007); and as the individual's perception that work and non-work activities are compatible and promote growth in accordance with his/her current life priorities (Kalliath & Brough, 2008). In summary, WLB is often associated with equilibrium or maintaining an overall sense of harmony in life (Clarke, Koch, & Hill, 2004). Hayman (2005) proposed that the concept of WLB is multidimensional, comprising of three dimensions which include: work interference with personal life (WIPL), personal life interference with work (PLIW) and work/personal life enhancement (WPLE). Guest (2002) outlined organizational factors, individual factors, cultural factors and social factors as categories of factors which influence all the domains of WLB. Wei, Yili and Tian (2013) further stated that conflicts between competing work and family demands can have negative effects at the workplace, at home and on the individual, while WLB interventions can reduce the stress associated with balancing multiple roles. However, it is unclear which domains of WLB would be most effectively cushioned by intervention strategies. The present study looks at these three subdomains of WLB and seeks to understand associations that may exist between them.

Psychological detachment from work (PDfW) was introduced into scientific literature by Etzion, Eden and Lapidot (1998) to represent a sense of being away from the work situation. They opined that PDfW was important for improving well-being during non-work time. PDfW in this sense would not only mean being physically absent from work but being mentally switched off from work related thoughts and activities. When studied independently, low levels of PDfW have been associated with increased levels of fatigue, sleeping problems, emotional exhaustion, anxiety, frustration, stress, low-job satisfaction and burnout (Grebner, Semmer, & Elfering, 2005; vanHooff, Geurts, Kompier, & Taris, 2007; Sonnentag, Binnewies, & Mojza2010). However, research linking PDfW and WLB have demonstrated that PDfW might have specific implications on WLB (e.g. Bakker & Demerouti, 2012). Previous research on WLB has been prevalently among industrial workers (Thakur & Kumar, 2015), medical doctors (Junhui, Jiana, Li, Wei, & Hui, 2016). It appears that the interest in studying WLB among health workers is only gaining attention in recent years. The present study in addition to using a health worker population, screened for the possible implication PDfW might have across the three subdomains of WLB. It was hypothesized that PDfW will be a significant predictor of the three domains of WLB investigated in the present study.

Perceived organizational support (POS) embodies perception of the care, value and commitment organizations place on their employees (Rhoades & Eisenberger, 2002). Health workers are prone to pay more attention to this value on and organizational commitment to them because of the extra commitment they (health workers) on their path give to the organization. In previous research, (e.g., Rhoades & Eisenberger, 2002), POS was consistently related with and predicted several other work-related variables. The Job demand-Resources (JD-R) model posits that interactions between job demands and resources are important, such that certain

resources (e.g., social support, organizational support) can lessen the negative psychological effects of stress (Kossek, Pichler, Boduer & Hamer, 2011). Owing to this assertion, some authors (e.g., Demerouti, Bakker, Sonnentag, & Fullagar, 2012; Bakker & Demerouti, 2012) suggest that organizational support can act as a resource to moderate the demands imposed by work and life. They opine that individuals with greater access to organizational support are able to acquire additional job related psychological resources that provide a buffer to manage strain. In this study we try to investigate the levels of POS of health workers and the contributions this might have in WLB. Literature available on POS among health workers and the nature of its contribution to WLB among health workers in a sub-Saharan region is scarce and it appears the concept has not been robustly investigated in Nigeria. The present study attempts to add to the available global literature on POS among health workers and also investigate the concept and its implications on WLB among health workers in a sub-Saharan country. We hypothesized that POS will be a significant predictor across the three domains of WLB.

Method

Participants

Two hundred (200) healthcare workers conveniently drawn from two different hospitals in Enugu State, Nigeria, participated in the study. They consisted of 85 men and 115 women. The age of the participants ranged from 21 to 58 years, (Mean = 35.75; $SD = 8.32$). The full time workers were one hundred and sixty three (163) and part time workers were thirty seven (37). A hundred and fourteen (114) reported being married while eighty-six (86) reported being unmarried. A hundred and sixty-three (163) worked full time while thirty seven (37) were employed as part time workers.

Instruments

The questionnaire for data collection consisted of two sections. The first section covered statements on demographics such as age, gender, marital status, and job status. The second section focused on assessing respondents' levels of WLB, PDfW and POS.

Work-Life Balance Scale (WLBS)

The WLBS was originally developed by Fisher-McAuley, Stanton, Jolton, and Gavin (2003) and subsequently adapted by Hayman (2005). Hayman's adaptation of the WLBS resulted in shortening of the length of the scale from 19 to 15 items. The WLBS was designed to measure work-life balance from three dimensions: work interference with personal life (WIPL) e.g., "personal life suffers because of work", personal life interference with work (PLIW) e.g., "Job makes personal life difficult", and work/personal life enhancement (W/PLE) e.g., "job gives me energy to pursue personal things". Respondents rate each item on the WLBS using a scale of 1 (not at all) to 7 (all the time) to indicate the degree to which it applies to them. Item seven on the WIPL is reverse scored. Hayman (2005) reported Cronbach's alpha reliability coefficient of .93, .85, and .69 for the WIPL, PLIW, and W/PLE respectively. Reliability obtained in the current study was .88, .73 and .68 for the WIPL, PLIW, and W/PLE respectively.

Psychological Detachment Scale

The Psychological Detachment Scale is a sub-scale of the Recovery Experience Questionnaire (REQ) by Sonnentag and Fritz (2007). It was used to measure psychological detachment in the present study. It contains 4-items, with statements such as "During time after work, I forget about work". The responses are in a five-point Likert-type structure with options ranging from (1 = I do not agree at all to 5 = I fully agree). Sonnentag and Fritz (2007) established the reliability of the scale using Cronbach's alpha to have a coefficient of .89. For the present study, α of .66 was obtained for the PDS subscale of the REQ.

Survey of Perceived Organizational Support Scale (SPOS)

A short version of Eisenberger, Huntington, Hutchison and Sowa (1986) Survey of Perceived Organizational Support Scale (SPOS) was used to assess employee's perceived support from their organization. The original version of SPOS is a 36 item unidimensional questionnaire that measures employee perceived support from their organization. Eisenberger, Huntington, Hutchison and Sowa (1986) provided two short forms of the original 36 items, a 16 items short form and an 8 item short form. For the present study, the 16 item short form was adopted. The original questionnaire is a seven point Likert type structure (1 = strongly disagree, 7 = strongly agree). Positively worded items are direct scored while negatively worded items are reversed scored. Sample items include, "My Organization values my contribution to its wellbeing", "My Organization strongly considers my goals and values", and "My Organization fails to appreciate any extra effort from me". Eisenberg, et al (1986) reported reliability co-efficient (α) of .97. For the present study, an α of .94 was obtained.

Procedure

Health workers from the two hospitals were approached at work, told about the study and asked if they were willing to participate. Those who agreed were given copies of the questionnaire. A total of two hundred and fifty copies of the questionnaire packs were distributed to health workers. However, only two hundred and seventeen (217) copies were filled and returned. After further screening, seventeen (17) were again dropped due to incompleteness or ambiguity in responses or ticking more than one option. A return rate of 80% was therefore recorded.

Design/ Statistics

A cross-sectional design was used and a hierarchical multiple regression was adopted for data analysis. The data obtained from respondents were analyzed with the use of the Statistical Package for the Social Sciences® (SPSS) 20.0.

Results**Table 1. Means, standard deviation and intercorrelation between study variables**

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8
1 Gender	.58	.50	—							
2 Marital status	.57	.50	.09	—						
3 EC	.19	.39	.10	-.21**	—					
4 Age	35.75	8.32	-.15*	.44***	-.19**	—				
5 PDfW	14.22	4.01	-.12	-.13	.08	-.13	—			
6 POS	39.11	8.80	.13	.15*	-.03	.11	.01	—		
7 WIPL	18.80	3.50	-.01	.03	.05	-.00	-.08	-.09	—	
8 PLIW	14.54	4.17	-.12	-.08	.04	-.14	.90***	-.02	-.04	—
9 WPLE	14.55	4.12	-.12	-.11	.07	-.13	.86***	-.04	-.01	.92***

Note. $N = 200$, * = $p < .05$ (two-tailed), ** = $p < .01$ (two-tailed), *** = $p < .001$ (two-tailed). EC = employment condition, PD = psychological detachment, POS = perceived organizational support, WIPL = work interference with personal life, PLIW = personal life interference with work, WPLE = work/personal life enhancement. Gender was coded 0 = female, 1 = male; marital status: 0 = single, 1 = married; employment condition: 0 = full-time, 1 = part-time. Age was coded in years, such that higher scores represent older age.

The results in Table 1 indicate that none of the demographic variables (i.e., gender, marital status, employment condition, and age), significantly correlated with any of the work-life balance sub-dimensions. There was no significant correlation between psychological detachment and WIPL. However, psychological detachment was significantly positively and strongly correlated with both PLIW and WPLE. Perceived organizational support (POS) was not significantly correlated with any of the work-life balance sub-dimensions.

Table 2. Prediction of work-life balance dimensions by Psychological detachment from work, perceived organizational support and demographics

Variable	WIPL			PLIW			WPLE		
	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3
	β	β	β	β	β	β	β	β	β
Controls									
Gender	-.02	-.03	-.02	-.15*	-.03	-.03	-.14	-.02	-.01
Marital status	.05	.04	.05	.02	.07	.07	-.03	.03	.03
Employment condition	.06	.06	.06	.03	-.02	-.02	.06	.01	.01
Age	-.02	-.03	-.02	-.16*	-.06	-.06	-.12	-.03	-.03
Predictors									
PDfW		-.08	-.08		.90***	.90***		.86***	.86***
POS			-.09			-.03			-.04
Adjusted R^2	-.016	-.015	-.012	.021	.803	.803	.019	.741	.741
ΔR^2	.004	.006	.007	.041	.767	.001	.039	.709	.002
ΔF	.218	1.244	1.461	2.084	774.628***	1.028	1.958	543.672***	1.391

Note. $N = 200$, * = $p < .05$ (two-tailed), ** = $p < .01$ (two-tailed), *** = $p < .001$ (two-tailed).

Demographic variables (i.e., gender, marital status, employment condition, and age) did not collectively nor individually account for any significant contribution in predicting WIPL. PDfW accounted for 6% variance in WIPL but was not a significant predictor of WIPL ($\beta = -.08, n.s.$). POS contributed 7% variance in WIPL but was not a significant predictor of WIPL ($\beta = -.09, n.s.$).

Demographic variables collectively accounted for 2.1% variance in PLIW, with gender ($\beta = -.15, p = .036$) and age ($\beta = -.16, p = .048$) making unique statistically significant contributions in predicting PLIW. PDfW accounted for 76.7% variance in PLIW significantly and positively predicting PLIW ($\beta = .90, p < .001$). POS contributed only .1% variance in PLIW and was not a significant predictor of PLIW ($\beta = -.03, n.s.$).

Demographic variables did not collectively or individually account for any significant contribution to the prediction of WPLE. PDfW accounted for 70.9% variance in WPLE and positively predicted WPLE ($\beta = .86, p < .001$). POS accounted for 2% additional variance in WPLE and was not a significant predictor of WPLE ($\beta = -.04, n.s.$).

Discussion

The need for a balance between work and personal life has become an integral element of employee expectations from employers across all sectors of work. Focusing on this aspect of employee wellbeing therefore is very crucial for organisational growth and development. In the health sector, work life balance will go a long way not just to promote organisational growth but also promote health and wellbeing of the society. It is necessary therefore that correlates of work life balance in health workers be researched. In an attempt at this, we investigated the contributions of psychological detachment from work (PDfW) and perceived organisational support (POS) in work-life balance of health workers.

Results from our present data set showed an insignificant relationship between PDfW and WIPL. This suggests that PDfW has no significant associations with the interference of work (ambitions and business) with health workers' personal life (pleasure, leisure, family and health); that whether health work interferes with personal life or not, psychological detachment would have no significant effect on the interference. Sonnentag et al. (2007) had reported that the ability to mentally distance oneself from work during off-job time (PDfW) is most beneficial for employees' affective states; and in line with this finding, it was expected that PDfW should in essence either positively or negatively have an effect on WIPL. This could be because being properly detached from work in itself, does not allow for work to interfere with personal life. That is to say, detachment from work is a measure against work and thoughts of work interfering with personal life. It is also possible that health workers, because of the shifts and turns they take (that is, being on and off duty at

some points) experience work interference with personal life differently from other workers. It is also possible that because they spend just a quarter of each day at work (except on days when they have opted to cover for others), they have readjusted to making up for personal life (pleasure, family and leisure) with the remainder of the day. It was also observed that the sample mean score for WIPL was relatively low ($M = 18.8$) compared to studies with other samples. This could in effect mean that health workers (within the present sample) perceive work as not interfering with their personal life and therefore PDfW would add little or no value to their work commitment. Sonnentag (2010) opined that persons who find their job very meaningful may find it very difficult to achieve PDfW.

The results showed that when personal life interferes with work, psychological detachment plays a role in cushioning the interference. This was in line with expectation and consistent with the finding of Hahn and Dormann (2013) which reported that the more an employee psychologically detaches from work during non-work hours, the less personal life is likely to interfere with work. Hernandez et al. (2012) also noted that psychological detachment enhanced positive affect at night thereby improving work-family facilitation. PLIW is of most concern to employers and is most unwanted by them since it has direct impacts on job performance and commitment of employees. The present findings suggest that health workers will have their personal life interfere with work if they had low levels of psychological detachment. This may mean that roster systems and shift working as is obtained in Nigerian hospitals and health centres might just be the most ideal for health workers since it allows them time to detach from work. However, in line with the present findings, rosters and shift plans would be more appropriate if they consider rest periods, shift duration and order of rotation. Also, the practical implication of this for employers is that employees' psychological detachment from work should be a priority to organisations and workers should be encouraged to maximise their work-leaves and off-work hours to socialise. More importantly, in creating rosters and shifts, management should adopt personalised time schedules and reduce the amount of hours spent working night and evening shifts.

PDfW did not associate with WPLE. This suggests that the reciprocal enhancement that may exist between work and personal life is not influenced by psychological detachment. Or probably the flexibility between work and personal life is already enhanced in health workers as they have time (off-duty hours) to compensate for work-related stress.

An insignificant relationship between POS and the three domains of WLB was observed in the present study. This is inconsistent with previous literature (e.g., McCarthy, Darcy & Grady, 2010; Thakur & Kumar, 2015) where POS positively related with and imparted overall WLB of participants. This raises questions as to whether health workers in Nigeria experience levels of organisational support at all. With the recent incessant industrial actions, it might be that health workers' POS levels were low (if a construct measured is absent in respondents at the time of the research, it is logical to expect that there would be no significant associations with other constructs). However, there is substantial argument in literature for the insignificant association of POS with WIPL (a domain of WLB). The work-family border theory views the segmentation end of the work-family continuum as having work and family as mutually exclusive categories with distinctive mentalities (Clark, 2000). This suggests that work and family are separate spheres which may not influence each other (Edwards & Rothbard, 2000). And if this is the case, then little or no associations are to be expected between a third party construct when two parties lumped as one (work and family life) are mutually exclusive. This has structural and methodological implications on future measurement of the construct if associations are to be sought with a third party construct.

The insignificant relationship between POS and WLB could be that organisational support is low among health workers and therefore its association with WLB could not attain statistical significance. Whatever the case may have been, the fact remains that health organisations, hospitals and the government in general can still raise their level of support for workers while further investigation into the relationship between POS and

WLB especially among health worker populations need be conducted.

The implication of this is that imbalance between work and life could continue to translate to demands for increase in pay and allowances and consequent industrial actions if demands are not met. This cycle is likely to continue and this would have dangerous implications on the health sector in Nigeria. Work-life balance has implications for long term job commitment and performance of health workers. Further studies are needed to examine whether lack of POS is detrimental to not just health workers but everybody and in all situations.

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