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Relationship between Work-Family Conflict and Psychological Well-being among Doctors

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Abstract

This correlational study aimed to examine the relationship between work-family conflicts and the psychological well-being of 120 doctors. Two scales, the 10-item Work and Family Conflict (WAFC) scale and the 18-item Psychological Well-being (PWB) scale, were used to measure the variables. The objective of this study was to explore the associations between work-family conflicts (WFC) and family-work conflicts (FWC) and psychological well-being and to investigate potential gender differences. The findings revealed a negative correlation between WAFC and PWB, indicating that higher levels of conflicts were associated with lower psychological well-being among doctors. Additionally, a positive correlation was observed between WFC and FWC, indicating a connection between these types of conflict. Furthermore, results depict that no significant gender differences were found in work and family conflicts, indicating similar experiences for both male and female doctors. The implications of this study are noteworthy for healthcare organizations and policymakers. By addressing work and family conflicts, doctors' psychological well-being can be enhanced, potentially leading to improved job performance and better patient care. Healthcare institutions should consider implementing tailored work-life balance programs and support systems to reduce conflict-related stress. Ultimately, recognizing and managing work-family conflicts is crucial for promoting doctors' overall well-being and professional satisfaction.

Keywords**:** *work and family conflict, psychological well-being, work-family conflict, family-work conflict, doctors.*

For the last 20 years, attention has been turned to issues of work and family conflict, which has come under more and more scrutiny (Eby et al., 2005). This is primarily due to the significant changes in the economic, political, and social environments, which indicate that the integration of work and family life will become more difficult and that work-family issues will become more and more significant. There are more dual-income households, working single-parent families' heads, working mothers, working women of all ages, working men who are directly responsible for taking care of their families, and working people in the sandwich generation who are responsible for both childcare and eldercare (Duxbury & Higgins, 2006).

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A vital group to ensure a healthy healthcare system is doctors, who are more apt to struggle to balance work and family life due to high physical and emotional demands. Stressed doctors are more likely to provide subpar medical and psychological care to their patients. As a result, work-family conflicts may negatively impact both the well-being of physicians and the standard of patient treatment. Studies on work-family conflicts among doctors have grown in recent years (Ádám et al., 2008).

In the late 19th century, work family conflict was first studied. The theoretical frameworks used to examine work-family conflict are boundary theory and border theory (Lavassani et al., 2014).

Boundary theory examines how humans build, maintain, and shift borders to simplify and categorise the environment around them (Ashforth et al., 2000). It emerged from Nippert-Eng's (1996) classic sociological work and is based on a broad cognitive theory of social categorization that focuses on outcomes such as the meanings individuals ascribe to work and home and the ease with which they transition between the two. Boundary theory, as applied to the work-family literature, is concerned with the cognitive, physical, and/or behavioral borders that exist

between people's work and family realms and distinguish the two entities as separate from one another. Boundaries can be thick (as in keeping work and family separate) or thin (associated with blending work and family) (Ashforth et al., 2000; Nippert-Eng, 1996).

Border theory is concerned with the distinctions between the times, places, and individuals connected with work and family duties. Border theory is a theory concerning work-family balance that proposes that work-family balance may be achieved in a variety of ways based on characteristics such as the similarity of the work and family domains and the strength of the domain borders. According to border theory, people cross borders regularly, both literally and psychologically, as they commute between work and home (Clark, 2000). By considering the effects each portion has on the other, border theory broadens this. The goal of border theory is to identify strategies for resolving conflicts and achieving a balance between conflicting identities. Individuals may opt to handle these segments separately, alternating between their duties in the workplace and at home (exhibiting border theory), or they may opt to integrate the segments to achieve balance (Lavassani et al., 2014).

The conflict between work and family is bi-directional. The terms work-to-family conflict and family-to-work conflict are distinct from one another. When expectations and responsibilities at work come into conflict with family obligations, work-family conflict results. When family events and responsibilities collide with job obligations, family-work conflict results. The conflict between family and work is said to affect employees' productivity at work (Lavassani et al., 2014).

The work-family conflict has been extensively studied. It has been noted that this is a serious worry for both the employees and the organization. According to a report, organizations that support staff in striking a work-life balance get benefits in the form of improved loyalty, high job engagement, and positive workplace attitudes (Moore, 2007). Work-life balance can improve employee satisfaction, decrease work-life conflicts, promote commitment, boost productivity, and decrease withdrawal behavior (Waltman & Sullivan, 2007).

Psychological well-being is a vast and dynamic notion that encompasses both health-related difficulties and behaviors as well as the social and subjective components of human psychology (Deci & Ryan, 2008). This concept is used in terms of optimal functioning, meaning, and self-actualization. Therefore, it is thought that people who exhibit high levels of psychological well-being experience greater support and life satisfaction. According to research, employees who have a higher level of psychological well-being are more committed, live better lives, and are more productive than those who have a lower level (Rathi, 2009).

Ryff's (1995) Scale of Psychological Well-Being is a theoretically grounded tool that focuses on assessing several components of psychological well-being. Some examples of these components are as follows: The following six components contribute to psychological well-being: (self-acceptance), having life-affirming goals and objectives (purpose in life), being able to handle the demands of day-to-day life (environmental mastery), feeling as though one is continually developing and reaching their potential (personal growth), having trustable and positive relationships with others (positive relationships with others), and being able to act on one's convictions (autonomy) (Khan et al., 2009).

The topic of work and family conflict has grown in popularity within organizational studies (Carlson & Kacmar, 2000). Though they are considered separate concepts, work-family conflict and family-work conflict are interrelated. Researchers have demonstrated a positive correlation between family-work conflict and work-family conflict (Beutell & Witting-Berman, 1999). There was a positive relationship between work-family conflict and family-work conflict. This has been theoretically supported in earlier research (Nabavi et al., 2013). Many studies examine the connection between work-family conflict and family-work conflict using correlation analysis, but few consider causal paths between the two. Carlson and Kacmar (2000) revealed a reciprocal and positive relationship between work-family conflict and family-work conflict.

According to Eby et al. (2005), for a complete understanding of the work-family interaction, gender inequality and gender role issues must be considered. According to gender role theory, men's primary domain is work, whereas women's major domain is the home and family (Rajadhyaksha et al., 2015). Therefore, it would be expected that men would report more family-work conflict, while women would report more work-family conflict. These variations haven't all been discovered, though. For instance, in a meta-analytic evaluation, Byron (2005) observed that women reported a greater degree of family-work conflict, and males reported a greater degree of work-family conflict. The level of overall work family conflict did not significantly differ by gender (Matai et al., 2008), but women had much greater levels of family interference with work, and men had a higher work-family conflict.

Ansari (2011) found no statistically significant differences between men and women in terms of work-family and family-work interference. The same result was obtained by other researchers as well (Castilla, 2005). There is no gender difference in the amount of interference that men and women experience in each area, and both encounter equivalent levels of interference (Byron, 2005).

According to an Italian study, up to 25% of doctors have a psychiatric illness (Renzi et al., 2012). Severe physical ailments, including cardiovascular disease and blood sugar issues, are long-term consequences of low psychological well-being (Chandola et al., 2008). Another study that was conducted at Peshawar's teaching hospitals revealed that, compared to the general population (17.8%), healthcare personnel like managers, doctors, nurses, and other professions related to medicine (26.8%) had minor psychiatric disorders. Additionally, research revealed that female doctors had a significantly higher prevalence than their male counterparts. This study reveals that medical professionals in Peshawar, Pakistan, teaching hospitals are at risk, particularly female doctors who suffer from greater psychological distress than their male coworkers (Qureshi et al., 2014).

Past literature on work and family conflict has shown a negative relationship between well-being and both family-work conflict and work-family conflict (Amstad et al., 2011). According to Ryff (2014), negative psychological outcomes like anxiety and depression are decreased when levels of significant outcomes (personal development, environmental mastery, and self-acceptance) are higher. The conflict between work and family and psychological well-being appears to be substantially inversely correlated: there is a causal relationship between greater conflict and lower well-being (Allen et al., 2000) and more depression (Brough et al., 2009). According to Fotiadis et al. (2019), the conflict between work and personal life negatively affects employees' well-being and increases their psychological stress.

The majority of studies on work-family conflict have acknowledged that there is a significant risk to one's health and well-being (Winefield et al., 2014) as well as job-related consequences (Zaman et al., 2014). A study was conducted in Spain to look into the psychological health of medical professionals. Findings showed that doctors who reported having more emotional demands, family conflicts, and work-related stress generally had poorer levels of psychological well-being. The emotional strain made their anxiety and despair worse (Burke et al., 2012).

Rationale of the study

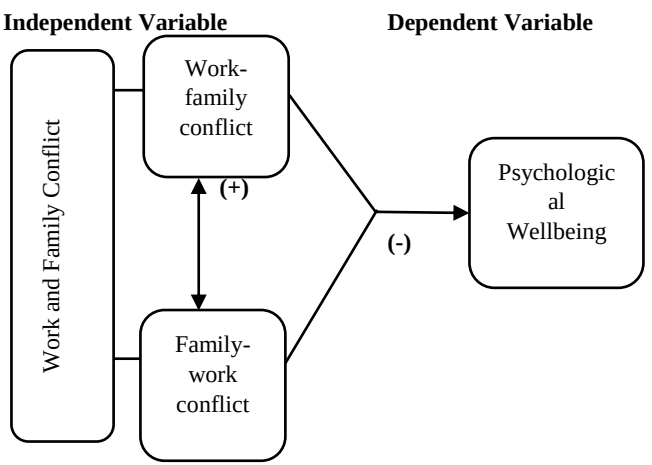
Doctors are crucial in taking care of patients and accepting them for who they are. Due to several factors, including growing job duties, multitasking, the need to be familiar with evolving technologies, job insecurity, a competitive workplace, and conflicts between work and family life, since healthcare personnel is primarily involved in providing direct patient care, it is crucial to evaluate their work and family conflict and overall wellbeing. With this context, the current study investigates and evaluates the psychological health of doctors and work and family conflict.

Doctors who perceive that their workload exceeds their capacity are susceptible to unpleasant emotions and stress (Gill & Davidson, 2001). Employees who have a high workload find it difficult to maintain ties with their family and at work (Smith & Clark, 2017). According to WHO (2011), there is just one doctor in Pakistan for every 1000 patients. Sustaining a work-family balance depends on psychological well-being. A doctor needs psychological stability and poise to fulfill their professional obligations and achieve patient care goals. Since it was founded, Pakistan has experienced serious health problems, which have increased the workload for medical professionals. The primary goal of the study was to investigate the impact of work and family conflict on psychological well-being. The findings presented here may serve as a foundation for the start of social discourse aimed at enhancing the working environment and psychological health of doctors, as well as assisting in the development and implementation of suitable coping mechanisms, human resources, and social and organizational policy.

Conceptual Framework

Figure 1

Schematic representation of the association of work and family conflict and psychological well-being.



Note. Figure shows the conceptual framework that directs our study. Based on the evidence that is currently available, we argue that inter-role conflicts resulting from the demands of the two universal spheres of life, work, and family have a detrimental influence on psychological well-being. Further, our model suggests that work-family conflict and family-work conflict are correlated in a positive way.

Objectives

- To evaluate the correlation between doctors' psychological well-being and the conflict between work and family.
- To examine the correlation between family-work conflict and work-family conflict.
- To determine if there are any major differences between male and female doctors regarding conflict between work and family.

Hypotheses

- Work and family conflict will be negatively correlated with psychological well-being.
- There will be a positive relationship between work-family conflict and family-work conflict.
- Female doctors will have a higher level of family-work conflict than male doctors.
- Male physicians have a higher degree of work-family conflicts than female physicians.

Instruments

Work Family Conflict

Work-family conflict is characterized as a type of inter-role conflict wherein the responsibilities of work and family roles clash, resulting in a conflict between these two domains. Work-to-family conflict (WFC) occurs when demands from work disrupt family responsibilities, whereas family-to-work conflict (FWC) arises when family demands to impede one's ability to perform effectively at work (Haslam et al., 2015).

Psychological Wellbeing

According to Keyes et al. (2000), psychological well-being has to do with how well employees perceive and evaluate the quality of their lives as well as how well they function psychologically and socially. Physical, mental, occupational, and overall life satisfaction are all included in the concept of "psychological well-being," which is vast a concept.

Methodology

Sample

The study's sample consists of doctors (N = 100), including male (n = 50) and female (n = 50) doctors from different hospitals in the Abbottabad division. Demographic information includes gender and age. Samples were drawn from different private and government hospitals in Abbottabad city.

Instruments

Work and family conflict scale (WAFCS)

The Work and Family Conflict Scale (WAFCS) is a measurement tool developed by Haslam et al. (2015) that was used to measure work and family conflict among doctors. It is a self-report measure and has 10 items. It includes 2 subscales: work-family conflict (WFC) (5 items) and family-work conflict (FWC) (5 items). Each item is rated on a 7-point Likert scale (1= strongly disagree, 7=strongly agree). Higher scores indicate individual is high on work and family conflict. The Work and Family Conflict Scale has good psychometric properties, including internal consistency.

The Work–Family Conflict Scale (WAFCS) [23] is short 10-item measure assessing WFC (five items) and FWC (five items). Respondents are asked to rate their level of agreement with each item on a 7-point scale from 1 (very strongly disagree) to 7 (very strongly agree). Sample Items include: "My work prevents me from spending sufficient quality time with my family'' (Work-to-family subscale) and "My family has a negative impact on my day-to-day work duties'' (Family-to-work subscale).

Psychological Wellbeing Scale (PWBS)

Psychological wellbeing scale (PWBS) is a measurement tool developed by Ryff and Keyes (1995), was used to measure psychological wellbeing among doctors. It is a self-report measure and has 18 items. Each item is rated on a 7-point Likert scale (1= strongly agree, 7=strongly disagree). Some of the items were negatively worded so prior to analysis, those items were reverse scored. Higher scores indicate the individual is high on psychological well-being. Psychological wellbeing scale has good psychometric properties including internal consistency.

Procedure

To validate the researcher's institutional affiliation and ensure that the study is part of the requirements for a BS degree in Psychology, the researcher obtained an authorization letter from the government. Girls Post Graduate College NO.1 ATD. Data was collected from hospitals within the Abbottabad division, including INOR Hospital, Abbottabad Medical Complex, Shaheena Jameel Hospital, Ayub Medical Complex, DHQ, and Christian Hospital Qalandarabad. The hospital administrators were contacted, and they provided written consent through an authority letter, granting permission for data collection in their hospitals. Participants were approached individually for data collection, and the study's nature, objectives, and purpose were clearly explained to them to establish trust and rapport.

Results

Table 1

Cronbach's Alpha Reliability of Work and Family Conflict and Psychological Wellbeing Scale (n=120)

Variable	Cronbach's α	*M*	*SD*	Range
WAFC	.81	38.33	9.73	18-69
PWB	.70	89.32	12.00	63-120

Note. N= Number of items; M= Mean; SD= Standard deviation; WAFC= work and family conflict; PWB= psychological well-being.

Table 1 indicates the Cronbach's alpha reliability of the 10 items scale for work and family conflict is α= .81 which shows that this scale is very good to measure the level of work and family conflict in doctors. The table further indicates that Cronbach's alpha reliability of the 18-tem psychological well-being scale is α=.70, which shows that this scale has acceptable reliability and is good to measure the level of psychological well-being in doctors.

Table 2

Correlation between WAFC and PWB, WFC and FWC (N=120)

Variables	*WAFC*	*PWB*	*WFC*	*FWC*
WAFC	-	-.276**	.794**	.836**
PWB		-	-.035	-.396**
WFC			-	.330**
FWC				-

Note. WAFC= work and family conflict; PWB= psychological well-being; WFC= work family conflict; FWC= family work conflict.
***P<.01*

The results from Table 2 indicate that work-family conflict is negatively correlated with psychological well-being. As work-family conflict increases, psychological well-being tends to decrease, leading to lower overall well-being in individuals facing challenges in balancing their work and family roles. Additionally, the table shows a positive correlation between family-work conflict and work-family conflict, suggesting that individuals experiencing conflicts between family responsibilities and work commitments are also likely to face conflicts between their work and family roles.

Table 3

Mean Comparison of Gender on Work-Family Conflict and Family-Work Conflict (N=120)

	Male (n=60)		Female (n=60)				
Variables	*M*	*SD*	*M*	*SD*	*T*	*p*	Cohen's *d*
WFC	22.68	5.44	22.47	5.91	.20	.83	.03
FWC	14.85	5.28	16.68	7.07	-1.50	.11	.29

Note. WFC=work-family conflict; FWC= family work conflict; M=Mean; SD= Standard deviation P>.05

Table 3 revealed a non-significant mean difference of gender on work-family conflict with t = .20, p > .05. The findings revealed that females scored higher on work-family conflict (*M*=22.47, *SD*=5.91) compared to men (M=22.68, SD=5.44). Cohen's d-value was 0.036 (< 0.50), indicating a small effect size.

Furthermore, the table depicts a non-significant mean difference of gender on family-work conflict with t = -1.50, p > .05. Findings indicated that females scored higher on family-work conflict (*M*=16.68, *SD*= 7.07) compared to males (*M*= 14.85, *SD*= 5.28). The value of Cohen's d was 0.29 (< 0.50), which indicated a small effect size.

Discussion

This study investigates the correlation between a doctor's psychological well-being and the conflict between work and family. The correlation between work and family conflict and psychological well-being was tested in hypothesis 1. The results of this study suggest that there is a negative correlation between the conflict between work and family and doctors' psychological well-being. This finding is consistent with existing literature, including studies by Amstad and Semmer (2013) and Matthews et al. (2014), which have shown that work-family conflict is detrimental to an employee's psychological wellness. In the context of Pakistani culture, where family values and responsibilities are highly emphasized, the conflict between work and family may be particularly significant. Doctors, like many other professionals in Pakistan, often face challenging work schedules and long hours, which can lead to difficulties in balancing their work and family responsibilities. This imbalance may negatively impact their psychological well-being, as they may feel torn between fulfilling their professional duties and meeting their family's expectations. Pakistan faces a shortage of competent physicians, with only one physician available for every 1000 patients (WHO, 2011).

This scarcity of medical professionals puts immense pressure on the existing workforce. Additionally, the underrepresentation of females in the healthcare profession further contributes to heavy workloads (Shahzad et al., 2019). A Physicians resorting to privatization as an additional income source due to poor financial compensation exacerbates their workloads and emotional stress. Moreover, work conditions vary significantly across different areas of Pakistan, particularly in remote regions, making it challenging to attract healthcare professionals to work in such environments (Sheikh et al., 2018). The passion and irresistible desire to work among doctors lead them to juggle diverse roles, allocating their resources between work and family, resulting in an inability to achieve a satisfactory work-family balance. This imbalance has led to work-family conflicts, which are among the top stressors in the workplace, causing emotional strain due to inflexible working hours (Kelloway et al., 1999).

The second hypothesis confirms that work-family conflict and family-work conflict are positively correlated. This means that if a doctor experiences conflict in balancing work and family responsibilities, it is likely to spill over into their family domain and vice versa. The finding is consistent with the literature that a difference exists between work-family conflict and family-work conflict, with each having an impact in positive ways on both of them, and that there is a relationship between the two (Judge et al., 2006). There was a positive correlation between family-work conflict and work-family conflict. Theoretically, this has been supported in earlier research (Alhani & Oujiyan, 2013). In the context of Pakistani culture, there may be societal expectations and norms that contribute to the interplay between work and family roles. For instance, doctors in Pakistan may face pressure to fulfill their professional duties and also meet traditional family expectations, which could lead to higher conflict in both areas. Recognizing this interdependence between work and family roles can help employers and policymakers implement strategies to mitigate the negative effects and support individuals in managing these conflicts effectively.

Regarding the third hypothesis, the study did not find a significant difference between male and female doctors in terms of family-work conflict. This contradicts previous research that suggested women might experience higher levels of family-work conflict due to societal expectations and familial responsibilities (Boles et al., 2003). In the context of Pakistani culture, which traditionally places more emphasis on women's roles within the family, these findings may indicate that both male and female doctors face similar challenges in balancing work and family responsibilities. It might also imply that in the medical profession, regardless of gender, doctors are likely to encounter comparable family-work conflicts. The findings of research conducted by Malik et al. (2010) in Pakistan align with the results of this study. According to their study, both male and female employees encounter similar levels of work-life conflict.

Similarly, the fourth hypothesis, indicating that male doctors tend to show a higher level of work-family conflict compared to female doctors, was not supported by the study's findings. The study's findings were consistent with those of a prior study by Senecal et al. (2001), which found no difference in levels of work and family conflict between men and women in a French-Canadian sample of physical therapists and psychologists. In contrast to the findings of present study, earlier research found gender differences, with men exhibiting more work-family conflict and women exhibiting higher levels of family-work conflict (Fu & Shaffer, 2001). In Pakistani culture, traditional gender roles may shape perceptions of work and family responsibilities for male and female doctors differently. The lack of significant gender differences in work-family conflict in this study may be influenced by the changing cultural norms and the evolving roles of men and women in the workplace and the family in Pakistan. According to the study conducted by Rehman and Waheed (2012), married faculty members in Pakistan encounter higher levels of Work-Family Conflict compared to unmarried faculty members. However, the study did not find any significant gender difference in this regard.

Conclusion

This study found a negative correlation between the two study constructs of psychological well-being and work-family conflict among doctors employed in the major hospitals of Abbottabad, Pakistan. Doctors who are overworked experience greater psychological distress, which negatively impacts their mental health. Furthermore, family-work conflict and work-family conflict are not significantly different from one another in terms of gender; all sexes equally suffer from work and family conflict, which lowers psychological well-being. In addition, this study also found that there is a positive relationship between work-to-family conflict and family-to-work conflict.

Limitations and Future Recommendations

This study has several limitations that should be acknowledged. First, the findings are specific to doctors working in major hospitals in Abbottabad, which limits the generalizability of the results to other hospitals or cities across Pakistan. Additionally, the data collected were self-reported, which raises concerns about potential biases such as underreporting or overreporting, and the extent of these biases cannot be accurately determined.

The study focused on the relationship between work and family conflict and psychological well-being, but other factors from both work and family domains, such as supervisor support, spouse support, family involvement, and parental demands, could also influence these outcomes. Future research could broaden the scope by including these additional variables to gain a more comprehensive understanding. Moreover, the sample size of 120 participants is relatively small, which may limit the ability to generalize the findings. Future studies should consider using a larger sample within the same industry to enhance the generalizability of the results. Additionally, other demographic factors, such as marital status, number of children, and job sector, should be included in future research to provide a more nuanced analysis.

Implications

The first national human resources vision for health was formed in 2018; nevertheless, it is not fully implemented, and many doctors who work in hospital settings are dissatisfied with the conditions of their workplace. The study's findings have significance for administrators in the healthcare sector, who can reduce the high turnover rate of doctors by adopting culturally sensitive and flexible management of human resources that reduces work and family conflict and increases psychological empowerment among them. Human resource managers may assist doctors in developing their sense of psychological empowerment by implementing a plan that makes them feel like their work is meaningful and visible and instills a sense of competence in them. The culture of medicine must change from one of excessive rivalry and prejudice to one of teamwork, compassion, and the adoption of self-care practices among physicians. Furthermore, cultural sensitivities must be considered when designing interventions, as the expectations and pressures related to work and family roles can be deeply ingrained in Pakistani society. Future research should delve deeper into the cultural factors influencing work-family dynamics in Pakistan and explore ways to promote a healthier work-life balance for doctors and other professionals in the country. Future research will benefit from looking at this noble profession (medicine) and.

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