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STUDYING THE OUTCOMES OF WORK-FAMILY CONFLICT AMONG FEMALE MARRIED AND UNMARRIED HEALTH CARE WORKERS THE MODERATING EFFECT OF RESILIENCE

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Abstract

Background:
Work–family conflict (WFC) is a major occupational stressor for female healthcare workers who balance professional and caregiving responsibilities. It contributes to psychological distress, reduced resilience, and impaired well-being.

Objective:
This study examined the outcomes of WFC among married and unmarried female healthcare workers in Pakistan, focusing on the moderating role of resilience.

Methods:
A cross-sectional survey design was employed on N= 400 female doctors and nurses from public and private hospitals in Rawalpindi and Islamabad. Participants completed the Work–Family Conflict Scale (Carlson et al., 2000), Perceived Stress Scale (Cohen et al., 1983), and Brief Resilience Scale (Smith et al., 2008). Data were analyzed using descriptive statistics, Pearson correlations, independent samples t-tests, regression, and moderation analyses in SPSS (v.25).

Results:
WFC showed a strong positive correlation with perceived stress ($r = .89$, $p < .01$) and a strong negative correlation with resilience ($r = -.89$, $p < .01$). Married participants and those in joint family systems reported significantly higher stress and WFC, and lower resilience, compared to unmarried and nuclear-family participants. No significant differences were found across profession (doctor vs. nurse) or duty hours. Moderation analysis confirmed that resilience buffered the relationship between WFC and stress.

Conclusion:
Findings highlight resilience as a protective factor mitigating the negative effects of WFC on stress, consistent with the Conservation of Resources theory. Practical implications include resilience-building interventions, stress management workshops, and family-friendly workplace policies to support female healthcare workers' well-being and performance.

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INTRODUCTION

Family is a primary social unit that shapes values, emotional support, and role expectations across the lifespan. Within the family, marriage commonly functions as a central partnership that contributes to emotional security and social stability; how spouses negotiate responsibilities and role boundaries influences individual well-being and marital satisfaction (Cavagnis et al., 2023). Over recent decades, shifting economic and social patterns have increased women's labor-force participation, altering traditional role distributions and creating new demands on married and unmarried women alike (Cavagnis et al., 2023).

Women who work outside the home must often balance paid employment with domestic responsibilities, producing a dual role burden that can increase conflict and perceived strain when work and family demands are incompatible (Yang et al., 2024). Non-working women are not immune to stress; economic dependency, social expectations, or restricted opportunities for social engagement can also erode mental health and life satisfaction (Cavagnis et al., 2023). For healthcare professionals particularly nurses and doctors, these pressures are frequently magnified by long or irregular hours, high emotional labour, and exposure to stressful clinical situations (Andlib et al., 2022; Abid et al., 2022).Work–family conflict (WFC) describes a form of inter-role tension that arises when the demands of work and family roles are mutually incompatible.

Contemporary research conceptualizes WFC as bidirectional work-to-family conflict and family-to-work conflict and recognizes multiple forms (time-based, strain-based, and behavior-based) that differentially affect outcomes (Cavagnis et al., 2023; Yang et al., 2024). WFC has consistently been linked to poorer employee well-being, reduced job satisfaction, and diminished family functioning in both international and country-specific studies (Yang et al., 2024; Bolado et al., 2024).In Pakistan, evidence collected during and after the COVID-19 pandemic indicates substantially elevated psychological burden among healthcare workers. Cross-sectional surveys of Pakistani nurses and mixed samples of healthcare workers reported high rates of burnout, anxiety, depression, and perceived distress, often associated with heavier workloads, inadequate training or resources, and fear of infection (Andlib et al., 2022; Abid et al., 2022).

Studies conducted in Pakistan have also highlighted moral injury and variations in resilience among clinicians, with female healthcare workers frequently reporting higher distress and related vulnerabilities (Akhtar et al., 2022). These findings underscore the relevance of examining WFC and mental health specifically among female doctors and nurses in Pakistan, who occupy caregiving roles both at work and at home. A central mechanism linking WFC to mental health is perceived stress that is defined as the individual appraisal of stressors as overwhelming, unpredictable, or beyond one's coping capacity.

Perceived stress mediates the relationship between role conflict and outcomes such as anxiety, depressive symptoms, and burnout and helps explain why similar objective demands may produce different psychological outcomes across individuals (Yang et al., 2024; Bolado et al., 2024). In healthcare settings, sustained perceived stress is associated with emotional exhaustion and reduced personal accomplishment. These are core dimensions of occupational burnout that negatively affect clinician well-being and quality of care (Andlib et al., 2022).How individuals respond to WFC and perceived stress depends in part on coping strategies. Adaptive coping such as problem-solving, seeking social support, effective time management, tends to buffer negative effects, whereas maladaptive responses such as avoidance or denial often exacerbate distress (Cavagnis et al., 2023).

Interventions that strengthen coping skills and improve organizational supports have shown promise in reducing WFC and associated stress in clinical populations (Bolado et al., 2024).

Resilience on other hand is the capacity to adapt and recover in the face of adversity, it emerges as a critical protective factor for healthcare workers. Recent studies and reviews show that resilience, whether conceptualized at an individual or organizational level, can mitigate the psychological

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impact of high job demands and WFC (Akhtar et al., 2022; Guraya et al., 2025).

Evidence from Pakistan during the pandemic found that higher resilience was linked with lower moral injury and better psychological adjustment among health professionals (Akhtar et al., 2022). International research likewise indicates that resilience training and institutionally supported programs can improve coping, reduce perceived stress, and support sustained well-being among clinicians (Guraya et al., 2025; Cavagnis et al., 2023).Taken together, these findings show that female healthcare workers , those who are positioned at the intersection of professional caregiving and substantial family responsibilities are especially vulnerable to work–family conflict and perceived stress, and their mental health is shaped by both individual coping and broader organizational resources. In Pakistan, recent studies reflect similar patterns. Jamshed et al. (2023) found that intrinsic motivation moderated the link between WFC and organizational outcomes among female nurses, while resilience and social support buffered the negative effects on stress. COVID-19 further intensified WFC among healthcare workers due to increased workloads and caregiving responsibilities (Saleem et al., 2021). Comparable evidence from China (Liu & Hong, 2023) and Poland (Kowalczuk et al., 2022) also shows that resilience attenuated the adverse impact of WFC during the pandemic.

Gender and marital status remain crucial factors. Married female healthcare workers, especially in collectivist cultures like Pakistan, experience higher levels of WFC and emotional strain due to multiple caregiving responsibilities (Hwang & Yu, 2021; Jamshed et al., 2023). Similar gendered caregiving patterns are reported globally, underscoring the cultural universality of WFC.

Resilience consistently emerges as a key moderator. Studies from India and Pakistan demonstrate that resilience, often enhanced by family and workplace support, reduces burnout and stress (Gupta & Srivastava, 2020; Jamshed et al., 2023). Evidence from Egypt (Abdelghani et al., 2023) and Turkey (Dönmez et al., 2023) likewise indicates that resilience enables individuals to withstand the psychological and professional consequences of WFC.

This study draws on the Conservation of Resources (COR) theory (Hobfoll, 2018), which asserts that individuals strive to acquire and protect valued resources (e.g., time, energy, social support). Stress arises when these resources are threatened, depleted, or insufficient to meet demands (Allen et al., 2020). In collectivist contexts like Pakistan, married women carrying dual professional and caregiving roles are highly vulnerable to WFC and its health consequences (Jamshed et al., 2023). Within COR, resilience is conceptualized as a personal resource that buffers stressors by helping individuals reframe challenges, mobilize coping strategies, and recover from strain (Hartmann et al., 2020; Liu & Hong, 2023).

Research focused on Pakistan has documented high levels of burnout and distress among nurses and other health professionals and highlights resilience as a promising buffer. This evidence supports the need for targeted, contextually sensitive investigation of WFC, perceived stress, coping, and resilience among Pakistani female doctors and nurses to inform interventions that protect well-being and preserve quality of care.

Methodology

A cross-sectional survey design was used to examine work–family conflict (WFC), resilience, and perceived stress among female healthcare workers. Data was collected at a single point in time using standardized, validated self-report questionnaires.

The sample size was calculated using the formula: $n=(Z^2\sigma^2)/E^2$, where Z = 1.96 (95% confidence level), σ = 7.11 (from a prior Iranian study), and E = margin of error. The estimated sample was 312, which was increased by 10% for non-response, resulting in 343 participants. To enhance representativeness, simple random sampling was applied from hospital staff lists. Ultimately, N= 400 female healthcare workers (210 doctors, 190 nurses) from government and private hospitals in Rawalpindi and Islamabad participated. Participants were stratified by marital status

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(married/unmarried) and family structure (joint/nuclear).

Inclusion and Exclusion Criteria

Inclusion criteria include female healthcare workers (doctors or nurses), currently employed in hospitals/clinics and married or unmarried, with ≥ six months of experience. On the other hand exclusion criteria include male healthcare professionals and non-clinical staff (technicians, pharmacists, administrators were excluded.

Measures

- **Demographics:** Age, marital status, family structure, parental status, job experience.
- **Perceived Stress Scale (PSS; Cohen et al., 1983):** A 10-item scale rated on a 5-point Likert scale. Higher scores indicate greater perceived stress.
- **Work–Family Conflict Scale (WFCS; Carlson et al., 2000):** A 10-item measure capturing time-based, strain-based, and behavior-based conflict.
- **Brief Resilience Scale (BRS; Smith et al., 2008):** A 6-item scale assessing the ability to bounce back from stress.

Procedure and Ethics

Participants were recruited in person. After receiving information about the study's aims and confidentiality, they signed informed consent forms. Questionnaires were administered face-to-face and completed individually. Ethical approval was obtained from the Ethical Review Committee of institution.

Data Analysis

Data were analyzed using SPSS (version 25). Preliminary analyses included descriptive statistics, normality checks, and reliability (Cronbach's α). Hypothesis testing involved independent sample t-tests, correlations, hierarchical regression, and moderation analysis (Aiken & West, 1991). Significance was set at $p < .05$, and analyses followed APA 7th guidelines.

RESULTS

Table 01

Socio-demographic Characteristics of Participants (N=400)

Characteristics	*N*	%
Profession		
Doctor	210	52.5
Nurse	190	47.5
Marital Status		
Married	181	45.3
Single	219	54.8
Family Structure		
Joint family system	202	50.5
Nuclear family system	198	49.5
Duty Hours		
8 hours	70	17.5
More than 8 hours	330	82.5

Note.n=sample size.

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Table 01 reveals that greater number of doctors (n = 210, 52.5%) participated in the study compared to nurses (n = 190, 47.5%). More participants were single (n = 219, 54.8%) compared to married (n = 181, 45.3%). Greater number of participants belonged to joint family system (n = 202, 50.5%) compared to nuclear family system (n = 198, 49.5%). Majority of participants worked more than 8 hours (n = 330, 82.5%) compared to those working 8 hours (n = 70, 17.5%).

Table 02

Psychometric properties of scale (N = 400)

Scale	M	SD	Cronbach's α	Range	Skewness	Kurtosis
Perceived Stress Scale	21.85	2.25	.82	16-27	-.33	-.36
Work and Family Conflict Scale	46.46	11.44	.92	30-64	.03	-1.65
Brief Resilience Scale	18.01	1.844	.80	13-23	-.13	-.02

Table 02 presents psychometric properties for the scales used in the present study.

Table 03

Pearson correlations between study variables (N = 400)

Variable	**1**	**2**	**3**
1. Perceived Stress	-	.89**	-.85**
2. Work–Family Conflict		-	-.89**
3. Resilience			-

Note. $^{**}p < .01$

A Pearson correlation analysis was conducted to examine the relationships among perceived stress, resilience, and work–family conflict among female healthcare providers. Results indicated a strong positive correlation between perceived stress and work–family conflict ($r = .89$, $p < .01$), and negatively correlated with resilience ($r = -.85$, $p < .01$). In contrast, work–family conflict was negatively correlated with resilience ($r = -.89$, $p < .01$).

Table 04

Moderating Role of Resilience in the Relationship between Work–Family Conflict and Stress(N=400)

Variables	Model 1			Model 2		
	B	β	*SE*	B	B	*SE*
Constant	28.85***		*.12*	28.68***		*.25*
Work Family Conflict	3.67***	.68***	.28	3.69***	.65***	.28
Resilience	-1.58***	-2.28***	.28	-1.50***	-.27***	.28

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Work-family conflict x Resilience			-1.98	-.02	.25
R^2	.81		.81		
ΔR^2			.00		

*** *p*<.001

Table 04 shows the moderation of resilience between perceived stress and work-family conflict. In Model 1, the R^2 value of 81 revealed that the predictors explained 81% variance in the outcome with F (2, 397) = 853.25, *p* < 001. The findings revealed that work-family conflict (B = .68, p<.001) and Resilience predicted work-family conflict (β = -2.28, p <.001). In Model 2, the R^2 value of .81 revealed that the predictors explained 81% variance in the outcome with f (3, 396) = 3435.32 , p < .001). The findings revealed that work-family conflict (β = .65, *p* < .001), resilience (β = -.27, *p* < .001) and work-family conflict x resilience negatively predicted perceived stress. The ΔR^2 value of .00 revealed 0% change in the variance of model l and model 2 with (1, 396) = .644, *p* < 001. Findings show that resilience moderated the relationship between perceived stress and work-family conflict. almost equally. Cohen's *d* was 0.03 (< 0.20), again indicating a negligible effect size.

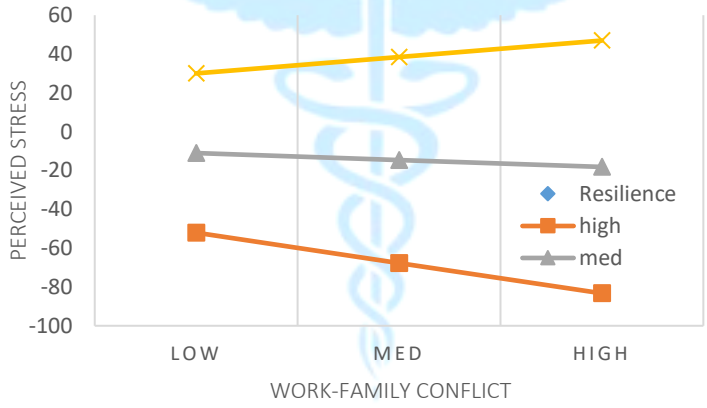

Figure 01 Mod-Graph of Moderating effect of resilience between perceived stress and work-family conflict

Table 05

Independent Samples t Test Comparing Work–Family Conflict and Stress Across Family System (N=400)

	Joint Family System (n= 202)		Nuclear Family System (n= 198)				
Variables	M	SD	M	SD	*t(398)*	*P*	Cohen's *d*
Perceived Stress	31.00	5.33	26.66	5.12	8.30	.000	0.83

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Work-Family Conflict	50.86	11.90	41.93	10.88	7.82	.000	0.78
Resilience	18.07	4.83	21.59	4.36	-7.63	.000	0.77

Table 05 revealed significant mean differences between doctors and nurses belonging to joint versus nuclear family systems. For perceived stress, individuals from joint family systems (M = 31.00, SD = 5.33) reported significantly higher stress compared to those from nuclear families (M = 26.66, SD = 5.12), $t(398) = 8.30$, $p < .001$, $d = 0.83$, indicating a large effect size. Similarly, a significant difference was observed for work–family conflict, with joint family system members (M = 50.86, SD = 11.90) reporting greater conflict than nuclear family system members (M = 41.93, SD = 10.88), $t(398) = 7.82$, $p < .001$, $d = 0.78$, also reflecting a large effect size. In contrast, for resilience, individuals from nuclear families (M = 21.59, SD = 4.36) scored significantly higher than those from joint families (M = 18.07, SD = 4.83), $t(398) = -7.63$, $p < .001$, $d = -0.77$, again demonstrating a large effect size.

Table 06

Independent Samples t Test Comparing Work–Family Conflict and Stress Across Marital Status (Married vs. Single)

	Married (n=181)		Unmarried (n=219)				
Variables	M	SD	M	SD	*t(398)*	*p*	Cohen's *d*
Perceived Stress	34.41	2.41	24.26	2.61	39.96	.000	4.04
Work-Family Conflict	59.10	3.45	35.97	4.62	55.75	.000	5.67
Resilience	15.03	2.24	23.76	2.36	-37.675	.000	–3.79

Table 06 compared doctors and nurses on perceived stress, work–family conflict, and resilience. Significant group differences were found across all three variables. For perceived stress, doctors (M = 34.41, SD = 2.41) reported significantly higher stress than nurses (M = 24.26, SD = 2.61), $t(398) = 39.96$, $p < .001$, $d = 4.04$, reflecting a very large effect size. Similarly, work–family conflict scores were significantly higher among doctors (M = 59.10, SD = 3.45) compared to nurses (M = 35.97, SD = 4.62), $t(398) = 55.75$, $p < .001$, $d = 5.67$, indicating an extremely large effect. In contrast, resilience was significantly lower in doctors (M = 15.03, SD = 2.24) compared to nurses (M = 23.76, SD = 2.36), $t(398) = -37.68$, $p < .001$, $d = -3.79$, which also indicated a very large effect size.

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Discussion

This study examined the outcomes of work–family conflict (WFC) among married and unmarried female healthcare workers in Pakistan, with a focus on the moderating role of resilience. Results demonstrated that WFC was strongly and positively correlated with perceived stress, while resilience was negatively associated with both WFC and stress. Married participants reported significantly higher levels of stress and WFC, and lower resilience compared to their unmarried counterparts. Similarly, participants from joint family systems experienced higher stress and conflict, but lower resilience, than those in nuclear families. In contrast, no significant differences were found by profession (doctor vs. nurse) or duty hours.

The findings align with prior research showing that WFC increases stress and psychological distress among healthcare workers (Kowalczuk et al., 2022; Abdelghani et al., 2023). Consistent with the Role Conflict Theory (Kahn et al., 1964), competing professional and family demands were shown to undermine well-being. Married participants' higher WFC scores corroborate earlier studies emphasizing the burden of caregiving responsibilities (Babapour et al., 2021). Similarly, results from joint family systems parallel previous findings that extended family expectations amplify role strain in collectivist cultures (Hwang & Yu, 2021).

Interestingly, unlike earlier studies (Li et al., 2023; Gheshlagh et al., 2021), no significant differences emerged by duty hours or profession, suggesting contextual or institutional factors may buffer these effects in Pakistani hospitals.

Findings support the Conservation of Resources (COR) Theory (Hobfoll, 2018), which posits that stress arises from resource depletion. Married women and those in joint families had higher conflict and stress, likely due to multiple caregiving responsibilities depleting time and energy resources. Resilience emerged as a critical personal resource that buffered against stress, consistent with international evidence (Li et al., 2023; Gupta & Srivastava, 2020). This confirms resilience as a protective factor within role conflict and stress-coping frameworks.

This study contributes to occupational health by highlighting the protective role of resilience among female healthcare workers. Hospitals can address WFC through resilience-building interventions, stress management workshops, and flexible scheduling. Organizational support measures, such as childcare services, family-friendly policies, and counseling, may also reduce stress and turnover intentions. Importantly, interventions should be tailored to marital and family contexts, as married and joint-family workers were disproportionately affected.

Several limitations should be acknowledged. The cross-sectional design precludes causal conclusions, and reliance on self-report data may have introduced bias. The sample was restricted to Rawalpindi and Islamabad, limiting generalizability. Only doctors and nurses were included, excluding other healthcare professionals. Finally, factors such as income, number of dependents, and organizational support were not controlled.

Future research should employ longitudinal and mixed-methods designs to capture causal and contextual dynamics of WFC. Expanding the sample across regions, rural settings, and diverse healthcare roles would enhance representativeness. Cross-cultural studies could explore how WFC differs in societies with varying family structures and gender norms. Intervention-based studies evaluating resilience training and organizational policies would provide applied evidence for reducing stress and enhancing well-being.

Conclusion

The study highlights that female healthcare workers, particularly those who are married or in joint families, are highly vulnerable to WFC and stress. Resilience significantly reduced the negative impact of WFC, confirming its role as a protective factor. These findings emphasize the importance of strengthening coping resources and developing supportive organizational practices to improve well-being and productivity in the healthcare sector.

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