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A COMPREHENSIVE ANALYSIS OF WORK-LIFE DYNAMICS IN NORTH INDIAN NURSES

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Debrecen, 1st March, 2024



Khateeb Fatima Riyaz

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List of Abbreviations

CD	Cognitive Demands
CFA	Confirmatory Factor Analysis
COR	Conservation of Resources
FTWC	Family to Work Conflict
FTWE	Family to Work Enrichment
JA	Job Autonomy
JD	Job Demands
JD-R	Job Demand and Resources
J&K	Jammu and Kashmir
JR	Job Resources
PCS	Perceived Coworker Support
POS	Perceived Organization Support
PWB	Psychological Wellbeing
QD	Quantitative Demands
SEM	Structural Equation Modelling
UT	Union Territory
WFC	Work Family Conflict
WFE	Work Family Enrichment
WLB	Work Life Balance
WTFC	Work to Family Conflict
WTFE	Work to Family Enrichment

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INTRODUCTION

The present research delves into the intricate relationship between work, family domains, and the well-being of nurses in North India. Historically, the role of women in North India has been multifaceted. While traditional studies on work and family have primarily underscored challenges arising from these dual roles, known as work-family conflict (WFC), more recent explorations highlight the potential benefits, coined as work-family enrichment (WFE) (Chen & Powell, 2012). Both conflict and enrichment are identified as distinct constructs, and published research has shown that nurses can experience both simultaneously.

The 21st century, particularly in the healthcare industry, has seen a transformative shift in how care is delivered and how professionals within the sector manage their work patterns. With advancements in medical technology, the increasing demand for telemedicine, and the continuous evolution of patient care paradigms, the healthcare landscape has become more dynamic and demanding (Lovejoy et al., 2021). Alongside these changes, there's been a marked rise in non-traditional work patterns across industries. The gig economy, characterized by temporary positions and short-term contracts, challenges the conventional notions of work-life balance, and this challenge becomes even more pronounced in the healthcare sector, where patient care is paramount (Romate & Rajkumar, 2022). How does a healthcare professional achieve this balance when work is sporadic, hours are unpredictable, and the stakes are high?

As urbanization has increased, so has the participation of women in professions, with many entering the nursing sector. Nurses constitute a significant portion of the healthcare workforce in North India (Sharma, 2022). With higher living costs and dual-earning families, urban living demands a balance between professional responsibilities and familial duties. Coupled with the inherent challenges of the nursing profession, these nurses face diverse stressors. Despite the demands of their profession, many continue to be primary caregivers at home, adding to the pressures of balancing work and family. This often leads to tension, impacting their psychological well-being (PWB) (Romate & Rajkumar, 2022).

In lieu of effects of modernity on Indian societies the broader societal landscape have shifted towards fragmented households, the nature of these stressors has also evolved, especially in the context of work dynamics and family responsibilities. As highlighted in various studies, men and women navigate different stressors. Men typically grapple with financial challenges

and job responsibilities, whereas women confront issues such as discrimination, role conflict, role ambiguity, and WFC (Shah, 2015). Given nurses' critical role in healthcare, it is essential to understand their unique challenges.

The intricate tapestry of North India's socio-cultural fabric is replete with diverse customs, religious practices, and familial structures. Many parts of this region still firmly adhere to the joint family system, where multiple generations cohabitate and share responsibilities. While providing a support network, such a system can also enhance role expectations, especially for women. In the context of work-life dynamics, nurses are not only negotiating their professional and immediate familial responsibilities but also the broader expectations of the extended family. This multi-layered network of responsibilities offers a perspective distinct to North India, underscoring the importance of studying work-family dynamics in this region.

Another crucial dimension to consider is the healthcare infrastructure prevalent in North India. While metropolises and larger cities in the region have witnessed a surge in state-of-the-art healthcare facilities, many peripheral areas still grapple with fundamental healthcare challenges. Nurses in these environments face varied stressors – from handling advanced medical technologies and demanding work schedules in urban centres to dealing with limited resources and overwhelming patient loads in smaller towns and rural areas. This varied work experience of the nurses demands that this complex landscape be studied with deserving breadth and profundity. While it is not possible to address all this complexity of healthcare in North India, this study focuses on the peripheries of this landscape and UT of J and K forms an ideal setting for such an endeavour.

Work-life balance (WLB), a term that emerged in the latter half of the 20th century, has become an indispensable topic of discussions surrounding modern employment practices, employee well-being, and organizational productivity (Naithani, 2010). This balance, which refers to the equilibrium between work-related activities and personal or family commitments and leisure, has been influenced by many factors, ranging from technological shifts to changing societal norms. As we probe deeper into the global and regional intricacies of work-life balance, it becomes evident that cultural, economic, technological, and demographic influences play a pivotal role in shaping its dynamics (Juntunen, 2019).

In the age of digitization, the conventional boundaries between work and home have grown increasingly porous. Connectivity tools, from smartphones to instant messaging apps, have redefined what it means to be at work. On the upside, this means greater flexibility and the rise

of remote work and digital nomadism (Bellmann & Hübler, 2021). Conversely, it has also resulted in many individuals feeling perpetually tethered to their jobs, with no apparent disconnect, leading to potential burnout and mental fatigue.

This research sheds light on WLB, especially against societal dynamics among nursing professionals in North India. The present study incorporates the Job Demand-Resources (JDR) model to navigate these complexities. The JD-R framework posits that high job demands (JD) might lead to exhaustion, while adequate job resources (JR) can mitigate the effects of high demands and enhance work engagement. By exploring this balance, the research seeks to decipher the impact of work-family dynamics on the PWB of nurses, offering potential pathways for improved support structures that enhance their well-being and, by extension, the quality of healthcare delivery.

The researcher seeks to conduct this study on nurses in North India. The first step in this undertaking was to survey healthcare facilities and the nurses working in those healthcare facilities in the region. This survey provided a clear understanding of the prevailing nursing practices. A literature review was conducted alongside this survey to assess current academic knowledge on the topic. The researcher formulated specific research questions using the insights gathered from the survey and the literature review. These questions were significant in guiding the direction and focus of the subsequent stages of the research.

1. BACKGROUND

In the pursuit of understanding the intricate dynamics between professional demands and resources, family responsibilities, and individual well-being among nurses, several pivotal questions arise. These questions endeavour to delineate the relationships and interdependencies within the work-family nexus, especially as they relate to the psychological health of the professionals in question. By examining the correlations between job demands, job resources, work-family conflict, work-family enrichment, and psychological well-being, this research seeks to unravel the various interactions that influence the daily lives of nursing professionals. The following research questions have been formulated to guide this exploration and offer a structured framework for the study:

- 1. Is there a positive relationship between job demands and work-family conflict?*
- 2. Is there a positive relationship between job resources and work-family enrichment?*
- 3. Is there a negative relationship between job demands and psychological well-being?*
- 4. Is there a positive relationship between job resources and psychological well-being?*
- 5. Is there a negative relationship between work-family conflict and psychological well-being?*
- 6. Is there a positive relationship between work-family enrichment and psychological well-being?*
- 7. Does work-family conflict mediate the relationship between job demands and psychological well-being?*
- 8. Does work-family enrichment mediate the relationship between job resources and psychological well-being?*

1.1 Significance of the Research

This research offers significant insights into the work-family dynamics, specifically tailored to the nursing sector in North India. The justification for undertaking this study arises from the complex interplay between job demands, resources, and their subsequent impact on work-

family balance and PWB. Furthermore, the following sections will elaborate on the reasons for emphasizing work-family challenges nurses face in North India and the choice of study design.

Work and family are deeply intertwined in nurses' lives, especially in North India. Both spheres are essential to their identity; while work confers them with professional satisfaction and financial stability, the family remains their core source of emotional support and moral reassurance. Even as nurses devote their skills and time to the healthcare sector, many remain central in their households, balancing caregiving and domestic responsibilities (Khan & Fazili, 2016).

The juxtaposition of these responsibilities often results in WFC, where the pressures from the professional sphere infringe upon their familial duties and vice versa. These dual roles can result in stress, decreased satisfaction, and even physical and psychological strain. The challenges are pronounced especially in North India, where societal norms and expectations might place a higher onus on women for household chores and caregiving. Such an environment also underscores the significance of understanding WFE - situations where professional roles can enhance and complement family life. The interplay of these dynamics is further complicated when considering factors like the demands of the job and the resources available to the nurses, as suggested by the JD-R model (Bakker et al., 2023). While the studies in the western hemisphere have provided a foundational understanding of WLB among various professionals, including healthcare workers, the nuances of North India — with its unique cultural, societal, and professional contexts — require tailored research.

Moreover, nurses' coping strategies to manage WFC have not been thoroughly explored. Such strategy could range from problem-focused approaches, where one tackles the root causes, to emotion-focused approaches, where individuals handle the emotional consequences. These coping mechanisms could significantly influence their well-being and professional performance.

Furthermore, while much of the existing literature has shed light on WFC, it is critical to probe deeper into how work and family enrich each other (Agrawal & Mahajan, 2021). Thus, this research aims to understand how participation in multiple domains, in addition to being conflicting in light of given job demands and responsibilities, may also enhance and positively influence each other, leading to better PWB. By comprehensively examining these elements, this research seeks to provide critical insights that can guide organizational policies and interventions. Such endeavours can create a supportive environment for nurses, allowing them

to flourish in both their professional and personal lives, ultimately benefiting the healthcare sector in North India and society at large.

While a considerable amount of research on work and family dynamics has been conducted in Western contexts (Gatrell et al., 2013; Liu et al., 2022), one must approach the North Indian scenario with distinct sensitivity due to its unique cultural, societal, and professional landscape. With its intricate tapestry of traditions and values, North India often leans towards collectivist principles. The family is a fundamental unit, often prioritized above individual aspirations (Bhat et al., 2019). This cultural setting is further nuanced when examining the lives of nurses, especially women. They not only serve as healthcare professionals but also, quite often, take on the role of primary caregivers at home. The societal expectations moulded by traditions and customs emphasize their responsibilities toward the family. These dynamic makes understanding WFC and WFE in their lives all the more critical (Fernandes & Nirmala, 2017).

Moreover, the coping strategies prevalent in North India might differ significantly from their Western counterparts. Cultural norms play a pivotal role in shaping these strategies. For instance, North Indian society may lean more towards emotion-focused coping due to its collectivist values, emphasizing familial harmony and societal expectations. Such coping mechanisms can have profound implications for nurses grappling with work-family challenges (Fernandes & Nirmala, 2017). Furthermore, while extensively researched in the West, it is still in nascent stages in the context of North Indian nurses. Understanding how their professional roles can bolster and support their familial roles offers fresh research and policy formulation avenues. The challenges faced by North Indian nurses can be better understood under the following headings.

Infrastructure & Equipment

In North India, particularly in less urbanized areas, nursing professionals confront several challenges tied to infrastructure and equipment. Many hospitals operate within the confines of aging infrastructure, often presenting issues like limited room sizes, inadequate ventilation, and outdated utilities (Bhat et al., 2019). Such limitations can significantly impact patient care. Sanitation, a critical component in healthcare settings, becomes notably challenging in these facilities. Ensuring a consistent, clean water supply and maintaining a sterilized environment becomes increasingly difficult with aging infrastructure (Pandian et al., 2020).

Furthermore, these hospitals frequently grapple with equipment-related challenges. The absence of up-to-date medical equipment can not only introduce delays in treatment but also

risk the accuracy and quality of diagnosis (Bajpai, 2014). Consequently, due to the unavailability of advanced equipment, some hospitals depend on external facilities. This necessitates sending patients elsewhere for specific tests, a process that is not only time-consuming but also adds to the financial burdens of patients and their families (Pandian et al., 2020).

Training & Skill Enhancement

In North India, nursing confronts many training and skill enhancement challenges. One salient issue is the outdated curriculum, which can sometimes overlook emerging global health threats, new medical technologies, and evolving patient care methodologies (Dash et al., 2016). Concurrently, as telemedicine and digital health platforms surge in prevalence, there is a pressing necessity for nurses to use these technologies adeptly (Nair & Rajan, 2017). The limited training in various specialties further complicates this landscape, potentially diminishing nurses' confidence when positioned in those departments (Dash et al., 2016). Moreover, the emphasis on continuing education, vital for keeping pace with medical advancements, seems to be lacking for nurses in this region.

Societal & Cultural Barriers

In the context of North India, nursing encounters certain societal and cultural barriers that can affect patient care and the nurses' morale. For instance, there are instances where families, owing to their traditional beliefs, might give precedence to home remedies or traditional healers over hospital treatments (Sowmini & De Vries, 2009). This can result in delayed hospital admissions or even resistance to recommended medical treatments. In addition, some religious beliefs may oppose medical advice, placing nurses in the challenging position of navigating and mediating these intricate situations. Another pervasive issue is the societal hierarchical views. Nurses are often perceived as being lower in the medical hierarchy compared to other professionals, which can harm their morale and self-worth (Nair & Rajan, 2017).

Work Environment

The work environment in which nurses operate in North India presents its unique challenges that can have tangible impacts on their well-being. One of the primary concerns is the extended working hours. Such relentlessly long shifts can wreak havoc on a nurse's health, making them vulnerable to chronic fatigue, weakened immunity, and other long-term health complications (Kesarwani et al., 2020). Compounding this issue is the often-glaring lack of support. The combined emotional and physical strains, when not alleviated by counselling or supportive

services, can push many nurses toward severe burnout. Additionally, the nature of their job means they are chronically exposed to trauma, suffering, and the stark reality of mortality, all of which can have profound psychological ramifications (Bhagwagar, 2022). This exposure can escalate to the point where nurses may manifest symptoms akin to PTSD, a condition termed as secondary traumatic stress, which emerges from the continuous witnessing and internalizing of patients' traumatic experiences (Kesarwani et al., 2020). Given the many nurses working in North Indian hospitals, cultural issues are at the forefront. In a study on South Indian nurses in Delhi, it was observed that they find more freedom and independence in their new roles, moving away from traditional community ties. However, their identity in the city is still influenced by their language and gender. While relocating offers a chance to challenge male-dominated norms, gender and ethnic hierarchies remain strong in the new environment, especially as traditional community roles shift (Nair, 2007).

Accessibility & Logistics

Accessibility and logistics present a distinct set of challenges for nurses in North India. For many, simply reaching the workplace can be a daunting task. This is especially true for those stationed in areas with harsh terrains, such as the mountainous regions of Jammu and Kashmir, Himachal Pradesh, and Uttarakhand. The daily commute in these areas can be particularly grueling, and this difficulty is often exacerbated during extreme weather conditions, making it an arduous journey (Sharma et al., 2022). Beyond the challenges of daily transit, there is also the more significant issue of relocation. Given the limited job opportunities in specific areas, many nurses face the difficult decision to relocate. Such relocations can mean separating from their families or necessitating rapid adaptations to entirely unfamiliar environments, which can take a toll on their personal and emotional well-being (Kodoth & Kuriakose Jacob, 2013).

Economic Concerns

Economic factors weigh heavily on the nursing profession in North India, bringing to light several concerns. At the forefront is the issue of salary disparities. The remuneration offered to nurses often mirrors the societal perception of the profession. If nursing is undervalued or misconstrued in its significance within the healthcare sector, it gets reflected in the inadequate salaries offered (Sharma et al., 2022). Beyond the base pay, there is an additional concern regarding the supplementary benefits and perks. Many nurses might find that, apart from their basic salaries, they are not provided with essential benefits that can significantly impact their well-being and job satisfaction (Singh, 2013). This includes crucial provisions like health insurance, housing allowances, or even educational perks for their children. Such omissions

underscore the pressing need to re-evaluate and uplift the economic stature of the nursing profession (Nair & Zadey, 2022). In a study on Accredited social health activists (ASHAs), it was found that with the workload of 12 hours a day and without a day off, the nursing professionals were paid around 30 to 45 pounds (3200 – 4800 INR) a month (Jain, 2021).

Professional Growth

Professional growth, a pivotal aspect of any career, has its unique challenges in the domain of nursing in North India. A significant concern is the need for clear opportunities for advancement. Without a well-defined progression path, many nurses may feel demotivated or perceive stagnating in their roles, affecting their overall job satisfaction. Coupled with this is the issue of recognition and awards. Systems that recognize and reward exemplary performance can be powerful motivators for nurses (Devi, 2020). Unfortunately, such systems are either conspicuously absent or, if they do exist, they need to be given the visibility and acknowledgment that they deserve. In summary, while nursing stands as an indispensable pillar of the healthcare system in North India, it grapples with a myriad of challenges. Addressing these issues holistically is not just crucial for the enhancement of the nursing profession but is also imperative for the overall betterment of the healthcare ecosystem in the region.

Table 1 below summarizes various organizational, personal, and societal pressures Indian Nurses face.

1.2 Nursing in India

Modern medicine, including nursing, flourished in India under British rule. Nursing as a profession was first developed by the British Medical Services and was later known as the Indian Medical Services (Gill, 2011). Even though many nursing schools were established between the 18th and 19th centuries, only Europeans and Anglo-Indians were trained in these schools. In 1867, the training of Indian girls as nurses for the first time was started at St Stephens Hospital, Delhi (Gill, 2018). In 1871, the Government General Hospital, Madras, started training six nurses. A lady superintendent and four trained nurses were recruited to train these nurses. Lady Dufferin established the Countess of Dufferin Fund in 1885 to improve women's health in India. It was the first organized effort to extend Western medicine to Indian women (Gill, 2011). Many 'Dufferin hospitals' established by this fund started training Indian women as nurses. Lady Dufferin is considered a chief pioneer of Indian nursing.

Table 1: Various obstacles faced by Indian nurses owing to their context and profession.

<i>Barriers Faced by Indian Nurse</i>		
<i>Organizational</i>	<i>Personal</i>	<i>Societal</i>
<i>Low pay and long working hours</i>	<i>Poor self-image</i>	<i>Nursing in India not considered as a professional line of work</i>
<i>No defined cadre and hierarchy</i>	<i>Ignorance about roles and responsibilities</i>	<i>Patriarchal value system</i>
<i>Need-based rather than specialty based</i>	<i>Nursing chosen as a last resort</i>	<i>Ignorance in society w.r.t nursing roles</i>
<i>Minimal representation in policy-making</i>	<i>Lack of any programs for career guidance</i>	<i>Media portrayal of nurses as obedient and passive</i>
<i>No policy for continued education and training</i>	<i>Lack of proper leadership and supervision</i>	
<i>Issues with gender discrimination</i>	<i>Lack of motivation and lobbying</i>	
<i>No career growth and opportunities</i>		
<i>Rewards and appreciation not incorporated</i>		
<i>Nurses undertaking non nursing roles like admin and reception</i>		
<i>Violent behavior of patients and attendants</i>		
<i>Non availability of facilities like running water, food, washrooms etc</i>		

Source: Sharma et al. (2020)

In 1908, the Trained Nurses Association of India (TNAI), a national organization of nurse professionals at different levels, was established. TNAI started the Nursing Journal of India, a trade publication that allowed nursing professionals to share their views and experiences at work. However, the representation of Indian nurses in the TNAI was limited during British rule, and no native were in the roles of President or General Secretary (Gill, 2018). Post-independence, with the establishment of the Indian Nursing Council (INC) and the efforts of TNAI, significant changes were brought about in nursing education. To make the uniformity

of nursing training throughout the country possible, the Indian Nursing Council was established in 1949 (Gill, 2011). In 1946, RAK College of Nursing in Delhi and CMC College of Nursing in Vellore started offering the first four-year BSc program (Suresh, 2013). The result of these efforts was that by the end of 1964, there were 30,000 auxiliary nurses and midwives, 33,500 nurses, and 4,000 health visitors as against 5,000 midwives and 7,750 nurses and health visitors in 1946 (Suresh, 2013)

Over the years, this evolution was further steered by the insights and recommendations of several essential committees set up by the government of India. Starting with the Bhore Committee (1943-46), it explored the health conditions and infrastructure of nursing in the pre-independence era up to 1941. Beyond merely analysing the state of affairs of nursing in India, it came up with many recommendations, including regulating the nursing field, ramping up the numbers of trained professionals to intensify training avenues, and even championing financial support for nursing students. After gaining independence, a committee named the Shetty Committee was constituted in 1954, which identified and highlighted gaps in the availability of trained nurses, emphasizing both academic and practical facets of the profession. Taking stock of the progress post-Bhore recommendations, the Mudaliar Committee (1959-1961) evaluated the strides made in the previous decades and offered input on structuring the nursing profession based on training levels and qualifications. In 1963, the Chadha Committee centred around a holistic integration of nursing services and their diverse roles. They put forward a holistic understanding of the broader spectrum of health by underlining the vital role of family planning. The Kartar Singh Committee (1973) advocated the assimilation of multipurpose health workers into the main nursing framework. The Shrivastava Committee (1975) envisioned a network of part-time community health workers, culminating in the Community Health Workers Scheme launch in 1977. The Bajaj Committee (1986) paved the way for the establishment of dedicated health universities across the nation, placing significant emphasis on streamlining and standardizing courses, with nursing education being a prime focus (Healey, 2014; S. Nair & Rajan, 2017; Wilkinson, 1958).

The National Nursing and Midwifery Commission Bill, 2023, was presented in the Lok Sabha on July 24, 2023, with the primary aim of revoking the Indian Nursing Council Act of 1947. This proposed legislation seeks to establish comprehensive guidelines and standards for nursing and midwifery practitioners' education and professional services. Among its notable provisions is the formation of the National Nursing and Midwifery Commission, comprised of 29 members, with the chairperson requiring a postgraduate degree in nursing and midwifery

and substantial field experience. Ex-officio members include representatives from various healthcare and education bodies, while other members encompass nursing and midwifery professionals and charitable institutions (Peter & Sharma, 2022). The Commission's key responsibilities involve shaping policies, standardizing admission processes for relevant educational institutions, regulating such institutions, and defining faculty standards.

Furthermore, the Bill outlines the creation of three autonomous boards under the National Commission's supervision: the Nursing and Midwifery Undergraduate and Postgraduate Education Board, the Nursing and Midwifery Assessment and Rating Board, and the Nursing and Midwifery Ethics and Registration Board, each serving distinct functions. In addition, every state government is mandated to constitute a State Nursing and Midwifery Commission, comprising ten members representing various healthcare and educational stakeholders (Peter & Sharma, 2022). The State Commissions are entrusted with duties such as enforcing professional codes of conduct and ethics, maintaining registers of registered professionals, issuing specialization certificates, and conducting skill-based examinations, with appeals against their decisions subject to review by the Ethics and Registration Board and potentially the National Commission.

The Bill introduces regulations for establishing new nursing and midwifery institutions, requiring approval from the Assessment and Rating Board. Practitioners must enroll in the National or State Register to legally practice nursing or midwifery, with penalties, including imprisonment and fines, imposed for non-compliance. Additionally, it establishes the Nursing and Midwifery Advisory Council, chaired by the National Commission's chairperson, which includes representatives from various healthcare and educational bodies, offering guidance and support on matters related to nursing and midwifery education, services, training, and research (SECRETARIAT & DELHI, 2021). This Bill represents a significant step towards ensuring the quality and integrity of nursing and midwifery professions in India.

To fully grasp healthcare organization in India, it is crucial to understand the country's political framework. Politically recognized as a Union of States, India is structured with a Central Government and individual State Governments. The Indian Constitution methodically divides administrative and legislative powers between these entities, categorizing them into three primary lists: the Union List (tasks designated for the Central Government), the State List (items under the purview of the State Governments), and the Concurrent List (areas where both State and Centre have the authority to legislate) (Nair, 2020).

Health, as a primary area of concern, predominantly rests with the State Governments, as highlighted by Mahato et al. (2017). Nevertheless, the Central Government plays a supportive role, intervening to assist states in areas like control and eradication of major communicable and non-communicable diseases, medical and paramedical education alongside regulatory measures, drug control, prevention of food adulteration, and initiatives like Child Survival and Safe Motherhood (CSSM) and immunization programs (Mathur & Reddy, 2019). Over the years, the Central Government has launched numerous targeted interventions, known collectively as the National Health Programs (NHP). These programs address specific health challenges such as HIV/AIDS, mental health, and cancer. A significant milestone in India's healthcare evolution was the establishment of the Indian Nursing Council (INC) in 1947, which came into existence following the recommendations of the Bhore Committee (Sharma et al., 2020). This committee underscored the need for a national body to oversee and regulate nursing standards. By 1950, the INC had brought about notable reforms, standardizing courses like General Nursing and Midwifery. Simultaneously, state-level Nursing Councils emerged, ensuring consistency and regulation in nursing education and practices nationwide (Nair, 2020). The healthcare infrastructure in India operates in a tiered manner, ranging from the national framework down to the village level, a structure visually represented in Figure 1.

Transitioning into the realm of hospital institutions, Figure 2 sketches a generalized hierarchy found within these establishments. However, it is crucial to recognize the uniqueness of each hospital's organizational culture and operational hierarchy. These may exhibit variations depending on managerial philosophies, financial robustness, and the institution's overall magnitude. At the foundation of this structure, nurse assistants, who typically possess nursing certificates, are expected to support staff nurses (Garner et al., 2015). The latter often have nursing diplomas, differentiating them from fully certified nurses. In many hospitals, a prevalent practice is the engagement of nursing students in roles akin to assistants or even staff nurses, but always under an experienced nurse's guidance, an approach that proves economical. The nursing superintendent occupies a position above the staff nurses. Standing at the top of this structure is the medical superintendent. Layering this hierarchy further, senior physicians exert a profound influence, often eclipsing the nursing superintendent.

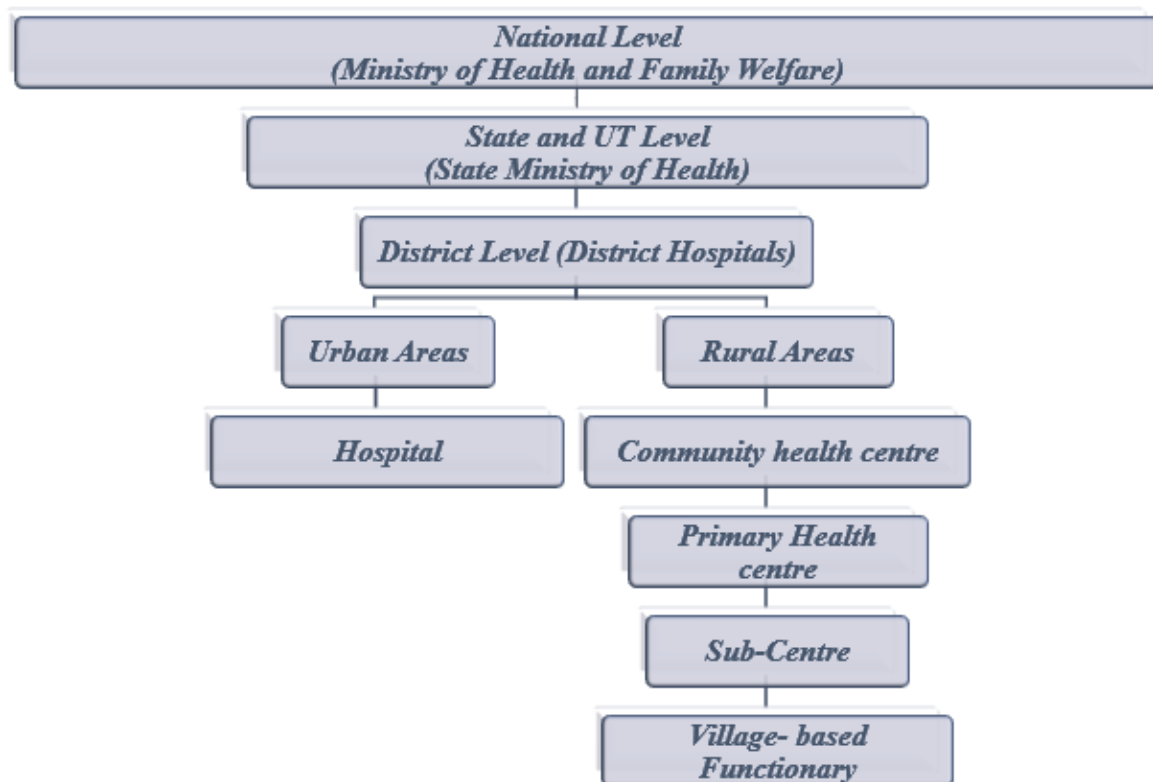


Figure 1 General organizational structure of healthcare across states and UTs in India
Source: (Nair, 2020)

Contemporary Indian nursing stands at a crossroads, wrestling with pressing anxieties over its professional status. Deeply entrenched perceptions of nursing as 'dirty work' remain pervasive in the Indian psyche, a view that has held sway for the last two decades (Mendonca & D'Cruz, 2021). These sentiments further accentuate the already challenging service conditions faced by nurses in Indian hospitals — low wages, demanding night shifts, and a staggering nurse-patient ratio that strains their capabilities and mental well-being. Amplifying these challenges is the weight of gender dynamics (Walton-Roberts, 2015a). In a society where women are conventionally assigned the role of 'carers,' nurses, women find themselves tethered to traditional expectations and roles of caregiving. However, despite these pressing challenges, the state's intervention appears largely apathetic. The focus has remained mainly on curriculum adaptations and the expansion of nursing institutions, sidelining more urgent concerns like revising service conditions or addressing the palpable hierarchies within the profession. These hierarchies are external and internal (Walton-Roberts, 2015b).

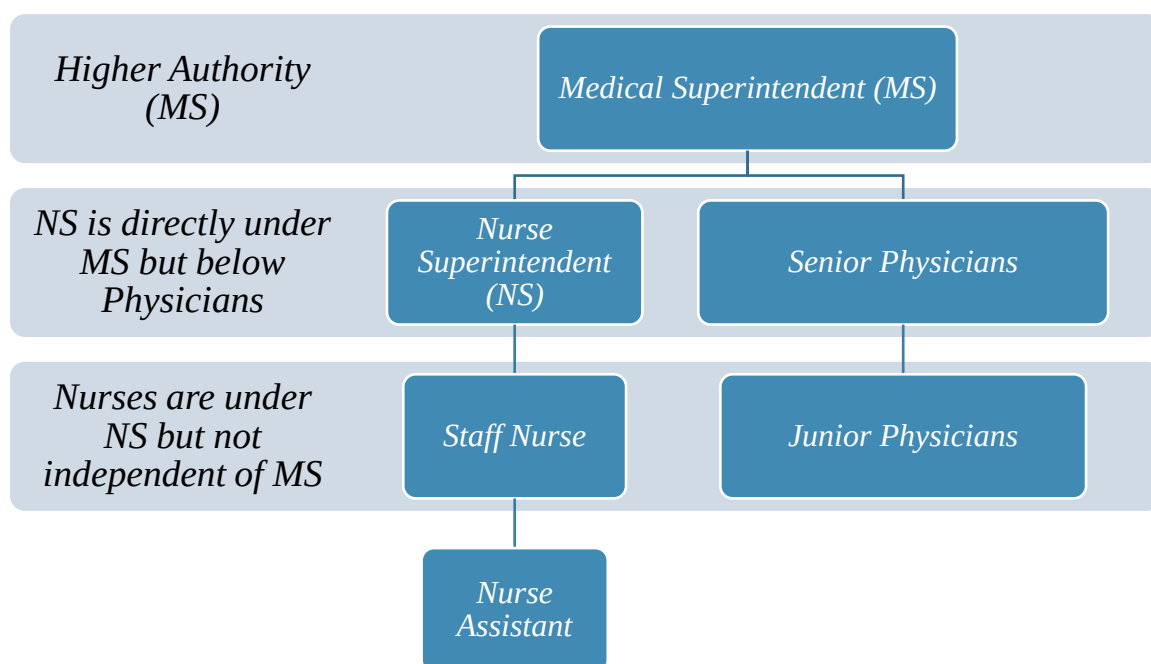


Figure 2: Hierarchical structure of doctors and nurses in a typical healthcare setting in India

Source: (Nair, 2020)

Within the nursing profession, disparities between 'A-grade' and 'B-grade' nurses further exacerbate the challenges, with the latter often trapped in a cycle of lower wages and fewer opportunities. Moreover, with rampant privatization and a lack of stringent regulatory oversight, the nursing profession in North India grapples with additional administrative issues (Rastogi et al., 2021).

However, the overarching concern remains the broader socio-economic positioning of women in India. This impacts the nursing profession two-fold: first, in the workplace, where their subordination often mirrors the traditional underpinning of women in society, and second, in the broader societal context, where their demands for better conditions are often brushed aside, presumably because they are predominantly women voicing these issues (Das & Mohpal, 2016). Despite the promise of economic independence that nursing might offer to many women, it is juxtaposed against the backdrop of a society still steeped in patrifocal values. This tension between modern aspirations and traditional gender roles underlines the need for a comprehensive revaluation of the profession and society's perceptions (Rastogi et al., 2021).

Modernization has bypassed the nursing profession in India. There is a prevailing perception among some doctors that nurses are only proficient in basic tasks such as measuring temperature and blood pressure and assisting with feeding and bathing. This limited view

fosters an environment where quacks can falsely represent the nursing profession (Sarkar, 2021). Unfortunately, even mandates from higher authorities do not have a lasting impact. However, executing such directives in a setting where nurses are undervalued, often equated to labourers or servants, is daunting.

To this day, many nurses receive salaries ranging from INR 2000 to 10,000 per month. Astonishingly, it is not just small healthcare facilities that perpetuate this inequity; large corporate hospitals, despite their substantial profits, are also the offenders. They readily offer competitive salaries to physicians based on the notion that doctors directly contribute to the hospital's revenue (Rastogi et al., 2021). This narrow perspective overlooks the nurses' round-the-clock care, supporting patients from admission to discharge. Furthermore, given that a majority of nurses in India are females, their safety remains a paramount concern. Alarming, both government and private sectors have made insufficient strides to address workplace safety for nurses.

In North India, like many other regions worldwide, nurses are the linchpins ensuring smooth operations within the medical ecosystem. However, despite their undeniable contributions, they grapple with myriad challenges across infrastructure, training, societal perceptions, administrative hurdles, and more. These challenges affect their professional lives and have broader implications for the overall healthcare sector. Probing deep into the intricacies of these obstacles provides insights into the resilience of these healthcare professionals and highlights the areas needing urgent attention and reform.

2. LITERATURE REVIEW

Academic research has often explored work-life balance, especially in professions with unique challenges. With its demands and responsibilities, the nursing profession provides a relevant context for this exploration. This section reviews the literature on extant theories of Work life balance, Job demand resources model and psychological wellbeing and consequently highlights challenges to nursing in North India. This review sets the foundation for further discussions and analyses in this thesis.

The section begins by presenting an overview of work-life balance from a perspective of published literature in the past decade. The demanding nature of the nursing profession introduces unique challenges concerning this balance. In the specific context of North India, the combination of socio-cultural norms, infrastructure constraints, training needs, and other factors create a distinct work-life dynamic. Subsequent sections delve into various theoretical models proposed to explain work-life balance. Theories such as the Spillover Theory, Border and Boundary Theory, and others offer insights into the interaction between personal and professional realms.

An essential component of this research is the JD-R model. This model provides a structured approach to understanding the specific demands a job places on an individual and the resources available to address these demands. For nursing, the model offers insights into the profession's unique pressures and available resources. Furthermore, the PWB of professionals remains integral when discussing work-life balance. The review examines the psychological health of nurses, linking it to the demands of their profession.

2.1 Systematic Review of the Literature

The PRISMA methodology was used to sort and filter the published research the flowchart of which is depicted in Figure 3, sifting through the published research, the SCOPUS, Web of Science, and NCBI databases were accessed while appending some more research using Google Scholar.

The search queries inputted are as under:

(ALL=("nurses" AND "work life balance")) AND ALL=("nurses" AND "psychological well being"), ALL=("nurses" AND "Job resources" AND "Job demands"), ALL=("nurses" AND "work life enrichment") and ALL=("nurses" AND "work life conflict").

The databases returned a total of 1418 publications. Eliminating the duplicate entries, and those articles not accessible, 432 papers were chosen for examination. Upon further screening, the review comprised 234 articles from 2013 to 2023.

Two prominent software applications, VOS viewer 1.6 and Bibliometrix, were utilized to investigate the possible relationships between the research articles and explore various other descriptive parameters. From 2013 to 2023, the systematic literature review underscored significant developments in PWB, JDR, and work-life balance (WLB), shown in figure 4.

Across this decade, 234 articles on these topics were published. Interestingly, the growth is progressive. Starting from a modest combined total of 8 articles in 2013, there is a steady increase each year, culminating in 44 articles in 2023. This trajectory underlines a growing interest in these research areas over the years.

Though early research in the work and life of professionals, including nurses, was predominantly located in the western hemisphere, with the turn of the millennium, most of the research in the present context has been conducted in the eastern hemisphere, including China, India, and Malaysia (Lapierre et al., 2018). In the past decade, Asia, prominently with contributions from countries like China, Malaysia, India, and Japan, appeared as a dominant region, as shown in Figure 5, constituting a significant portion of the total literature.

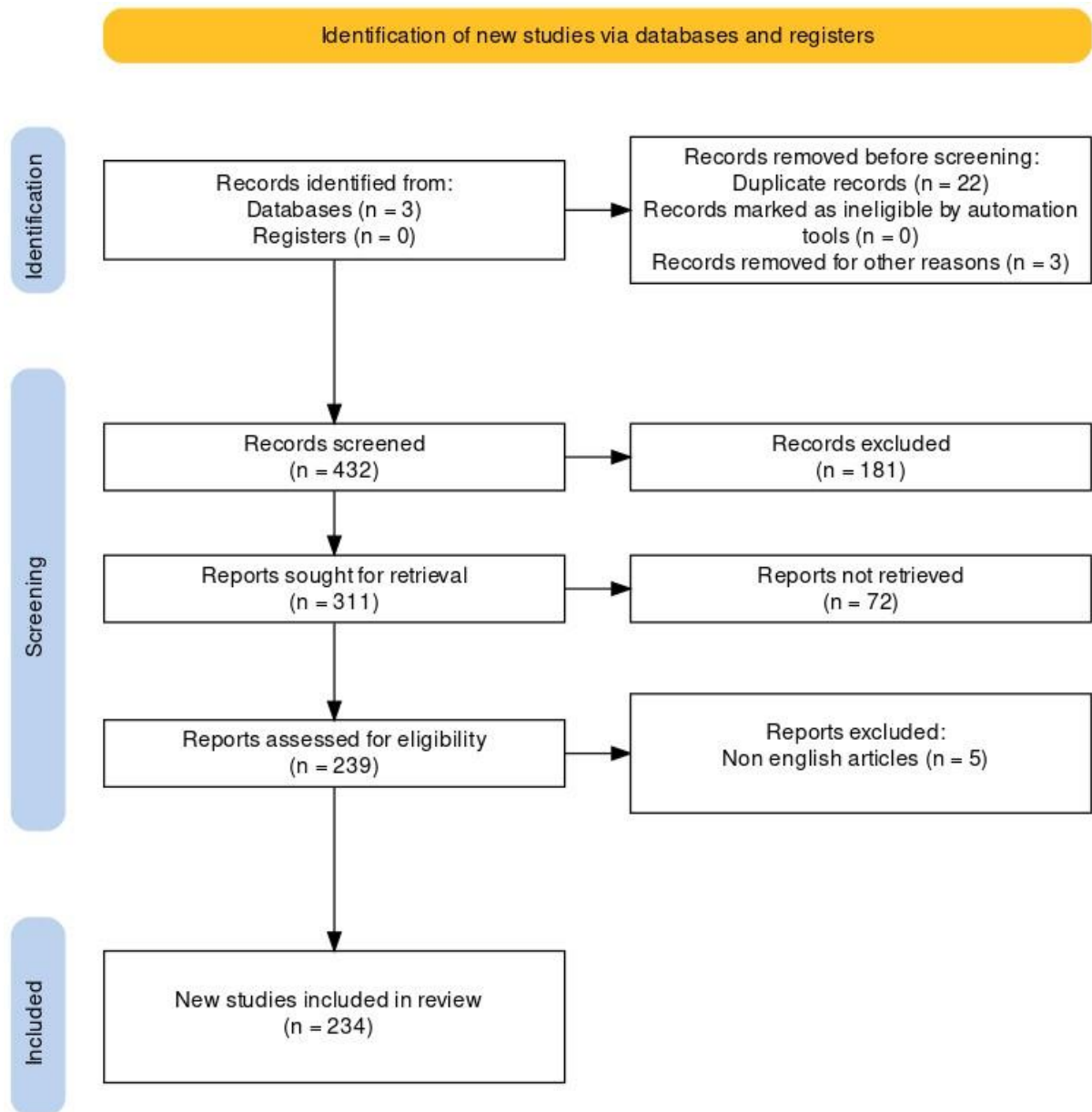


Figure 3: Sifting of the articles using PRISMA methodology.

Source: Own editing (2023)

Europe, represented by nations such as Italy, Sweden, the Netherlands, and Poland, also displayed a rich research repository, illustrating the continent's dedicated exploration into these subjects. North America, mainly through the United States and Canada, showcased consistent academic contributions. Although Africa, with countries like South Africa and Niger, were relatively fewer, they played a pivotal role in diversifying the research narrative. Australia and New Zealand voiced Oceania's perspective, while the Middle East, through nations like Saudi Arabia, Oman, and Jordan, marked its growing academic footprint in workplace dynamics.

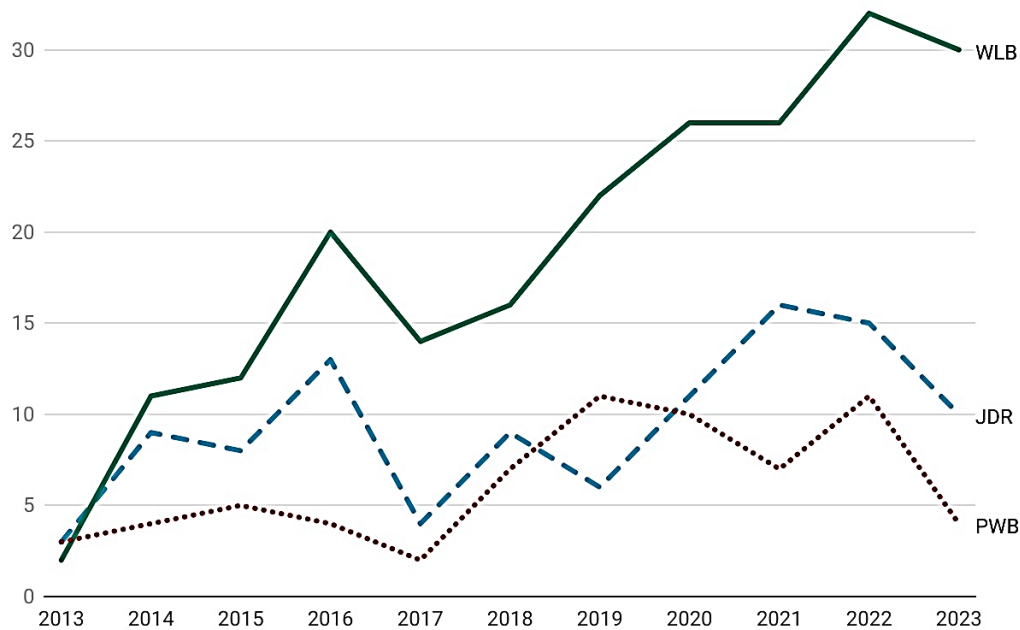


Figure 4: Evolution of published literature from 2013 to 2023

Source: Own editing (2023)

Articles by country

■ < 7
 ■ 7–12
 ■ 12–18
 ■ 18–23
 ■ ≥ 23

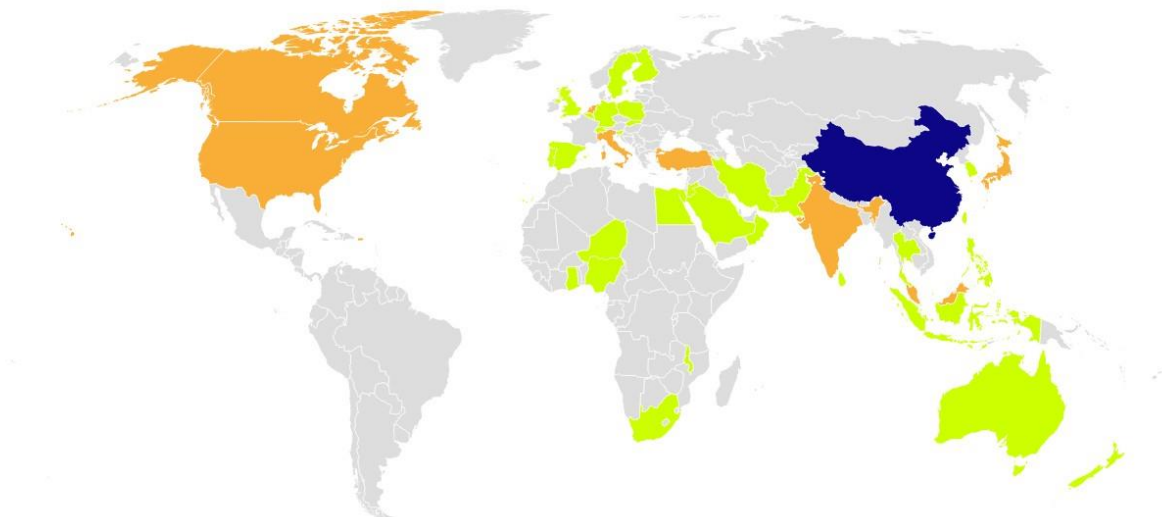


Figure 5: Global distribution of collected papers on nursing in the present theoretical context.

Source: Own editing (2023)

2.2 Work-Life Balance: Literature Review

From 2013 to 2023, the academic literature has reflected a sustained focus on work-life balance, which in the current endeavour includes WFE and WFC. The initial years of this decade, starting in 2013, registered modest contributions, which expanded by 2023, as shown in Figure 6, indicating the evolving importance of WLB in academic discourse. Like other topics, research in WLB, though extensive in the West in the early decades, was more extensive in East Asia in the preceding decade (Lapierre et al., 2018).

In the collected research from 2013 to 2023, some researchers appear noteworthy. Notably, Wang, Zhang, Liu, Chen, and Mauno may be mentioned. These authors' locale and affiliations point to a general trend of research shifting to the East and, more particularly, to East Asia. Wang and Zhang, in particular, have produced a substantial number of works, suggesting their centrality in WLB research. Surprisingly, all these researchers hail from China, underscoring the nation's significant role in advancing this specific area of academic inquiry. Their contributions have augmented the existing literature and set a precedent for subsequent academic investigations in the field of work-life balance.

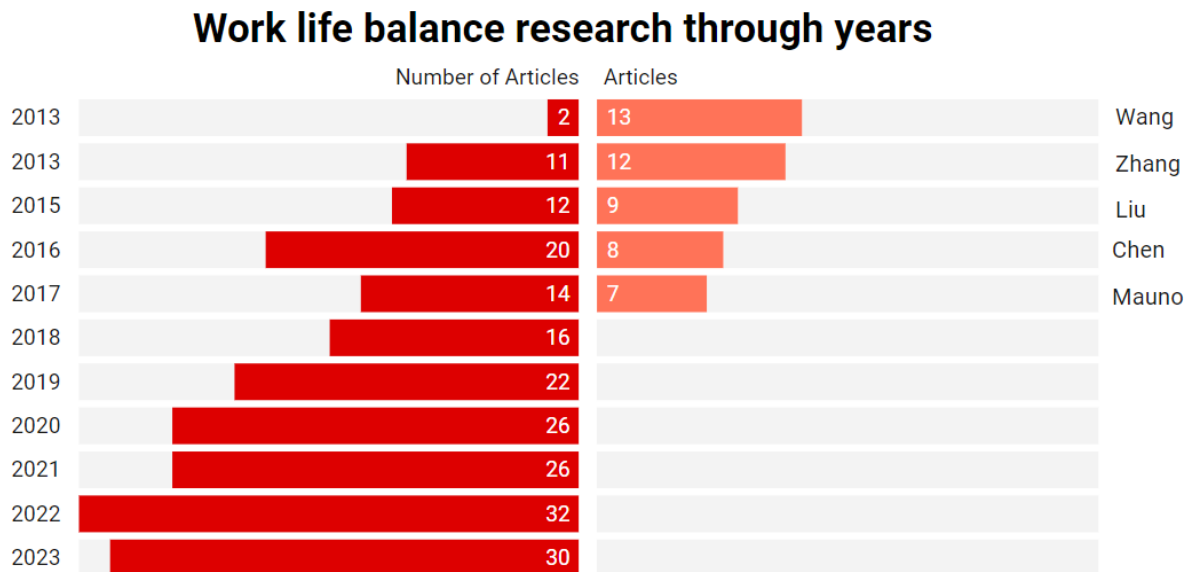


Figure 6: WLB contours of the published research

Source: Own editing (2023)

Using the VOS viewer plug-in, all the author keywords of the published research were analyzed, and a network of keywords was generated, as shown in Figure 7. As mentioned above, WLB encompasses both WFC and WFE. In the generated keyword network, four

primary clusters can be identified. These clusters are categorized by terms of WLB, job satisfaction, work environment, and job commitment. The inputted keywords encapsulated a wide range of focal points, illustrating the diverse aspects of WLB research. Themes related to the global COVID-19 pandemic were prevalent, emphasizing its impact on healthcare professionals, especially in the nursing sector. Other notable keywords were associated with specific geographies, such as Japan and China, or professional characteristics like nurse educators and psychiatric nurses.

Additionally, the influence of cultural contexts, as inferred from keywords like "Chinese version of the safety attitudes questionnaire" or job-specific concerns like "shift schedule," indicated the depth and breadth of the researched topics. There were also several instances where the WLB theme intersected with burnout, quality of life, leadership, job control, and resilience. The diverse range of keywords underscores the multifaceted nature of WLB and its wide-ranging implications in the nursing domain. This keyword network provides a roadmap for delving deeper into the specific nuances and intricacies associated with WLB in various professional and cultural settings.

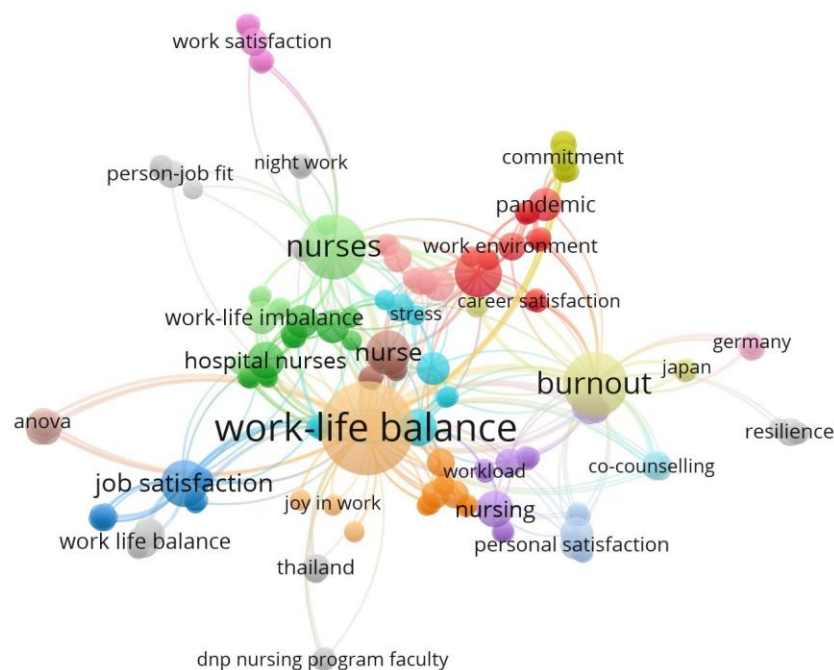


Figure 7: Keyword network for the collected literature for WLB

Source: Own editing (2023)

2.3 Work-Life Balance: The Concept

Work-life balance indicates an employee's capacity to manage professional and personal responsibilities successfully. This concept encompasses the balance between occupational demands and family life and extends to other facets of an individual's life. This research emphasizes the broader term "work-life balance" due to its more encompassing implications. Felstead, Jewson, Phizacklea, & Walters (2002) describe work-life balance as the interplay between the designated times and spaces allocated for work-related tasks and personal activities in societies primarily driven by labour markets. Meanwhile, Aycan (2008) take a more holistic approach, introducing the idea of "life balance." This broader concept views life balance as adequately meeting the requirements across three pivotal aspects of life: work, family, and personal time. Work-life balance is a concept that resonates profoundly within the healthcare sector, particularly among nurses.

At its heart, this balance refers to the stability an individual strives to preserve between work demands and personal life pursuits. This equilibrium becomes incredibly complex for nurses due to their profession's unique nature and demands. Their role bridges healthcare's clinical, administrative, and deeply human aspects, making their work-life experience distinctive. The distinction between work and personal life was more apparent in historical settings. Traditional roles followed more or less fixed hours (Bardhan, 1985). However, nursing has always been somewhat atypical, with long shifts, night duties, and the unpredictability of healthcare emergencies. The advent of modern healthcare settings, technology, and changing patient needs have blurred these lines for nurses even more.

Hospital nurses are prominently recognized as a vital workforce dedicated to patient care. The hospital's reputation largely hinges on the proficiency of these nursing professionals. Their roles demand mental and physical exertion, often due to heavy workloads from staff shortages. This situation is exacerbated by frequent night shifts and missed standard holidays (Garrett & McDaniel, 2001; Greenglass et al., 2001). Concurrently, they must also balance their personal, familial, and social responsibilities. Struggling to find equilibrium between their professional and personal lives or to effectively manage life's demands can lead to diminished commitment to the organization, early signs of burnout, heightened job stress, pronounced job dissatisfaction, and disruptions in their personal and family life (Aiken et al., 2002).

Zedeck & Mosier (1990) highlight that five primary models are generally used to elucidate the connection between work and personal life outside of it. The segmentation model proposes that

work and non-work domains are discrete entities that remain uninfluenced by each other. While this concept has theoretical merits, it has lost currency contemporaneously (Michel et al., 2011). The spillover model, contrastingly, suggests that one domain can either bolster or impair the other. Even though a considerable amount of research supports this model, its overarching nature demands a more nuanced understanding regarding its dynamics, origins, and outcomes (Martinez-Corts et al., 2015). Closely aligned within the conceptual landscape of work and life is the compensation model. The compensation model theorizes that one realm can compensate for what is missing in the other, such as engaging in community activities to counterbalance a mundane job. The instrumental model posits that successes in one domain can be attributed to endeavours in the other. A case in point would be individuals prioritizing earnings, even in routine jobs, to make significant life purchases (Zaresani & Scott, 2020). The conflict model, however, posits that intense demands from all life facets can force tough decisions, leading to potential conflicts and possible individual strain. A marked trend in academic circles has concentrated on the conflict model, especially in the milieu of dual-career households (Kothari & Pingle, 2020). However, studies on spillover and compensation models remain in vogue. A notable shortcoming of these models is their inability to define the genuine essence of "balance" between work and other life components. Delving deeper, it is essential to segregate between objective measures (like work hours) and subjective sentiments. These objective yardsticks often mirror societal ethos, while subjective perceptions might differ based on varying stakeholder viewpoints; an individual's sense of balance might be at odds with their partner's or employer's perception.

Furthermore, it is imperative to recognize that these conventional models lack in addressing certain positive dynamics, like facilitation and enrichment (Driscoll, Brough, & Kalliath, 2013). Such models can offer a more optimistic perspective on how work and personal life can mutually benefit and uplift each other, an aspect that will be explored in subsequent discussions.

2.4 Theories Underpinning Work-Life Balance

Theories addressing WLB have emerged from empirical research and conceptual dialogues within the academic domain. With each domain providing a lens to interpret and conceptually formulate balance between professional and the traditional concept of 'work'. This section reviews select theories integral to the WLB discourse, from early concepts like the Spillover Theory to more recent constructs such as the Ladder Theory. Each theory's historical context,

core principles, empirical support, critiques, and implications for future research are examined. Central to the discussion are the WFC and WFE theories. These concepts are explored extensively after a survey of the broader theoretical landscape.

Work-family spillover, a fundamental notion in occupational literature, examines the emotions and behaviours from one sphere to another. This transfer can have both positive and contrary results. Positive spillover can enhance alternate domain performance, highlighting the benefits of multiple roles (Stevens et al., 2007). This is supported by role-enhancement theory (Marks, 1977), suggesting benefits like improved self-worth and expanded social interactions (Kinnunen et al., 2006). On the other hand, negative spillover can lead to conflicts between professional and personal roles.

Boundary theory, rooted in the cognitive framework of social classification (Zerubavel, 1991, 1996), delves into the distinctions people draw between various life domains, notably home and work (Nippert-Eng, 1996). It explores outcomes such as the significance of these domains and the switches between roles (Ashforth et al., 2000). Distinct from this, the work-family border theory focuses solely on the interplay between work and family. It emphasizes achieving work-family balance, an optimal state where individuals experience satisfaction and harmony in both work and home domains, with minimal role conflict (Clark, 2000). Facilitation Theory, on the other hand, pioneered by notable researchers like Voydanoff (2004) and Frone (2003), focuses on the beneficial interplay between work and personal spheres, highlighting how skills and experiences in one domain can enrich the other. The paradigm of Segmentation and Integration offers insights into how individuals delineate or intertwine their professional and personal realms. Some individuals prefer strict boundaries (segmentation), while others embrace a seamless blend (integration), with implications for navigating work-family activities. A deeper exploration into these paradigms reveals the intricacies of individual preferences in the continuum. "Segmenters," as identified by Liu et al. (2013), are individuals who advocate for a strict demarcation, endeavouring to insulate their family environment from professional disruptions. This preference stems from a conscious desire to prevent work challenges from permeating their familial sphere. On the other end of the spectrum are the "integrators," who embrace a seamless blend of both domains. Characterized by permeable boundaries, they allow experiences from one realm to flow into and influence the other naturally (Kreiner, 2006).

Compensation Theory sheds light on how individuals offset discontent in one sphere by seeking satisfaction in another. Focused initially on emotional rewards, it is now applied such that it encompasses both tangible and intangible elements, albeit with debates over potential oversimplification and risks of escapism or burnout (Wiese et al., 2010). Compensation Theory has emerged as an analytical tool for understanding how individuals achieve balance amidst the ever-present tensions and rewards of their dual domains. Resource Drain Theory, rooted in the premise of limited human resources, addresses the challenges posed by limited resources in balancing personal and professional life, highlighting the subtractive nature of resource allocation. When one life domain heavily draws upon these resources, the other inevitably experiences a deficit, delineating the theory's core tenet (Magni et al., 2023). The Congruence Theory emphasizes alignment between work and non-work realms, incorporating external mediators in shaping work-life equilibrium. Originating from the drive to comprehend positive spillovers between these spheres, the theory diverged from traditional paradigms focusing primarily on conflict or cohesion. Instead, it postulated the significant role of external mediators—ranging from genetic predispositions and individual personality traits to overarching socio-cultural dynamics—in shaping one's approach to work-life equilibrium (Magni et al., 2023). Its applicability spans organizational policies and individual strategies, although criticisms include potential overgeneralizations and debates over individual agency.

Given the specific focus of this research on contrasting theories of work-family conflict and work-family enrichment as integral components of a worker's work-life balance, a comprehensive exploration of these theories is essential. Based on the collected literature, the subsequent subsection of this chapter discusses the theories of work-family conflict and work-family enrichment. Following this discussion, the exploration extends to the conception of the Job Demands-Resources (JD-R) model and psychological well-being, serving as the independent and dependent variables within the model, respectively.

2.5 Work-Family Conflict

In recent decades, the interplay between one's professional and personal life has been thrust into the academic limelight, mainly due to evolving societal dynamics and the increasing influx of women into the workforce. As organizations ramp up their drive for excellence in today's ultra-competitive corporate milieu, employees grapple with intensified job demands. As Nadeem & Abbas (2009) highlighted, extended working hours and continuous performance pressures have made it challenging for individuals to find a balance between their professional

commitments and personal lives. WFC, as conceptualized by Greenhaus & Beutell, (1985), encapsulates the tensions arising when professional responsibilities collide with familial obligations. Instances like work-related travels conflicting with familial commitments such as attending a child's event or caring for an elderly relative are routinely experienced. This tension is not merely a modern-day phenomenon; it resonates with the inter-role conflict described by Kahn et al. (1964), where the concurrent roles one assumes in one's professional and personal lives become mutually exclusive.

Broadening the lens, WFC delves deeper, accounting for potential clashes between job responsibilities and a diverse array of personal roles. Beyond familial interactions, this includes engagements in personal hobbies, social activities, religious commitments, and even moments of self-care, as emphasized by Kossek (2016).

Tracing back the academic journey of this topic, early studies on WFC can be dated to the 1970s, with notable contributions from researchers like Herman & Gyllstrom (1977). Greenhaus & Beutell (1985) further enriched the discourse by categorizing the conflict into three primary types: Time-Based, Strain-Based, and Behaviour-Based Conflicts. Time-based conflicts arise when commitments in one sphere bleed into the other, reducing the time available for either work or family. In strain-based conflict, stressors, or emotional strains from one domain, such as work-induced stress, impede effective functioning in the other. On the other hand, behaviour-based conflict becomes apparent when behaviours that are acceptable or nurtured in one realm are in direct contrast with the other, like a relentless work ethic clashing with the relaxed ambiance of family time (Allen et al., 2012).

One of the more critical methodological concerns in this domain lies in the conflation of the concepts of work-family conflict and work life conflict. While these terms may be used interchangeably in many discussions, scholars have frequently differentiated between them. Nevertheless, empirical evidence to separate these two remains to be seen, a point of contention raised by Greenhaus & Allen, (2011). A study by Carlson et al. (2009) further highlighted the potential of the WLB construct, suggesting it offers unique insights into understanding outcomes beyond the traditional scope of WFC.

Distinct from the positive dynamics of WFE, WFC has its unique character, separate from other constructs like role overload or job stress. While "role overload" signifies the overwhelming nature of tasks across roles, "conflict" zooms into the incompatibility between work and family

roles. "Job stress" captures the strain experienced in the professional domain, whereas WFC is about the stress triggered by the intersection of work and family.

Much like its counterpart, WFE, the WFC paradigm has been shown to act in two directions: work-to-family conflict (WTFC) and family-to-work conflict (FTWC). This dual model provides a profound understanding of how professional demands can impact familial responsibilities and vice versa.

Three primary reasons have been cited to underpin the importance of comprehending WFC (Greenhaus & Beutell, 1985):

1. **Complex Role Interactions:** WFC highlights the potential frictions arising from our professional endeavours and familial duties. Recognizing these tensions is essential to manage and balance our roles effectively.
2. **Resource Depletion:** Unlike WFE, which emphasizes resource aggregation, WFC underscores resource depletion. When work demands more time, energy, or commitment, our family might get the shorter end of the stick, and vice versa.
3. **Boundary Challenges:** In modern professional landscapes, especially in high-demand sectors like healthcare, the boundaries between work and family can blur. WFC serves as a lens to understand and address overlaps and intrusions between these domains.

2.5.1 Mechanisms Underlying work-family conflict

Within the framework of the WFC theory, several mechanisms elucidate the dynamics of this conflict. A core mechanism is derived from the Conservation of Resources (COR) theory by Hobfoll (1989). The COR theory proposes that individuals seek to protect and retain tangible and intangible resources. In the context of WFC, individuals have constrained resources such as time, energy, and attention. When work demands consume these resources, there is a subsequent reduction in the resources available for family or personal roles, leading to conflict. Another mechanism, Emotional Crossover, relates to the transfer of emotions from one domain to another. In the realm of WFC, emotions experienced in the professional sphere can influence the personal domain. For example, the stress from work-related challenges might carry over to the home environment, affecting family interactions.

The model of Role Overload, derived from role theory, is also relevant. Role Overload occurs when the demands of a role go beyond the available resources. In the work-family dynamic,

when professional demands intensify, there may be insufficient resources to meet family obligations (Bolino & Turnley, 2005). This imbalance can further exacerbate the conflict between work and family roles.

The Behavioral Consistency Theory provides another perspective. This theory posits that individuals maintain consistent behaviors across different situations. However, in the interplay between work and family, behaviors appropriate for the work environment might not align with family expectations (Kopelman et al., 1983). Such inconsistencies can contribute to WFC.

2.5.2 Work-Family Conflict in Nurses

When tailored to healthcare, the WFC theory becomes particularly appropriate. Healthcare professionals often grapple with demanding schedules, emergencies, and emotional tolls, which can strain their family life. While being at the forefront of patient care, these professionals also have family responsibilities, emotional needs, and personal aspirations. While healthcare professionals are trained to handle crises, the unpredictability and intensity of their roles can often spill into their personal lives. On-call duties, extended shifts, and the emotional aftermath of challenging medical cases can lead to missed family events, reduced leisure time, or emotional drain (Yildiz et al., 2021).

Moreover, the multifaceted roles that healthcare professionals adopt, not just as doctors or nurses but also as spouses, parents, or community members, can sometimes conflict. A surgeon who stays late to perform an emergency operation might miss their child's school play. Conversely, a nurse dealing with a sick child at home might be distracted or stressed during her shifts (Ekici et al., 2020). The cumulative effect of these role clashes is not merely additive but multiplicative. The stress or fatigue from demanding work schedules can strain familial relationships or lead to health issues. Likewise, familial tensions or challenges can impact focus, decision-making, or patient care quality (Kengatharan & Kunatilakam, 2020).

WFC is a significant topic of study within organizational psychology and sociology, leading to the development of numerous scales to gauge the extent of conflict between an individual's work and family life. An oft-used scale developed by Carlson et al. (2000) delves into both time-based, behavior-based and strain-based WFC, considering both work-to-family and family-to-work directions. Frone et al. (1992) proposed a scale that encapsulates both facets of WTFC and its inverse. Additionally, while not strictly about family, Matthews et al.'s (2010)

Work-to-Leisure Conflict Scale is noteworthy as it examines how work commitments might encroach upon leisure time, indirectly impacting family interactions.

The Work-Family Conflict Scale, formulated by Netemeyer et al. (1996), is a comprehensive tool to assess the intricate tensions that arise between one's professional duties and personal life. Created with an eye for detail, this multidimensional scale meticulously pinpoints specific areas where discord might emerge. In terms of WTFC, the scale delves into time-based conflict, which evaluates the intrusion of work obligations into family time; strain-based conflict, which quantifies the repercussions of work-related stress on family responsibilities; and behaviour-based conflict, which examines the behavioural shifts when one transitions between professional and familial settings. On the flip side, the FTWC dimension of the scale inspects time-based conflict by assessing how family commitments encroach upon work time, strain-based conflict by gauging the impact of familial stressors on work efficiency, and behaviour-based conflict by determining potential clashes in behaviour emanating from familial roles and spilling into professional spheres (Allen et al., 2020).

Participants interact with the scale using a Likert-type format, deliberating on diverse statements that mirror the intricate challenges of balancing work and family roles. This scale's robustness and precision have led to its adoption in several seminal research studies. For instance, studies by Carlson et al. (2000) employed the scale to explore the link between WFC and job satisfaction. Likewise, research by Ernst Kossek & Ozeki (1998), used the instrument to investigate the international variations in the relationship between WFC and work-related outcomes. Through extensive validation and empirical testing, the Netemeyer et al. (1996) WFC scale has proven instrumental in furnishing reliable insights into the nuanced arenas of conflict individuals grapple with in harmonizing work and family demands.

2.6 Work-Family Enrichment

Delving deeper into WLB, the positive synergy between professional and personal life domains becomes essential. This study introduces the idea of WFE to scrutinize the positive facets of this synergy, focusing on female nurses in India. WFE delves into the beneficial aspects that one's job can have on family life and vice versa. It signifies the situations where positive elements from one's professional or personal life elevate experiences in the other sphere.

Greenhaus and Powell's groundbreaking research in 2006 laid the bedrock for WFE, contesting the conventional paradigms of WFC. This perspective forwards the idea that each domain, be

it professional or personal, can serve as a catalyst for the other's enhancement. This holistic view posits both realms as intertwined entities, conducive to mutual growth rather than adversarial.

As articulated by Greenhaus & Powell (2006), this notion suggests that WFE emerges when experiences in one sphere amplify the life quality in the other. This is a synergy of roles where one domain (work or family) can positively affect the other. Furthermore, Wayne et al. (2007) described WFE as the degree to which one responsibility augments execution of responsibilities or sentiments in the counterpart. They emphasized its quintessential nature in the work-life continuum, advocating its distinctiveness from merely an absence of conflict.

It's imperative to recognize WFE as a unique entity, distinct from related constructs like positive spillover, facilitation, and enhancement. While "enhancement" orbits around harnessing resources that aid individuals in navigating life's hurdles, "enrichment" pivots on boosting performance in one sphere through resources from another. "Positive spillover" is about transferring experiences between domains, whereas enrichment expands on it, emphasizing the importance of effectively utilizing transferred assets (Powell & Greenhaus, 2010). "Facilitation" is rooted in the idea of domain engagement leading to systemic improvements (Wayne et al., 2007).

The WFE paradigm, mirroring WFC, acknowledges the two-fold nature of work-family relationships: work-to-family enrichment (WTFE) and family-to-work enrichment (FTWE). This dual approach offers a robust understanding of how professional and personal lives can symbiotically enhance each other.

Adopting WFE as a guiding principle is rooted in three main reasons:

- **Unified Understanding:** WFE elucidates the symbiosis between our professional commitments and personal responsibilities, emphasizing that they are not mutually exclusive but can have mutual benefits.
- **Asset Aggregation:** WFE underscores the idea that one's profession or personal life can accumulate resources beneficial to the other. This perspective is paramount for sectors like healthcare, where professionals might derive invaluable skills and resilience from their roles, enriching their personal lives and vice versa.
- **Harmonious Fusion:** Moving beyond the traditional dichotomy of WLB, WFE champions the ethos of harmonious fusion. This viewpoint resonates with the evolving

landscape of modern professions, especially in high-demand sectors like healthcare, where the demarcation between professional and personal can often be fluid.

The WFE theory, when contextualized within the healthcare domain, offers a profound insight into the confluence of professional responsibilities and familial roles assumed by healthcare practitioners. Contemporary discourse on healthcare dynamics elucidates the bidirectional enhancement between these domains, eschewing traditional models that typically delineate a dichotomous relationship (Mauno et al., 2015). Instead of portraying one realm as a potential detriment to the other, the enrichment framework posits a symbiotic interface, especially salient for healthcare professionals, frequently at the intersection of demanding vocational obligations and personal commitments. Central to this discourse is the dynamic transference and assimilation of resources. While encapsulating quantifiable metrics like fiscal incentives or adaptive scheduling (especially relevant in the round-the-clock healthcare sector), these resources also embrace the intangible competencies accrued through clinical and non-clinical experiences (Russo & Buonocore, 2012). The dexterity and emotional resilience sharpened in high-pressure medical environments, the empathy fostered through patient interactions, and the gratification derived from clinical successes are not confined within hospital walls but can transcend to enrich a practitioner's familial life and vice versa.

A pivotal dimension of this theoretical construct emphasizes the myriad roles a healthcare professional embodies. Beyond their clinical or administrative capacities, these individuals navigate complex terrains as caregivers, parents, partners, or community members. Each role's unique challenges and learnings contribute to an extensive tapestry of experiences. Such experiences, rich in their diversity and depth, become instrumental in shaping diagnostic reasoning, therapeutic interactions, and overall patient care. Simultaneously, they provide a robust foundation for informed decision-making in personal spheres (Mauno et al., 2015).

For healthcare professionals, adeptly juggling these roles doesn't just culminate in linear enrichment. The cumulative effect is multiplicative. The compassion and patience nurtured in familial interactions can enhance patient rapport and team collaboration. Inversely, the methodical approach and critical thinking developed in clinical settings can inform and streamline personal commitments and family engagements (Russo & Buonocore, 2012). In essence, for healthcare professionals, the tenets of WFE, when cogently integrated, foster a harmonious balance, allowing each domain to augment and be augmented by the other.

2.6.1 Mechanisms Underpinning Work-Family Enrichment

The WFE theory elucidates many mechanisms that serve as conduits for positive cross-domain interactions in the intricate nexus between professional commitments and personal roles. Central to this discourse is the malleability and versatility of skills and competencies, meticulously acquired and refined in one domain and subsequent applicability in the other. One of the most salient mechanisms is the adaptive application of skills. Within the healthcare milieu, professionals often cultivate a systematic approach and organizational acumen, essential for clinical efficacy and patient care. While honed in a professional setting, these acquired proficiencies find relevance in personal spheres, aiding in efficiently orchestrating familial events or managing household chores (L'Abate & O'Callaghan, 1977). Conversely, the nurturing ethos intrinsic to familial settings – caregiving, empathetic interactions, and understanding intricate familial dynamics – lends itself impeccably to patient interactions, fostering enhanced rapport and trust.

Beyond skill transference, these domains' emotional and psychological landscapes also exhibit profound interconnectedness. The emotional resonance from one domain often permeates the other, creating a cascade of positive psychological outcomes. The euphoria associated with familial milestones, such as a child's accomplishments or celebratory family gatherings, can invigorate a healthcare professional's morale, potentially translating into enhanced motivation, focus, and clinical efficacy. In a parallel vein, the gratification derived from clinical successes or peer recognition within a medical setting can be a wellspring of positive emotions, fostering enriched interpersonal interactions in personal realms (Mauno et al., 2015). Additionally, the enrichment theory has been shown to accentuate the therapeutic and buffering attributes of roles. In the volatile and often emotionally taxing world of healthcare, familial roles and the sanctity of family life can serve as rejuvenating sanctuaries, offering solace, emotional sustenance, and grounding (Mishra et al., 2019). Conversely, the structure, sense of purpose, and financial stability associated with a rewarding healthcare career can act as bulwarks against familial challenges or financial stresses.

Concomitant with these mechanisms is the expansion of personal identity. Engaging in multifaceted roles, both as healthcare professionals and as pivotal members of familial structures, healthcare workers cultivate a diverse, enriched self-concept. This expanded self-identity amplifies experiential depth and instils a sense of resilience, adaptability, and

resourcefulness. When harnessed effectively, such attributes can bolster performance and well-being in both professional and personal spheres, emphasizing the holistic essence of WFE.

Among the numerous scales developed to assess the dynamics between professional and personal roles, the Work-Family Enrichment Scale by Carlson et al. (2006) is a predominantly used instrument for examining WFE. This scale moves beyond quantifying positive spillovers, providing a comprehensive framework to understand how work can enhance family life and vice versa.

In its detailed exploration of WFE, the scale evaluates facets such as Developmental enrichment, focusing on transferring skills like discipline from the workplace to family scenarios. Affective Enrichment gauges how emotions and satisfaction from work roles can influence the familial atmosphere. Capital enrichment considers tangible (e.g., income) and intangible (e.g., social connections) resources gained from work and their significance in the family context. Efficiency enrichment assesses whether organizational skills developed at work can enhance the management of family roles.

The FTWE dimension is equally rigorous. Developmental enrichment here evaluates how familial roles, such as caregiving, shape valuable attributes in a professional setting. Affective enrichment studies the impact of positive family dynamics on workplace motivation and morale. Capital enrichment explores how family-derived resources might prove advantageous in the work context. Finally, Efficiency enrichment determines if managing family roles can bolster workplace efficiency. With respondents providing feedback via a Likert-type format, the multi-dimensional structure of the scale ensures a holistic understanding of WFE. Given its depth and precision, the Work-Family Enrichment Scale by Carlson et al. (2006) has become a cornerstone in research endeavours to understand the beneficial intersections of work and family domains.

2.7 Work-Life Balance: Between conflict and enrichment.

In healthcare professionals, the conceptualization of WLB extends beyond the mere distribution of temporal resources across professional and personal spheres. It delves into a nuanced exploration of the interplay between these domains, accentuated by the constructs of WFC and WFE (Gatrell et al., 2013). The literature on WFC elucidates its emergence from juxtaposing role-specific demands and responsibilities inherent to the medical profession with those of familial commitments. Healthcare practitioners, confronted with the rigors of clinical

duties, extended working hours, and the emotional gravity of patient interactions, often find these professional exigencies incongruous with familial roles. Such incongruities can engender strain, with potential implications for burnout, attenuated job satisfaction, and perturbations in familial dynamics. The ramifications of this dyadic tension, underpinned by role conflict, underscore the imperative for adaptive mechanisms, institutional support, and potential recalibration of role expectations.

Conversely, the construct of work-family enrichment posits a more symbiotic relationship between the professional and personal realms. It purports that healthcare professionals, through their intricate and demanding vocation, accrue a repertoire of competencies, emotional resilience, and values that can reciprocally enrich their familial interactions (Agrawal & Mahajan, 2021). The diagnostic acumen, the finesse of empathetic communication fostered in patient care, and the exigencies of critical decision-making paradigms can be extrapolated to enhance familial engagements, decision-making, and relational depth. In tandem, the family domain, characterized by its emotional sanctuary, support structures, and relational bonds, can augment professional resilience, fortify emotional equanimity, and bolster clinical efficacy. This bidirectional enrichment is a testament to the potential synergies that can be harnessed, accentuating a more integrated, holistic professional identity.

As healthcare professionals navigate the intricate tapestry of work-life dynamics, the dialectic of conflict and enrichment presents a rich avenue for academic exploration. Recognizing the inherent tension and potential harmonization between these constructs offers a holistic lens to appraise the sustainability of medical vocations (Mauno et al., 2015). Institutional interventions, predicated on empirical insights, must be oriented towards mitigating the vectors of conflict while concurrently amplifying avenues for enrichment. Such an approach, rooted in evidence-based strategies, holds the promise of fostering a cadre of healthcare professionals who are clinically proficient and anchored in a harmonized integration of their professional and personal identities.

2.8 Job Demand Resources Model

JD-R theory has emerged as a cornerstone in understanding the complexities of occupational environments. Rooted in a deep appreciation for the multifaceted nature of workplace dynamics, this theory offers a holistic lens through which we can evaluate the relationship between job roles, employee well-being, and overall performance (Bakker et al., 2023). As we

delve deeper into the JD-R theory, we discover its capacity to integrate many insights, serving as both a bridge and a beacon in the realm of job design and occupational health.

The JD-R model emerged in the early 2000s as researchers began to recognize the limitations of the Demand Control Model and Effort Rewards Imbalance models, with mainly their focus on specific job characteristics. The JD-R model aimed to provide a more comprehensive framework that could be applied across various occupations and sectors. Initially, the JD-R model concentrated on the dual processes of health impairment and motivation (resulting from high resources) (Bakker et al., 2023).

The JD-R model has its roots in two prominent job stress models: The Demand-Control Model by Karasek and the Effort-Reward Imbalance Model by Siegrist. Both these models identified specific job demands and their outcomes on employee health. The JD-R model further broadened this scope by including various job resources and recognizing their dual role in combating job demands and enhancing motivation (Demerouti et al., 2001). As a bridge between historical and contemporary insights, JD-R synthesizes and proposes that burnout and work engagement are intricately tied to diverse job characteristics. Drawing from a wide range of scholarly works, JD-R delineates that while every organization and job role is unique in its challenges and rewards, all job features can invariably be categorized into two primary segments: job demands and job resources, a concept pioneered by Demerouti et al. (2001).

The job demands include sustained exertion, whether physical, cognitive, or emotional, encompassing facets such as physicality, psychology, social interactions, or organizational tasks. These demands often translate to physiological or psychological tolls on an employee. On the other end of the spectrum, job resources emerges as a motivational catalyst, assisting in achieving work goals, acting as a buffer against the stressors of job demands, and promoting continuous learning and personal growth (Voydanoff, 2004). Real-world examples provide clarity: nurses and police officers typically face heightened emotional and physical demands, while professions like software developers and scientists grapple more with cognitive challenges. Yet, the JD-R theory's profundity doesn't end at merely cataloguing these demands and resources. It delves into the dynamic interface of these elements with employee well-being, behaviours, and overall performance. The theory also underscores an employee's proactive potential in sculpting their job demands and resources, a phenomenon termed 'job crafting,' originally introduced by Wrzesniewski & Dutton (2001).

The concept of job crafting propounds a bottom-up, employee-driven approach to job redesign, aiming to enhance the synergy between an individual's capabilities and their job specifications. The objective is multifaceted—optimize job characteristics, augment the fit between an employee and their role, and subsequently elevate work engagement (Wrzesniewski & Dutton, 2001). Empirical research in recent years echoes this sentiment, emphasizing that even nuanced adjustments to daily job parameters can significantly amplify work engagement and overall performance. Such proactive realignment, achieved through crafted strategies, has demonstrable benefits, fostering more rewarding, meaningful work experiences, mitigating burnout, and propelling engagement and performance to new heights (Lesener et al., 2019). Consequently, the JD-R theory and its subsidiary concepts embody the expansive understanding of workplace dynamics in the modern era, offering an all-encompassing lens to scrutinize the intricate dance between job demands, resources, and individual agency.

2.8.1 Job Demand and Resources: Literature

For the current literature review for this dissertation, 104 articles are related to JDR were identified from the collected articles. The JD-R model has steadily risen in prominence over the last decade, establishing itself as an integral framework for understanding facets of occupational stress, burnout, engagement, and various work-related outcomes.

Figure 8 presents a graphical representation of the growth in scholarly articles on the JD-R model from 2013 to 2023. Starting from modest beginnings in 2013, there has been an undulating yet discernible increase in the attention it has garnered among researchers. By 2023, the volume of publications, while not at its absolute peak, denotes a thriving and dynamic field of study. Several researchers have consistently contributed to the JD-R literature during this period. Figure 8 also highlights the most prolific among them.

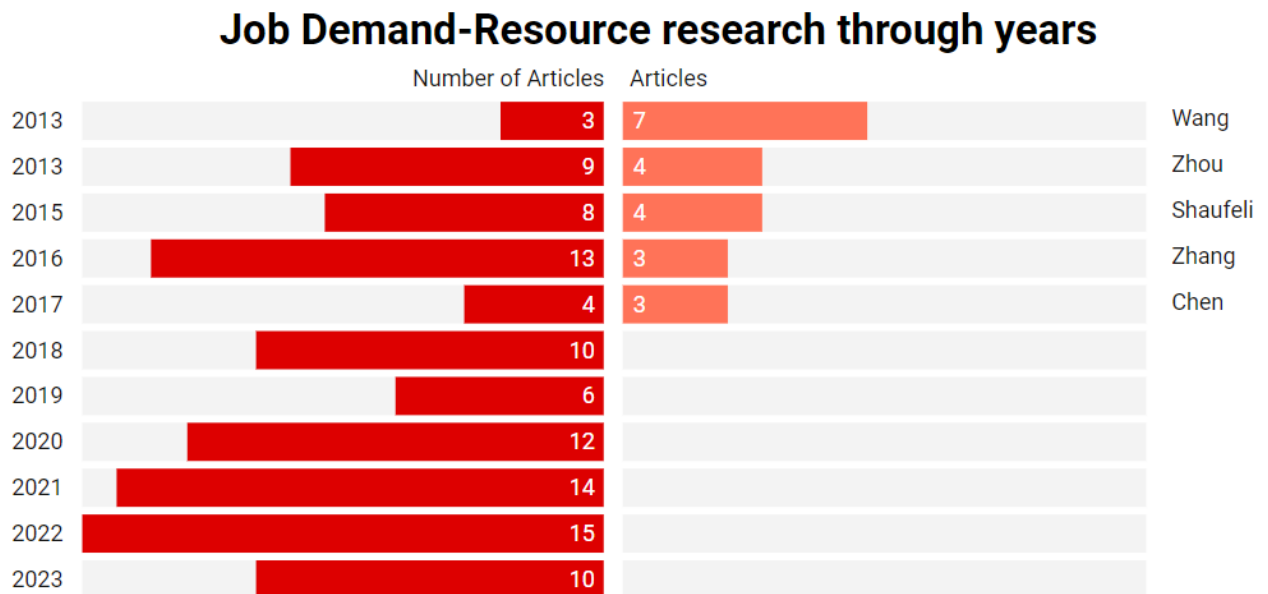


Figure 8: Decade-long Trends in JD-R Literature: Publication Count (2013-2023) and Top Contributors.

Source: Own editing (2023)

A keyword network for 104 identified articles was generated, as shown in Figure 9. This model's comprehensive keyword network analysis provides insights into the various dimensions' researchers have been focusing on.

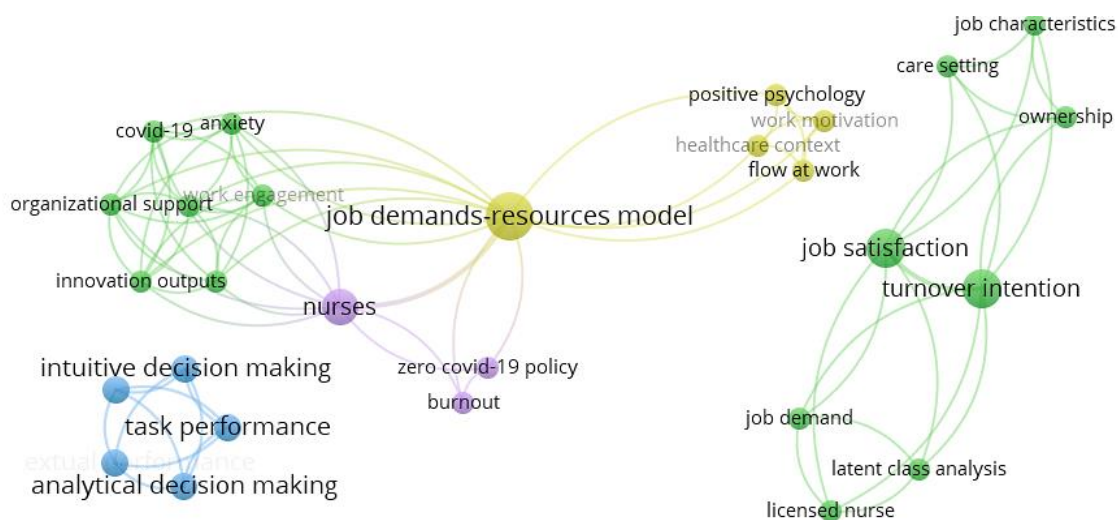


Figure 9: Visualizing the Landscape: A Keyword Network Analysis of the JDR

Source: Own editing (2023)

The network can be visualized with three distinct clusters, each representing a unique thematic focus:

- **Job Satisfaction and Turnover Intention:** This cluster emphasizes factors affecting employee satisfaction levels and their eventual influence on turnover intentions. Keywords that resonate in this theme include 'turnover intention,' 'job satisfaction,' 'occupational turnover intention,' and 'intention to leave.' Factors such as 'role conflict,' 'work engagement,' 'employee burnout,' and 'work-life balance' highlight the myriad influences on a worker's satisfaction and decision to remain with or leave an employer.
- **Decision Making:** This theme centralizes around the cognitive processes employees engage in, ranging from 'analytical decision making' to 'intuitive decision making'. Relevant keywords such as 'contextual performance', 'task performance', and 'active learning' suggest a broader exploration of how decision-making processes intersect with job demands and resources.
- **Positive Psychology:** Rooted in the holistic well-being of employees, this cluster incorporates terms like 'positive psychology', 'flow at work', 'passion for work', 'flourishing', and 'well-being at work'. The emphasis is on how job demands and resources influence PWB and overall work-related positivity.

Beyond these clusters, the network is populated with numerous interconnected terms. Notably, the role of the 'nurse' profession emerges prominently with terms like 'emergency nurse,' 'nursing staff,' and 'healthcare workers'. It suggests a considerable volume of research focusing on nursing in the context of the JD-R model, potentially due to the profession's high demands and specific resources. Geographical contexts such as 'South Africa,' 'Poland,' 'Nordic countries,' 'Italy,' and 'China' pinpoint regional-specific studies, indicating the JD-R model's global relevance. Moreover, the recurrent mention of 'COVID-19' and 'pandemic' underscores the recent focus on understanding job demands and resources in the wake of global health crises. Other frequently occurring terms like 'job resources,' 'burnout,' 'job demands,' 'work engagement,' 'occupational health,' 'emotional exhaustion,' and 'organizational support' weave into various aspects of the JD-R model, offering a detailed panorama of the topics researchers deem significant.

JDR has been conceived in terms of process flows (Demerouti et al., 2001), the details of which are as follows:

Health Impairment Process: Fundamental to the JD-R model is an essential understanding that continuous exposure to elevated job demands affects an individual's well-being. Persistent high job demands, whether in the form of excessive workloads, constant pressure, or emotional

challenges, can drain an employee's mental and physical energy reserves (Bauer et al., 2014). With time, this energy depletion, if not thwarted, manifests in detrimental outcomes. Individuals may grapple with burnout, a pervasive feeling of professional exhaustion and detachment. Additionally, chronic fatigue becomes a looming concern, not merely as fleeting tiredness but as a lasting damage affecting the daily functioning of the employees. Beyond these psychological outcomes, the prolonged strain can result in tangible health issues, from stress-induced ailments to more severe conditions exacerbated by the absence of recovery periods.

Motivational Process: The JD-R model emphasizes the stimulating power of job resources. Employees have perceived these resources as supportive colleagues, opportunities for professional growth, or clarity in job roles. The resources have been shown to act as catalysts for motivation (Vogt et al., 2016). When employees have access to such resources, they not only combat the strains of job demands but also find themselves propelled towards a more engaged, fulfilling professional life. This dynamic results in a slew of positive outcomes. Work engagement becomes palpable, with employees immersing themselves with enthusiasm and dedication. Such engagement often merges with heightened job satisfaction, where employees find value, meaning, and gratification in their roles (Cooke et al., 2019).

Dynamic Interplay: The JD-R model has been construed as dynamic rather than static. It identifies that job demands and resources are in flux, continually evolving and adapting. These shifts can be triggered by several factors, from personal life changes, such as family dynamics or health concerns, to broader organizational transformations, mergers, or restructuring. Moreover, the cultural context within which an organization operates can also shape this interplay, with societal norms, values, and expectations influencing perceptions of demands and resources (Wrzesniewski & Dutton, 2001).

Crossover and Spillover: Another assumption of the JD-R model is the recognition that an individual's experience with job demands and resources does not exist in isolation. There's a 'crossover' effect, where the conflicts and/or benefits experienced by an employee in a domain can impact other domains (Haun et al., 2023). Additionally, a 'spillover' effect is observed where these strains or benefits traverse the boundary between professional and personal domains. An employee grappling with high job demands tends to carry the resultant stress into their home life, affecting familial dynamics or personal well-being (Eisenberger et al., 1986).

Feedback Loop: In the case of a closed system, JD-R works on feedback. It proposes that the outcomes generated by the interplay of job demands and resources further influence these elements in a feedback loop. For example, an employee experiencing burnout might, over time, perceive even standard job demand as more taxing or may feel a diminishing sense of available resources. Similarly, an engaged employee might actively seek out or even create additional resources, further bolstering their motivation and satisfaction (Riedl & Thomas, 2019).

2.8.2 Job Demands

Complementing job resource in JD-R is job demand, which represents those elements of a profession that necessitate consistent effort on various fronts—be it physical, psychological, social, or organizational. These demands, while integrally tied to the nature of multiple roles, can sometimes escalate to levels that strain an employee's capabilities. Particularly when such demands become excessive or relentless, they pave the way for potential physiological and psychological costs, which can have far-reaching implications for both the individual and the organization. Probing the literature various types of job demands can be gleaned from the literature:

- **Work Pressure:** This is one of the most universally recognized of the JD (Balducci et al., 2014). Whether it's the urgency of decision-making, the pressing nature of deadlines, or the sheer volume of tasks at hand, work pressure can be palpable across industries and roles. Such pressure doesn't merely impose a time constraint; it often dictates the quality of output and the strategies employed to achieve results.
- **Emotional Demands:** Professions that hinge on human interaction, like healthcare officials, unvaryingly go together with emotional demands. Nurses, for instance, experience the various facets of patient emotions like hope, despair, gratitude, and anguish daily (Trinkoff et al., 2003).
- **Physical Demands:** Given the ever-increasing physical boundaries of modern healthcare facilities, professionals are required by default to have a reliable physical stamina. This unfailing stamina is exemplified in case of nurses who are on their feet for hours on end, attending to various needs of patients. The wear and tear on the body in these professions are palpable and affect the long-term health of professionals (Lu et al., 2019).

- **Role Conflict:** Role conflict emerges from a surplus of often contradictory expectations (Elfering et al., 2017). An employee might feel caught in the middle when different teams want different things while also feeling stressed trying to please many people who want other things. This can make them feel like they are perennially being pulled in different directions while not giving their best in any one area.
- **Cognitive Demands:** The intellectual needs of certain professions are particularly demanding, for they may require critical problem-solving, decision-making, and innovation. (Tschan et al., 2014) reports that the emotional abuse of nurses and the emotional demands placed on their teams lead to increased stress cognitive that may then jeopardize surgical performance and patient safety (Fernandez & Zahavi, 2020).

Due to these additional demands at work, employees suffer from many consequences, characteristics of which have been identified in the literature as the following:

Burnout: It is a concept that has gained prominence in modern corporate lexicons. Prolonged exposure to high JD, without adequate resources or coping mechanisms, can culminate in burnout—a state characterized by emotional fatigue and a decline in professional efficacy (Kesarwani et al., 2020).

Decreased Job Satisfaction: As an employer it is incumbent to balance the efforts put in by the employee on the job and the financial recompense of that work in form of remuneration. Job satisfaction declines when employees continuously struggle to meet high goals without receiving adequate resources, recognition, or rewards. This may have a variety of effects, ranging from decreased motivation to higher attrition rates (Singh, 2013).

Health Impairments: The consequences of job-related stress aren't confined to professional performance alone. Over time, the body and mind bear the brunt of these demands. Physically, individuals might experience conditions ranging from recurrent headaches to more severe ailments like cardiovascular diseases. Psychologically, the strain can manifest as anxiety, depression, or other mental health challenges.

2.8.3 Job Resources

Central to the JD-R model are job resources, which play a pivotal role in a professional setting. They are instrumental in facilitating the accomplishment of work objectives, and equally, they act as a counterbalance to the potentially negative impacts of job demands, as noted by

Demerouti et al. (2001). Beyond simply aiding in the day-to-day work, these resources significantly contribute to an employee's personal and professional development journey. They ensure that individuals are not just confined to their immediate responsibilities but are also equipped to evolve in their broader roles.

Autonomy, an essential job resources, has taken on a pronounced significance in contemporary workplaces. More than merely granting an employee the discretion to make decisions, it encompasses a broader spectrum wherein they are empowered to own both the process and the outcome. This sense of ownership often translates into heightened intrinsic motivation (Raso, 2019). When an individual feels that they have a direct stake in the results and the means to shape them, their level of investment in the task invariably deepens.

Furthermore, the professional ecosystem is inherently construed as collaborative, which employees perceive as a resource. Employees continually engage with various stakeholders - from peers and subordinates to managers and leadership (Mishra et al., 2019). This network of interactions underscores the importance of social support. Positive, supportive interactions can offer emotional relief during challenging phases and serve as a knowledge base, aiding individuals to traverse complex professional terrains. Diversity in tasks, or skill variety, introduces another dimension. The advantage here isn't just about staving off monotony; it's about the continuous intellectual stimulation it offers (Wei et al., 2020). By engaging in diverse tasks, employees remain continuously engaged, encounter new challenges frequently, and are saved from the rut of redundancy.

Moreover, training and development opportunities have become indispensable with the fast-paced industry changes. They ensure that employees are included. Such platforms arm them with the requisite skills for their current roles and prepare them for future challenges, fostering a continuous growth mindset.

Lastly, the aspect of role clarity cannot be overstated. In a world where job roles can be multifaceted, clearly understanding one's responsibilities and objectives is fundamental. Such clarity eliminates potential bottlenecks, reduces ambiguity-related stress, and ensures an employee's effort is laser-focused on achieving set goals (Lovejoy et al., 2021).

The presence and accessibility of these resources have profound implications for an individual's trajectory within an organization. They influence various outcomes, ranging from the depth of engagement and satisfaction in one's role to the prevention of burnout and facilitation of personal and professional growth. Understanding the consequences of these job resources

becomes crucial for organizations aiming to cultivate a motivated, satisfied, and progressive workforce. Some of the implications of JR pointed out in the literature are as follows:

Increased Work Engagement: Resources, by their very nature, empower. When employees have the tools, support, and environment they need, their connection to their work deepens. They become more than just contributors—they become stakeholders, deeply invested, enthusiastic, and immersed in their roles (Cooke et al., 2019).

Higher Job Satisfaction: The relationship between ample resources and job satisfaction is undeniable. When employees feel equipped to handle challenges and see avenues for growth, their perception of their role and the organization becomes increasingly positive (Haun et al., 2023).

Reduced Burnout: Burnout is often the shadow of unmet demands. But with the right resources in place, this shadow recedes. Employees find that they can meet, and often exceed, their JD without depleting their mental and emotional reserves (Greenglass et al., 2001).

Personal and Professional Growth: Resources, in essence, are catalysts. They not only facilitate immediate tasks but also spur growth. Whether through training, feedback, or autonomy, employees find avenues to hone their skills, embrace more significant challenges, and chart a path of continuous evolution within their roles (Broetje et al., 2020).

2.8.4 Job Demands and Resources and Nurses

Healthcare is an emotionally charged, high-stakes domain, with professionals constantly balancing patient care and personal well-being. The JD-R model offers insights into the challenges and dynamics faced by healthcare professionals, especially nurses. Nurses grapple with diverse demands as the prime point of interaction between patients, doctors, and the broader healthcare team (Lesener et al., 2019). They engage deeply with patients in distress, pain, or fear, demanding emotional resilience and a consistently professional approach. Physically, the role is also demanding, with extended hours, constant mobility, and the need to assist patients physically. Cognitively, the responsibility is immense as nurses rapidly assimilate vast amounts of data, from patient backgrounds to medication details. Overlaying all these demands is the ever-present high-stakes pressure, where the margin for error is minuscule given the potential ramifications of mistakes (Broetje et al., 2020).

The primary JD in the case of nurses is work overload. This demand primarily focuses on the sheer volume of tasks expected within a specific timeframe, not necessarily the tasks' intricacies. Another concern they identify is the need for adequate rewards. Many reviews consistently bring up issues surrounding the adequacy and fairness of pay. The researchers note that while sufficient rewards might not necessarily be an added motivator, their absence undoubtedly depletes morale. Similarly, the limited avenues for career progression add to the demands. Lastly, they highlight the challenge of maintaining WLB, especially in relation to shift timings and their subsequent impact on personal time (Goodare, 2017).

The challenging nature of nursing emphasizes the critical need for adequate JR. Regular training ensures nurses stay updated with evolving medical knowledge and methodologies. Guidance from experienced medical professionals' aids in navigating complex patient scenarios (Pejtersen et al., 2010). A cohesive team fosters a supportive environment, allowing nurses to lean on each other during demanding times. Lastly, having well-defined roles and responsibilities streamlines patient care processes and eliminates potential confusion.

2.8.5 Job Demand Resources: Scale

When examining the intricacies of the JD-R model, selecting robust and validated scales is essential for accurately capturing the multifaceted components of the model. Given that job demands and resources cover a disparate field, as a consequence multiple scales and sub-scales have been selected for this study:

Job Demands:

In the case of JD, the second rendition of the Copenhagen Psychosocial Questionnaire (Pejtersen et al., 2010) has been employed, which provides a granular assessment of specific JD, and they include:

- Quantitative Demands: Addressing the volume and intensity of work tasks.
- Emotional Demands: Gauging emotional strains and challenges.
- Cognitive Demands: Evaluating the mental load and cognitive difficulties.

Following the discussion above, the scales for the three identified resources are as follows:

Perceived Organizational Support: Specific items (items 1, 4, 9, 20, 23, and 27) from the scale by Eisenberger et al. (1986) have been employed. The decision to use this scale is rooted

in its well-established reliability and one-dimensionality, as evinced by multiple studies across various occupations and organizations (Luo & Hancock, 2020; Rhoades & Eisenberger, 2002; Shore & Tetrick, 1991; Shore & Wayne, 1993). This adherence to the recommendations of Shore & Tetrick (1991) guarantees a comprehensive evaluation of organizational support perceptions.

Perceived Coworker Support: It has been computed using the scale of Haynes et al. (1999), emphasizing the perceived camaraderie from colleagues. The choice of this scale for the research has been brought about as it has been construed in the case of healthcare workers.

Job Autonomy: This has been assessed through the scale constructed by Voydanoff (2004), focusing on the degree of control an employee possesses over tasks. The scale delves into job autonomy, probing beyond just the superficial layer. It doesn't merely assess the degree of control an employee has over tasks but also examines their discretion in decision-making processes, flexibility in structuring their work schedule, and ability to influence procedures and strategies.

2.9 Psychological Well-Being

PWB remains a foundational theme within the landscape of psychology, human behavior, and human resource studies. As opposed to a mere absence of mental illness or distress, PWB paints a comprehensive picture, signifying a state where individuals perceive their lives in favorable terms, finding meaning, purpose, and a sense of direction. Diving deeper into the constituents of PWB, one discerns an intricate tapestry woven from several threads. Among them, self-acceptance is pivotal; it's about recognizing and accepting oneself, understanding one's past life choices, and coming to terms with them (Bar-On, 1988). Positive relations with others emphasize the depth and warmth of interpersonal relations and the capability to love, empathize, and maintain strong, healthy bonds with others. Autonomy, on the other hand, emphasizes personal self-determination and independence. It's about resisting social pressures and crafting a unique path. Further components include environmental mastery, where individuals effectively manage their situations, capitalizing on opportunities and creating contexts appropriate to personal needs and values (Bryant & Veroff, 1982). Moreover, personal growth is about realizing one's potential, seeing oneself as growing and expanding, and having a purpose in life, where individuals comprehend their life's meaning and have goals and objectives for living.

2.9.1 Psychological Well-being: Literature

The figures provide a comprehensive overview of the publication dynamics within the realm of PWB over the past decade. Over the decade, there have been shifts in the annual publication volume concerning PWB. Notably, some years witnessed heightened research interest, potentially reflecting critical societal events or emerging global challenges. There was a marked uptick in publications around the latter part of the decade, emphasizing the growing acknowledgment of the importance of PWB. The most recent year observed a relative decrease, suggesting a potential shift in research focus or other external influencing factors. During this period, 68 articles were published on the subject.

When looking at the contributions from individual authors, Cheng and Lee emerge as significant voices within the domain, closely followed by Liu, Okele, and Tsaras. These individuals have consistently contributed to the literature, underlining their role in shaping and enriching discussions on PWB.

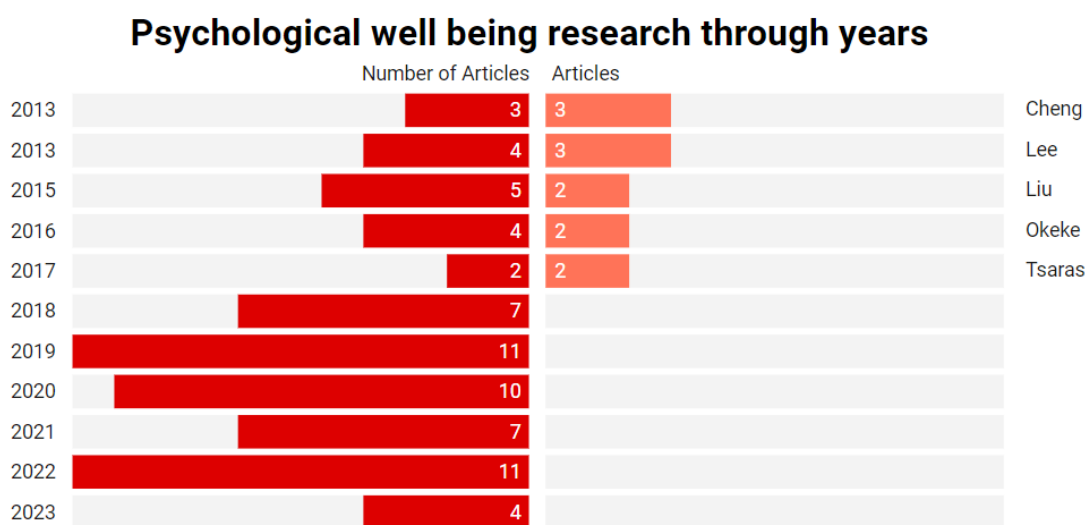


Figure 10: Decade-long Trends in PWB Literature with Publication Count and Top Contributors.

Source: Own editing (2023)

The keyword network centered around PWB paints a comprehensive picture, shedding light on various facets and nuances of the topic, particularly in the healthcare sector. This network highlights five significant clusters, which are indicative of the predominant themes within the literature:

Burnout: An unmistakably dominant theme, burnout touches upon the psychological challenges healthcare professionals, especially nurses, face. Keywords such as 'job burnout,' 'occupational burnout,' and 'burnout—professional' emphasize the prevalent issue of occupational stress and fatigue, often interlinked with factors like 'workplace stress' and 'emotional exhaustion.'

Empathy: Another central theme, empathy is linked with keywords like 'humor styles' and 'emotional intelligence'. These terms underscore the importance of interpersonal skills and the ability of professionals to resonate emotionally, especially in the context of 'pain management' and patient care.

Healthcare Professionals: The significant emphasis on healthcare professionals, especially 'nurses,' delineates the specific challenges and psychological dynamics this group faces. With terms like 'frontline,' 'healthcare worker (HCW),' and 'COVID-19', there's a clear indication of the recent focus on understanding the mental health implications of the epidemic on frontline healthcare workers.

Emotional Labor: This cluster pertains to healthcare professions' emotional demands and challenges. Keywords like 'emotional labor,' 'affective intensity,' and 'emotional exhaustion' emphasize the emotional toll and the coping mechanisms associated with professions requiring continuous emotional regulation and interaction.

Character: Anchored by the broader term 'character,' this theme navigates the inherent traits, personalities, and values of healthcare professionals. Keywords such as 'self-efficacy,' 'resilience,' and 'organizational commitment' hint at the intrinsic qualities that play a role in determining PWB.

Beyond these primary clusters, numerous interconnected terms emerge. The recurrent mention of 'COVID-19' and 'pandemic' is a testament to the contemporary focus on understanding the pandemic's impact on PWB. Additionally, terms such as 'mindfulness,' 'anxiety,' 'depression,' 'coping strategies', and 'well-being' further enrich the network, suggesting diverse methodologies and angles of research.

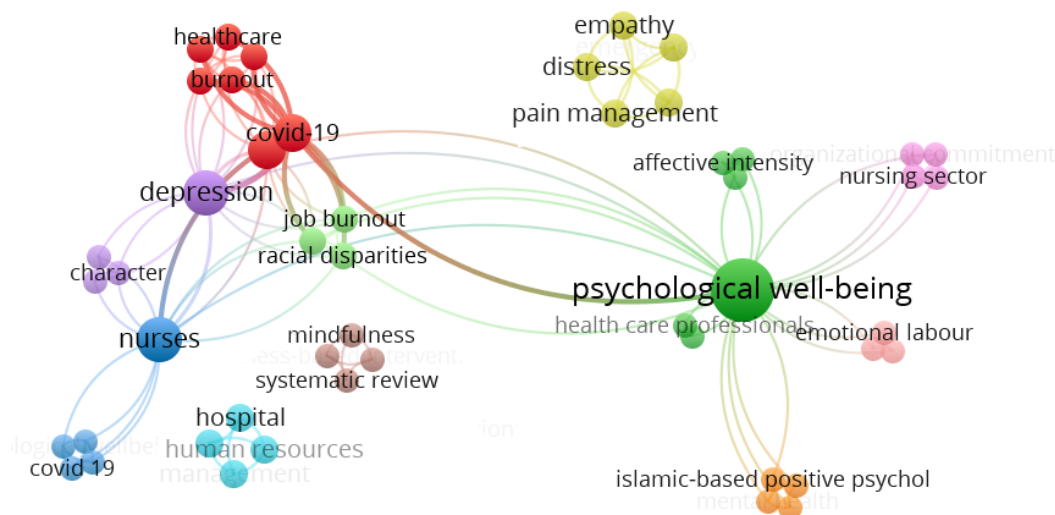


Figure 11: Visualizing the Landscape: A Keyword Network Analysis of the PWB
Source: Own editing (2023)

2.9.2 Psychological Well-being and Nurses

In professional spheres where human interaction, care, and well-being are paramount, the significance of PWB is amplified manifold. Consider the healthcare sector, for instance. Here, professionals are consistently at the nexus of life-altering decisions, personal interactions, and emotional labor. Their PWB isn't just a personal asset; it becomes a critical determinant of the care they provide, their interactions with patients and peers, and the overall health outcomes they facilitate (Sulosaari et al., 2022). For a clinician or a healthcare worker, an optimal state of PWB translates to enhanced focus, empathy, and resilience — qualities indispensable to their roles. Conversely, any compromise in their PWB might not only impact their personal lives but can have cascading effects on their professional efficacy and patient care. Therefore, in realms like healthcare, fostering PWB is not just a matter of personal importance but an organizational and societal imperative (Philip & Cherian, 2020).

Nurses at the core of patient care often find themselves shouldering more than just clinical responsibilities. Their day-to-day involves

- navigating a complex web of interpersonal interactions,
- managing patient expectations,
- providing emotional support to both patients and their families, and

- frequently making crucial decisions under pressure.

The intrinsic nature of their profession, which demands constant empathy and a high degree of emotional investment, can be both rewarding and draining. This dynamic makes their PWB a personal matter and a critical determinant in the larger healthcare framework (Sulosaari et al., 2022).

The influence of a nurse's PWB is manifold. A nurse operating at an optimal level of PWB becomes an embodiment of patience, demonstrating an enhanced ability to understand and cater to the diverse needs of patients (Bourgault et al., 2015). Their heightened sense of compassion aids in building trust, a foundational element in patient care. Moreover, an elevated PWB gives them the clarity and focus required for effective decision-making, even in high-stress scenarios, ensuring that patient care is neither compromised nor delayed. Such a state of well-being also fortifies them against the debilitating effects of professional burnout.

The intricate balance between work and personal life significantly influences nurses' PWB. Chronic engagement with work-related tasks, even during personal hours, can intensify stress levels (Tyler & Cushway, 1992). This continual stress, if unchecked, can transition into burnout, further leading to severe mental health challenges. Nurses, pivotal players in patient care, undergo a unique set of challenges. Their roles demand emotional investment, empathy, and decision-making in high-pressure situations. Consequently, their PWB is critical in determining their quality of care (Daniels & Guppy, 1994).

Additionally, nurse's well-being doesn't only influence their health but also the broader healthcare delivery system. Nurses with optimal PWB exemplify crucial traits such as compassion, patience, and acute decision-making, and thus, by preventing burnout and ensuring consistent care, the overall efficiency of healthcare delivery is enhanced (Søvold et al., 2021). Nursing, inherently, is a profession steeped in emotional labour. With nurses being at the frontline of patient interactions, they are routinely thrust into emotionally charged situations. The gamut of emotions they engage with ranges from the profound joy of patient recovery to the overwhelming sorrow accompanying patient loss. Specialized sectors, such as palliative care, further amplify this emotional spectrum, requiring nurses to frequently shoulder the weight of both death and the subsequent grieving process of families left behind.

The Physical and Structural Strains:

Beyond emotional demands, the nursing profession poses substantial physical challenges. Regular tasks, seemingly simple, such as lifting or transitioning patients, accrue into significant physical strain over time. This strain is magnified by long, often gruelling working hours, sometimes extending beyond scheduled shifts. The structure of nursing shifts, often rotating between day and night, disrupts the body's innate circadian rhythms. This disruption affects sleep patterns, leading to disorders, and has profound implications on social engagements, sometimes resulting in feelings of detachment or isolation. Coupled with this, there are mounting organizational pressures. As healthcare systems increasingly integrate technology, nurses grapple with administrative tasks like electronic health record maintenance, potentially detracting from patient care. Interpersonal dynamics, whether with colleagues, superiors, or patients and their families, add another layer of complexity to their role.

Organizational and Social Implications of Nurses' Well-being:

The ripple effects of a nurse's well-being are far-reaching. On an immediate level, their capacity to connect, empathize, and engage with patients is contingent on their emotional and psychological state. When chronically stressed or fatigued, their natural capacities for empathy might be overshadowed, leading to perfunctory patient interactions (Fernandez & Zahavi, 2020). Beyond interpersonal relations, chronic stress poses a tangible risk to the quality of healthcare delivery, potentially increasing the probability of oversight or medical errors. The repercussions aren't confined to patient care. Nurses grappling with psychological challenges within the healthcare setting might find effective collaboration difficult, leading to team discord.

Furthermore, the broader implications on job satisfaction are undeniable. Persistent job dissatisfaction, stemming from chronic stress, burnout, or unaddressed challenges, can escalate into higher attrition rates, destabilizing the continuity of care. Such dissatisfaction is also mirrored in increased absenteeism, as nurses might grapple with health issues or seek mental health breaks (Sulosaari et al., 2022).

Proactive Strategies to Augment Nurses' Psychological Well-being:

To address these multifaceted challenges, a comprehensive strategy is imperative. Initiating regular debriefing sessions, where nurses can unburden emotionally in a non-judgmental space, can offer significant relief. Embedding these sessions with professional guidance from

psychologists can further empower nurses with coping mechanisms (Søvold et al., 2021). Parallely, promoting professional growth through skill enhancement opportunities and clear career pathways can provide direction and motivation. Adjusting the work environment to reduce physical strain, whether through ergonomic interventions or by creating tranquil resting spaces, can offer immediate relief. As mental health challenges become increasingly prevalent, direct access to on-site counsellors or therapists becomes paramount, aiding in early intervention. Organizing regular workshops can normalize mental health discussions, fostering an environment where seeking help isn't stigmatized. Lastly, integrating robust feedback mechanisms and recognizing the relentless efforts of nurses can not only pinpoint areas of intervention but also boost overall morale (Sulosaari et al., 2022).

2.9.3 Measuring Psychological Well-being

When positioning PWB as an outcome for a study, the primary challenge lies in its measurement. Given its multifaceted nature, capturing the essence of well-being requires a combination of validated scales, questionnaires, and qualitative inputs. Ryff's Scales of Psychological Well-being delve into the six essential dimensions of well-being, such as self-acceptance, personal growth, purpose in life, environmental mastery, positive relations with others, and autonomy, offering nuanced insights. Using such tools, researchers can quantify and analyse changes or differences in well-being in response to various interventions or under different conditions.

According to Ryff's model, there are six significant aspects of PWB:

1. **Self-Acceptance:** It's an acknowledgment that encompasses all facets of the individual, from strengths to weaknesses, achievements to failures. Such acceptance doesn't merely contribute to a positive self-image, but it fortifies mental resilience. With high self-acceptance, individuals can traverse life's challenges without succumbing to debilitating negative self-perceptions.
2. **Personal Growth:** Recognizing and cherishing the sense of growth is pivotal for sustained motivation. It sets the trajectory for personal aspirations, invigorating individuals to step out of their safe spaces continually. Those aligned with this dimension frequently showcase an openness to novel experiences, a reflection upon the transformative changes in their past, and a relentless drive toward realizing their potential.
3. **Purpose in Life:** This dimension addresses the more profound existential quest for meaning, prompting individuals to introspect on their life's objectives, roles in the larger tapestry of

existence, and the values they want to champion. Possessing a well-defined purpose provides an unwavering compass for both momentary decisions and long-term goals.

4. Positive Relations with Others: This dimension emphasizes the richness of human connections, from fleeting interactions to deep-rooted bonds. It's not just about forming relationships but cultivating them, ensuring they are steeped in trust, mutual respect, and understanding. The depth and quality of these connections are testamentary to an individual's ability to empathize, exhibit vulnerability, and both give and receive affection.

5. Environmental Mastery: The ability to navigate, manage, and sometimes even reshape this external environment to align with personal needs is encapsulated in this dimension. It's about carving out physical and metaphorical spaces where one can thrive. Individuals who resonate with this dimension display a remarkable adaptability, moulding and shaping their surroundings to reflect their values, needs, and aspirations.

6. Autonomy: Autonomy reflects an individual's internal locus of control, where actions, decisions, and beliefs stem from personal convictions rather than external pressures. This dimension underscores the significance of leading life authentically, making choices rooted in personal conviction, even in the face of countervailing societal norms.

This chapter presented the conceptual framework of work and life theories that have been put forth in past few decades with greater focus on the research literature produced on the theories of psychological well-being, job demand and resources, work family enrichment and work family conflict in the past decade. The subsequent section will present the development of hypotheses for this study, accompanied by an exploration of the background literature that has shaped their formulation.

3 RELATIONSHIPS AND HYPOTHESES DEVELOPMENT

The finalized research structure and methodology stem from the early stages of the researcher's PhD journey. After cultivating a thorough understanding of the subject from 2018 to 2020, an exploratory study was launched in 2021 to gain deeper insights and validate the research's direction and tools. This exploratory study targeted nurses and their work-life balance in North India using various frameworks, including enrichment, spillover, and conflict. This preliminary exploration contributed in two significant ways. First, it shaped the research theory and framework, prompting revisions to the study's parameters based on data analysis and feedback. Secondly, it influenced research procedures, including population selection, sampling, and instrument design. In the subsequent sections, the research constructs, underlying factors, and their hypothesized relationships will be elaborated upon and discussed in detail. In 2022, a pilot study was conducted in a hospital to verify and validate the questionnaire for the dissertation.

The theoretical framework centres on the interplay among job demands, job resources, and psychological well-being, with work-family enrichment and work-family conflict serving as intermediary elements. Job demands encompass quantitative, cognitive, and emotional dimensions. Quantitative demands pertain to task volume, cognitive demands involve mental exertion, and emotional demands relate to interpersonal challenges encountered by employees. Conversely, job resources comprise perceived organizational support, reflecting the level of support an employee perceives from the organization; perceived coworker support, indicating assistance from colleagues; and job autonomy, which concerns decision-making freedom. These resources are envisioned to counterbalance the pressures of job demands, potentially enhancing overall job satisfaction.

Work-family enrichment and conflict function as direct factors and mediators in the nexus between work dynamics in form of demands and resources and psychological well-being. Work-family enrichment signifies the positive transfer of benefits from professional to personal life, while work-family conflict delineates the challenges of balancing work and personal responsibilities. The framework investigates partial and complete mediation in the relationships among various work and life parameters. Partial mediation acknowledges the coexistence of direct effects of job factors on well-being alongside mediated effects, contributing to understanding how professional environments shape the mental well-being of their workforce.

Given the inherent demands of the nursing profession, characterized by extended working hours, emotional labour in patient interactions, and the cognitive load of medical responsibilities, it is hypothesized that these demands, spanning quantitative, cognitive, and emotional aspects, may generate pressure extending from the workplace to the domestic realm, potentially resulting in a discord between work and family domains. The research seeks to validate whether higher job demands faced by nurses are directly linked to an elevated level of work-family conflict.

Several prior studies have indicated a significant association between job demands and work-family conflict in the general workforce. Researches by Demerouti et al. (2004), Lesener et al. (2019) and Tone Innstrand et al. (2008) underscore this relationship, indicating that an escalation in job demands leads to heightened work-family conflict. Individuals facing high job demands often experience burnout symptoms, perceiving various aspects of their lives, including family life, as unfavourable (De Hert, 2020). Moreover, increased stress resulting from job demands can alter the recall of situations, causing individuals to focus selectively on specific aspects of work-family interactions. In the context of nursing, similar to other professions, heightened job demands have been identified as principal determinants of work-family conflict (Molino et al., 2015; O’driscoll et al., 2006). A study by Ekmekci et al. (2021) examining workload and emotional dissonance in public hospitals in Türkiye affirms the positive correlation amongst these job demands and work-family conflict.

Workload, defined as high work volume, fast-paced work, and working under time pressure, is associated with decreased job satisfaction, reduced psychological well-being, and elevated levels of work-family conflict (Byron, 2005; Van der Doef & Maes, 1999). Quantitative workload, specifically the sheer volume of work assigned to an employee, has been constantly linked to work-family conflict in nursing studies (Pennbrant & Dåderman, 2021). Various factors contribute to job demands, comprising working hours, time pressure, expectations of work, and stressors related to one's role. Quantitative demands are frequently measured in terms of perceived workload. (Van der Doef & Maes, 1999).

The COR theory by Hobfoll (1989) implies that the adverse effects of high amount of work on employees’ attitudes and well-being, both at work and in their family roles, occur due to the diminution of resources resulting from sustained effort. Recent studies confirm substantial variations in workload across workdays (Butler et al., 2005; Ilies et al., 2010) .

Elevated workloads and emotional job distress may lead to conflict between work and family responsibilities through stress-related pathways. (Byron, 2005; Theorell & Karasek, 1996).

Empirical data suggests that individuals facing heavier workloads encounter increased work-family conflict, attributed to heightened energy resource allocations and elevated levels of psychological distress caused by the workload. (O'Driscoll et al., 1992). Work-related emotional distress stemming from job stressors has also been linked to work-family conflict, particularly strain-based conflict, on a daily basis. (Grzywacz et al., 2002). Quantitative workload correlates with role conflict, frustration, fatigue after the working day (Okuhara et al., 2021), and burnout (Gribben & Semple, 2021). A high workload introduces uncertainty, leading to feelings of worry and anxiety, as employees overwhelmed with tasks may neglect aspects of both work and family life. Additionally, quantitative demands are linked to a low nurse-to-patient ratio, resulting in a high workload that may lead to excessive absorption and difficulty detaching from work (Caldas et al., 2021).

The second job demand under investigation is emotional demand, unique to people-oriented professions. It involves a misalignment between felt and displayed emotions. Bakker & Heuven, (2006) found a link between emotional labour, emotional dissonance, and burnout. Studies in nursing and other fields highlight the connection between emotional dissension and work-family conflict in roles involving frequent public contact (Back et al., 2020). Workplace interpersonal conflicts, a significant stressor, pose risks such as violence (Gimenez Lozano et al., 2021). Conflicts, ranging from minor disagreements to severe violence, are linked to decreased team efficiency and productivity. Non-physical violence, such as incivility or verbal abuse, is more commonly observed (Spector et al., 2014). Interpersonal conflicts at work, including raised voices, threats, and dangerous attitudes, are prevalent in nursing. Conflict-related stressors may extend beyond the workplace into personal life (Spector et al., 2014). Cognitive demands encompass the mental effort required for task accomplishment and coordination, capturing the processing, decision-making, and learning requirements of work. Empirical studies on cognitive demands are limited, and the relationship between cognitive demands and employee well-being remains underexplored (Meyer & Hünefeld, 2018). While recent studies show a positive association between cognitive demands and employee well-being, including personal development and job satisfaction (Meyer & Hünefeld, 2018; Prem et al., 2017), no study has specifically investigated the connection between cognitive demands and work-family conflict among nurses.

Prior research indicates a strong correlation between enhanced job demands and heightened work-family conflict, especially within professions requiring intensive human interactions, like nursing. Consequently, this research aims to test the hypothesis:

H1. A positive relationship between job demands and work-family conflict.

In effect,

H1.1 A positive relationship between quantitative demands and work-family conflict.

H1.2 A positive relationship between emotional demands and work-family conflict.

H1.3 A positive relationship between cognitive demands and work-family conflict.

Research findings suggest that diverse contextual job resources are linked to increased Work-Family Enrichment (WFE) (Kinnunen et al., 2014; Kossek et al., 2011; Michel et al., 2011). These resources, emphasizing support and control, are crucial for successful work and family interface across various professions, including nursing (Mauno & Rantanen, 2013; Peters et al., 2009; Pisarski et al., 2008). The predictive power of contextual resources is most evident within their respective contexts. Work-related resources show a strong association with conflict and enrichment in the work-to-family direction, while family-related resources impact the family-to-work direction. Occasionally, there are cross-domain effects, such as spousal support predicting reduced work-to-family conflict. (Michel et al., 2011).

Job Demands-Resources (JD-R) paradigm asserts a positive relationship between job resources and work engagement. Resources encompass physical, social, or organizational aspects at the work, including perceived organizational support, perceived coworker support, and job autonomy (Bakker & Demerouti, 2007). Job resources are seen to reduce physiological and psychological costs, contribute to work goal achievement, and accelerate personal progress and development (Lapierre et al., 2018).

Family-friendly organizational policies, which alternatively also constitute a resource in the work-family literature, have been shown to contribute to work enrichment. Measures such as adaptable work hours, aid for childcare, and support for elder care empower employees by granting them greater autonomy over their schedules, thus mitigating conflicts between work and family commitments (Carlson et al., 2019). Even if some employees cannot utilize these policies, the mere existence of such family-friendly initiatives communicates organizational care. Beyond organizational support, coworker support positively correlates with work-family

enrichment (Lapierre et al., 2018). Both types of social support, organizational and coworker, intrinsically and extrinsically promote work engagement. Emotional support, especially from superiors and co-workers/teams, is associated with low WFC (Lapierre & Allen, 2006); Mauno & Rantanen, 2013; Pisarski et al., 2008). Job control is linked to low WFC and high WFE, particularly in the work-to-family direction (Mauno & Rantanen, 2013; Voydanoff, 2004). Job autonomy, as per Job Characteristics Theory (JCT), is recognized for its link to intrinsic motivational potential. Autonomy supports psychological autonomy, enhancing vigour and intrinsic motivation (Hackman & Oldham, 1980; Ryan & Frederick, 1997). As a role resource, family support also enhances work engagement by lending instrumental assistance and affective resources, motivating employees to achieve work goals (Grzywacz & Marks, 2000; Powell & Greenhaus, 2006).

Specific job resources, such as opportunities for skill development, predict high job satisfaction, which, in turn, benefits WFE. Autonomy and task significance result in job satisfaction, supporting WFE (Bhargava & Baral, 2009). Occupational prestige influences WFE through increased autonomy (Huang et al., 2019). In the family sphere, family support results in family satisfaction and Family Work Enrichment (FWE) (Siu et al., 2015). Leadership, as an organizational resource, contributes to better WFE by developing personal resources (Tang et al., 2016). Contrary to the assumption of domain-specific dynamics, where job resources primarily lead to WFE and family resources to FWE, empirical results indicate that predictors linked to one form of enrichment are also associated with the other. For instance, partner support and support from colleagues positively affect FWE and WFE (Lu et al., 2009). This reciprocity aligns with the propositions of Greenhaus & Powell (2006) suggesting a reciprocal, enriching process between work and family roles, where knowledge, skills, and resources from either role set yield both WFE and FWE.

In nursing studies, the focus has generally been on WFC rather than WFE (Cortese et al., 2010). High levels of WFC have been found among Italian nurses, connected with burnout, sleep issues, and presenteeism (Camerino et al., 2010). However, Dutch midwives demonstrated relatively high levels of WFE (Tummers & Den Dulk, 2013). The presence of family-friendly policies and organizational and professional effects correlate with elevated levels of WFE among nurses (Russo & Buonocore, 2012). In light of this discussion indicates a relationship between increased job demands and greater work-family enrichment in case of nursing. Consequently, this research aims to test the hypotheses:

H.2. A positive relationship between job resources and work-family enrichment,

And consequently,

H.2.1 A positive relationship between perceived organizational support and work-family enrichment.

H.2.2 A positive relationship between perceived coworker support and work-family enrichment.

H.2.3 A positive relationship between job autonomy and work-family enrichment.

The literature consistently indicates a negative effect of job demands on psychological well-being (Karasek Jr, 1979; Pisanti et al., 2011; Scanlan & Still, 2019; Søvold et al., 2021). Nurse fatigue, exacerbated by inordinate job demands, workplace characteristics, and nonwork-related issues, heightens the strain on emotional and psychological well-being (Bowling et al., 2015; Hazzard et al., 2013; Parhizi et al., 2013). Coping with high demands leads to resource depletion, aligning with the Conservation of Resources (COR) theory (Denning et al., 2021). COR theory underscores the importance of resources, encompassing objects, conditions, individual traits, and social support, with the depletion of these resources causing stress.

The healthcare sector's continuous need for 24/7 services results in greater job stability but demands exhausting workloads and 12-hour shifts, hindering work-life balance (Hysong et al., 2019). Restricted resources in form of workforce and equipment contribute to emotional strain approaching exhaustion (Harrod et al., 2019). Various work environment dimensions, such as workload, decision latitude, social support, and work engagement, have been linked to nurses' quality of service, safety, and job satisfaction (Aiken et al., 2002; Rochefort & Clarke, 2010; Van Bogaert et al., 2010, 2013, 2014). Overwhelming workloads heighten the responsibilities for nurses, leading to increased work-related stress, dissatisfaction, burnout, and poor quality of care (Aiken et al., 2002; Hayes et al., 2006; Rochefort & Clarke, 2010). Role conflict, role meaningfulness, and supervisor support predict nurses' well-being and work-induced psychological strain (Terry et al., 1993; Van Bogaert et al., 2014). The nursing sector, experiencing the elevated rate of nonfatal occupational disorders and injuries, sees an rise in medical leave due to factors like stress, deteriorating health, and depression negatively impacting work-life balance (Khan et al., 2020).

In terms of cognitive demands and psychological demands, nurses regularly make time bound and crucial decisions, exposing them to traumatic events (Voydanoff, 2004). A systematic

review and meta-analysis indicate elevated suicide rates among healthcare professionals, particularly women, with specific medical specialties at higher risk (Dutheil et al., 2019). Psychological issues, mental stress, empathy fatigue, and burnout are significant factors causing healthcare workers to consider leaving their work worldwide (Hämmig, 2018; Nooney et al., 2010; Smart et al., 2014). Contrastingly, some studies suggest a positive effect of job demands on psychological well-being when coupled with sufficient corresponding job resources. Cognitively challenging tasks, when supported by adequate cognitive job resources, may accelerate anticipatory learning and inspiration (de Jonge et al., 2008).

As established by this discussion, previous studies have strongly highlighted a significant link between heightened job demands and diminished psychological well-being in nurses. Based on this, the present research seeks to examine the hypotheses further in the context of north Indian nurses.

H.3. A negative relationship exists between job demands and psychological well-being.

Therefore,

H 3.1 A negative relationship exists between quantitative demands and psychological well-being.

H 3.2 A negative relationship exists between cognitive demands and psychological well-being.

H 3.3 A negative relationship between emotional demands and psychological well-being.

In the realm of nurses' psychological well-being, job resources play a crucial role by influencing healthcare quality, safety, and the well-being of both patients and nurses (Lake et al., 2019). During a pandemic, such as the case of COVID-19, job resources become even more essential as job demands increased (Catania et al., 2021; Shanafelt et al., 2020). Organizational support, acting as a psychological stimulant, involves providing mental health resources and clear communication, effectively alleviating uncertainty and fear (Finset et al., 2020; Labrague & De los Santos, 2020). Addressing nurses' fears and anxiety symptoms is crucial through strong, clear communication and regular updates on the COVID-19 outbreak (Duden et al., 2022; Liberati et al., 2021; Nobles et al., 2020). Emotional exhaustion tends to increase when nurses lack adequate supervisory support (Johnson et al., 2021). Supervisor support is vital in

reducing stress among frontline nurses, preventing emotional exhaustion, and preserving their health and well-being.

In situations of stress, employees' perception of psychological safety is disrupted as essential resources face threats. Stress arises with each risk to the loss of resources, such as financial insecurity, threats to self-worth, concerns about marital status or job security, fiscal downturns, or the illness of a family member (Hobfoll, 1991, 2001). The COR model provides a fitting understanding of intra- and inter-role stress, where job and family distress are reciprocally linked, creating challenges in one sphere that lead to challenges in the other (Grandey & Cropanzano, 1999).

Job autonomy in the workplace, deemed a valuable resource within the psychosocial work environment, is anticipated to alleviate the stress linked with job requirements. Moreover, it is expected to empower employees to attain their work objectives more effectively, while also fostering individual and professional advancement, as well as facilitating continuous learning and development. (Bakker & Demerouti, 2017; Schaufeli & Bakker, 2004).

Based on the JD-R model, there is an assumed positive correlation between job autonomy and employee well-being. This association is believed to bolster individuals' ability to manage job requirements and navigate other stress-inducing factors within the work setting. (Bakker & Demerouti, 2007). This perspective aligns with the Job Characteristics Model (Hackman & Oldham, 1976) and Self-Determination Theory (Ryan & Deci, 2000), where job autonomy is considered a positive resource for psychological well-being.

An alternative perspective comes from Csikszentmihalyi's theory of flow, suggesting an inverted U-shape relationship linking job autonomy with psychological well-being. According to this theory, a work situation that matches situational demands and worker skills leads to psychological well-being. However, if situational demands exceed worker skills, it may cause anxiety and lead to diminished psychological well-being (Csikszentmihalyi, 2000). Divergent findings across occupational groups regarding the relationship between psychosocial working conditions and work-related outcomes have been observed (Bakker & Demerouti, 2007; Clausen et al., 2014). Variances in the association between job autonomy and psychological well-being among various professional groups highlight potential detrimental effects in some workers, such as human service workers, while not necessarily in others like IT workers (Chung-Yan, 2010; Dettmers & Bredehöft, 2020; Kubicek et al., 2014; Rothenberger, 2017; Rydstedt et al., 2006; Stiglbauer & Kovacs, 2018).

In nursing, where important decisions are a constant, more autonomy is needed to ensure task accomplishment. Empirical evidence indicates that autonomy aids to a reduction in emotional exhaustion and depersonalization while increasing personal success and attainment (Lee & Ashforth, 1996; Rafferty et al., 2001).

In light of this discussion, an association between increased job resources and greater psychological well-being in the case of nursing is construed. Consequently, this research aims to test the hypotheses:

H.4. A positive relationship between job resources and psychological well-being

And consequently,

H.4.1 A positive relationship between perceived organizational support and psychological well being

H.4.2 A positive relationship between perceived coworker support and psychological well-being

H.4.3 A Positive Relationship between job autonomy and psychological well being

Work-family conflict has been associated with mental health problems, potentially leading to a drop in an individual's cognitive faculties (Moen et al., 2015). The reflection of work-related stress in familial relationships can diminish the effectiveness of work and family roles, thereby impacting psychological wellbeing and psychological safety, a critical factor shaping how individuals inhabit their roles within the organization (Kahn, 1990)

Various studies based on the COR theory suggest that direct resource deficit predicts work-family conflict. In contrast, resource gain weakens the positive relationship between work-family conflict (Chen & Powell, 2012). Conflict is, therefore, tied to the depletion of resources (Oren & Levin, 2017). The crossover model by Westman et al. (2001) posits that psychological stress and WFC may be transmitted via a spillover effect on other team members, influencing negative experiences related to minimizing resource loss, potentially leading to unfavourable outcomes such as job quitting or taking sick leave. Work-family conflict has been associated with detrimental results like depression (Kayaalp et al., 2021) and alcohol abuse (Viertiö et al., 2021). Conversely, the reduced WFC has positive effects, leading to increased work engagement and personal satisfaction (Allen et al., 2020; Liu et al., 2019), contributing to psychological safety.

In nursing, work-family conflict's consequences on psychological health are often explained concerning work-related psychological health, family-related psychological health, and general psychological wellbeing. Most empirical literature on the relationship between WFC and psychological health among nurses is derived from cross-sectional research (Gisler et al., 2018). Burnout, especially emotional exhaustion, is a frequently discussed outcome of work-family conflict for nurses (Gisler et al., 2018). Numerous authors agree that WFC significantly predicts nurse burnout (Boamah & Laschinger, 2016; Braunstein-Bercovitz et al., 2012; Goong et al., 2016). Dimensions of burnout, such as emotional exhaustion, are significantly related with WFC among Italian nurses (Camerino et al., 2010). Other studies demonstrate the positive influence of WFC on the relationship between depersonalization and cynicism (Simha et al., 2014) or the increased risk of emotional exhaustion and perception of reduced personal achievement (Leineweber et al., 2014). Healthcare workers, including nurses, often face long and irregular work schedules, emotional labour, and prolonged periods away from home, making work-family conflict a common occurrence (Frank et al., 2021). Tour-leading jobs, for instance, can deprive individuals of family time, making work-family conflict a significant stressor. Evidence indicates that increased work-family conflict leads to lower well-being (Lu et al., 2016). Time-based conflict, such as working overtime or during holidays, reduces the time available for family obligations (Tsaur & Tang, 2012). Studies on nurses further confirm the negative impact of time-based work-to-family conflict and time-based family-to-work conflict on individuals' psychological and physiological health (Ghislieri et al., 2017). The diminishing of resources necessary to perform tasks in both work and family spheres, such as being a mother or maintaining daily work performance, can cause physical and psychological strain among nurses (Pien et al., 2021). Scarce resources like time and energy contribute to physical and psychological burden when nurses recognize the need to allocate more resources to either work or family (Labrague & De los Santos, 2020). Strain-based work-to-family conflict has been associated to harmful effects on psychological and physiological health (Charkhabi et al., 2016). The interference of stress from work or family commitments with family or work leads to frustration and diminished psychological wellbeing (Clayton & Marczak, 2023; Gupta & Sahoo, 2020).

The impact of work-family role conflict on psychological wellbeing among professional workers has been extensively explored. Work-family role conflict predicts low job satisfaction (Labrague & Obeidat, 2022), positively affecting emotional exhaustion and depersonalization (Rheume, 2021). Nurses with higher job and private life satisfaction exhibit lower levels of

work-family conflict dimensions: time-based, strain-based, and behaviour-based conflict (Patel et al., 2008). Research conducted on nurses in Pakistan demonstrates a direct impact of work-family conflict on psychological welfare (Hanif & Naqvi, 2014). Similarly, work-family conflict has been linked negatively to psychological health and positively to stress in Indian female nurses (Sharma et al., 2016).

As established by this discussion, previous studies have strongly highlighted a significant link amongst heightened work-family conflict and reduced psychological well-being in nurses. Based on this, this research examines the hypothesis further in the context of north Indian nurses.

H.5. A negative relationship exists between work-family conflict and psychological well-being.

Work-family enrichment involves utilizing resources to enhance work performance and quality of life of an employee, as reported in a study by Chan et al. (2020). Researchers like Baumann (2023) and Kalliath et al. (2019) have delved into the theory of family enrichment to address the absence of positive spillover, integrating factors of self-report on job enrichment into the family sphere. This includes considering the impact of gender on physical and psychological well-being. When workers perceive that their work enriches their family lives, it gives them a sense of purpose and meaning in their professional lives. Meaningful work, as defined by Hackman & Oldham (1976), is characterized by an individual's perception of it being valuable and worthwhile. In accordance with the job characteristics model, meaningfulness serves as a psychological state that acts as a mediator in the correlation between work characteristics and outcomes in the workplace. (Kim et al., 2021). Family life improvement due to skills acquired at work contributes to the purposefulness of work, aligning with Steger et al.'s (2012) assertion that meaningful work correlates with life satisfaction and psychological health. Meta-analytical findings support the idea that individuals engaged in professions they love exhibit higher job satisfaction and improved performance, emphasizing the positive impact of meaningful work on psychological wellbeing (Ghorbani et al., 2021). Work-family enrichment has been linked to enhanced performance both at work and at home, as evidenced by empirical studies (Perry-Jenkins et al., 2000). Positive psychological experiences in the home environment have been associated with WFE (Abd Aziz et al., 2021; Kalliath et al., 2019), along with positive organizational attitudes (Shockley & Singla, 2011). Resources generated from both work to family enrichment and family to work enrichment are believed to assist individuals in coping

with stress and improving their psychological and physical wellbeing, according to researchers (Williams et al., 2006).

With regard to nursing, empirical studies show that work-family enrichment contributes to increased life satisfaction (Ghislieri et al., 2017; Lim et al., 2012; Mauno et al., 2013), overall health maintenance (Carlson et al., 2011), and effective stress coping mechanisms (Carlson et al., 2014; Janzen & Kelly, 2012).

Prior research indicates a strong correlation between increased **work-family enrichment** and better **psychological well-being**, particularly in nursing. Consequently, this research aims to test the hypothesis:

H6. A Positive Relationship Between work-family enrichment and Psychological Wellbeing

Mediating role

Venkatraman (1989) provided a definition of mediation as the presence of a substantial intervening mechanism between preceding and resulting variables. Conversely, Baron & Kenny (1986) articulated this concept differently, stipulating three prerequisites that must be met before assessing mediation:

1. There must be a correlation between the independent and mediator variables.
2. A correlation must exist between the independent and dependent variables.
3. There should be a correlation between the mediator and dependent variables.

Mediation implies that the effect of IV on DV is less when the mediator is involved than when it is not included.

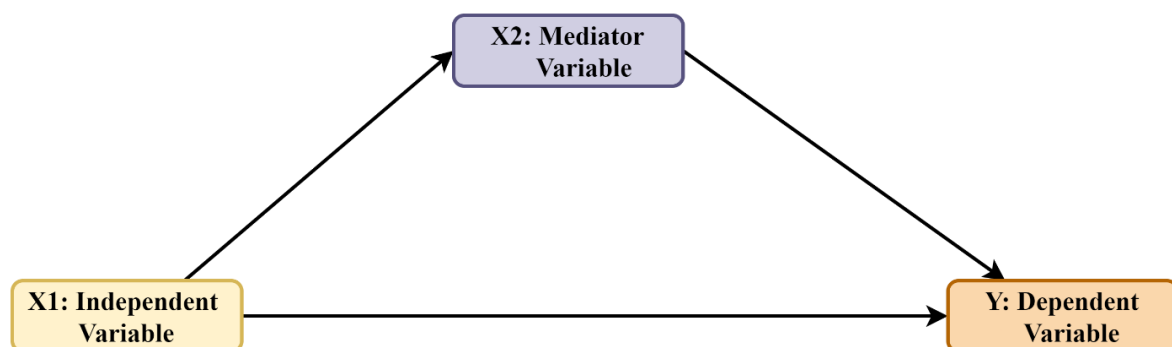


Figure 12: Diagram illustrating the mediation model

Source: (Baron & Kenny, (1986)

Malhotra et al. (2014) suggested that mediation doesn't necessarily demand X's overall impact on Y to be significant, thus implying that the second step in Baron and Kenny's approach may not be obligatory. Thus, a mediated relationship analysis should focus on the indirect effect. Figure 13 shows the One-Mediator Mediation Model with no direct impact a, b.



Figure 13: Diagram illustrating the mediation model.

Source: (Baron & Kenny, 1986)

The JD-R theory sheds light on the impact of work-family conflict by suggesting that managing both work and family roles can deplete personal resources. This strain is evident in studies such as Meliala et al. (2020), which indicate that elevated WFC levels result in diminished vigour and vitality. Additionally, heightened WFC is linked to increased emotional exhaustion, anxiety, pressure, and depression, as emphasized by Grandey & Cropanzano (1999). Job demands become stressors when they demand excessive effort, particularly without adequate recovery during non-working hours. This imbalance can lead to fatigue, job strain, and severe mental health consequences, as explored in studies by Bakker, Demerouti, Taris, Schoufeli, Schreurs, and others. Professions involving intensive interaction, like nursing, are particularly susceptible, as supported by van Daalen et al.'s (2009) findings. Emotional demand stands out as a significant factor. Professionals, in managing daily demands, often regulate their emotions, concealing the true impact of these demands. This emotional regulation is influenced by job demands, as seen in the work of Brotheridge & Lee (2002), and reinforced by Gosserand & Diefendorff, (2005) and Cheng et al. (2020). WFC plays a crucial role in emotional labour, where higher WFC leads to increased suppression of genuine emotions at work, known as 'surface acting,' especially in roles with high cognitive demands. The nature of WFC demands emotional regulation, depleting individuals' resources, as discussed by Meliala et al. (2020).

Considering both cognitive and emotional demands, Hobfoll (1989) suggests that the mere depletion of resources is inherently stressful. De Jonge & Dormann (2003) argue that compounded demands, such as WFC coupled with cognitive job demands, intensify the need for emotional regulation in the workplace. Researchers like Huynh et al. (2014) have explored this relationship. Their study among emergency service workers found that exhaustion could mediate the relationship between demands and outcomes like depression and anxiety. Similarly,

Laschinger et al.'s (2012) investigation among Canadian nurses revealed that job demands influenced mental health through emotional fatigue. The mediating role of burnout and engagement in determining health and organizational outcomes was also demonstrated in Halbesleben's (2010) work.

Given these antecedents, this research seeks to investigate the hypothesis:

H7. Work-family conflict mediates the relationship between job demands and psychological wellbeing,

And consequently:

H7.1. Work-family conflict mediates the relationship between quantitative demands and psychological well-being.

H7.2. Work-family conflict mediates the relationship between emotional demands and psychological well-being.

H7.3. Work-family conflict mediates the relationship between cognitive demands and psychological well-being.

Resources, encompassing objects, individual traits, environments, energy, and social support, as defined by Hobfoll (1989), play an important role in mitigating stress and influencing the enrichment process. Supervisor support, self-esteem, and enthusiasm are critical resources contributing to the interplay between WFE and job satisfaction. Elevated levels of mentorship, self-esteem, and enthusiasm directly or indirectly enhance WFE, ultimately leading to increased job satisfaction. Various studies, including pioneers like McNall et al. (2010), as well as subsequent research by Baral & Bhargava (2010), (Tang et al., 2014), and Fung et al. (2015). Fung, Ahmad, & Omar (2015), confirm the mediating role of WFE in relationships relating job characteristics, support, and job outcomes.

Contemporary research, as highlighted by Agrawal & Mahajan (2021), Rani et al. (2022), and Yildiz et al. (2021), consistently demonstrates a positive association between work-family enrichment and satisfaction in both work and family realms. The enhancement in one responsibility positively impacts the quality of life in another, contributing to increased satisfaction. However, this relationship is significantly mediated by an individual's mood. Moods, described as pervasive streams of affective experiences, inform individuals about their environmental context, influencing behaviour and information processing, as emphasized by

George & Zhou (2007) and Schwarz & Clore (1983, 2003). In the context of work-family enrichment, individuals often acknowledge the positive impact of their work on family life, resulting in positive emotions about their job. Drawing from Fredrickson's (1998, 2001) broaden-and-build theory, these positive moods stimulate actions and thoughts, foster social connections, and facilitate the gaining of new proficiencies and resources. These resources, essential for adapting to life's challenges and capitalizing on opportunities, consistently correlate with positive satisfaction evaluations, as evidenced by research from Hunter et al. (2010).

The association between job resources and demands, work-family enrichment, and psychological wellbeing, grounded in COR theory and supported by a plethora of research, convincingly advocates for the hypothesis that work-family enrichment mediates the relationship between job resources and psychological well-being. Given these antecedents, this research seeks to investigate the hypothesis:

H.8 Work-family enrichment mediates the relationship between job resources and psychological well-being,

and therefore:

H8.1. Work-family enrichment mediates the relationship between perceived organizational support and psychological well-being.

H8.2. Work-family enrichment mediates the relationship between perceived co-worker support and psychological well-being.

H8.3. Work-family enrichment mediates the relationship between job autonomy and psychological well-being.

4 MATERIAL AND METHODS

This chapter delineates the research methodology for a quantitative descriptive study to investigate the interplay between job demands, job resources, work-family conflict, work-family enrichment, and psychological well-being among the nurses working in the healthcare system of north Indian UT of Jammu and Kashmir. The primary objective is to explore the psychological well-being of nurses in light of job demands and resources while investigating how work-family conflict and work-family enrichment mediates these relationships. This chapter describes the rationale for adopting a quantitative approach and details the research plan, methodology, study participants, procedures, analysis methods, and ethical considerations.

4.1 Conceptual Development

To address the research objectives, the prior chapter assessed studies and literature delving into the intricacies of JD, JR, work-family dynamics, and PWB. These topics exhibit complex interactions that manifest differently across organizational and individual contexts. Over time, as studies in the HRM landscape evolved, there's been a transition in research focus: from examining internal dynamics and business processes to considering broader factors such as individual perceptions and broader organizational implications.

The aim is to develop a valid conceptual framework that sheds light on these multifaceted relationships. The framework, depicted in Figure 14, is structured to investigate the hypothesized interactions and their implications.

Specifically, it seeks to answer:

- The potential bearing of JD on WFC.
- The probable positive association between JR and WFE.
- Whether JD influences the PWB of the nurses.
- The anticipated positive relationship of JR with PWB.
- The speculated detrimental relationship between WFC and PWB.
- The postulated beneficial relationship of WFE with PWB.
- The potential mediation of WFC in the connection between JD and PWB.

- The role of WFE as a mediator in the association between JR and PWB.

These dimensions are central to comprehending the dynamics of modern HR roles, particularly as healthcare organizations battle the challenges and opportunities presented by rapidly evolving workplace demands and resources.

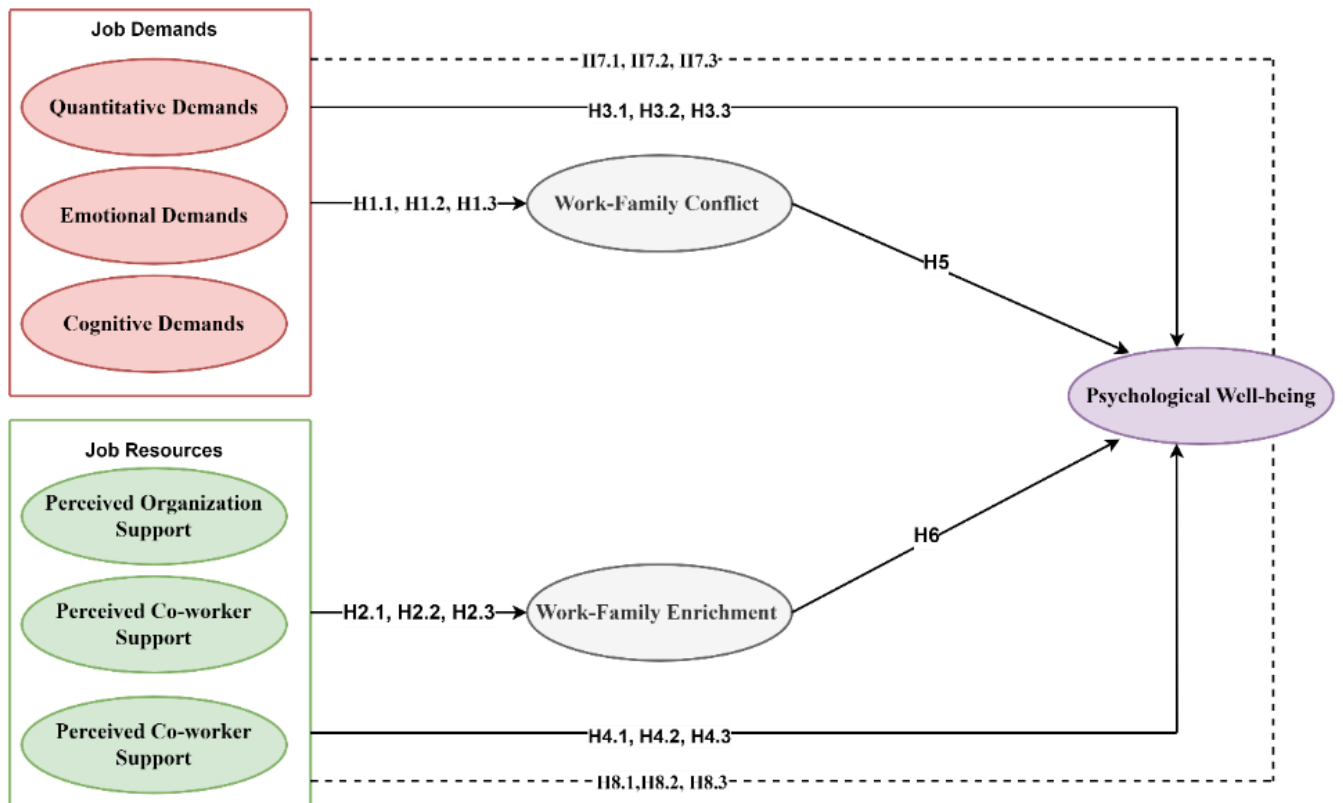


Figure 14: Diagram illustrating the mediation model

Source: Own editing (2023)

Note: Dotted Lines represent mediated relationships and solid lines represent direct relationships

4.2 Union Territory of Jammu and Kashmir: Background

Jammu and Kashmir is a territory with an area of 42,241 sq. kilometres and a populace of 12.4 million, as per the latest 2011 census. Established as a State on October 26, 1947, its status was changed to a union territory (UT) on August 5, 2019. The capital of the UT alternates between Srinagar in the summer and Jammu in the winter. The region of Jammu and Kashmir boasts several valleys, each with its unique charm. Among these are the famous Kashmir Valley, Tawi Valley, Chenab Valley, Poonch Valley, Sind Valley, and Lidder Valley. The Kashmir Valley,

stretching 100 kilometres (62 miles) wide and covering an area of 15,520.3 square kilometres (5,992.4 square miles), stands out as a prominent feature of the landscape. It is nestled between the Himalayas to the north and the Pir Panjal range to the west and south, separating it from the Punjab Plain of the Indo-Gangetic Plain. To the northeast, the Valley is flanked by the main range of the Himalayas, enhancing its natural beauty and allure.



Figure 15: Map of UT of Jammu and Kashmir

Source: Data from GOI

With an average elevation of 1,850 meters (6,070 ft) above sea level, this valley contrasts sharply with the towering Pir Panjal range, which averages 10,000 feet (3,000 m) in height. Meandering through the heart of the Kashmir valley is the Jhelum River, a central waterway originating from the Himalayas. Transitioning to the southern Jammu region reveals a predominantly mountainous terrain, where the Shivaliks, middle, and great Himalayas form parallel ridges in a southeast–northwest orientation. Along the southwestern fringe, a narrow strip of fertile plains emerges. Flowing through the Jammu region are the Chenab, Tawi, and Ravi rivers, adding to its geographical diversity.

J&K UT occupies 19th place in terms of population in India, with about 12.26 million people as per the 2011 census. The projected population of Jammu-Kashmir is shown in the Table 2. UT of J&K has two distinct regions, viz. Kashmir and Jammu comprise 20 districts and 6,431 villages as per census, 2011. Administratively, the districts are divided into blocks for development purposes. Urdu is the official language, while other languages such as Kashmiri, Dogri, Pahari, Balti, Ladakhi, Punjabi, Gojri, and Dadri are also spoken. Surrounded by Himachal Pradesh and Punjab, Jammu and Kashmir are administered as Union territories. In

the Indian context, a UT is a region or administrative division that the Central Government of India directly governs. With a literacy rate of 83.45%, the state is divided into 20 districts, and its sex ratio stands at 880 females per thousand males.

4.3 Healthcare in UT of J&K

The healthcare system in Jammu and Kashmir has a rich historical backdrop marked by the contributions of Christian missionary activities and the establishment of medical missions dating back to the pre-independence era. The Kashmir Medical Mission, founded by the Rev. Robert Clark in 1865, pioneered Western medicine in the region. Despite opposition from local authorities, missionaries like Dr. William J. Elmslie and Dr. Theodore Maxwell persevered in providing medical care to the people of Kashmir.

Table 2: Population of UT of J&K

<i>Figures in millions</i>			
Year	<i>UT of Jammu & Kashmir</i>		
	Population	Male	Females
2011	12.267	6.484	5.783
2023*	14.126	7.398	6.728
*Projected figures Source: Census of Government of India			

Source: Own editing (2023)

Over the years, various hospitals and dispensaries were established, including the Mission Hospital, John Bishop Memorial Hospital, and St. Joseph's Mission Hospital, contributing significantly to healthcare development. The role of organizations like the Church of England Zenana Missionary Society (CEZMS) was crucial in addressing epidemics, providing medical education, and establishing hospitals. The Jammu and Kashmir Paramedical and Nursing Council, formed in 2001, has worked towards improving healthcare standards, developing nursing staffing norms, and enhancing safe practices. The Trained Nurses' Association of India (TNAI) has also played a vital role in promoting professional, educational, and economic advancement for nurses in the region. Today, the healthcare sector in Jammu and Kashmir continues to evolve, addressing the diverse healthcare needs of its population. Presently, the

district-wise list of healthcare institutions in the UT of Jammu and Kashmir is tabulated in Appendix 2.

4.4 Institutions Covered in the Study

The study covers public healthcare institutions in the Union Territory of Jammu and Kashmir, associated with three parent institutions: SMHS, SMGS, and SKIMS. Shri Maharaja Hari Singh (SMHS) Hospital Srinagar is one of the largest government hospitals, offering various medical specialties and serving as a medical education and research center. Other institutions include the Government Dental College Hospital, J&K Institute of Ophthalmology, Government Chest Diseases Hospital, and Government Bone and Joint Hospital. SMHS Hospital evolved into a significant teaching institute, providing medical training in various specialties. Its expansion included the establishment of the 100-bed Maternity Hospital at Lal Mandi, which later expanded to the 500-bed Lal Ded Maternity Hospital. Associated hospitals include G.B. Pant, Children's Hospital, Lal Ded Maternity Hospital, Psychiatric Diseases Hospital, Chest Diseases Hospital Barzulla, and Chitranjan Mobile Hospital. Ongoing upgrades are acknowledged to align with changing trends in medical care.

Sher-i-Kashmir Institute of Medical Sciences (SKIMS) is the largest medical institute in Srinagar under the State Legislature Act. SKIMS is the only medical university in the Union Territory, governed by the Lieutenant Governor. It encompasses various healthcare units, including the State Cancer Institute, Maternity Hospital, Nursing college, Paramedical college, and an affiliated medical college and hospital. SKIMS' history dates back to 1976, partially commissioning in 1982 and gaining university-like status in 1983. SKIMS has over 50 departments, which are crucial in providing medical education and healthcare services in the region.

Sri Maharaja Gulab Singh (SMGS) Hospital Jammu, established in 1973, is a premier institution in the Union Territory. Initially starting in temporary facilities, it has grown into a comprehensive institute with associated hospitals. The college aims to provide quality education and healthcare services, offering undergraduate and postgraduate training courses. With an increased seating capacity, it caters to a significant patient population from Jammu province, parts of the Kashmir valley, and neighboring states. The College Council, led by the Principal and Dean, serves as an advisory body, guiding the institution in various matters related to education and healthcare.

4.5 Research Approach

In the current study on the interplay between JD, JR, WFC, WFE, and PWB among nurses in the healthcare system of the North Indian Union Territory of Jammu and Kashmir, a deductive research approach is adopted. The deductive approach involves a systematic process of verifying observed events, defining problem statements, hypothesizing, determining measures, and collecting and analysing data to interpret results. This aligns with the study's objective of exploring the relationships and dynamics between these psychological and work-related variables.

The research design employed is a quantitative, non-experimental design, specifically utilizing Factor Analysis and Structural Equation Modelling (S.E.M.). This design is chosen for its appropriateness for correlational research, allowing for examining relationships between variables without manipulating them. Surveys are administered to gather data on the variables of interest, including PWB, JD, JR, WFC, and WFE. among nurses in the healthcare system of Jammu and Kashmir. Using SEM allows for the exploration of both direct and indirect effects, providing a thorough insight of the interplay between these variables. The study's goals are not only to examine the direct relationships between JD, JR, WFC, WFE, and PWB but also to explore the moderating roles of WFC and WFE. on the relationship between JD/JR and PWB. This research design enables the quantitative assessment of these relationships, contributing to a layered appreciation of the factors influencing nurses' psychological well-being in the specified context.

To gain a comprehensive understanding of the research topic, this study employs a mixed-methods approach. Quantitative analysis, as outlined above, provides valuable numerical insights. To complement these findings, a thorough review of existing qualitative studies is conducted. Interviews of Nurses and Nursing managers from these qualitative studies are collected and analysed in tandem with the quantitative results. This triangulation of data strengthens the validity and robustness of the overall research findings by providing a more holistic view of the subject matter.

Overall, the deductive approach and the chosen research design are well-suited for systematically examining and analysing the complex relationships between these variables, shedding light on the intricate dynamics within the nursing profession in the healthcare system of Jammu and Kashmir.

4.6 Research Strategy

The selected research strategy for this study is an extensive survey methodology widely acknowledged in business research for its effectiveness in collecting data to address research inquiries. This approach is particularly suitable for conducting both exploratory and descriptive analyses, focusing on variables such as J.D., J.R., WFC, W.F.E., and P.W.B. among nurses in the healthcare system of the north Indian Union Territory of Jammu and Kashmir.

To ensure the research's comprehensiveness and alignment with the actual practices prevalent in North India, the researcher establishes liaisons with several regional medical boards. Their valuable input not only broadens the scope of the study but also provides depth to the contextual understanding of the research. Once the context is established, the researcher meticulously designs the study, drawing on insights from an extensive literature review and leveraging findings from previous studies on work-life balance among nurses in North India.

A questionnaire incorporating instruments related to JD, JR, WFC, WFE, and PWB is formulated based on the refined context. The collected responses undergo a meticulous checking process to eliminate errors, ensuring the integrity of the data. Subsequently, a detailed A cross-sectional time horizon is adopted, allowing for a comprehensive exploration of the relationships and dynamics between PWB, JD, JR, WFC, and WFE among nurses in the specified region. The data collection process encompasses secondary sources, including annual reports, official websites, academic books, articles, and primary data from administered questionnaires. Additionally, the researcher leverages archival data to gain insights from previous studies on the work-life balance among regional nurses, contributing valuable context to the research endeavour. This section meticulously outlines the comprehensive research methodology, aligning with the chosen deductive approach. The study is strategically designed to investigate the interactions and dynamics between PWB, JD, JR, WFC, and WFE among nurses in the specified healthcare context of the north Indian Union Territory of Jammu and Kashmir.

analysis is undertaken to identify trends, patterns, and insights gleaned from the survey responses.

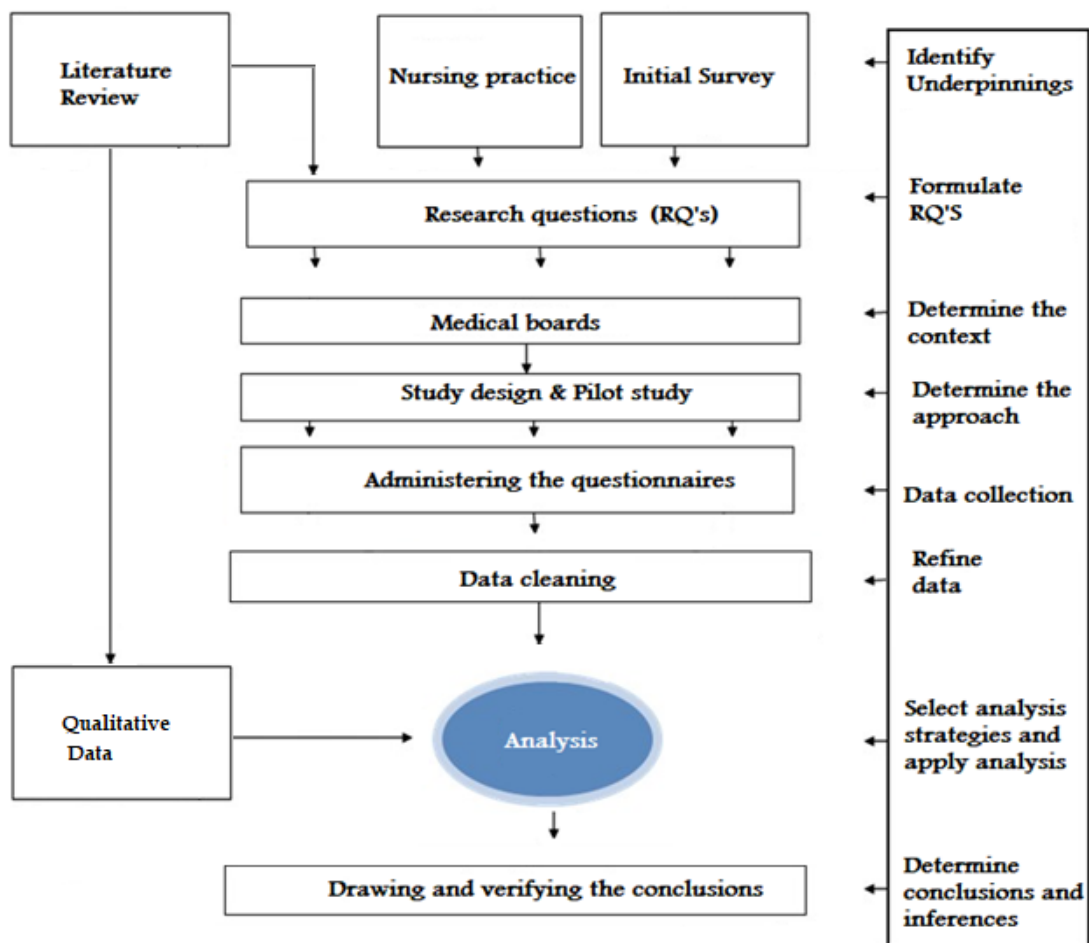


Figure 16: The flowchart representing the procedure of the undertaken
Source: Own editing (2023)

4.7 Sample Frame and Population

Nurses in the UT of J&K, following general practice in the rest of India, are categorized as Auxiliary Nursing Midwives (ANM), Registered Nurses and Midwives (RN & RM), and Lady Health Visitors (LHV). As of 2022, the total number of Nurses, as provided by TNAI (JK), in various institutions and on multiple profiles in Jammu and Kashmir are tabulated in Table 3.

Table 3: Registered nurses with various profiles working across UT of J&K

<i>Registered Nurses in J&K</i>		
ANM	RN & RM	LHV
5264	3999	0

Source: Own editing (2023)

The population of this study comprised all major public healthcare facilities in both the divisions of UT, viz., Jammu division and Kashmir division. A sampling frame engenders lists of all population elements (Sekaran & Bougie, 2019). This study's sampling frame represented all major public healthcare centres under the Department of Health and Medical Education in UT of J&K in 2023. The sampling frame was obtained from the Department of Health and Medical Education. The study population comprises 9200 staff, of whom 3,999 (43%) are registered nurses and midwives, and 5,264 (57%) represent the auxiliary nursing midwives. The current study has taken into account only registered nurses given that auxiliary nursing constitutes informal aspects of nursing and is not limited to formal institutions like hospitals and, therefore, not suited to the design of this study.

The study's population of interest comprises registered nurses working across the UT of J&K. The selection of an appropriate sample is crucial, and this study employed a probability sampling approach. Specifically, a random sampling method was adopted, ensuring that every individual within the population had a similar probability of being selected for the sample. This approach aligns with the need for broad generalization, allowing each qualified individual in the population an identified, nonzero chance of participation.

To achieve randomness and eliminate bias in the selection process, the investigator utilized the RAND function in Microsoft Excel to produce a random selection from the population units. This method ensures an unbiased and equitable representation of the nursing staff in the UT. Determining the sample size is an important aspect. In line with previous insights, a larger sample size was deemed appropriate to account for subtle differences in the variables of interest. Based on G*Power and considering a population of approximately 3,999 registered nurses and midwives, the computed sample size was 803.

The sample distribution, tabulated in Appendix 3, across various medical centres, providing a transparent overview of the data collection process for this comprehensive study.

4.8 Data Collection

This study employed a survey design, integrating six standardized instruments outlined in Appendix 1, along with personal and organizational demographics. The targeted sample comprised 803 registered nurses across the UT. Considering the formal nature of nursing in hospitals, this sample represents a proportionate distribution from the total population of 3,999 registered nurses and midwives.

Data collection occurred in two regions of the Union Territory – Jammu and Kashmir - with a meticulous approach to sample selection. The sampling frame from the Department of Health and Medical Education provided the necessary information for a probability sampling approach. The researcher adopted a random sampling method to ensure an unbiased and equitable representation of registered nurses.

The questionnaires were delivered directly to the registered nurses, emphasizing the academic purpose of the study. A clear directive was given to answer the questionnaire freely and without observation. After an interval of five days, the researcher collected the surveys from the nurses. The entire data collection process was systematically executed over twelve weeks, from questionnaire distribution to collection.

4.9 Instrumentation

The questionnaire employed in this research adopts a structured approach consisting of two distinct segments:

1. **Demographics Segment:** The first segment, as tabulated in Table 4, focuses on collecting demographic information from the respondents. It comprises seven closed-ended questions related to gender, age, and marital status, providing insights into the characteristics of the study participants.
2. **Primary Study Variables Segment:** The second segment is dedicated to exploring the primary study variables, which include JD, JR, WFC, WFE, and PWB. Table 5 outlines the sources and rated items for this segment.
 - **Job Demands:** Job Demands are measured using three sub-constructs, viz., Quantitative Demands, Cognitive Demands, and Emotional Demands. The items for each sub-construct are rated on a 5-point Likert-type scale based on the scale developed by Pejtersen, Kristensen, Borg, & Bjorner (2010)

Table 4: Various demographic variables in the questionnaire

<i>Demographic variables</i>	
<i>Dem 1</i>	Age of the Nurse
<i>Dem 2</i>	Marital Status
<i>Dem 3</i>	Seniority
<i>Dem 4</i>	Education qualification

Source: Own editing (2023)

- **Job Resources:** Job Resources are evaluated through three sub-constructs, viz., Perceived Organizational Support, Perceived Coworker Support, and Job Autonomy. Respondents rate their perception of each sub-construct on a 5-point Likert-type scale, with the sources being Eisenberger et al. (1986), Haynes et al. (1999) and Voydanoff (2004) respectively.
- **Work-Family Conflict:** Work-family conflict is assessed using a 10-item scale developed by Netemeyer et al. (1996). Participants rate their experience of Work-Family Conflict on a 5-point Likert-type scale.
- **Work-Family Enrichment:** Work-Family Enrichment is measured through an 18-item scale based on Carlson et al. (2006) work. Respondents rate how much their work enriches their family life on a 5-point Likert-type scale.
- **Psychological Well-being:** Psychological Well-being is evaluated using an 18-item version of Ryff Scales of Psychological Well-being, and respondents rate their psychological well-being on a 5-point Likert-type scale.

4.10 Validity and Reliability

Validity and reliability, crucial aspects of measurement accuracy, were diligently addressed in the study. Sekaran & Bougie (2019) emphasize the importance of validity, asserting that an instrument must measure its intended constructs. Reliability was evaluated through repeatability and internal consistency. Internal consistency, assessed by Cronbach's coefficient alpha, measured the homogeneity of items in a given construct. A coefficient closer to 1.0 signifies highest internal consistency and reliability, while aligning with Pallant (2020) assertion that a minimal Cronbach's alpha value of 0.60 is acceptable in ensuring scale dependability.

Table 5: Variables and sub instruments in the questionnaire

Variable	Sub-Variables	No. of Items	Rating Scale (Likert-type-scale)	Source
Job Demands	Quantitative Demands	4	5-Point	(Pejtersen et al., 2010)
	Cognitive Demands	4	5-Point	
	Emotional Demands	4	5-Point	
Job Resources	Perceived Organizational Support	6	5-Point	Eisenberger et al. (1986)
	Perceived Coworker Support	4	5-Point	Haynes et al. (1999)
	Job Autonomy	3	5-Point	Voydanoff (2004)
Work-Family Conflict	-	10	5-Point	Netemeyer et al. (1996)
Work-Family Enrichment	-	18	5-Point	Carlson et al. (2006)
Psychological Wellbeing	-	18	5-Point	(Ryff & Keyes, 1995)

Source: Own editing (2023)

5 RESULTS

In this chapter, the results of the study are presented, offering a comprehensive analysis of the collected data. The analyses are carried out using IBM SPSS version 23 with AMOS v 23. Beginning with descriptive statistics, a clear overview of the variables under examination is provided. Confirmatory Factor Analysis (CFA) is then employed to assess the validity of the measurement model. Following this, potential sources of bias and multicollinearity are addressed through an examination of Common Method Bias (CMB) and Multicollinearity diagnostics. Subsequently, the distribution of data is evaluated through a Normality Test, and the internal consistency of measures is assessed using Cronbach's alpha measure. Potential group differences are explored through One-Way Multivariate Analysis of Variance (MANOVA). Bivariate relationships between variables are then examined using Pearson's Correlation Analysis. Finally, Path Analysis is employed to investigate both direct and indirect relationships among study constructs, offering a deeper understanding of the mechanisms at play within the conceptual framework.

5.1 Descriptive Statistics

Out of the 803 questionnaires distributed to nurses in 22 identified hospitals, responses were received from 17 hospitals, resulting in 474 returned questionnaires. However, 51 questionnaires containing incomplete data were omitted from the statistical analysis, resulting in 423 questionnaires being included for further analysis. The overall response rate was 52.6%. The hospital-wise distribution of nurses in the sample for this study is depicted as follows in figure 17. The demographic data for the age is depicted in table 6.

Table 6: Distribution of age groups in the sample

<i>Age Range</i>	<i>Frequency</i>	<i>Percentage of Total</i>
20-29	36	8.51
30-39	137	32.39
40-49	154	36.41
50-59	92	21.75
60-69	4	0.95
Total	423	100

Source: Own editing (2023)

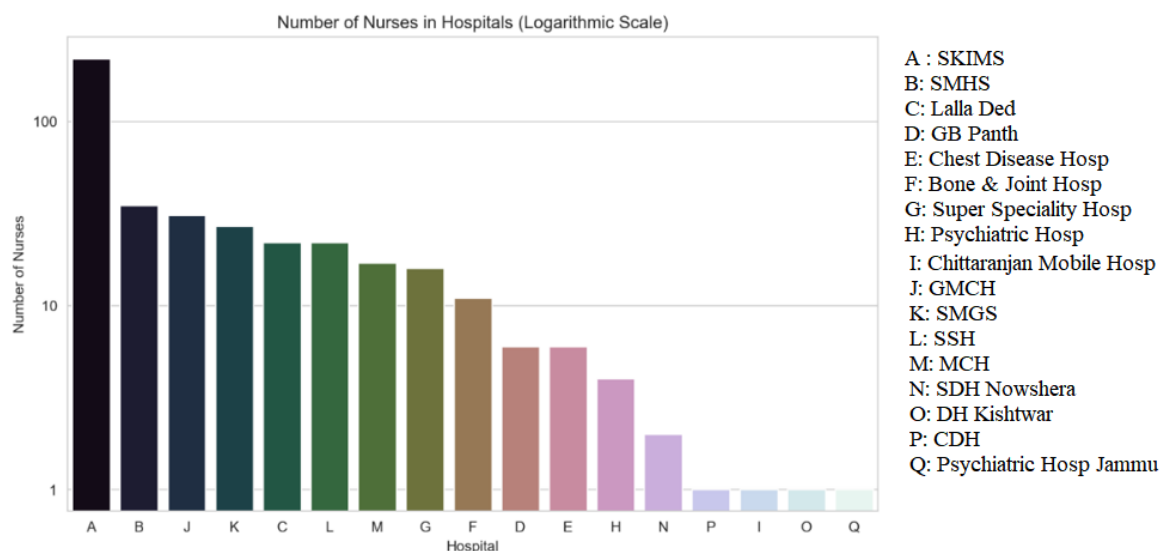


Figure 17: A logarithmic scale bar graph illustrating the distribution of nurses across various hospitals in the study sample.

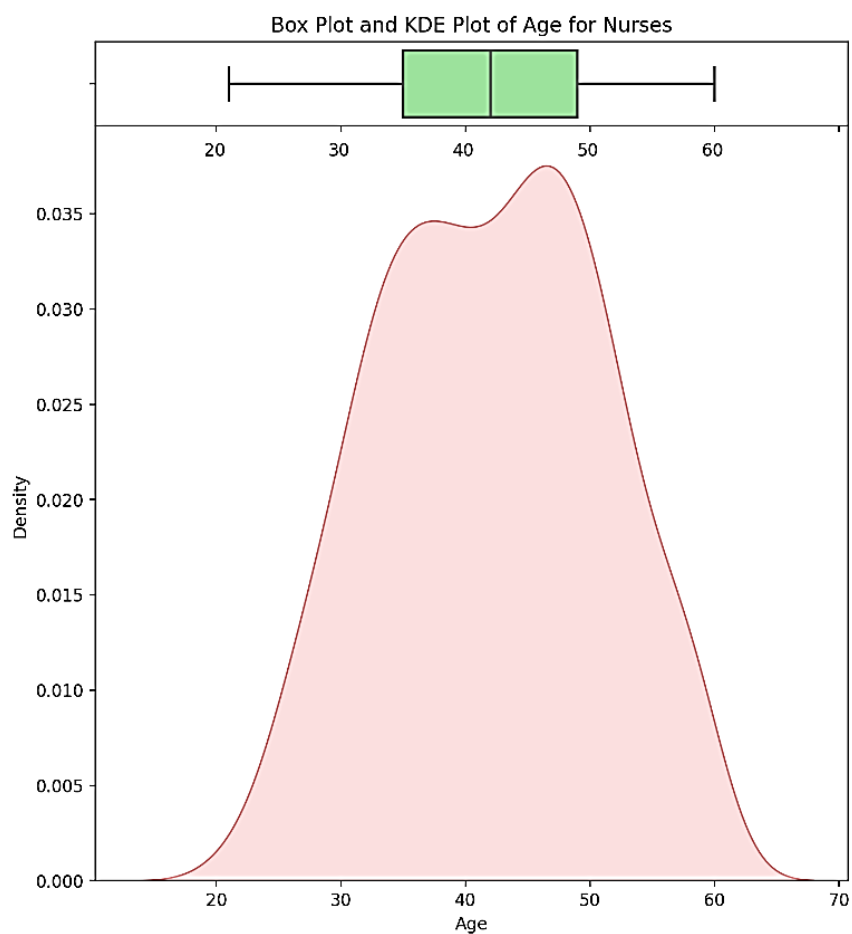


Figure 18: Box plot and KDE plot showing the distribution of nurses in the sample
Source: Own editing (2023)

The box plot also shows a notable concentration in the 40-49 age range, indicating a significant portion of nurses within this bracket. The distribution tails off for the 20-29 and 50-59 age ranges, as reflected in the decreasing density in the KDE plot and the shorter box lengths in these categories. The 60-69 age range has a minimal representation, as indicated by the KDE plot's trailing edge and the short box length. Overall, the age distribution is skewed towards the middle age range (30-49), suggesting a central tendency in the age profile of the nurse respondents. The combination of the box plot and KDE plot provides a visual representation of the age distribution, aiding in interpreting the demographic characteristics of the surveyed nurse population.

The marital status distribution among nurses shows that a significant majority, accounting for 93.1%, are married. Additionally, the seniority distribution reveals that 46.1% of the nurses fall into the senior category. Figure 19 illustrates these demographic parameters, clearly representing the percentage of senior nurses among the surveyed population. The combination of marital status and seniority distributions in the figure contributes to a comprehensive overview of the demographic composition of the nursing staff, enhancing the interpretability of these key characteristics.

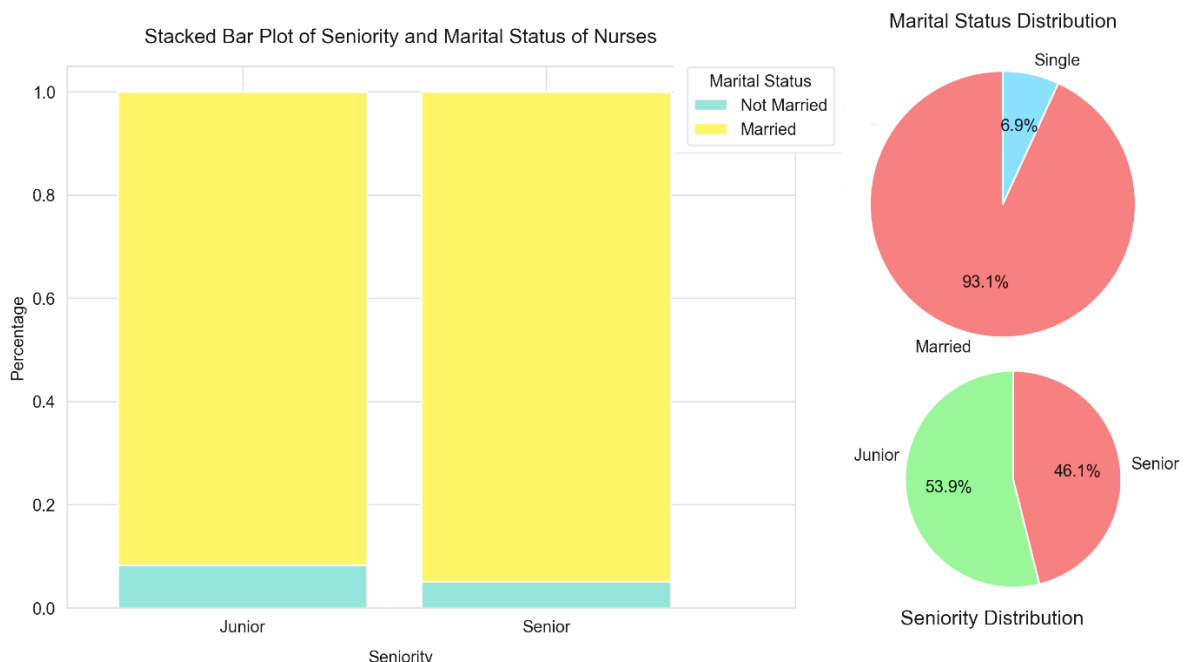


Figure 19: Seniority distribution and Marital distribution of the sample
Source: Own editing (2023)

Nurses were also asked about their education qualifications. Table 7 illustrates the educational qualifications of nurses categorized into different age groups. Four distinct age brackets are considered, namely 20-29, 30-39, 40-49, and 50-60, along with a total count of 423 nurses. The distribution of educational qualifications encompasses three categories: Graduation, Post-graduation, and Pre-graduation.

Table 7: Ages ranges and education qualifications of the nurses in the sample

Age Range	Graduation	Post-graduation	Pre-graduation	Total
20-29	22	17	4	43
30-39	68	43	33	144
40-49	59	50	46	155
50-60	18	20	43	81
Total	167	130	126	423

Source: Own editing (2023)

Figure 20 shows the distribution of nurses' education qualifications concerning their grades. As may be expected, younger/junior nurses are more qualified as they offer greater representation in the categories of post-graduation and graduation.

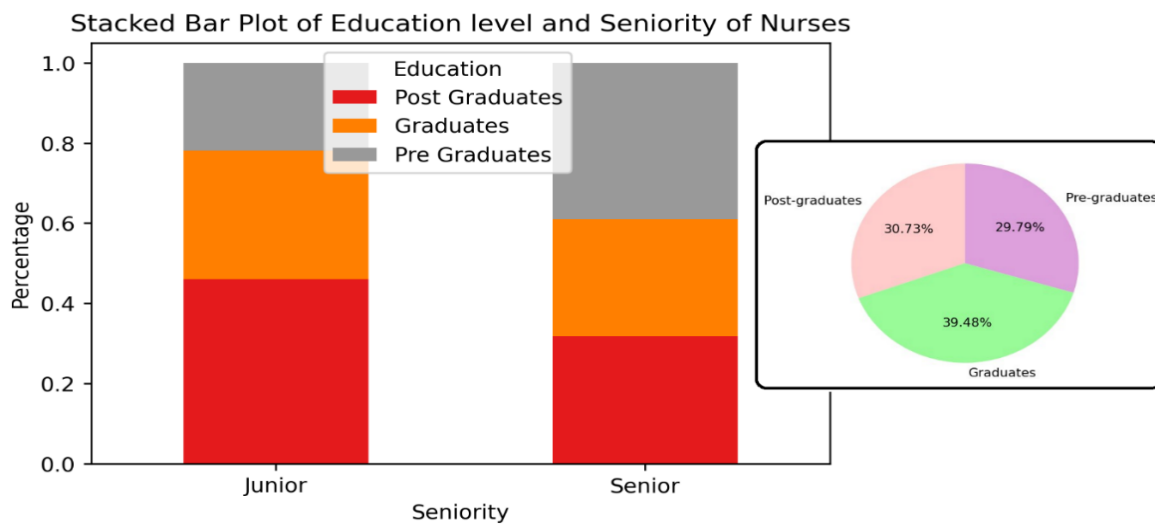


Figure 20: Educational qualification of nurses in the sample

Source: Own editing (2023)

To determine whether there is a significant difference between the age groups with respect to their education qualification, a chi square test was conducted. The age bins are 20-29, 30-39, 40-49, 50-59, and 60 and above. The results of the chi-square test are tabulated in Table 8. The

chi-squared test yielded a significant result ($\chi^2 = 98.62$, $p < 0.05$), indicating a significant association between age and education levels. Therefore, the null hypothesis was rejected, suggesting that the distribution of education levels is not independent of age groups among the nurses.

Table 8: Results of chi-square test on age and education

Chi-Square Value	98.62
Degrees of Freedom	6
p-value	2.17E-18

Source: Own editing (2023)

5.2 Confirmatory Factor Analysis

CFA is a statistical method to validate the structural relationships among variables. It assesses the measurement instrument's validity by determining the required number of factors linked to latent variables in the data. Researchers use CFA to examine the relationship between the number of items loaded to each variable associated with a latent variable. CFA, a subset of SEM, specifically focuses on measurement scales, scrutinizing connections between observed scales or indicators. The primary goal of latent variable measurement models is to establish the number and types of factors explaining variance and covariation among a set of indicators. These models reveal that an unobservable factor influences several observed measurements, elucidating relationships among these observed measures. In essence, observable measurements are interrelated because they share the same underlying construct, affected by the same root cause.

After an initial CFA run, a refinement process was undertaken by removing items with low factor loadings. Specifically, 2 items from WFC, 4 items from WFE and 3 items from PWB were eliminated due to their factor loadings falling below the threshold of 0.6 (Hair et al., 2014). After these adjustments, a subsequent CFA was performed, resulting in a well-fitting model. The CFA results indicate a comprehensive assessment of the measurement model's fit. The chi-square test reveals statistical significance ($\chi^2 = 2256.63$, $df = 1793$, $p < 0.05$). Additionally, the Root Mean Square Error of Approximation (RMSEA) and Root Mean Square Residual (RMR) values, at 0.02 and 0.04, respectively, indicate a minimal discrepancy between the model and observed data, signifying a very good fit. Furthermore, the Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI) values of 0.97 each illustrate an excellent fit, emphasizing the model's ability to represent the relationships among the observed variables

accurately. In summary, while the chi-square test attains significance, the collectively favorable values of the CMIN/df, RMSEA, RMR, CFI, and TLI imply that the measurement model effectively captures the underlying structure of the examined variables, offering robust support for its adequacy in explaining the observed data (Hair et al., 2006).

The AVE values for the constructs ranged from .51 to .67, surpassing the commonly accepted threshold of .5 (Fornell & Larcker, 1981; Hu & Bentler, 1999), indicating satisfactory convergent validity. Discriminant validity, represented by the square root of AVE ($\sqrt{\text{AVE}}$), exceeded the standardized correlation values between each construct and other constructs (Fornell & Larcker, 1981), verifying that the constructs were separate from one another.

Furthermore, each construct's reliability ranged from .85 to .94, surpassing the acceptable benchmark of 0.7 (Nunnally & Bernstein, 1994), indicating robust internal consistency. Consequently, these outcomes collectively affirm that the measurement model met the stipulated requirements, providing a solid foundation for the subsequent analyses and interpretations. Table 9 shows the test parameters prior of the questionnaire whereas the factor loadings for each variable are presented in Appendix 4

Table 9: Test Parameters for the reviewed questionnaire

Constructs/Items	AVE	CR	Collinearity statistics	
			Tolerance	VIF
<i>Quantitative Demands</i>	0.62	0.87	0.53	1.89
<i>Emotional Demands</i>	0.58	0.85	0.74	1.36
<i>Cognitive Demands</i>	0.62	0.86	0.55	1.82
<i>Perceived Organizational Support</i>	0.56	0.88	0.6	1.66
<i>Perceived Co-worker Support</i>	0.61	0.86	0.73	1.36
<i>Job Autonomy</i>	0.67	0.86	0.83	1.21
<i>Work-Family Conflict</i>	0.52	0.9	0.64	1.55
<i>Work-Family Enrichment</i>	0.51	0.94	0.75	1.33
<i>Psychological Wellbeing</i>	0.53	0.94		

Source: Own editing (2023)

The items, based on low factor loadings, that were removed are presented in Appendix 4

Table 10, depicts the model fit criteria of the measurement model

Table 10: Model fit criteria of measurement model

<i>CMIN</i>	<i>df</i>	<i>CMIN/df</i>	<i>RMSEA</i>	<i>RMR</i>	<i>CFI</i>	<i>TLI</i>
2256.63	1793	1.26	0.02	0.04	0.97	0.97

Source: Own editing (2023)

5.3 Common Method Bias (CMB) and Multicollinearity

Given that the data in this study was collected through a single source, specifically a questionnaire administered to the same respondents simultaneously, the concern of CMB was acknowledged. A principal component analysis with varimax rotation was conducted to evaluate the potential presence of CMB (Podsakoff et al., 2003). The results revealed nine factors with eigenvalues greater than 1. Notably, the first factor accounted for 14.003% of the total variance, meeting the criterion that the first factor should explain less than 50% of the variance. This outcome suggests no significant issue of common method bias in the present study. The analysis implies that the responses obtained from the questionnaire, despite being collected from the same source simultaneously, do not exhibit substantial bias that could unduly influence the study's findings, strengthening the credibility of the data and the subsequent interpretations. To assess the model's multicollinearity variance Inflation Factor (VIF) was used. The VIF statistics ranged from 1.21 to 1.89, thereby meeting the requirement of acceptable threshold of 3 (Neter et al., 1983). Thus, there no issues with multicollinearity were observed.

5.4 Normality Test

The description of the distribution of various constructs is tabulated, table12. The averages and standard deviations for the dependent variable, PWB, which are $M = 3.25$ and $SD = 0.87$, respectively. The mediators, WFC, display a mean of $M = 3.11$ and $SD = 0.96$, and WFE a mean of $M = 3.68$ and $SD = 0.64$. Detailed statistics for the independent variables in Table 12 include QD ($M = 2.83$, $SD = 1.05$), ED ($M = 3.19$, $SD = 0.99$), CD ($M = 3.37$, $SD = 0.96$), POS ($M = 3.57$, $SD = 0.84$), PCS ($M = 3.57$, $SD = 0.84$), and JA ($M = 2.92$, $SD = 0.77$). Additionally, all the variables have skewness and kurtosis values between the range of ± 2 signifying normality of sample data (George & Mallery, 2013).

Table 11: Description of variables of the normally distributed variables

Constructs	Mean	S.D.	Skewness	Kurtosis
QD	2.83	-1.05	0.66	-0.82
ED	3.19	-0.99	0.24	-0.83
CD	3.37	-0.96	0.16	-0.93
POS	3.61	0.78	-0.39	-0.12
PCS	3.57	-0.84	-0.15	-0.53
JA	2.92	-0.77	-0.08	-0.26
WFC	3.11	0.96	0.41	-1.12
WFE	3.68	-0.64	-0.41	0.48
PWB	3.25	-0.87	0.17	-0.75

Source: Own editing (2023)

To visualize the distribution of these variables and confirm their normality, KDE plots were created. As shown in Figure 21, the KDE plots of the variables closely resemble a normal distribution, supporting the assumption of normality for all variables used in the analysis.

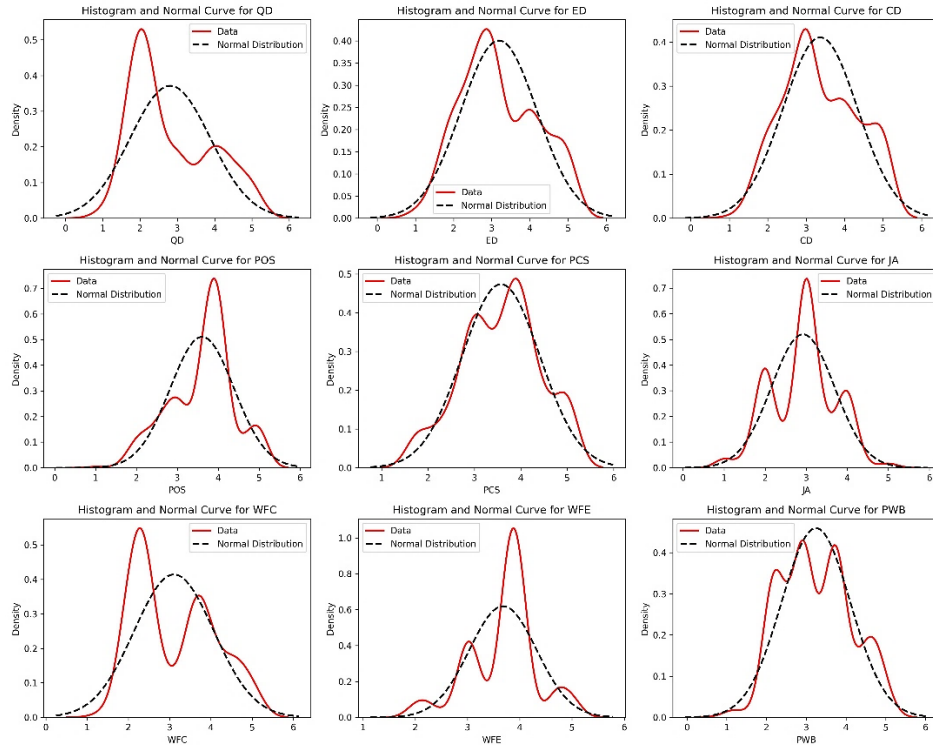


Figure 21: Distribution of the variables vs normal distribution

Source: Own editing (2023)

5.5 Reliability Analysis

Following the confirmatory factor analysis, the reliability of the variables was assessed applying Cronbach's alpha. Cronbach's alpha serves as a metric for the internal consistency of a set of items, evaluating how consistently these items measure the same underlying construct within the dataset. It indicates the homogeneity or reliability of the group of items under consideration.

Table 12: Values of Cronbach's alpha for the studied variables

Constructs	Cronbach's Alpha	Number of Items
<i>Quantitative Demands</i>	0.86	4
<i>Emotional Demands</i>	0.84	4
<i>Cognitive Demands</i>	0.86	4
<i>Perceived Organizational Support</i>	0.88	6
<i>Perceived Co-worker Support</i>	0.85	4
<i>Job Autonomy</i>	0.85	3
<i>Work Family Conflict</i>	0.89	10
<i>Work Family Enrichment</i>	0.93	18
<i>Psychological Wellbeing</i>	0.94	18

Source: Own editing (2023)

In Table 13 the alpha measure for each variable is provided alongside the number of items considered in the final analysis. Certain items were excluded during the CFA due to insufficient factor loadings. Specifically, four items from WFE, two items from WFC and three items from PWB were omitted for this reason.

Cronbach's alpha, a metric ranging from zero to one where values closer to one indicate higher reliability, was employed to assess the internal consistency of the variables. The study's findings reveal strong reliability across all scales, with alpha values ranging from 0.85 to the highest recorded value of 0.94. This internal consistency underlines the scales' reliability in capturing the intended constructs.

5.6 One-Way Multivariate Analysis of Variance (MANOVA)

To understand how different demographic groups scored concerning the studied variables of PWB, WFC, WFE, QD, ED, CD, POS, PCS, and JA, MANOVA was used. The Box's test assessed the equality of covariance and variance matrices. It's important to note that Box's test

is acknowledged for its high sensitivity. Due to this sensitivity, existing literature recommends a cautious approach by adopting a conservative significance level of 0.01 or lower, mainly when dealing with non-normally distributed data (Hair et al., 2010). The cautious adjustment helps mitigate the risk of drawing inaccurate conclusions in situations where the data deviates from a normal distribution.

The MANOVA findings, utilizing Pillai's trace and Wilk's Lambda (λ), indicate meaningful differences in specific variables concerning age, seniority, and education among nurses. Markedly, Levene's Test of Equality of Error Variances reveals significant variations in QD, CD, and WFC across distinct age groups. A parallel significance is observed in the case of nurses' education, with marked differences in QD, CD, WFC, and WFE. In the exact likeness, Seniority also shows significant differences in the case of QD, ED, CD, POS, WFC, and WFE. However, marital status displays no discernible significant differences across the studied variables.

Analysing the means of the significant associations, in the case of age groups, the age group of 40-49 shows the highest QD at 2.73, the age group 30-39 shows the highest score CD at 3.62, and the age group of 30-39 shows the highest WFC at a score of 3.60. In the case of education, postgraduates show the highest QD, CD, and WFC at 3.10, 3.54, and 3.37, whereas nurses who are pre-graduates show the highest WFE at 3.75.

In the case of Seniority, junior scale nurses show higher QD, ED, CD, and WFC, at 2.96, 3.33, 3.45, and 3.27, respectively. Meanwhile, senior scale nurses show higher POS and WFE at 3.71 and 3.82. Data shows a clear relationship between demographics and the studied variables.

5.7 T-tests for Socio-Cultural parameters

To investigate the disparities in workplace experiences among nurses in India, independent T-tests were conducted to compare the responses of nurses from different social castes and geographical locations. The information regarding the geographical and caste associations of the nurse was collected from the gazette of the health directorate with their permission. Appendix 10.6 presents the results of these independent t-tests.

Social Caste-Based Disparities in Workplace Experiences

Lower caste nurses reported significantly higher quantitative demands (mean: 2.91) compared to their upper caste counterparts (mean: 2.7), with a t-value of -2.023 and a p-value of 0.04. This indicates that lower caste nurses perceive a higher workload or feel more pressured to

complete tasks within a given time frame. The higher demands may stem from systemic issues such as discrimination, lack of resources, or higher expectations placed on lower caste individuals, leading to an increased burden in their professional roles. The cognitive demands were also significantly higher among lower caste nurses (mean: 3.47) compared to upper caste nurses (mean: 3.22), with a t-value of -2.607 and a p-value of 0.009. Cognitive demands refer to the mental effort required to perform tasks. The disparity suggests that lower caste nurses might face more complex or mentally taxing tasks, potentially due to inadequate training, lack of support, or biased task allocation that places a greater cognitive burden on them.

Lower caste nurses reported higher work-family conflict (mean: 3.22) compared to upper caste nurses (mean: 2.93), with a t-value of -3.035 and a p-value of 0.003. This suggests that lower caste nurses experience more significant challenges in balancing their work and family responsibilities. The higher WFC could be due to less flexibility in their jobs, lower social support, or greater familial obligations, which are exacerbated by societal expectations and economic constraints. Interestingly, upper caste nurses reported significantly higher perceived coworker support (mean: 3.71) and job autonomy (mean: 3.07) than lower caste nurses (PCS mean: 3.48; JA mean: 2.82), with t-values of 2.816 and 3.37, and p-values of 0.005 and 0.001, respectively. This suggests that upper caste nurses feel more supported by their colleagues and have greater control over how they perform their work. The higher PCS and JA among upper caste nurses could be linked to better social networks, less discrimination, and more empowerment within the workplace.

Upper caste nurses also reported higher work-family enrichment (mean: 3.78) and psychological well-being (mean: 3.55) compared to lower caste nurses (WFE mean: 3.61; PWB mean: 3.05), with t-values of 2.65 and 6.054, and p-values of 0.008 and 0.000, respectively. Work-family enrichment reflects the extent to which work, and family roles enhance each other. The disparity in WFE and PWB suggests that upper caste nurses are more likely to experience positive interactions between their work and family life, contributing to better overall well-being. This could be due to better access to resources, less stress from discrimination, and more supportive social environments.

The results highlight significant caste-based disparities in workplace experiences among nurses. Lower caste nurses face higher demands and conflicts while receiving less support and autonomy. This reflects broader social inequities that persist in India, where caste-based discrimination can influence various aspects of life, including work. The findings suggest that

lower caste nurses might be subjected to systemic disadvantages that affect their work-life balance, mental health, and job satisfaction. Addressing these disparities requires targeted interventions that promote equity in the workplace, such as anti-discrimination policies, increased support for lower caste nurses, and initiatives to improve their working conditions.

Geographical Disparities in Workplace Experiences

The T-test results reveal significant geographical differences in the demands faced by nurses. Urban nurses reported higher quantitative (mean: 3.34), emotional (mean: 3.39), and cognitive demands (mean: 3.78) compared to rural nurses (QD mean: 2.6; ED mean: 3.1; CD mean: 3.18), with t-values of -7.288, -2.858, and -6.262, and p-values of 0.000, 0.004, and 0.000, respectively. These findings suggest that urban nurses perceive their jobs as more demanding across various dimensions. The higher demands in urban settings could be attributed to factors such as higher patient volumes, more complex cases, greater expectations, and the fast-paced nature of urban healthcare environments.

Interestingly, rural nurses reported higher perceived organizational support (mean: 3.75) and coworker support (mean: 3.63) than urban nurses (POS mean: 3.32; PCS mean: 3.45), with t-values of 5.527 and 2.149, and p-values of 0.000 and 0.032, respectively. This suggests that rural nurses feel more supported by their organizations and colleagues. The higher POS and PCS in rural areas might be due to the close-knit nature of rural communities, where stronger interpersonal relationships and a sense of solidarity among healthcare workers are more common. Rural nurses also reported higher job autonomy (mean: 3.06) compared to urban nurses (mean: 2.63), with a t-value of 5.521 and a p-value of 0.000. This indicates that rural nurses have more control over their work, possibly due to less rigid hierarchical structures or the need to take on multiple roles in resource-constrained settings. The greater autonomy in rural areas might also be a result of the lower supervision and more flexible work practices common in such environments.

Urban nurses reported higher work-family conflict (mean: 3.62) than rural nurses (mean: 2.87), with a t-value of -8.034 and a p-value of 0.000. This suggests that urban nurses struggle more with balancing their work and family responsibilities, which could be due to the demanding nature of urban healthcare jobs, longer working hours, and the challenges of commuting in urban areas. The higher WFC in urban settings may also reflect the pressures of maintaining work-life balance in environments where work demands are more intense and family support systems may be less accessible. Rural nurses reported higher work-family enrichment (mean:

3.8) and psychological well-being (mean: 3.58) compared to urban nurses (WFE mean: 3.42; PWB mean: 2.54), with t-values of 5.84 and 14.073, and p-values of 0.000 and 0.000, respectively. These findings suggest that rural nurses experience more positive interactions between their work and family lives and have better overall well-being. The higher WFE and PWB in rural areas might be due to the less stressful work environment, stronger community ties, and a slower pace of life that allows for better integration of work and family roles.

5.8 Pearson's Correlation Analysis

The findings of Pearson correlation between constructs are summarized in Table 14. The correlational landscape shows moderate associations among variables. With regards to the correlations concerning independent and dependent variables, opposing tendencies are shown by JD and JR variable groupings. The constituents of JD viz., QD, ED, and CD show a moderate but negative correlation with PWB. The magnitude of the correlation between QD-PWB, ($r = -0.49$), is the highest, and at the lowest for ED ($r = -0.33$). One infers from these values that the increase in JD is concurrent with a decrease in the PWB of the nurses. In the case of constituents of JR, viz., POS, PCS, and JA, they show moderate to low but positive correlation with PWB. The correlation magnitude between POS-PWB is the highest ($r = 0.46$) and the lowest for PCS ($r = 0.24$). One infers from these values that the increase in JD is concurrent with an increase in the nurses' PWB.

Table 13: Values of Pearsons correlation between constructs

Constructs	QD	ED	CD	POS	PCS	JA	WFC	WFE	PWB
QD	-	.40**	.61**	-.45**	-.26**	-.23**	.49**	-.24**	-.49**
ED	.40**	-	.46**	-.32**	-.18**	-.17**	.35**	-.23**	-.33**
CD	.61**	.46**	-	-.37**	-.25**	-.21**	.45**	-.26**	-.43**
POS	-.45**	-.32**	-.37**	-	.47**	.31**	-.36**	.37**	.46**
PCS	-.26**	-.18**	-.25**	.47**	-	.25**	-.15**	.31**	.24**
JA	-.23**	-.17**	-.21**	.31**	.25**	-	-.30**	.32**	.34**
WFC	.49**	.35**	.45**	-.36**	-.15**	-.30**	-	-.36**	-.49**
WFE	-.24**	-.23**	-.26**	.37**	.31**	.32**	-.36**	-	.50**
PWB	-.49**	-.33**	-.43**	.46**	.24**	.34**	-.49**	.50**	-
√AVE	0.79	0.77	0.79	0.75	0.78	0.82	0.72	0.72	0.73

** Correlation is significant at the 0.01 level (2-tailed).

Source: Own editing (2023)

Similarly, the correlation between WFC (a variable depicting the negative effects of work) and constituents of JD is moderately positive, suggesting increased conflict is concurrent with increased Job demands. In the exact likeness, the correlation between WFE (a variable depicting positive effects of work) and constituents of JR is moderately positive. WFE and WFC show a negative correlation, suggesting that increased WFC is concurrent with decreased WFE. Similarly, along the same lines, WFC shows a negative correlation with PWB, and WFE shows a positive correlation with PWB. The $\sqrt{\text{AVE}}$ values are in case of every construct greater than their inter-correlations, ranging from 0.72 to 0.82, indicates discriminant validity. In essence, the results comprehensively understand the relationships and characteristics encapsulated within the variables under scrutiny.

5.9 Path Analysis: Direct Relationships

Direct relationship paths linking independent variables and mediator variables, independent variables and dependent variables, and mediator variables and dependent variables were sought. For which the structural model was formulated. The model fit criteria for the structural model are indicated in Table 15.

Table 14: Model fit criteria for structural model

<i>CMIN</i>	<i>df</i>	<i>CMIN/df</i>	<i>RMSEA</i>	<i>RMR</i>	<i>CFI</i>	<i>TLI</i>
2307.94	1800	1.28	0.03	0.06	0.97	0.96

Source: Own editing (2023)

The results for the structural model display satisfactory fit indices. The CMIN/df ratio of 1.28 suggests a reasonable fit, indicating that the specified model aligns reasonably well with the observed data. The RMSEA at 0.03 indicates a close fit, further supporting the adequacy of the model. Additionally, the CFI and TLI values of 0.97 and 0.96, respectively, strongly fit the model. Recollecting the hypotheses,

H1. A positive relationship exists between JD and WFC.

In effect,

H1.1 A positive relationship exists between QD and WFC.

H1.2 A positive relationship exists between ED and WFC.

H1.3 A positive relationship between CD and WFC.

Table 15: Relationship of various aspects of JD viz QD, ED, and CD to WFC

Hypotheses	Direct Relationship	β	p-value	Result
H1.1	QD→WFC	0.36	0.000	Accepted
H1.2	ED→WFC	0.14	0.007	Accepted
H1.3	CD→WFC	0.19	0.023	Accepted

Source: Own editing (2023)

H1.1 suggests that an increase in QD corresponds to a significant rise in WFC, supported by a $\beta = 0.36$ and a p-value of 0 ($p < 0.001$), leading to its acceptance. H1.2, connecting ED to WFC, is backed by $\beta = 0.14$ and a p-value of 0.007, indicating that higher ED contributes to increased WFC, hence accepted. H1.3, associating CD with WFC, is supported by $\beta = 0.19$ and a p-value of 0.023, confirming a significant positive link. In essence, the straightforward results affirm that each type of job demand—Quantitative, Emotional, and Cognitive—has a direct and statistically significant impact on elevating levels of Work-Family Conflict in the nurses of UT of JK.

H.2. A positive relationship exists between JR and WFE,

And consequently,

H.2.1 A positive relationship exists between POS and WFE.

H.2.2 A positive relationship exists between PCS and WFE.

H.2.3 A positive relationship exists between JA and WFE.

Table 16: Relationship of various aspects of JR viz POS, PCS, and JA to WFE

Hypotheses	Direct Relationship	β	p-value	Result
H2.1	POS→WFE	0.28	0.0000	Accepted
H2.2	PCS→WFE	0.13	0.039	Accepted
H2.3	JA→WFE	0.19	0.000	Accepted

Source: Own editing (2023)

H2.1 suggests that an increase in POS corresponds to a significant rise in WFE, supported by $\beta = 0.28$ and a p-value of 0 ($p < 0.001$), leading to its acceptance. H2.2, connecting PCS to WFE, is supported by $\beta = 0.13$ and a p-value of 0.039, indicating that higher PCS contributes to increased WFE, hence accepted. H2.3, associating JA with WFE, is supported by $\beta = 0.19$

and a p-value of 0 ($p < 0.001$), strengthening a significant positive link. In essence, the results affirm that each type of job resource—POS, PCS, and JA—has a direct and statistically significant impact on elevating levels of Work-Family enrichment in the nurses of UT of JK.

H.3. A negative relationship exists between JD and PWB.

Therefore,

H 3.1 A negative relationship exists between QD and PWB.

H 3.2 A negative relationship exists between CD and PWB.

H 3.3 A negative relationship between ED and PWB.

Table 17: Relationship of various aspects of JD viz QD, ED, and CD to PWB

Hypotheses	Direct Relationship	β	p-value	Result
H3.1	QD→PWB	-0.22	0.002	Accepted
H3.2	ED→PWB	-0.01	0.844	Rejected
H3.3	CD→PWB	-0.08	0.248	Rejected

Source: Own editing (2023)

H3.1 shows a negative link between QD and PWB, supported by a $\beta = -0.22$ and a p-value of 0.002, indicating that increased QD is associated with a significant decrease in psychological well-being. H3.2, exploring ED and PWB, is rejected due to an inconsequential $\beta = -0.01$ and a high p-value of 0.844, suggesting a lack of statistical significance. Similarly, H3.3, examining CD and PWB, is rejected as the modest inverse relationship, indicated by $\beta = -0.08$, lacks statistical significance with a p-value of 0.248. While heightened, QD negatively impacts PWB, ED, and CD do not exhibit a statistically significant direct influence in this context.

H.4. A positive relationship exists between JR and PWB

And consequently,

H.4.1 A positive relationship exists between POS and PWB.

H.4.2 A positive relationship exists between PCS and PWB.

H.4.3 A positive relationship exists between JA and PWB.

Table 18: Relationship of various aspects of JR viz POS, PCS, and JA to PWB.

Hypotheses	Direct Relationship	β	p-value	Result
H4.1	POS→PWB	0.16	0.013	Accepted
H4.2	PCS→PWB	-0.08	0.092	Rejected
H4.3	JA→PWB	0.11	0.023	Accepted

Source: Own editing (2023)

H4.1 establishes a positive link between POS and PWB, supported by $\beta = 0.16$ and a p-value of 0.013. This signifies that increased POS corresponds to a significant increase in PWB. Thus, the hypothesis was accepted. Conversely, H4.2, examining PCS and PWB, is rejected due to a modest $\beta = -0.08$ and a p-value of 0.092, suggesting a lack of statistical significance. Similarly, H4.3, exploring JA and PWB, is accepted as $\beta = 0.11$, and a p-value of 0.023 indicates a significant positive relationship. In essence, heightened POS and JA are validated as positively influencing PWB, while PCS lacks a statistically significant direct impact among nurses in UT of J&K.

H.5. A negative relationship exists between WFC and PWB

Table 19: Relationship of WFC to PWB.

Hypotheses	Direct Relationship	β	p-value	Result
H5	WFC→PWB	-0.16	0.002	Accepted

Source: Own editing (2023)

$\beta = -0.16$ and a low p-value of 0.002 indicate a statistically significant inverse relationship between WFC and PWB. This suggests that an increase in WFC corresponds to a significant decrease in PWB. Therefore, H5 is accepted, highlighting the impactful negative influence of heightened WFC on PWB in the studied context.

H6. A positive relationship exists between WFE and PWB.

Table 20: Relationship of WFE to PWB.

Hypotheses	Direct Relationship	β	p-value	Result
H6	WFE→PWB	0.31	0.000	Accepted

Source: Own editing (2023)

A sizeable positive $\beta = 0.31$ and a low p-value of 0 ($p < 0.001$) indicate a statistically significant and positive association between WFE and PWB. This implies that an increase in WFE corresponds to a significant improvement in PWB. Therefore, H6 is accepted, affirming the noteworthy positive impact of heightened WFE on PWB in the studied context. The direct relationships are well represented in Figure 21 which shows significant and non-significant relationships between various variables in the model.

To summarize, the QD, ED, and CD exhibit significant positive links with WFC, emphasizing the direct impact of increased demands on heightened conflict between work and family responsibilities. Conversely, POS, PCS, and JA demonstrate positive associations with WFE, underscoring the importance of organizational and social support and JA in enriching the work-family experiences of nurses. In contrast, when examining the direct impact on PWB, heightened QD is linked to a significant decrease in PWB. However, ED and CD do not exhibit statistically significant direct influences on PWB. POS and JA link positively with PWB, emphasizing their positive influence on psychological well-being. However, PCS lacks a statistically significant direct impact on PWB. Pearson's correlation largely agrees with the results presented in the path analysis, though correlation, unlike the path analysis, shows significance across all the relationships.

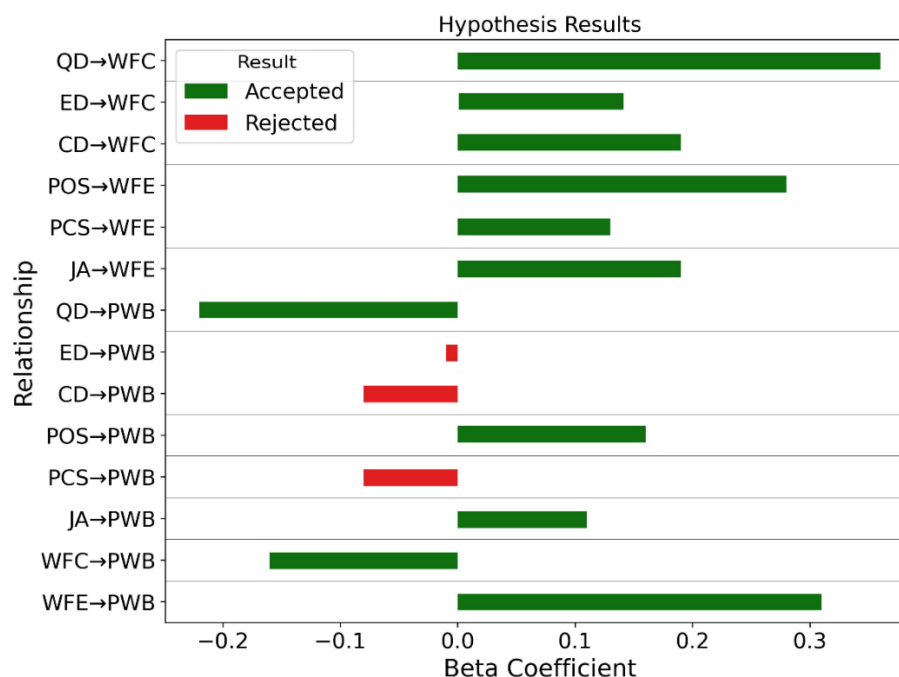


Figure 22: Beta coefficient values for each of the direct relationships between the variables.

Source: Own editing (2023)

5.10 Path Analysis: Indirect Relationships

Indirect relationship paths linking independent variables and mediator variables, independent variables and dependent variables, and mediator variables and dependent variables were sought whereby testing the following hypotheses:

H7. WFC mediates the relationship between JD and PWB,

And consequently:

H7.1. WFC mediates the relationship between QD and PWB.

H7.2. WFC mediates the relationship between ED and PWB.

H7.3. WFC mediates the relationship between CD and PWB.

Table 21: WFC mediating the relationship between Job demands and PWB.

Hypotheses	Indirect Relationship	β	LLCI	ULCI	p-value	Result
H7.1	QD→WFC→PWB	-0.06	-0.116	-0.021	0.001	Partial Mediation
H7.2	ED→WFC→PWB	-0.02	-0.057	-0.006	0.004	Full Mediation
H7.3	CD→WFC→PWB	-0.03	-0.076	-0.004	0.014	Full Mediation

Source: Own editing (2023)

The results of the indirect relationship analysis, examining the mediating role of WFC in the association between job demands (QD, ED, and CD) and PWB, reveal interesting insights into the complex interplay of these variables among nurses in the Union Territory of Jammu and Kashmir. The indirect effect through WFC is significant for the relationship between QD and PWB, with $\beta = -0.06$. The confidence interval (LLCI: -0.116, ULCI: -0.021) does not include zero, suggesting that the mediating effect is statistically different from zero. This means a partial mediation, implying that while a direct negative impact of QD on PWB exists, a portion of this effect is mediated by the presence of WFC. In the case of ED and CD, both exhibit full mediation through WFC in their relationships with PWB. The indirect effects are significant, with $\beta = -0.02$ for ED and $\beta = -0.03$ for CD. The confidence intervals (LLCI: -0.057, ULCI: -0.006) for ED and (LLCI: -0.076, ULCI: -0.004) for CD again do not include zero, indicating

that WFC mediates the entire relationship between ED and CD with PWB. This implies that the presence of WFC entirely explains the impact of ED and CD on PWB.

H.8 WFE mediates the relationship between JR and PWB,

and therefore:

H8.1. WFE mediates the relationship between POS and PWB.

H8.2. WFE mediates the relationship between PCS and PWB.

H8.3. WFE mediates the relationship between JA and PWB.

Table 22: WFE mediating the relationship between Job resources and PWB.

Hypothesis	Indirect Relationship	β	LLCI	ULCI	p-value	Result
H8.1	POS→WFE→PWB	0.09	0.048	0.145	0.000	Partial Mediation
H8.2	PCS→WFE→PWB	0.04	0.004	0.083	0.028	Full Mediation
H8.3	JA→WFE→PWB	0.06	0.029	0.103	0.000	Partial Mediation

Source: Own editing (2023)

The findings from the analysis of indirect relationships, exploring the mediating role of WFE in the relationship between job resources (POS, PCS, and JA) and PWB among nurses in the Union Territory of Jammu and Kashmir, provide valuable insights into the layered form of these associations. For the relationship between POS and PWB, the indirect effect through WFE is significant, with a β of 0.09. The confidence interval (LLCI: 0.048, ULCI: 0.145) does not include zero, signifying that the mediating effect is statistically different from zero. This suggests a partial mediation, implying that while POS has a direct positive impact on PWB, a portion of this effect is mediated by WFE. In contrast, PCS exhibits full mediation through WFE in its relationship with PWB, as indicated by a significant indirect impact with a β of 0.04. The confidence interval (LLCI: 0.004, ULCI: 0.083) excludes zero, emphasizing that WFE mediates the entire relationship between PCS and PWB. This implies that the presence of WFE entirely explains the positive impact of PCS on PWB.

Similarly, JA demonstrates partial mediation through WFE in its relationship with PWB, with a significant indirect effect and a $\beta = 0.06$. The confidence interval (LLCI: 0.029, ULCI: 0.103) does not include zero, indicating that WFE mediates part of the relationship between JA and PWB.

To summarize, in the case of job demands, QD exhibits partial mediation through WFC, with a significant indirect effect suggesting that while there is a direct negative impact on psychological well-being, a portion of the total effect is mediated by the presence of work-family conflict. ED and CD show full mediation through WFC, indicating that the entire impact of ED and CD on psychological well-being is explained by the mediating function of work-family conflict. On the other hand, job resources portray a different picture.

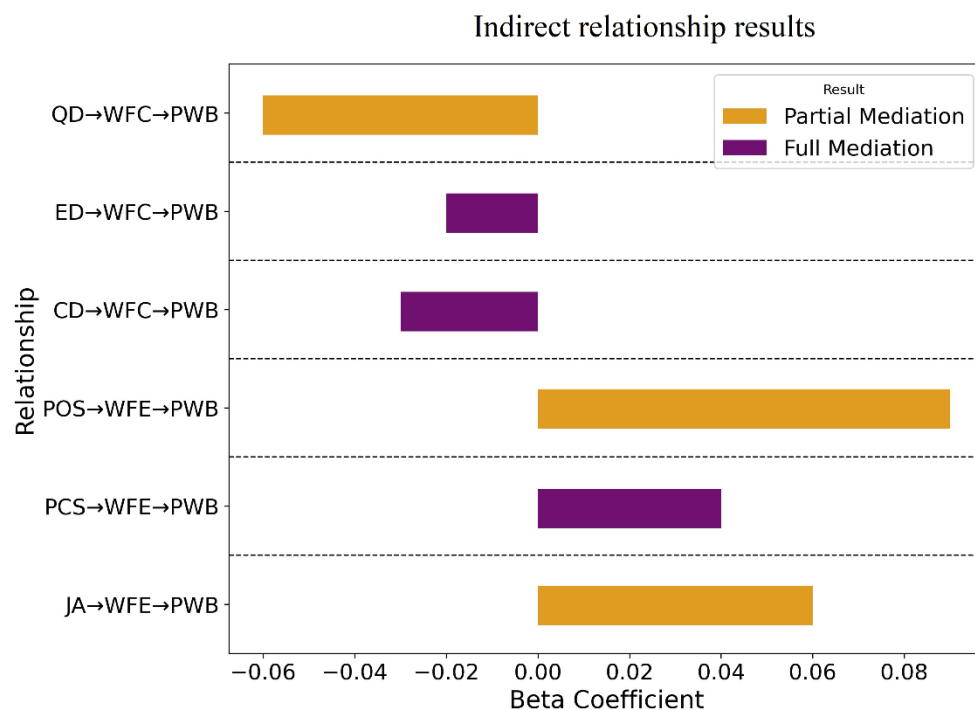


Figure 23: Beta coefficient values for each of the indirect relationships between the variables

Source: Own editing (2023)

POS has a partially mediated relationship with psychological well-being through WFE, indicating only a part of the positive impact of POS on psychological well-being is explained by the enriching aspects of the work-family interface. PCS exhibits full mediation through WFE, suggesting that the positive impact of PCS on PWB is entirely explained by the presence of WFE. JA shows partial mediation through WFE, emphasizing that the positive impact of JA on PWB is, to some extent, mediated by work-family enrichment.

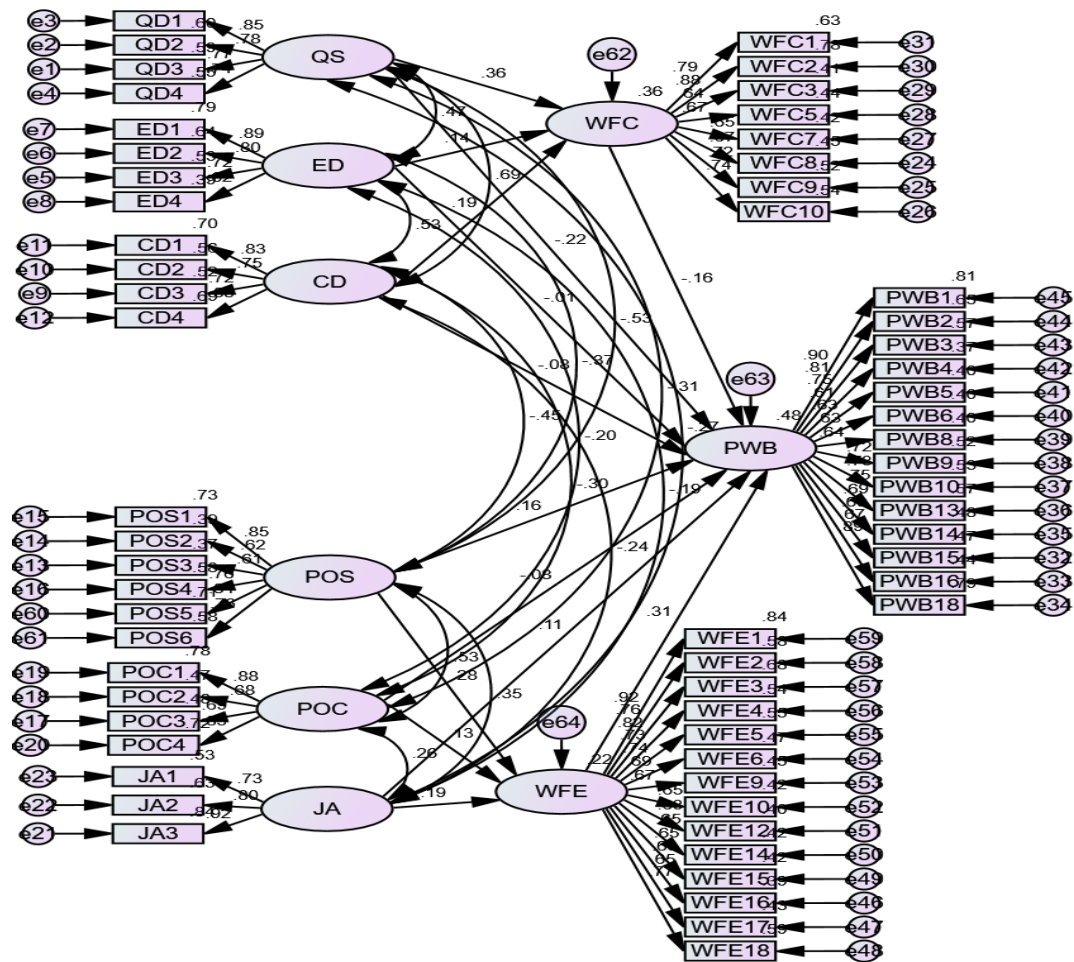


Figure 24: Path analysis as generated using AMOS 23

Source: Own editing (2023)

5.11 Qualitative Analysis of Nursing Experiences: Synthesizing literature

Although the methodology used in this research is fundamentally quantitative, it is pertinent that the results of this research are amplified and strengthened by qualitative research in the field to have a broader understanding of the issue at hand. This synthesis of qualitative data enriches our understanding of the factors influencing nurses' well-being and job satisfaction, highlighting both the disparities and commonalities across different settings and populations.

Six qualitative studies from India on nurses and their interviews were sampled to provide insights into the factors influencing the nursing profession in relation to this study's variables. The details of those studies are tabulated in Appendix 6. The first study examined the development of the nursing profession through twenty interviews with various stakeholders, including striking nurses, activists, and educators (Timmons et al., 2016). The second study

explored occupational satisfaction among sixteen public hospital nurses through in-depth interviews, highlighting their job experiences (Joseph et al., 2023). The third study focused on nurses' intentions to leave by conducting six focus groups with forty-four participants, categorized as 'stayers' and 'leavers,' to understand retention challenges in private hospitals (Dasgupta 2014). The fourth study investigated work-related health by interviewing nineteen registered nurses, identifying key facilitators and barriers (Thapa et al., 2022). The fifth study looked into the well-being of mental health professionals by conducting interviews with seventeen practitioners, complemented by mental health assessments (Aggarwal & Sriram 2018). Lastly, the sixth study analysed motivating and demotivating factors for community health workers through focus groups, comprising interviews with approximately thirty-two to forty participants (M. S. George et al., 2017). These studies collectively provide qualitative data that align with the quantitative findings of this research, emphasizing the interplay between job demands, resources, work-family dynamics, and psychological well-being among nurses in India.

Quantitative demands emerged as a significant stressor for nurses, as evidenced by statements from both the nurses and administrators. In Study 1 conducted by Timmons et al. (2016), a Senior Nursing Official highlighted the broad scope of duties nurses are expected to perform, many of which fall outside their official job descriptions. The official noted that nurses are often required to perform tasks such as selling items in maternity wards or handling non-nursing activities, which should ideally be done by support staff. This overburdening of nurses with tasks unrelated to their professional roles contributes significantly to job dissatisfaction and stress.

Nurses' experiences in Study 2 conducted by Joseph et al. (2023) further corroborate this. One nurse described the frustration of being forced into non-nursing activities due to a lack of manpower: "I experienced a lack of manpower, including attendants in my ward, and I often had to do non-nursing activities, which led to a waste of time and dissatisfaction." Another nurse expressed stress over increasing patient loads without corresponding increases in staff, exacerbating feelings of stress and dissatisfaction.

The high nurse-to-patient ratios were also a major concern in Study 3 conducted by Dasgupta (2014), where one participant noted the extreme workload in previous employment, with nurse-to-patient ratios exceeding 1:5. This overwhelming workload not only leads to stress but also

hampers the quality of patient care, highlighting the critical impact of quantitative demands on nurses' psychological well-being.

Job resources, particularly those related to organizational support, co-worker support, and job autonomy, play a vital role in moderating the negative effects of job demands. In Study 4, conducted by Thapa et al. (2022), a nurse emphasized the positive impact of co-worker support, noting how teamwork and cooperation in the ward made it easier to manage the complex workload. Another nurse expressed a sense of belonging, stating that the support from colleagues made her feel at home in the ward.

However, significant challenges were also reported. In Study 2, a nurse expressed dissatisfaction with the lack of teamwork and conflict between senior and junior staff, which negatively impacted patient care. The lack of perceived organizational support was another issue, as evidenced by a nurse in Study 3 who cited an unsupportive supervisor as the reason for leaving her previous job.

The interviews also shed light on the complex interplay between work and family life for nurses, highlighting both enrichment and conflict. In Study 6, conducted by M. S. George et al. (2017) one nurse shared how family support enhanced her ability to perform her job effectively, noting the crucial role of her husband and mother-in-law in balancing work and home responsibilities. This family support enriched her work experience, contributing to job satisfaction and psychological well-being.

However, not all nurses had such positive experiences. In Study 3, a nurse described the toll that work took on her family relationships, leading her to leave her previous job due to the strain it placed on her personal life. This example underscores the negative impact that work-family conflict can have on nurses, potentially leading to turnover and reduced job satisfaction.

The interviews provide insights into how job demands, job resources, and work-family dynamics collectively influence the psychological well-being of nurses. Some nurses reported a sense of fulfillment and resilience despite the challenges they face. For instance, in Study 5, conducted by Aggarwal & Sriram (2018) one nurse expressed satisfaction with both personal and professional duties, despite the emotional demands of the job. Yet, others revealed the emotional toll their work takes on them, particularly due to the constant exposure to patients' suffering.

Although the qualitative data provide valuable insights into how job demands, job resources, and work-family dynamics impact the psychological well-being of nurses, the synthesis of these findings with the quantitative results will be undertaken in the discussion section.

6 DISCUSSION

Work-family interaction has been the subject of many scholarly publications during the last few decades. The influence between the work and family spheres is commonly recognized. This relationship has been theoretically conceived along various conceptual pathways, including conflict, facilitation, enrichment, and spillover. However, this conceptual profusion is not readily reflected in the actual practice as most of the research has only considered the negative interaction between work and life. As pointed out above, various studies across India have indicated that nurses experience high job and life satisfaction and lower turnover. But concurrently, many studies also point to negative effects of employment like stress, burnout, and psychological strain, among others. To address this paradox, this study hypothesized that nurses could experience both enrichment and conflict simultaneously, which are linked to beneficial job resources and detrimental job demands, respectively. These, in turn, have their positive and negative effect on the psychological well-being of the nurses. The locale of this study, the UT of Jammu & Kashmir, where no prior research exists on the interaction of work and family, provides a unique opportunity to explore an unstudied sample and contribute novel insights.

The sample for this study was chosen from all the central institutions of healthcare in Jammu and Kashmir, but the sample shows the predominance of three hospitals viz., SKIMS, SMHS, and SGMS. These healthcare institutions are predominant in the sample owing to their significant size and influence in the region, as they are the primary employers of nurses in the UT. Notably, a considerable portion (57%) of the surveyed nurses were above 40, reflecting an aging demographic of nurses in public healthcare institutions. Several reasons may be cited for the aging population of nurses, including a lower number of recruits in recent years, limited opportunities for specialization, and the extended duration required for specialization, which further delays the entry of nurses into the healthcare sector.

The study utilized CFA to validate the structural relationships among variables, ensuring a well-fitting model with robust internal consistency and satisfactory convergent and discriminant validity. Refinement processes, including item removal and subsequent CFAs, confirmed the model's adequacy. Addressing common method bias, principal component analysis supported data credibility. Normality tests verified a normal distribution across constructs, and reliability analysis established strong internal consistency. These comprehensive assessments provide a

reliable foundation for subsequent analyses, emphasizing the measurement model's credibility and suitability for interpretation.

Before examining the results of this study, it is important to highlight prior research that has explored how demographic variables interact with the studied concepts in contexts similar to ours. This study acknowledges these prior findings as foundational and seeks to build upon them, further extending the understanding of the relationships between demographic variables and the key constructs under investigation. The significance of specific and distinct nature of experience Indian nurses has been examined by Pal & Øystein Saksvik (2006). The study examined cultural and national differences in work-family conflict between Norwegian and Indian nurses. It found that while Indian nurses experienced high job control, they faced limited flexibility in their working hours. A study conducted with dual-earner nurses in South Delhi, a highly urbanised setting in North India, highlighted that work-family conflict was notably high among dual-income households, particularly when considering demographic factors such as gender and dual-income status (Reghunathan, 2019)

Anagha & Kanchan's (2019) study on female nurses in Pune showed that gender and personal life responsibilities significantly impact work-life balance and psychological well-being, with personal issues often affecting work. Pande-Desai & Rajadhyaksha, (2017) highlighted that working mothers in India face heightened work-family conflict due to childcare responsibilities and societal expectations. These studies underscore the critical role of demographic variables—such as gender, household structure, and cultural background—in shaping work-family outcomes, laying a key foundation for this study's demographic considerations. The examination of demographic variables in these studies provides important context for understanding the current findings. These studies illuminate critical aspects such as age, education, and gender, which resonate with the dynamics explored in the current analysis. This study builds on those insights by further exploring how these demographic factors influence job demands, work-family conflict, and overall well-being among nurses.

To analyse the demographic aspects of the sample, a chi-square test was applied, checking whether there are significant variations in education across the age groups in nurses. The sample shows significant differences in the education levels of the nurses based on their ages. The results revealed a significant relationship, leading to the rejection of the null hypothesis, indicating that the distribution of education levels is not independent of age groups in the studied population of nurses. A cursory look at the distribution of post-graduation and

graduation rates among nurses shows that younger nurses are significantly better trained than their older counterparts.

Examining age groups and education levels among nurses, particularly with the majority being above 40, provides insights into the sample composition. It indicates a diversity in educational backgrounds within different age groups among the nurses of the Union Territory. The prevalence of nurses above 40 suggests potential variations in training needs and experiences, emphasizing the importance of considering demographic distribution when designing educational initiatives.

The results of MANOVA were utilized to gain further insight into how the studied sample may be described. Being in line with the hypothesized model, these results lay the groundwork for the subsequent investigation of hypotheses. The results of MANOVA show clear and significant differences in scores of studied variables (JD, JR, WFC, WFE, and PWB) concerning demographic variables of age, seniority, and educational qualification of the nurses.

Regarding nurses' ages, the MANOVA results indicate that mid-career nurses experience higher job demands and work-family conflict. This finding underscores a potential relationship between demands and conflict, a central hypothesis in this study, further explored through path analysis via SEM. Similarly, post-graduate nurses face increased job demands (QD and CD). In contrast, nurses without a college education (pre-graduates) perceive the relations between job and family as enriching. In line with the observations of post-graduate nurses, junior-scale nurses encounter not only significantly more demands, including higher quantitative demands (QD), emotional demands (ED), and cognitive demands (CD) but also higher work-family conflict (WFC). Conversely, senior-grade nurses experience elevated job resources, indicated by higher perceived organizational support (POS) and more significant work-family enrichment (WFE).

The MANOVA outcomes offer valuable inferences into the complex dynamics of nurses' experiences, particularly about age, educational background, and career stage. It appears that mid-career nurses grapple with heightened JD, possibly impacting their work-family equilibrium—a significant feature that is further explored through path analysis. Similarly, the positive interaction perceived by pre-graduate nurses between their job and family roles suggests an interesting dimension meriting further exploration. The experience-specific analysis reveals junior scale nurses facing pronounced JD and WFC, signalling a need for

targeted support. In contrast, senior-grade nurses benefit from enhanced job resources, underscoring the positive impact of organizational support during later career stages.

The results from the t-tests highlight significant disparities in workplace experiences among nurses in the Union Territory of Jammu and Kashmir, particularly when analysed along caste and geographical lines. Lower caste nurses reported higher quantitative and cognitive demands compared to their upper caste counterparts, reflecting systemic issues such as discrimination and biased task allocation that leads to an increased burden in their professional roles. Additionally, lower caste nurses experienced greater work-family conflict, less coworker support, and lower job autonomy, which collectively contribute to lower work-family enrichment and psychological well-being. In contrast, upper caste nurses reported more favourable conditions, including higher perceived support from colleagues, greater autonomy, and better overall well-being. These findings suggest that caste-based discrimination continues to influence workplace experiences, leading to unequal access to resources, support, and opportunities for job satisfaction and mental health.

Geographical disparities were also evident, with urban nurses facing significantly higher quantitative, emotional, and cognitive demands compared to their rural counterparts. Despite these increased demands, rural nurses reported higher levels of perceived organizational and coworker support, as well as greater job autonomy. These factors likely contribute to the higher work-family enrichment and psychological well-being observed among rural nurses, in contrast to the higher work-family conflict and lower well-being reported by urban nurses. Given the limited number of studies and instruments addressing these issues in the context of Jammu and Kashmir, these results underscore the potential heterogeneous nature of work perceptions along caste and geographical variables, pointing to the need for targeted interventions that address these disparities at a grassroots level.

Nursing often reflects the societal conflict between traditional patriarchal norms and modern notions of individual autonomy. While women's education and employment have challenged traditional gender roles, the lingering influence of patriarchy can still be seen in how nurses are perceived and treated. However, it's important to note that the status of nursing and nurses in India has evolved significantly over the past few decades. The focus has shifted from addressing societal stigma to promoting the profession's status and recognition. Efforts to define and measure status in concrete terms have played a crucial role in these advancements (S. Nair & Healey, 2006). A study indicates that while caste remains a significant factor in

understanding Indian occupations, there are signs that the traditional link between caste and occupation is weakening (Desai & Dubey, 2012).

Though these results are promising, more stringent tests are needed to conclude anything definitive about the nature of the work and life of nurses. Given this, Pearson's correlation and Path analysis through SEM are conducted serially to understand further various aspects of various (proposed) relationships of the sample variables.

The correlational analysis carried out using Pearson's correlation, generally lines up with anticipated patterns, indicating that increased JD corresponds to decreased PWB, while heightened JR relates to improved PWB. WFC correlates positively with JD and negatively with JR, while WFE shows the opposite pattern. This evidence, conveyed by correlation analysis, thus supports the anticipated causalities among the studied variables.

The hypothesized model designed to explore direct and indirect relationships among JD JR, WFC, WFE, and PWB, exhibits a satisfactory fit with the observed data. Key fit indices validate the model, indicating a reasonable and strong fit. This robust foundation allows for an in-depth examination of the complex interplay between these variables among nurses in the UT of J&K.

The direct relationships within the model are examined through specific hypotheses. QD, ED, and CD all show significant positive links with WFC, underscoring the direct impact of increased demands on heightened conflict between work and family responsibilities. On the other hand, POS, PCS, and JA demonstrate positive associations with WFE, emphasizing the significance of organizational and social support, as well as job autonomy, in enriching the work-family experiences of nurses. Figure 24 indicates the detailed model showing direct relationships.

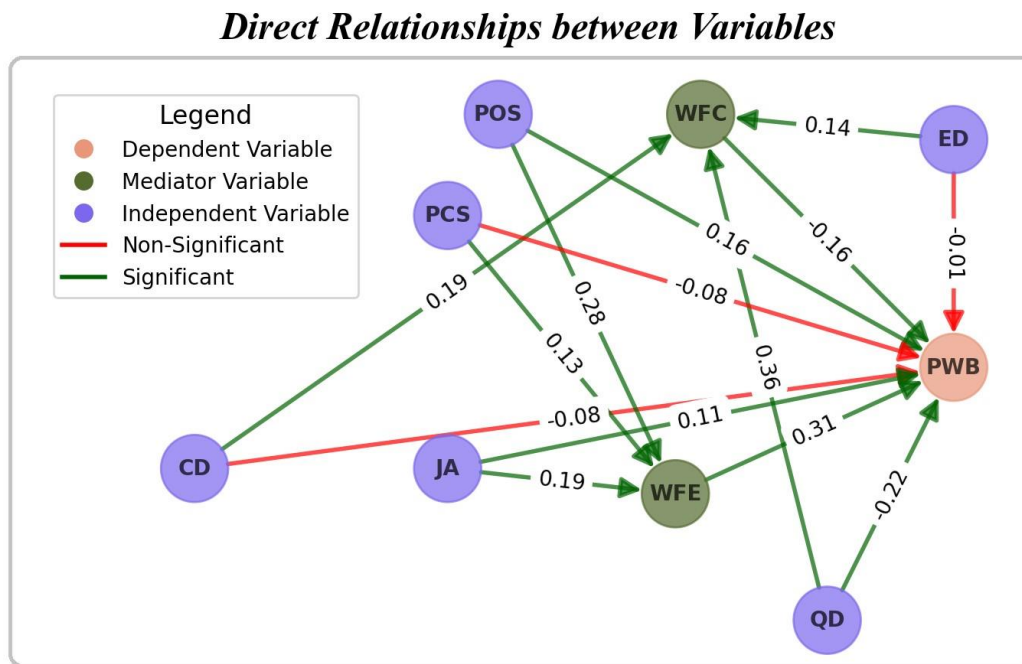


Figure 25: Strength of direct relationships of the variables studied and their significance

Source: Own editing (2023)

Before addressing the results pertaining to the hypotheses, it is pertinent to highlight the studies that have examined the nursing profession in relation to the variables this study seeks to investigate. The studies of Pal & Øystein Saksvik (2006) identified how high job demands contribute to work-family conflict among Indian nurses, while Philip & Cherian (2020), highlighted the psychological toll of stressful work environments on healthcare workers. These studies confirm the link between job demands and negative outcomes.

Work-family conflict (WFC) has been extensively studied in the Indian nursing context, with numerous researchers highlighting its significant impact on nurses' well-being. Reghunathan, (2019), for instance, found high levels of WFC among dual-earner nurses in South Delhi, while Raina et al. (2020) emphasized the role of organizational climate in mitigating this conflict. Many studies have also examined WFC as both an outcome and a mediator in workplace dynamics. For example, Sharma et al. (2006) demonstrated that stress mediates the relationship between WFC and psychological health.

Before proceeding with a detailed analysis of WFE, it is important to acknowledge the work of Rastogi et al. (2017), who validated the Carlsons Work-Family Enrichment Scale (WFES) for the Indian context. This is particularly relevant to the present research, as the validated scale is utilized to assess enrichment among North Indian nurses in this study.

The concept of work-family enrichment (WFE) remains relatively underexplored in Indian research, though a few pioneering studies stand out. Premchandran & Priyadarshi's (2020) research, an instance of such, found that WFE is positively associated with job satisfaction, while family-work enrichment significantly improves family satisfaction. Furthermore, Raina et al. (2020) challenged the Western notion that less boundary demarcation between work and family increases conflict. In the Indian context, they found that such fluid boundaries foster enrichment. The present study supports this cultural insight and fills a gap by showing that, in the Indian nursing profession, enrichment can mitigate the negative effects of conflict, thereby offering a more culturally nuanced understanding of the work-family interface. Job resources have been shown to positively affect outcomes like work engagement, as seen in the work of Rastogi & Saikia (2019), who emphasized the role of supervisor support and family-work enrichment in enhancing work engagement among nurses. Rashmi & Kataria, (2023) demonstrated the mediating role of work-life balance between job resources and job satisfaction. While these studies focus on engagement and satisfaction, the current study seeks to be exhaustive by showing how job resources contribute to psychological well-being through both work-family conflict and enrichment.

The first hypothesis theorized that increased JD and increased WFC are in agreement with each other. The obtained results corroborate the literature, highlighting a positive relationship between JD and WFC, specifically delving into the dimensions of QD, ED, and CD. The findings align with prior research by Demerouti et al. (2004), Tone Innstrand et al. (2008), and Lesener et al. (2019), which demonstrates a positive correlation between increased workload and heightened WFC. The causal link indicates that higher quantitative demands (QD) correspond to a significant rise in WFC, validating the perception that an elevated workload negatively impacts the work-family interface. Similarly, ED and CD exhibit statistically significant positive links with WFC, reinforcing the broader understanding that increased emotional and cognitive demands contribute to heightened work-family conflict among nurses. ED, particularly prominent in people-oriented professions like nursing, affirms the previous studies suggesting a positive relationship with work-family conflict. This supports the findings of Bakker & Heuven (2006) and Back et al. (2020), linking emotional demands to burnout and interpersonal conflicts at the workplace.

On the other hand, CD, an area less explored in previous research, also shows a significant positive relationship with WFC. This result aligns with the recent studies that have indicated positive relations between CD and employee well-being indicators (Meyer & Hünefeld, 2018;

Prem et al., 2017). While the results confirm and extend the existing knowledge base, a deeper understanding of cognitive demands in healthcare must be explored, particularly in the present context.

The second Hypothesis postulates that WFE and JR are in agreement with each other such that increased JR would lead to increased WFE in nurses. The obtained results provide empirical support for this premise. These findings support established literature, echoing the dual pathways model proposed by Powell & Greenhaus (2006), which posits that job and family resources contribute to WFE. The results, in line with the literature, affirm the positive association between POS and WFE. This supports the recent research by Lapierre et al. (2018), which emphasizes the role of POS and facilitation between jobs and work.

Similarly, the positive relationship between PCS and WFE is supported by a β coefficient of 0.13 and a p-value of 0.039. The published literature supports this in the context that emphasizes the importance of social support within the workplace, as outlined by Lapierre & Allen (2006), Mauno & Rantanen (2013), and Pisarski et al. (2008). The findings suggest that supportive colleagues and supervisors contribute to successful work performance and engagement, fostering a positive work-family interface in nurses. The relationship between JA and WFE is also confirmed, with a significant β coefficient of 0.19 and a p-value of 0. The association is consistent with the principles of Job Characteristics Theory by Hackman & Oldham, (1980) and self-determination theory (Ryan & Deci, 2000). The results indicate that autonomy in the workplace, allowing employees greater control over their tasks, enhances intrinsic motivation and vigour, contributing to the positive aspects of the work-family interface.

Within the Indian nursing landscape, psychological well-being (PWB) has been explored in various studies, particularly in relation to stress and work-life balance. Sharma et al. (2006) found that stress mediates the relationship between WFC and psychological health, while Anagha & Kanchan (2019) identified positive correlations between work-life balance and PWB among nurses. Building on these findings, this study examines both work-family conflict and enrichment as mediators of psychological well-being. This dual mediation model fills a gap in the literature by showing that while conflict has a negative impact on well-being, enrichment can simultaneously enhance it. Additionally, this contributes region-specific insights by focusing on North Indian nurses. While Philip & Cherian (2020) focused on external stressors during epidemic outbreaks, the present research shifts the focus to the

everyday dynamics of job demands and resources. This provides a more detailed understanding of how these factors shape psychological well-being on a day-to-day basis, offering new insights that go beyond crisis-driven research.

The third hypothesis theorizes a negative relationship between JD and PWB. Only the QD, among the three variables in the sample of nurses, has shown a significant relationship with PWB. The findings indicate that heightened QD is associated with a significant decrease in psychological well-being, as supported by a negative β coefficient of -0.22 and a low p-value of 0.002. Published literature that supports these results includes studies by Karasek Jr, (1979) and Scanlan & Still (2019), which highlight the negative impact of excessive job demands on psychological well-being. The COR theory further explains that coping with high demands depletes psychological and physiological resources, leading to increased stress and supporting the observed negative relationship. However, ED and CD did not exhibit statistically significant direct influences on PWB. The inconsequential β coefficients of -0.01 and -0.08 and very high p-values of 0.844 and 0.248, respectively, suggest a lack of statistical significance in these relationships. This result is in contrast to some studies that suggest the potential negative impact of ED and CD on PWB. The absence of statistical significance may highlight the complexity of these relationships and the need for further exploration in the nursing context. This is nonetheless contrasted by a study on nurses, where a positive impact of employment on the psychological well-being of women in dual-earner families is contingent upon the quality of both their work and home environments (Sinha, 2017).

The findings supporting a positive relationship between POS and PWB are also reflected in literature emphasizing the role of organizational support in mitigating stress and promoting well-being among healthcare professionals, particularly during challenging times such as a pandemic (Finset et al., 2020; Labrague & De los Santos, 2020). The case also highlights the importance of clear communication and support from organizational leaders in alleviating nurses' fears and anxiety symptoms (Duden et al., 2022). Additionally, the result supporting a positive relationship between JA and PWB resonates with the Job Demands-Resources (JDR) model, the Job Characteristics Model (Hackman & Oldham, 1976), and the Self-Determination Theory (SDT) (Ryan & Deci, 2000), highlighting the positive impact of JA on PWB. However, the lack of a statistically significant impact of PCS on PWB is contrary, given the literature suggesting the crucial role of supervisory support in reducing nurse stress and emotional

exhaustion (Johnson et al., 2021). Contrarily, a study on geriatric nurses found no evidence of the moderating effect of any of Job resources on the well-being of the nurses (Vermaak, 2016).

The significant negative relationship between WFC and PWB links with the published literature whence WFC has been linked to mental health problems, burnout, and diminished well-being among nurses (Boamah & Laschinger, 2016; Braunstein-Bercovitz et al., 2012). It is reinforced by the findings emphasizing the crossover effects of psychological stress and WFC on team members, potentially leading to adverse outcomes for the organization, such as increased turnover or sick leave. One may also highlight the broader consequences of WFC, including depression and substance abuse, underscoring the far-reaching impact on nurses' overall well-being (Kayaalp et al., 2021; Viertiö et al., 2021). The result supports the conceptualization of WFC as a significant predictor of burnout among nurses and adds valuable insights into the specific dimensions of burnout affected by work-family conflict (Camerino et al., 2010; Simha et al., 2014).

Path analysis has also pointed to a positive and significant relationship between WFE and PWB. The literature emphasizes the positive outcomes of enrichment processes, including high performance at work, positive psychological experiences at home, and positive attitudes toward the organization (Perry-Jenkins et al., 2000; Shockley & Singla, 2011). This hypothesis is further supported by the findings that highlight the impact of WFE on life satisfaction, overall health, and stress coping mechanisms among nurses (Carlson et al., 2014; Ghislieri et al., 2017). The discussion on meaningful work and the meaningfulness derived from family enrichment processes adds depth to the interpretation, aligning with the Job Characteristics Model and emphasizing the importance of perceiving work as valuable and worthwhile for overall well-being (Hackman & Oldham, 1976; Steger et al., 2012). Thus, reinforcing the notion that when work is perceived as enriching family life, it contributes to nurses' psychological well-being.

Turning to indirect relationships, the mediation analysis reveals complex patterns shown in Figure 25 below. QD exhibits partial mediation through WFC, emphasizing that while there is a direct negative impact on PWB, a portion of the total effect is mediated by the presence of WFC. ED and CD show full mediation through WFC, suggesting that the entire impact of ED and CD on psychological well-being is explained by the mediating role of work-family conflict. In contrast, job resources present a different picture, with POS showing partial mediation

through WFE, while PCS exhibits full mediation through WFE. JA demonstrates partial mediation through WFE, highlighting the complex interplay of JR in influencing PWB.

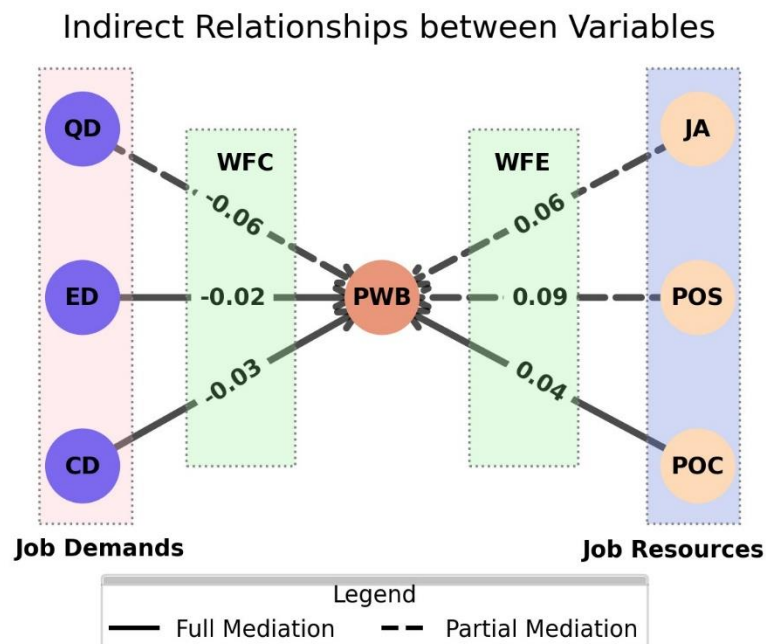


Figure 26: Indirect relationships between variables studied showing full and partial mediation

Source: Own editing (2023)

In a wide-ranging study on different Indian organizations, it was found that work-family conflict tends to occur within the same domains as work and family responsibilities, while work-family enrichment often involves benefits that extend beyond these domains (Jain & Nair, 2021). The evidence of partial mediation in the relationship between QD and PWB suggests a subtle dynamic. While the direct negative impact of QD on PWB is acknowledged, the mediation by WFC implies that the toll of balancing work and family responsibilities intensifies the adverse effects of QDs. This mirrors the findings of Meliala et al. (2020), who highlight that pronounced levels of WFC lead to reduced vigor and vitality. The struggle for balance, it seems, exacerbates the impact of demanding workloads on the psychological well-being of nurses. The indication of full mediation through WFC for the relationship between ED and PWB sheds light on the emotional toll of nursing professions. The need for emotional regulation at work, influenced by JDs, resonates with the literature on emotional labor (Brotheridge & Lee, 2002; Gosserand & Diefendorff, 2005). The finding implies that the emotional demands of the job, when coupled with the challenges of work-family conflict, entirely explain the impact on nurses' psychological well-being. Comparing the Experiences of

Public and Private Sector nurses a study found significant differences between public and private sector employees only in terms of burnout levels. Private sector employees reported higher levels of burnout compared to their public sector counterparts. However, there were no significant differences in overall conflict, family-work conflict, work-family conflict, or health outcomes between the two sectors (Ningthoujam et al., 2021).

Similar to EDs, the full mediation through WFC for the relationship between CD and PWB accentuates the stress associated with compounded demands. The need for emotional regulation in the face of cognitive job demands, as discussed by Hobfoll (1989) and De Jonge & Dormann (2003), stresses this relationship. Nurses, it appears, experience a depletion of resources that is intrinsically stressful, particularly when navigating the complexities of both CDs and WFC. However, in contrast, in case of other professions like police, it was found that inter-domain conflict between work and family did not significantly influence their psychological well-being of the employees (Karunanidhi et al., 2015)

The evidence of partial mediation through WFE for the relationship between POS and PWB emphasizes the multifaceted nature of organizational support. While POS directly contributes to PWB, the partial mediation suggests that the positive influence of organizational support is further augmented by the enrichment it brings to the work-family domain. This aligns with contemporary research highlighting the positive association between WFE and satisfaction in both work and family domains (Agrawal & Mahajan, 2021; Rani, Kaur, & Goel, 2022; Yildiz et al., 2021). The finding of full mediation through WFE for the relationship between PCS and PWB underscores the crucial role of interpersonal relationships. The enriching effects on the work-family interface explain the entirety of the relationship between co-worker support and well-being. This echoes the pioneer work of McNall, Nicklin, & Masuda (2010), emphasizing the mediating role of WFE in relationships between various job characteristics, supports, and job outcomes. For the relationship between JA and PWB, the evidence of partial mediation through WFE suggests a delicate balance. While JA directly contributes to PWB, the partial mediation indicates that a portion of this positive impact is attributed to the enriching aspects of autonomy in the work-family context. This aligns with the literature highlighting the importance of JA for employee well-being (Agrawal & Mahajan, 2021).

The integration of qualitative findings into the primarily quantitative study adds significant depth, particularly in illustrating how job demands (JD) and job resources (JR) affect nurses' psychological well-being (PWB). The qualitative data aligns well with the quantitative results,

reinforcing the impact of quantitative demands (QD) on job stress and dissatisfaction. Both the interviews and the statistical analysis highlight that nurses are overburdened with non-nursing tasks, leading to increased stress levels and reduced well-being. This consistent finding across both methodologies strengthens the argument that QD is a critical factor in understanding the challenges faced by nurses, particularly in regions like Jammu & Kashmir.

Moreover, the qualitative insights into the role of job resources support the quantitative findings regarding work-family enrichment (WFE). The interviews emphasize the positive effects of perceived organizational support (POS), co-worker support (PCS), and job autonomy (JA) on nurses' ability to balance work and family life, thus enhancing overall well-being. This alignment suggests that JR not only mitigates the negative effects of JD but also actively contributes to positive outcomes in the work-family interface. The qualitative narratives, such as those of nurses feeling supported by colleagues or receiving family support, provide a human context to the statistical links identified in the quantitative analysis, highlighting the importance of supportive work environments.

However, the qualitative findings reveal complexities that the quantitative analysis does not fully capture. Emotional demands (ED) and cognitive demands (CD), while not statistically significant in their direct impact on PWB in the quantitative study, emerge as important stressors in the qualitative data. Accounts of emotional exhaustion and the strain of constant patient care suggest that these factors may have indirect or long-term effects on well-being that the quantitative model does not address. Additionally, the qualitative data points to variability in team dynamics and organizational support, where negative experiences can undermine the generally positive influence of JR. These nuances suggest that while the quantitative study provides a broad understanding of the relationships between JD, JR, WFC, WFE, and PWB, the qualitative insights offer a more detailed and personalized view of how these factors play out in real-world settings (Banerjee et al., 2021; Skinner et al., 2014).

6.1 Recommendations for Future Research

Building upon the current findings, several recommendations are proposed for future research endeavours. Firstly, adopting a multiple-wave design with shorter time intervals would be beneficial, allowing for a more comprehensive exploration of the causal impact of work-family conflict on well-being. This approach could provide insights into the dynamic nature of work-family experiences over time and contribute to a deeper understanding of the causal stability

of these experiences. Such longitudinal studies could unveil patterns and fluctuations in work-family dynamics that might not be apparent in cross-sectional analyses.

Secondly, future research could enrich the investigation of coping strategies by incorporating both self-report measures and narrative approaches. Employing qualitative methods alongside quantitative assessments would enable researchers to delve deeper into the subjective experiences of individuals in stressful situations, capturing the nuanced meanings and coping mechanisms that may not be fully captured by standardized self-report measures alone.

Furthermore, future researchers are encouraged to measure the effects of various types of social support to gain a more holistic understanding of social support. Family support, friends and community support could be examined individually to paint a comprehensive picture of the social support networks that contribute to individuals' well-being in the face of work-family challenges.

Expanding the scope of research to include both directions of conflict and enrichment separately—both from work to family and from family to work—would offer a more comprehensive perspective. Investigating how these dynamics operate bidirectionally and independently would provide a nuanced understanding of the interplay between work and family roles, shedding light on the reciprocal influences that shape individuals' experiences.

Finally, considering the cultural context of the study, future research could explore the influence of religion and other cultural elements, such as family structures (nuclear vs. joint families) or rural-urban divisions. Examining these cultural factors in the context of work-family dynamics could reveal unique insights into how cultural elements shape individuals' experiences and coping strategies. Overall, these recommendations aim to enrich the understanding of work-family dynamics and contribute to developing targeted interventions to enhance the well-being of individuals, particularly in culturally specific contexts like the one studied in the UT of Jammu and Kashmir.

6.2 Conclusion

In conclusion, this study builds on and extends the body of research examining the relationship between job demands, job resources, work-family conflict, and work-family enrichment in Indian nursing. Previous studies have largely focused on the negative impact of work-family conflict on well-being, while job resources were linked primarily to job satisfaction and engagement. My research adds a new dimension by introducing a dual mediation model that

integrates both work-family conflict and enrichment as mediators. By applying a validated Work-Family Enrichment Scale in a regional context, this study supports the generalizability of past findings while offering new insights into how job resources can simultaneously alleviate conflict and foster well-being among North Indian nurses. In doing so, it bridges gaps in the literature, contributing a more nuanced understanding of the work-family interface within the Indian cultural framework.

This study investigates the complex relationships among job demands (JD), job resources (JR), work-family conflict (WFC), work-family enrichment (WFE), and psychological well-being (PWB) among nurses in the Union Territory of Jammu & Kashmir. Path analysis, a central analytical tool, scrutinized these connections, beginning with the first hypothesis, which posited a positive relationship between increased JD and heightened WFC. Confirming this, quantitative demands (QD), emotional demands (ED), and cognitive demands (CD) displayed significant positive links with WFC, aligning with existing literature on the adverse impact of elevated workloads and emotional or cognitive demands on the work-family interface. Notably, QD demonstrated a substantial direct negative impact on PWB, emphasizing the detrimental effects of excessive workload on nurses' mental health.

The second hypothesis proposed a positive relationship between WFE and JR, specifically perceived organizational support (POS), perceived co-worker support (PCS), and job autonomy (JA). Path analysis affirmed positive direct links between POS, PCS, JA, and WFE, aligning with the dual pathways model and underscoring the crucial roles of social support, organizational backing, and autonomy in fostering positive work-family experiences among nurses.

Exploring the third hypothesis, which hypothesized a negative relationship between JD and PWB, path analysis revealed that only QD exhibited a significant direct negative link with PWB. Emotional demands (ED) and cognitive demands (CD) did not show statistically significant direct influences on PWB, suggesting a more nuanced relationship influenced by additional factors. Moreover, mediation analysis uncovered intricate pathways, with QD exhibiting partial mediation through WFC and ED and CD showing full mediation through WFC. These results underscore the importance of considering not only direct relationships but also the mediating role of work-family conflict in understanding the impact of job demands on nurses' psychological well-being.

Revealing significant differences in scores based on age, seniority, and educational qualifications. Mid-career nurses faced heightened JD and WFC, while senior-grade nurses benefited from increased JR. Pearson's correlation analysis reinforced these patterns, further supporting the anticipated causalities among the studied variables. These integrated findings offer actionable insights for healthcare organizations, emphasizing the need for tailored interventions at different career stages and educational backgrounds to enhance the overall well-being of nurses in the unique context of the UT of Jammu and Kashmir.

The study at hand presents compelling evidence supporting the proposition that work-family conflict and enrichment represent distinct constructs, each with its unique outcomes. It is evident that these two dimensions can coexist, suggesting that examining them jointly within a model yields deeper insights compared to analyzing them in isolation, as advocated by (Mauno, Kinnunen, & Rantanen, 2011). However, it is worth noting that the application of moderating and mediating models to the Malaysian sample has revealed limitations. Specifically, there was scant support for the moderating influences of coping strategies and work-family facilitation, while the mediating role of work-family facilitation demonstrated only partial support in a cross-sectional context. Furthermore, the longitudinal data failed to confirm the hypotheses posited in this study regarding moderating and mediating effects. In summary, this study contributes empirical evidence shedding light on the interplay between work-family conflict, coping mechanisms, and work-family facilitation within the context of employment.

This study sheds light on the interplay between work-family conflict (WFC) and work-family enrichment (WFE) among nurses. The findings underscore the significance of considering these two constructs concurrently, as they are distinct entities with varying consequences for the well-being of healthcare professionals. The research acknowledges that WFC and WFE may co-occur, emphasizing the need to explore their combined impact in a comprehensive model. In the context of work-family conflict (WFC), the study unveils its mediating role between job demands (JD) and psychological well-being (PWB) among nurses in UT of JK. The empirical evidence suggests that heightened job demands may lead to an increase in work-family conflict, subsequently impacting the psychological well-being of nurses. This mediation pathway underscores the intricate relationship between the demands of the job and the resulting conflict between work and family responsibilities, revealing the potential negative consequences for the overall well-being of healthcare professionals in this region.

Conversely, the study also investigates the mediating role of work-family enrichment (WFE) between job resources (JR) and psychological well-being (PWB) among nurses in the UT of JK. The results illuminate a positive link between job resources and work-family enrichment, indicating that increased organizational support, co-worker assistance, and job autonomy enrich the work-family experiences of nurses in this region. Furthermore, the study reveals that this enrichment, in turn, has a positive impact on the psychological well-being of nurses, emphasizing the importance of fostering supportive work environments to enhance the overall well-being of healthcare professionals in UT of JK.

In summary, the research conducted in the UT of JK emphasizes the distinct roles of work-family conflict and work-family enrichment among nurses. Work-family conflict emerges as a mediator between job demands and psychological well-being, highlighting the potential negative consequences of heightened job demands on the work-family interface and, consequently, on the well-being of healthcare professionals. On the other hand, work-family enrichment serves as a mediator between job resources and psychological well-being, emphasizing the positive impact of organizational support, co-worker assistance, and job autonomy on the enrichment of work-family experiences and the overall well-being of nurses in the UT of JK.

6.3 Limitations of the Study

With its cross-sectional design and single-wave data collection, the current study has inherent limitations that should be acknowledged. The reliance on a one-time snapshot of data restricts the ability to establish causal relationships among variables. Furthermore, the exclusive focus on nurses limits the generalizability of the findings to other professional groups within the healthcare sector. It is important to note that the study did not include nurses working in private hospitals despite the significant rise in privately run healthcare institutions in recent years. This deliberate exclusion may impact the comprehensiveness of the study's insights, as the dynamics of work-family conflict and enrichment could vary between nurses in public and private healthcare settings. As healthcare provision evolves with an increasing number of private healthcare institutions, future research should consider including nurses from these settings to provide a more holistic understanding of work-family dynamics within the nursing profession.

Additionally, the single-wave data collection approach may not capture the dynamic nature of work-family interactions over time. While this design choice aligns with the scope of the current study, researchers should recognize the potential benefits of adopting a longitudinal

approach for future investigations. Longitudinal designs allow for exploring temporal relationships and a better understanding of how work demands, resources, and family-related factors interact and influence well-being over time.

6.4 Practical Implications

The significant association between age groups and education levels among nurses, particularly with the majority being above 40, highlights crucial implications for healthcare management. There is an urgent need for tailored educational programs to address diverse needs, strategic workforce planning to optimize resource allocation, and recruitment strategies aligning with the educational preferences of nurses. Policymakers should leverage these findings to formulate policies promoting continuous learning and address the shortage of adequately trained nurses in the public healthcare system. Closing knowledge gaps is essential for ensuring a uniformly skilled nursing workforce, and fostering inter-generational collaboration is vital for enhancing overall effectiveness. In essence, these implications underscore the necessity for a nuanced and age-sensitive approach to education, career development, and workforce management in the nursing profession, given the prevailing demographic trend of nurses being above the age of 40.

Findings from this study reveal significant disparities in work demands, support, and well-being among nurses based on caste and geographical location. These findings are corroborated by previous research, highlighting the systemic nature of these disparities within the healthcare sector. While recruitment policies, in public positions in the UT, prioritize lower castes and residents of backward areas, these policies may not fully translate into an equitable work environment. To address these disparities, healthcare organizations must implement robust monitoring and evaluation of recruitment policies, promote diversity and inclusion training, foster a supportive work environment, and advocate for policy changes that address systemic issues.

In response to the research findings in the UT of Jammu and Kashmir, healthcare organizations can implement targeted policies to enhance the well-being of nurses. Recognizing the need for flexibility, organizations should establish policies promoting flexible work arrangements and remote work options, particularly for mid-career nurses facing higher job demands. Stress management becomes a focal point with the introduction of training programs tailored to address coping strategies for emotional and cognitive demands, as identified in the study. Mentorship programs can be instituted to support junior-scale nurses navigating increased job

demands and work-family conflict. Strengthening organizational support mechanisms, such as Employee Assistance Programs and counselling services, aligns with the positive relationship between perceived organizational support and work-family enrichment. Senior-grade nurses, identified as benefiting from increased job resources, can be recognized and rewarded through policies promoting professional growth and autonomy. To ensure a comprehensive approach, healthcare organizations should conduct regular well-being assessments, transitioning from cross-sectional to longitudinal evaluations.

Moreover, the inclusion of nurses from private healthcare institutions in both research and policies acknowledges the evolving healthcare landscape. Lastly, integrating cultural sensitivity training into nursing education and organizational development initiatives can enhance support mechanisms by respecting and understanding the cultural context of Jammu and Kashmir. Collectively, these policies aim to create a positive work environment, address specific challenges identified in the study, and foster the overall well-being of nurses in the Union Territory.

7 NOVEL FINDINGS

This research aims to deepen insights into the intricate relationship between nurses' well-being and work-family dynamics in the UT of J&K. The study provides novel findings, uncovering the coexistence of conflict and enrichment, their divergent impacts on psychological well-being, and the nuanced experiences based on education and career stages among nurses. The empirical support for the proposed theoretical model enhances our understanding of these complex dynamics within the nursing profession. Some of the key findings of this work are:

1. The systematic literature review conducted as part of this research reveals novel insights into the existing body of knowledge regarding nurses' well-being and work-family dynamics, contributing significantly to the field. This comprehensive review identifies gaps in previous research and underscores the importance of further investigation into the unique challenges faced by nurses, particularly in the context of the Union Territory of Jammu and Kashmir.
2. The research model employed in this study introduces innovative approaches to measuring the mediating roles of contrasting factors, such as work-family enrichment and conflict, in the relationship between job demands, resources, and nurses' psychological well-being. Whereas previous studies have tended to be idealistic and unidimensional in conceiving the relationship between work and life, this study on the contrary, is more realistic in its understanding of this relationship and the first of its kind to deploy this model in the given context.
3. This study represents a seminal initiative, addressing a crucial gap in the current literature. Given a need for more comprehensive research concentrating on the well-being of nurses in the Union Territory of Jammu and Kashmir, the study's findings offer a foundational comprehension of the real-world situation of nursing employees in the region, encompassing various demographic aspects such as age, education, and other relevant factors, along with their experiences related to work and family balance.
4. The study emphasizes that the relationship between work and family for nurses in the UT is not solely characterized by conflict but also by enrichment. This indicates that nurses experience a complex interplay between their professional and family roles. The coexistence of conflict and enrichment suggests that while some aspects of their work may pose challenges,

some elements contribute positively to their family lives. This finding underscores the need for a comprehensive understanding of work-family dynamics, acknowledging both the stressors and the positive aspects that influence the overall well-being of nurses in this specific context.

The research highlights a crucial point of contrast between work-family conflict and work-family enrichment concerning their impact on the psychological well-being of nurses. While conflict is associated with detrimental effects on mental health, enrichment, on the other hand, has a positive influence. This contrast suggests that interventions and organizational policies aimed at reducing conflict and promoting enrichment could play a pivotal role in enhancing the psychological well-being of nurses in the Union Territory. Recognizing and addressing these opposing influences can guide targeted strategies for mental health support within the healthcare workforce.

5. The study brings to light the disparities in the experiences of work-family conflict and enrichment among different categories of nurses. Postgraduate and junior-scale nurses face higher demands and conflict, indicating potential stressors associated with advanced education levels and the early stages of one's career. In contrast, nurses with no college education and senior-grade nurses leverage job resources, leading to a more enriched work-family experience. This suggests that tailored interventions and support mechanisms must be designed based on educational levels and career stages.

6. The study highlights significant disparities in work demands and support among nurses based on caste and geographical location. Lower caste nurses encounter higher quantitative and cognitive demands, along with greater work-family conflict, reflecting systemic issues such as discrimination and unequal resource allocation. Conversely, upper caste nurses benefit from higher perceived support and autonomy, leading to better work-family enrichment and psychological well-being. Similarly, urban nurses face more intense work demands and higher work-family conflict compared to their rural counterparts, who experience greater support and job autonomy, resulting in better work-family enrichment and overall well-being. These findings underscore the need for targeted interventions to address these disparities and promote equitable working conditions across different caste and geographical contexts.

7. The study suggests that Cognitive Demands (CD) and Emotional Demands (ED) may not be explicitly experienced or reported by nurses in the given context. The absence of statistically significant direct effects on Psychological Well-being (PWB) implies that these demands might be implicit, surfacing only through their mediation by Work-Family Conflict (WFC). Given

that nurses do not overtly experience cognitive and emotional demands, it does not imply these demands do not exist. Instead, it suggests that nurses may not explicitly report or recognize these demands in their self-assessments or expressions. Cognitive and emotional demands are subtle, implicit, or ingrained aspects of the work environment that individuals may not consciously identify or articulate. These demands could manifest in various ways, such as the need for quick decision-making, managing emotional situations, or handling complex cognitive tasks. Nurses might navigate these demands as part of their routine without explicitly labelling them.

8 SUMMARY

This research investigates the complex relationship between work and family dynamics among North Indian Nurses, focusing on factors such as infrastructure, training, societal and cultural barriers, work environment, administrative concerns, accessibility, research and development, economic concerns, and professional growth. The study is structured into seven chapters, each contributing uniquely to this investigation.

The opening chapter of this study, contextualizing dynamics of nursing work, directs attention to the specific context of North Indian Nurses, probing the interaction between their work and family dynamics. Various factors such as infrastructure, training, societal and cultural barriers, work environment, administrative concerns, accessibility, research and development, economic factors, and professional growth are meticulously examined. The aim is to establish a foundation for understanding the complex challenges and opportunities encountered by nurses in this region. This chapter serves as a precursor, highlighting the significance of investigating work and family dynamics, particularly within the unique context of North Indian Nurses.

Turning the focus towards existing knowledge and theories, the second chapter develops a systematic review of the literature. A synthesis of a wide array of sources provides a comprehensive overview of key concepts such as work-life balance, relevant theories, work-family conflict, work-family enrichment, and the Job Demand Resources Model. Additionally, a brief overview of various other theoretical frameworks on work and life is presented. Through this review, the aim is to reveal the theoretical underpinnings that shape the experiences of North Indian Nurses as they navigate the balance between their professional responsibilities and personal lives.

Third chapter delineates the conceptual framework and hypotheses development process. Here, the focus is mapping out the theoretical constructs related to work-life balance, work-family conflict and enrichment, the Job Demand Resources Model, and psychological well-being. Through formulating hypotheses based on these theoretical underpinnings, the aim is to bridge the gap between theoretical frameworks and empirical investigations. The argument, supported

by existing literature, advocates for the hypotheses and underscores the necessity of exploring them further in the context of nurses of North India.

In the fourth chapter, the methodological aspects of the study are presented. A description of the research methodology is provided, including the study setting, time horizon, sample frame, population, sample size, data collection methods, instrumentation, and data analysis approaches. The detailing of the methodological approach aims to uphold the integrity of the study and provide a robust framework for empirical investigation. Through methodological consistency, the goal is to ensure the validity and reliability of the findings derived from the study.

Fifth chapter serves as the conclusion of the empirical investigation, presenting the findings derived from the study. Descriptive statistics, confirmatory factor analysis, common method bias analysis, normality tests, reliability analysis, multivariate analysis of variance, correlation analysis, and path analysis are employed to systematically present the results. By thoroughly presenting these findings, the aim is to offer valuable empirical insights into the dynamics of work and family dynamics among North Indian Nurses.

Following the presentation of results, a section on discussion, delves into a discussion and interpretation of findings. The implications of the results are explored, offering insights into their practical significance and theoretical contributions. Additionally, critical reflections on the limitations of the study are provided, along with recommendations for future research endeavours. The aim of this section is to enrich the academic dialogue surrounding work and family dynamics among North Indian Nurses, developing a deeper understanding of this complex phenomenon.

In this concluding chapter, a summary of the primary and innovative findings derived from the study is presented. Key insights are synthesized, and novel contributions are highlighted, providing a comprehensive overview of the implications of the research. Practical implications for stakeholders in the field are discussed, along with recommendations for future research directions. Through unravelling novelty, the aim is to advance scholarly discourse and contribute to the ongoing pursuit of knowledge in the realm of work and family dynamics among North Indian Nurses.

9 REFERENCES

1. Agrawal, M., & Mahajan, R. (2021). Work–family enrichment: An integrative review. *International Journal of Workplace Health Management*, 14(2), 217–241.
2. Aggarwal, P., & Sriram, S. (2018). Exploring well-being among mental health professionals in India. *Psychological Studies*, 63(4), 335–345
3. Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Jama*, 288(16), 1987–1993.
4. Allen, T. D., French, K. A., Dumani, S., & Shockley, K. M. (2020). A cross-national meta-analytic examination of predictors and outcomes associated with work–family conflict. *Journal of Applied Psychology*, 105(6), 539.
5. Allen, T. D., Johnson, R. C., Saboe, K. N., Cho, E., Dumani, S., & Evans, S. (2012). Dispositional variables and work–family conflict: A meta-analysis. *Journal of Vocational Behavior*, 80(1), 17–26.
6. Anagha, L. L., & Kanchan, D. P. (2019). A Study of Psychological Well-being and Work–life Balance of Female Nurses. *Indian Journal of Nursing Sciences*, 9-14.
7. Aycan, Z. (2008). Cross-cultural approaches to work-family conflict. In *Handbook of work-family integration* (pp. 353–370). Elsevier.
8. B Butler, A., G Grzywacz, J., L Bass, B., & D Linney, K. (2005). Extending the demands-control model: A daily diary study of job characteristics, work-family conflict and work-family facilitation. *Journal of Occupational and Organizational Psychology*, 78(2), 155–169.
9. Back, C.-Y., Hyun, D.-S., Jeung, D.-Y., & Chang, S.-J. (2020). Mediating effects of burnout

- in the association between emotional labor and turnover intention in Korean clinical nurses. *Safety and Health at Work*, 11(1), 88–96.
10. Bajpai, V. (2014). The challenges confronting public hospitals in India, their origins, and possible solutions. *Advances in Public Health*, 2014.
 11. Bakker, A. B., & Demerouti, E. (2007). The job demands-resources model: State of the art. *Journal of Managerial Psychology*, 22(3), 309–328.
 12. Bakker, A. B., & Demerouti, E. (2017). Job demands–resources theory: Taking stock and looking forward. *Journal of Occupational Health Psychology*, 22(3), 273.
 13. Bakker, A. B., Demerouti, E., & Sanz-Vergel, A. (2023). Job demands–resources theory: Ten years later. *Annual Review of Organizational Psychology and Organizational Behavior*, 10, 25–53.
 14. Bakker, A. B., & Heuven, E. (2006). Emotional dissonance, burnout, and in-role performance among nurses and police officers. *International Journal of Stress Management*, 13(4), 423.
 15. Balducci, C., Avanzi, L., & Fraccaroli, F. (2014). Emotional demands as a risk factor for mental distress among nurses. *La Medicina Del Lavoro*, 105(2), 100–108.
 16. Banerjee, D., Sathyanarayana Rao, T. S., Kallivayalil, R. A., & Javed, A. (2021). Psychosocial framework of resilience: navigating needs and adversities during the pandemic, a qualitative exploration in the Indian frontline physicians. *Frontiers in Psychology*, 12, 622132.
 17. Baral, R., & Bhargava, S. (2010). Work-family enrichment as a mediator between organizational interventions for work-life balance and job outcomes. *Journal of Managerial Psychology*, 25, 274–300. <https://doi.org/10.1108/02683941011023749>
 18. Bardhan, K. (1985). Women’s work, welfare and status: Forces of tradition and change in India. *Economic and Political Weekly*, 2207–2220.
 19. Bar-On, R. (1988). The development of a concept of psychological well-being.
 20. Baron, R. M., & Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology*, 51(6), 1173.
 21. Bauer, G. F., Hämmig, O., Schaufeli, W. B., & Taris, T. W. (2014). A critical review of the job demands-resources model: Implications for improving work and health. *Bridging Occupational, Organizational and Public Health: A Transdisciplinary Approach*, 43–68.
 22. Baumann, H. M. (2023). Work-Home Need Satisfaction Congruence, Work-Family Enrichment, and Well-Being. *Academy of Management Proceedings*, 2023(1), 14365.
 23. Bellmann, L., & Hübler, O. (2021). Working from home, job satisfaction and work–life balance—robust or heterogeneous links? *International Journal of Manpower*, 42(3), 424–441.
 24. Bhagwagar, H. (2022). Secondary trauma, burnout and resilience among mental health professionals from India: A review of research. *Asian Journal of Psychiatry*, 103227.
 25. Bhargava, S., & Baral, R. (2009). Antecedents and consequences of work-family enrichment among Indian managers. *Psychological Studies*, 54, 213–225. <https://doi.org/10.1007/s12646-009-0028-z>
 26. Bhat, A. A., Jan, Y., Jan, R., Mushtaq, B., & Yousuf, S. (2019). Adolescent Friendly Health Centres: A Review from North India. *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)* e-ISSN, 18, 44–48.
 27. Boamah, S. A., & Laschinger, H. (2016). The influence of areas of worklife fit and work-life interference on burnout and turnover intentions among new graduate nurses. *Journal of Nursing Management*, 24(2), E164–E174.
 28. Bolino, M. C., & Turnley, W. H. (2005). The personal costs of citizenship behavior: The relationship between individual initiative and role overload, job stress, and work-family conflict. *Journal of Applied Psychology*, 90(4), 740.
 29. Bourgault, P., Lavoie, S., Paul-Savoie, E., Grégoire, M., Michaud, C., Gosselin, E., & Johnston, C. C. (2015). Relationship between empathy and well-being among emergency nurses. *Journal of Emergency Nursing*, 41(4), 323–328.
 30. Bowling, N. A., Alarcon, G. M., Bragg, C. B., & Hartman, M. J. (2015). A meta-analytic examination of the potential correlates and consequences of workload. *Work & Stress*, 29(2), 95–113.

31. Braunstein-Bercovitz, H., Frish-Burstein, S., & Benjamin, B. A. (2012). The role of personal resources in work–family conflict: Implications for young mothers’ well-being. *Journal of Vocational Behavior*, 80(2), 317–325.
32. Broetje, S., Jenny, G. J., & Bauer, G. F. (2020). The key job demands and resources of nursing staff: An integrative review of reviews. *Frontiers in Psychology*, 11, 84.
33. Brotheridge, C. M., & Lee, R. T. (2002). Testing a conservation of resources model of the dynamics of emotional labor. *Journal of Occupational Health Psychology*, 7(1), 57.
34. Bryant, F. B., & Veroff, J. (1982). The structure of psychological well-being: A sociohistorical analysis. *Journal of Personality and Social Psychology*, 43(4), 653.
35. Caldas, M. P., Ostermeier, K., & Cooper, D. (2021). When helping hurts: COVID-19 critical incident involvement and resource depletion in health care workers. *Journal of Applied Psychology*, 106(1), 29.
36. Camerino, D., Sandri, M., Sartori, S., Conway, P. M., Campanini, P., & Costa, G. (2010). Shiftwork, work-family conflict among Italian nurses, and prevention efficacy. *Chronobiology International*, 27(5), 1105–1123.
37. Carlson, D. S., Ferguson, M., Kacmar, K. M., Grzywacz, J. G., & Whitten, D. (2011). Pay It Forward: The Positive Crossover Effects of Supervisor Work—Family Enrichment. *Journal of Management*, 37(3), 770–789. <https://doi.org/10.1177/0149206310363613>
38. Carlson, D. S., Grzywacz, J. G., & Zivnуска, S. (2009). Is work—Family balance more than conflict and enrichment? *Human Relations*, 62(10), 1459–1486. <https://doi.org/10.1177/0018726709336500>
39. Carlson, D. S., Hunter, E. M., Ferguson, M., & Whitten, D. (2014). Work–Family Enrichment and Satisfaction: Mediating Processes and Relative Impact of Originating and Receiving Domains. *Journal of Management*, 40(3), 845–865. <https://doi.org/10.1177/0149206311414429>
40. Carlson, D. S., Kacmar, K. M., Wayne, J. H., & Grzywacz, J. G. (2006). Measuring the positive side of the work–family interface: Development and validation of a work–family enrichment scale. *Journal of Vocational Behavior*, 68(1), 131–164. <https://doi.org/10.1016/j.jvb.2005.02.002>
41. Carlson, D. S., Kacmar, K. M., & Williams, L. J. (2000a). Construction and Initial Validation of a Multidimensional Measure of Work–Family Conflict. *Journal of Vocational Behavior*, 56(2), 249–276. <https://doi.org/10.1006/jvbe.1999.1713>
42. Carlson, D. S., Kacmar, K. M., & Williams, L. J. (2000b). Construction and Initial Validation of a Multidimensional Measure of Work–Family Conflict. *Journal of Vocational Behavior*, 56(2), 249–276. <https://doi.org/10.1006/jvbe.1999.1713>
43. Carlson, D. S., Thompson, M. J., Crawford, W. S., & Kacmar, K. M. (2019). Spillover and crossover of work resources: A test of the positive flow of resources through work–family enrichment. *Journal of Organizational Behavior*, 40(6), 709–722.
44. Chan, X. W., Kalliath, P., Chan, C., & Kalliath, T. (2020). How does family support facilitate job satisfaction? Investigating the chain mediating effects of work–family enrichment and job-related well-being. *Stress and Health*, 36(1), 97–104.
45. Charkhabi, M., Sartori, R., & Ceschi, A. (2016). Work-family conflict based on strain: The most hazardous type of conflict in Iranian hospitals nurses. *SA Journal of Industrial Psychology*, 42(1), 1–10.
46. Chen, Z., & Powell, G. N. (2012). No pain, no gain? A resource-based model of work-to-family enrichment and conflict. *Journal of Vocational Behavior*, 81(1), 89–98.
47. Cheng, H., Yang, H., Ding, Y., & Wang, B. (2020). Nurses’ mental health and patient safety: An extension of the Job Demands–Resources model. *Journal of Nursing Management*, 28(3), 653–663.
48. Clausen, T., Burr, H., & Borg, V. (2014). Do psychosocial work conditions predict risk of disability pensioning? An analysis of register-based outcomes using pooled data on 40,554 observations. *Scandinavian Journal of Public Health*, 42(4), 377–384.
49. Cooke, D. K., Brant, K. K., & Woods, J. M. (2019). The role of public service motivation in employee work engagement: A test of the job demands-resources model. *International Journal of Public Administration*, 42(9), 765–775.

50. Cortese, C. G., Colombo, L., & Ghislieri, C. (2010). Determinants of nurses' job satisfaction: The role of work–family conflict, job demand, emotional charge and social support. *Journal of Nursing Management*, 18(1), 35–43.
51. Csikszentmihalyi, M. (2000). The contribution of flow to positive psychology.
52. Daniels, K., & Guppy, A. (1994). Occupational stress, social support, job control, and psychological well-being. *Human Relations*, 47(12), 1523–1544.
53. Das, J., & Mohpal, A. (2016). Socioeconomic status and quality of care in rural India: New evidence from provider and household surveys. *Health Affairs*, 35(10), 1764–1773.
54. Dasgupta, P. (2014). Nurses' intention to leave: A qualitative study in private hospitals. *Globsyn Management Journal*, 8(1/2), 77.
55. Dash, S. K., Patel, S., & Chavali, K. (2016). Forensic nursing–Global scenario and Indian perspective. *Journal of Forensic and Legal Medicine*, 42, 88–91.
56. De Hert, S. (2020). Burnout in healthcare workers: Prevalence, impact and preventative strategies. *Local and Regional Anesthesia*, 171–183.
57. De Jonge, J., & Dormann, C. (2003). The DISC model: Demand-induced strain compensation mechanisms in job stress. In *Occupational stress in the service professions* (pp. 43–74). CRC Press.
58. de Jonge, J., Le Blanc, P. M., Peeters, M. C., & Noordam, H. (2008). Emotional job demands and the role of matching job resources: A cross-sectional survey study among health care workers. *International Journal of Nursing Studies*, 45(10), 1460–1469.
59. Desai, S., & Dubey, A. (2012). Caste in 21st century India: Competing narratives. *Economic and political weekly*, 46(11), 40.
60. Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands-resources model of burnout. *Journal of Applied Psychology*, 86(3), 499.
61. Demerouti, E., Geurts, S. A., Bakker, A. B., & Euwema, M. (2004). The impact of shiftwork on work–home conflict, job attitudes and health. *Ergonomics*, 47(9), 987–1002.
62. Denning, M., Goh, E. T., Tan, B., Kanneganti, A., Almonte, M., Scott, A., Martin, G., Clarke, J., Sounderajah, V., Markar, S., & others. (2021). Determinants of burnout and other aspects of psychological well-being in healthcare workers during the Covid-19 pandemic: A multinational cross-sectional study. *Plos One*, 16(4), e0238666.
63. Devi, T. U. (2020). A systematic review on predictors of work life balance of nurses working in Hospitals of India. *TNNMC Journal of Nursing Education and Administration*, 8(1), 51–55.
64. Duden, G. S., Gersdorf, S., & Stengler, K. (2022). Global impact of the COVID-19 pandemic on mental health services: A systematic review. *Journal of Psychiatric Research*.
65. Dutheil, F., Aubert, C., Pereira, B., Dambrun, M., Moustafa, F., Mermillod, M., Baker, J. S., Trousselard, M., Lesage, F.-X., & Navel, V. (2019). Suicide among physicians and health-care workers: A systematic review and meta-analysis. *PloS One*, 14(12), e0226361.
66. Eisenberger, R., Huntington, R., Hutchison, S., & Sowa, D. (1986). Perceived organizational support. *Journal of Applied Psychology*, 71(3), 500.
67. Ekici, D., Gurhan, N., Mert, T., & Hizli, I. (2020). Effects of work to family conflicts on services and individuals in healthcare professionals. *International Journal of Caring Sciences*, 13(2), 1355–1364.
68. Ekmekci, O. T., Xhako, D., & Camgoz, S. M. (2021). The buffering effect of perceived organizational support on the relationships among workload, work–family interference, and affective commitment: A study on nurses. *Journal of Nursing Research*, 29(2), e140.
69. Elfering, A., Grebner, S., Leitner, M., Hirschmüller, A., Kubosch, E. J., & Baur, H. (2017). Quantitative work demands, emotional demands, and cognitive stress symptoms in surgery nurses. *Psychology, Health & Medicine*, 22(5), 604–610.
70. Ernst Kossek, E., & Ozeki, C. (1998). Work–family conflict, policies, and the job–life satisfaction relationship: A review and directions for organizational behavior–human resources research. *Journal of Applied Psychology*, 83(2), 139.
71. Felstead, A., Jewson, N., Phizacklea, A., & Walters, S. (2002). Opportunities to work at home in the context of work-life balance. *Human Resource Management Journal*, 12(1), 54–76.
72. Fernandes, W. N., & Nirmala, R. (2017). Workplace stress and coping strategies among

- Indian nurses: Literature review.
73. Fernandez, A. V., & Zahavi, D. (2020). Basic empathy: Developing the concept of empathy from the ground up. *International Journal of Nursing Studies*, 110, 103695.
 74. Finset, A., Bosworth, H., Butow, P., Gulbrandsen, P., Hulsman, R. L., Pieterse, A. H., Street, R., Tschoetschel, R., & van Weert, J. (2020). Effective health communication—a key factor in fighting the COVID-19 pandemic. *Patient Education and Counseling*, 103(5), 873.
 75. Fornell, C., & Larcker, D. F. (1981). Evaluating structural equation models with unobservable variables and measurement error. *Journal of Marketing Research*, 18(1), Article 1.
 76. Frank, E., Zhao, Z., Fang, Y., Rotenstein, L. S., Sen, S., & Guille, C. (2021). Experiences of work-family conflict and mental health symptoms by gender among physician parents during the COVID-19 pandemic. *JAMA Network Open*, 4(11), e2134315–e2134315.
 77. Fredrickson, B. L. (1998). What good are positive emotions? *Review of General Psychology*, 2(3), 300–319.
 78. Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist*, 56(3), 218.
 79. Frone, M. R. (2003). Work-family balance. In J. C. Quick & L. E. Tetrick (Eds.), *Handbook of occupational health psychology*. (pp. 143–162). American Psychological Association. <https://doi.org/10.1037/10474-007>
 80. Frone, M. R., Russell, M., & Cooper, M. L. (1992). Prevalence of work-family conflict: Are work and family boundaries asymmetrically permeable? *Journal of Organizational Behavior*, 13(7), 723–729. <https://doi.org/10.1002/job.4030130708>
 81. Fung, N. S., Ahmad, A., & Omar, Z. (2015). Work-family enrichment: Its mediating role in the relationships between workplace support factors and teachers' job satisfaction. *American Journal of Applied Sciences*, 12(4), 242.
 82. G. Tummers, L., & Den Dulk, L. (2013). The effects of work alienation on organisational commitment, work effort and work-to-family enrichment. *Journal of Nursing Management*, 21(6), 850–859.
 83. Garner, S. L., Conroy, S. F., & Bader, S. G. (2015). Nurse migration from India: A literature review. *International Journal of Nursing Studies*, 52(12), 1879–1890.
 84. Gatrell, C. J., Burnett, S. B., Cooper, C. L., & Sparrow, P. (2013). Work-life balance and parenthood: A comparative review of definitions, equity and enrichment. *International Journal of Management Reviews*, 15(3), 300–316.
 85. George, D., & Mallery, P. (2013). *IBM SPSS Statistics 19 Step by Step a Simple Guide and Reference*.
 86. George, M. S., Pant, S., Devasenapathy, N., Ghosh-Jerath, S., & Zodpey, S. P. (2017). Motivating and demotivating factors for community health workers: a qualitative study in urban slums of Delhi, India. *WHO South-East Asia journal of public health*, 6(1), 82–89.
 87. George, J. M., & Zhou, J. (2007). Dual tuning in a supportive context: Joint contributions of positive mood, negative mood, and supervisory behaviors to employee creativity. *Academy of Management Journal*, 50(3), 605–622.
 88. Ghislieri, C., Gatti, P., Molino, M., & Cortese, C. G. (2017). Work-family conflict and enrichment in nurses: Between job demands, perceived organisational support and work-family backlash. *Journal of Nursing Management*, 25(1), 65–75.
 89. Ghorbani, M., Mohammadi, E., Aghabozorgi, R., & Ramezani, M. (2021). Spiritual care interventions in nursing: An integrative literature review. *Supportive Care in Cancer*, 29, 1165–1181.
 90. Gill, R. (2011). Nursing shortage in India with special reference to international migration of nurses. *Social Medicine*, 6(1), 52–59.
 91. Gill, R. (2018). Gender stereotypes: A history of nursing in India. *Social Action*, 68, 43–55.
 92. Gimenez Lozano, J. M., Martínez Ramón, J. P., & Morales Rodríguez, F. M. (2021). Doctors and nurses: A systematic review of the risk and protective factors in workplace violence and burnout. *International Journal of Environmental Research and Public Health*, 18(6), 3280.
 93. Gisler, S., Omansky, R., Alenick, P. R., Tumminia, A. M., Eatough, E. M., & Johnson, R. C. (2018). Work-life conflict and employee health: A review. *Journal of Applied Biobehavioral*

- Research, 23(4), e12157.
94. Goodare, P. (2017). Literature review: Why do we continue to lose our nurses? *Australian Journal of Advanced Nursing*, 34(4), 50–56.
 95. Gosserand, R. H., & Diefendorff, J. M. (2005). Emotional display rules and emotional labor: The moderating role of commitment. *Journal of Applied Psychology*, 90(6), 1256.
 96. Grandey, A. A., & Cropanzano, R. (1999). The Conservation of Resources Model Applied to Work–Family Conflict and Strain. *Journal of Vocational Behavior*, 54(2), 350–370. <https://doi.org/10.1006/jvbe.1998.1666>
 97. Greenglass, E. R., Burke, R. J., & Fiksenbaum, L. (2001). Workload and burnout in nurses. *Journal of Community & Applied Social Psychology*, 11(3), 211–215.
 98. Greenhaus, J. H., & Allen, T. D. (2011). Work–family balance: A review and extension of the literature.
 99. Greenhaus, J. H., & Beutell, N. J. (1985). Sources of Conflict between Work and Family Roles. *The Academy of Management Review*, 10(1), 76. <https://doi.org/10.2307/258214>
 100. Greenhaus, J. H., & Powell, G. N. (2006). When work and family are allies: A theory of work–family enrichment. *Academy of Management Review*, 31(1), Article 1.
 101. Gribben, L., & Semple, C. J. (2021). Factors contributing to burnout and work-life balance in adult oncology nursing: An integrative review. *European Journal of Oncology Nursing*, 50, 101887.
 102. Grzywacz, J. G., Almeida, D. M., & McDonald, D. A. (2002). Work–family spillover and daily reports of work and family stress in the adult labor force. *Family Relations*, 51(1), 28–36.
 103. Grzywacz, J. G., & Marks, N. F. (2000). Reconceptualizing the work–family interface: An ecological perspective on the correlates of positive and negative spillover between work and family. *Journal of Occupational Health Psychology*, 5(1), Article 1.
 104. Gupta, S., & Sahoo, S. (2020). Pandemic and mental health of the front-line healthcare workers: A review and implications in the Indian context amidst COVID-19. *General Psychiatry*, 33(5).
 105. Hackman, J. R., & Oldham, G. R. (1976). Motivation through the design of work: Test of a theory. *Organizational Behavior and Human Performance*, 16(2), 250–279.
 106. Hair, J. F., Black, B., Babin, B., & Anderson, R. E. (2010). *Multivariate Data Analysis* (7th ed.). Prentice-Hall.
 107. Hair, J. F., Black, B., Babin, B. J., & Anderson, R. E. (2006). *Multivariate Data Analysis*. PrenticeHall.
 108. Hair, J. F., Black, W. C., Babin, B. J., & Anderson, R. E. (2014). *Multivariate Data Analysis* (7th ed.). Pearson Education.
 109. Halbesleben, J. R. (2010). The role of exhaustion and workarounds in predicting occupational injuries: A cross-lagged panel study of health care professionals. *Journal of Occupational Health Psychology*, 15(1), 1.
 110. Hämmig, O. (2018). Explaining burnout and the intention to leave the profession among health professionals—a cross-sectional study in a hospital setting in Switzerland. *BMC Health Services Research*, 18(1), 1–11.
 111. Hanif, F., & Naqvi, S. (2014). Analysis of work family conflict in view of nurses, in health sector of Pakistan. *International Journal of Gender and Women's Studies*, 2(4), 103–116.
 112. Harrod, M., Petersen, L., Weston, L. E., Gregory, L., Mayer, J., Samore, M. H., Drews, F. A., & Krein, S. L. (2019). Understanding workflow and personal protective equipment challenges across different healthcare personnel roles. *Clinical Infectious Diseases*, 69(Supplement_3), S185–S191.
 113. Haun, V. C., Mülder, L. M., & Schmitz, A.-L. (2023). From job crafting to home crafting and back again: A shortitudinal study on the spillover between job and home crafting. *Journal of Occupational and Organizational Psychology*, 96(2), 332–350.
 114. Hayes, L. J., O'Brien-Pallas, L., Duffield, C., Shamian, J., Buchan, J., Hughes, F., Laschinger, H. K. S., North, N., & Stone, P. W. (2006). Nurse turnover: A literature review. *International Journal of Nursing Studies*, 43(2), 237–263.
 115. Haynes, C. E., Wall, T. D., Bolden, R. I., Stride, C., & Rick, J. E. (1999). Measures of

- perceived work characteristics for health services research: Test of a measurement model and normative data. *British Journal of Health Psychology*, 4(3), 257–275.
116. Healey, M. (2014). *Indian sisters: A history of nursing and the state, 1907–2007*. Routledge.
 117. Herman, J. B., & Gyllstrom, K. K. (1977). Working Men and Women: Inter-and Intra-Role Conflict*. *Psychology of Women Quarterly*, 1(4), 319–333.
 118. Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist*, 44(3), 513.
 119. Hobfoll, S. E. (1991). Traumatic stress: A theory based on rapid loss of resources. *Anxiety Research*, 4(3), 187–197.
 120. Hobfoll, S. E. (2001). The influence of culture, community, and the nested-self in the stress process: Advancing conservation of resources theory. *Applied Psychology*, 50(3), 337–421.
 121. Hu, L., & Bentler, P. (1999). Cutoff Criteria for Fit Indexes in Covariance Structure Analysis: Conventional Criteria Versus New Alternatives. *Structural Equation Modeling A Multidisciplinary Journal*, 6, 1–55. <https://doi.org/10.1080/10705519909540118>
 122. Huang, H., Liu, L., Yang, S., Cui, X., Zhang, J., & Wu, H. (2019). Effects of job conditions, occupational stress, and emotional intelligence on chronic fatigue among Chinese nurses: A cross-sectional study. *Psychology Research and Behavior Management*, 351–360.
 123. Hunter, E. M., Perry, S. J., Carlson, D. S., & Smith, S. A. (2010). Linking team resources to work–family enrichment and satisfaction. *Journal of Vocational Behavior*, 77(2), 304–312.
 124. Huynh, J. Y., Xanthopoulou, D., & Winefield, A. H. (2014). The job demands-resources model in emergency service volunteers: Examining the mediating roles of exhaustion, work engagement and organizational connectedness. *Work & Stress*, 28(3), 305–322.
 125. Hysong, S. J., Amspoker, A. B., Hughes, A. M., Woodard, L., Oswald, F. L., Petersen, L. A., & Lester, H. F. (2019). Impact of team configuration and team stability on primary care quality. *Implementation Science*, 14, 1–9.
 126. Ilies, R., Dimotakis, N., & De Pater, I. E. (2010). Psychological and physiological reactions to high workloads: Implications for well-being. *Personnel Psychology*, 63(2), 407–436.
 127. Jain, S. (2021). India's army of unrecognised, unpaid female health workers. *Bmj*, 375.
 128. Jain, S., & Nair, S. K. (2021). Integrating work–family conflict and enrichment: understanding the moderating role of demographic variables. *International Journal of Organizational Analysis*, 29(5), 1172–1198.
 129. Johnson, S., Dalton-Locke, C., Vera San Juan, N., Foye, U., Oram, S., Papamichail, A., Landau, S., Rowan Olive, R., Jeynes, T., Shah, P., & others. (2021). Impact on mental health care and on mental health service users of the COVID-19 pandemic: A mixed methods survey of UK mental health care staff. *Social Psychiatry and Psychiatric Epidemiology*, 56, 25–37.
 130. Joseph, H. B., Ravindran, V., & Sahoo, K. C. (2023). Occupational satisfaction of public hospital nurses in India: a qualitative explorative study. *Florence Nightingale Journal of Nursing*, 31(1), 42.
 131. Juntunen, S.-M. H. (2019). *Looking at Perceptions of Work/Life Balance with Technology in Young Adults [PhD Thesis]*. North Dakota State University.
 132. Kahn, R. L., Wolfe, D. M., Quinn, R. P., Snoek, J. D., & Rosenthal, R. A. (1964). *Organizational stress: Studies in role conflict and ambiguity*. John Wiley.
 133. Kahn, W. A. (1990). Psychological conditions of personal engagement and disengagement at work. *Academy of Management Journal*, 33(4), 692–724.
 134. Kalliath, P., Kalliath, T., Chan, X. W., & Chan, C. (2019). Linking work–family enrichment to job satisfaction through job well-being and family support: A moderated mediation analysis of social workers across India. *The British Journal of Social Work*, 49(1), 234–255.
 135. Karasek Jr, R. A. (1979). Job demands, job decision latitude, and mental strain: Implications for job redesign. *Administrative Science Quarterly*, 285–308.
 136. Karunanidhi, S., & Chitra, T. (2015). Job attitude in relation to perceived occupational stress, interrole-conflict and psychological well-being of women police. *Indian Journal of Positive Psychology*, 6(1), 19.
 137. Kayaalp, A., Page, K. J., & Rospenda, K. M. (2021). Caregiver burden, work-family conflict, family-work conflict, and mental health of caregivers: A mediational longitudinal study.

- Work & Stress, 35(3), 217–240.
138. Kengatharan, N., & Kunatilakam, S. (2020). Work-family conflict among female nurses in the healthcare sector. *International Journal of Work Organisation and Emotion*, 11(3), 213–230.
 139. Kesarwani, V., Husaain, Z. G., & George, J. (2020). Prevalence and factors associated with burnout among healthcare professionals in India: A systematic review and meta-analysis. *Indian Journal of Psychological Medicine*, 42(2), Article 2.
 140. Khan, O. F., & Fazili, A. I. (2016). Work life balance: A conceptual review. *Journal of Strategic Human Resource Management*, 5(2).
 141. Khan, S. A., Waqas, M., Siddiqui, M., Ujjan, B. U., Khan, M., Bari, M. E., & Azeem, M. A. (2020). Work-life balance amongst residents in surgical and non-surgical specialties in a tertiary care hospital in Karachi. *JPM J Pak Med Assoc*, 70, 252.
 142. Kim, S. Y., Shigemoto, Y., Neduvelil, A., & Grzywacz, J. G. (2021). Longitudinal stability of work–family enrichment and its association with well-being and personality traits. *The Counseling Psychologist*, 49(6), 907–939.
 143. Kinnunen, U., Rantanen, J., Mauno, S., & Peeters, M. C. (2014). Work-family interaction. An Introduction to Contemporary Work Psychology, 267–290.
 144. Kodoth, P., & Kuriakose Jacob, T. (2013). International Mobility of Nurses from Kerala (India) to the EU: Prospects and Challenges with special reference to the Netherlands and Denmark.
 145. Kopelman, R. E., Greenhaus, J. H., & Connolly, T. F. (1983). A model of work, family, and interrole conflict: A construct validation study. *Organizational Behavior and Human Performance*, 32(2), 198–215. [https://doi.org/10.1016/0030-5073\(83\)90147-2](https://doi.org/10.1016/0030-5073(83)90147-2)
 146. Kossek, E. E. (2016). Managing work-life boundaries in the digital age. *Organizational Dynamics*, 45(3), 258–270.
 147. Kossek, E. E., Baltes, B. B., & Matthews, R. A. (2011). Innovative ideas on how work–family research can have more impact. *Industrial and Organizational Psychology*, 4(3), 426–432.
 148. Kothari, T. P., & Pingle, S. (2020). Dual career couples: Development of concept matrix. *Prestige International Journal of Management and Research*, 30.
 149. Kreiner, G. E. (2006). Consequences of work-home segmentation or integration: A person–environment fit perspective. *Journal of Organizational Behavior*, 27(4), 485–507. <https://doi.org/10.1002/job.386>
 150. Kubicek, B., Korunka, C., & Tement, S. (2014). Too much job control? Two studies on curvilinear relations between job control and eldercare workers’ well-being. *International Journal of Nursing Studies*, 51(12), 1644–1653.
 151. L’Abate, L., & O’Callaghan, J. B. (1977). Implications of the enrichment model for research and training. *Family Coordinator*, 61–64.
 152. Labrague, L. J., & De los Santos, J. A. A. (2020). COVID-19 anxiety among front-line nurses: Predictive role of organisational support, personal resilience and social support. *Journal of Nursing Management*, 28(7), 1653–1661.
 153. Labrague, L. J., & Obeidat, A. A. (2022). Transformational leadership as a mediator between work–family conflict, nurse-reported patient safety outcomes, and job engagement. *Journal of Nursing Scholarship*, 54(4), 493–500.
 154. Lapierre, L. M., & Allen, T. D. (2006). Work-supportive family, family-supportive supervision, use of organizational benefits, and problem-focused coping: Implications for work-family conflict and employee well-being. *Journal of Occupational Health Psychology*, 11(2), 169.
 155. Lapierre, L. M., Li, Y., Kwan, H. K., Greenhaus, J. H., DiRenzo, M. S., & Shao, P. (2018). A meta-analysis of the antecedents of work–family enrichment. *Journal of Organizational Behavior*, 39(4), 385–401.
 156. Laschinger, H. K. S., Wong, C. A., & Grau, A. L. (2012). The influence of authentic leadership on newly graduated nurses’ experiences of workplace bullying, burnout and retention outcomes: A cross-sectional study. *International Journal of Nursing Studies*, 49(10), 1266–1276.

157. Leineweber, C., Chungkham, H. S., Westerlund, H., Tishelman, C., & Lindqvist, R. (2014). Hospital organizational factors influence work–family conflict in registered nurses: Multilevel modeling of a nation-wide cross-sectional survey in Sweden. *International Journal of Nursing Studies*, 51(5), 744–751.
158. Lesener, T., Gusy, B., & Wolter, C. (2019). The job demands-resources model: A meta-analytic review of longitudinal studies. *Work & Stress*, 33(1), 76–103.
159. Liu, J., Kwan, H. K., Lee, C., & Hui, C. (2013). Work-to-family spillover effects of workplace ostracism: The role of work-home segmentation preferences. *Human Resource Management*, 52(1), 75–93.
160. Liu, T., Wei, C., & Lee, Y. M. (2022). A systematic review of work–family enrichment in the hospitality industry. *International Journal of Contemporary Hospitality Management*, 34(8), 2884–2913.
161. Liu, T., Zeng, X., Chen, M., & Lan, T. (2019). The harder you work, the higher your satisfaction with life? The influence of police work engagement on life satisfaction: A moderated mediation model. *Frontiers in Psychology*, 10, 826.
162. Lovejoy, M., Kelly, E. L., Kubzansky, L. D., & Berkman, L. F. (2021). Work redesign for the 21st century: Promising strategies for enhancing worker well-being. *American Journal of Public Health*, 111(10), 1787–1795.
163. Lu, H., Zhao, Y., & While, A. (2019). Job satisfaction among hospital nurses: A literature review. *International Journal of Nursing Studies*, 94, 21–31.
164. Lu, J.-F., Siu, O.-L., Spector, P. E., & Shi, K. (2009). Antecedents and outcomes of a fourfold taxonomy of work-family balance in Chinese employed parents. *Journal of Occupational Health Psychology*, 14(2), 182.
165. Lu, L., Lu, A. C. C., Gursoy, D., & Neale, N. R. (2016). Work engagement, job satisfaction, and turnover intentions: A comparison between supervisors and line-level employees. *International Journal of Contemporary Hospitality Management*, 28(4), 737–761.
166. Magni, M., Ahuja, M. K., & Trombini, C. (2023). Excessive mobile use and family-work conflict: A resource drain theory approach to examine their effects on productivity and well-being. *Information Systems Research*, 34(1), 253–274.
167. Mahato, K., Srivastava, A., & Chandra, P. (2017). Paper based diagnostics for personalized health care: Emerging technologies and commercial aspects. *Biosensors and Bioelectronics*, 96, 246–259.
168. Malhotra, M. K., Singhal, C., Shang, G., & Ployhart, R. E. (2014). A critical evaluation of alternative methods and paradigms for conducting mediation analysis in operations management research. *Journal of Operations Management*, 32(4), 127–137.
169. Martinez-Corts, I., Demerouti, E., Bakker, A. B., & Boz, M. (2015). Spillover of interpersonal conflicts from work into nonwork: A daily diary study. *Journal of Occupational Health Psychology*, 20(3), 326.
170. Mathur, M. R., & Reddy, K. S. (2019). Child health policies in India: Moving from a discernible past to a promising future. In *The Indian Journal of Pediatrics* (Vol. 86, pp. 520–522). Springer.
171. Matthews, R. A., Barnes-Farrell, J. L., & Bulger, C. A. (2010). Advancing measurement of work and family domain boundary characteristics. *Journal of Vocational Behavior*, 77(3), 447–460.
172. Mauno, S., & Rantanen, M. (2013). Contextual and dispositional coping resources as predictors of work–family conflict and enrichment: Which of these resources or their combinations are the most beneficial? *Journal of Family and Economic Issues*, 34, 87–104.
173. Mauno, S., Ruokolainen, M., & Kinnunen, U. (2013). Does aging make employees more resilient to job stress? Age as a moderator in the job stressor–well-being relationship in three Finnish occupational samples. *Aging & Mental Health*, 17(4), 411–422.
174. Mauno, S., Ruokolainen, M., & Kinnunen, U. (2015). Work–family conflict and enrichment from the perspective of psychosocial resources: Comparing Finnish healthcare workers by working schedules. *Applied Ergonomics*, 48, 86–94.
175. McNall, L. A., Nicklin, J. M., & Masuda, A. D. (2010). A meta-analytic review of the consequences associated with work–family enrichment. *Journal of Business and Psychology*,

- 25(3), 381–396. <https://doi.org/10.1007/s10869-009-9141-1>
176. Meliala, Y. H., Eliyana, A., Buchdadi, A. D., Habibi, M. B., & others. (2020). The Effect of Work Family Conflict on Job Performance Through Emotional Exhaustion. *Systematic Reviews in Pharmacy*, 11(10), 459–465.
177. Mendonca, A., & D'Cruz, P. (2021). Workplace bullying, emotional abuse and harassment in the context of dirty work. *Special Topics and Particular Occupations, Professions and Sectors*, 551–586.
178. Meyer, S.-C., & Hünefeld, L. (2018). Challenging cognitive demands at work, related working conditions, and employee well-being. *International Journal of Environmental Research and Public Health*, 15(12), 2911.
179. Michel, J. S., Kotrba, L. M., Mitchelson, J. K., Clark, M. A., & Baltes, B. B. (2011a). Antecedents of work–family conflict: A meta-analytic review. *Journal of Organizational Behavior*, 32(5), 689–725.
180. Michel, J. S., Kotrba, L. M., Mitchelson, J. K., Clark, M. A., & Baltes, B. B. (2011b). Antecedents of work–family conflict: A meta-analytic review. *Journal of Organizational Behavior*, 32(5), 689–725. <https://doi.org/10.1002/job.695>
181. Mishra, P., Bhatnagar, J., Gupta, R., & Wadsworth, S. M. (2019). How work–family enrichment influence innovative work behavior: Role of psychological capital and supervisory support. *Journal of Management & Organization*, 25(1), 58–80.
182. Moen, P., Kaduk, A., Kossek, E. E., Hammer, L., Buxton, O. M., O'Donnell, E., Almeida, D., Fox, K., Tranby, E., Oakes, J. M., & others. (2015). Is work-family conflict a multilevel stressor linking job conditions to mental health? Evidence from the work, family and health network. In *Work and family in the New Economy* (Vol. 26, pp. 177–217). Emerald Group Publishing Limited.
183. Nadeem, M. S., & Abbas, Q. (2009). The impact of work life conflict on job satisfactions of employees in Pakistan. *International Journal of Business and Management*, 4(5), 63–83.
184. Nair, A., & Zadey, S. (2022). Ending violence against healthcare workers in India: A bill for a billion. *The Lancet Regional Health-Southeast Asia*, 6.
185. Nair, S. (2007). Rethinking citizenship, community and rights: The case of nurses from Kerala in Delhi. *Indian Journal of Gender Studies*, 14(1), 137–156.
186. Nair, S. (2020). *Moving with the times: Gender, status and migration of nurses in India*. Taylor & Francis.
187. Nair, S., & Healey, M. (2006). A profession on the margins: status issues in Indian nursing.
188. Nair, S., & Rajan, S. I. (2017). Nursing education in India: Changing facets and emerging trends. *Economic and Political Weekly*, 38–42.
189. Naithani, P. (2010). Overview of Work-Life Balance Discourse and Its Relevance in Current Economic Scenario. *Asian Social Science*, 6(6), p148. <https://doi.org/10.5539/ass.v6n6p148>
190. Netemeyer, R. G., Boles, J. S., & McMurrian, R. (1996). Development and validation of work-family conflict and family-work conflict scales. *Journal of Applied Psychology*, 81(4), 400–410. <https://doi.org/10.1037/0021-9010.81.4.400>
191. Neter, J., Wasserman, W., & Kutner, M. H. (1983). *Applied linear regression models*. Homewood, Illinois; Richard D. Irwin. Inc.
192. Ningthoujam, S., Singh, T., Gautam, V., Raina, A. D., & Zafar, M. (2021). Work-Life Conflict and Psychological Health Among Healthcare Sector Employees: A Comparative Study of Employees of Public and Private Hospitals. *IUP Journal of Organizational Behavior*, 20(4), 293-310.
193. Nobles, J., Martin, F., Dawson, S., Moran, P., & Savovic, J. (2020). The potential impact of COVID-19 on mental health outcomes and the implications for service solutions. Bristol: National Institute for Health Research, University of Bristol.
194. Nunnally, J., & Bernstein, I. (1994). *Psychometric Theory* (3rd ed.). MacGraw-Hill.
195. O'Driscoll, M., Brough, P., & Kalliath, T. (2013). Work—Family conflict and facilitation. In *Work-Life Balance* (pp. 117–142). Psychology Press.
196. O'Driscoll, M. P., Ilgen, D. R., & Hildreth, K. (1992). Time devoted to job and off-job activities, interrole conflict, and affective experiences. *Journal of Applied Psychology*, 77(3), 272.

197. O'driscoll, M. P., Pierce, J. L., & Coghlan, A.-M. (2006). The psychology of ownership: Work environment structure, organizational commitment, and citizenship behaviors. *Group & Organization Management*, 31(3), 388–416.
198. Okuhara, M., Sato, K., & Kodama, Y. (2021). The nurses' occupational stress components and outcomes, findings from an integrative review. *Nursing Open*, 8(5), 2153–2174.
199. Oren, L., & Levin, L. (2017). Work-family conflict/enrichment: The role of personal resources. *International Journal of Manpower*, 38(8), 1102–1113.
200. Pallant, J. (2020). *SPSS survival manual: A step by step guide to data analysis using IBM SPSS*. McGraw-hill education (UK).
201. Pal, S., & Øystein Saksvik, P. (2006). A comparative study of work and family conflict in Norwegian and Indian hospitals. *Nordic Psychology*, 58(4), 298-314.
202. Pande-Desai, T., & Rajadhyaksha, U. (2017). The Work-Family Interface in India. *The Work-Family Interface in Global Context*, 195-214.
203. Pandian, J. D., Kalkonde, Y., Sebastian, I. A., Felix, C., Urimubenshi, G., & Bosch, J. (2020). Stroke systems of care in low-income and middle-income countries: Challenges and opportunities. *The Lancet*, 396(10260), 1443–1451.
204. Parhizi, S., Steege, L. M., & Pasupathy, K. S. (2013). Mining the relationships between psychosocial factors and fatigue dimensions among registered nurses. *International Journal of Industrial Ergonomics*, 43(1), 82–90.
205. Patel, C., Beekhan, A., Paruk, Z., & Ramgoon, S. (2008). Work-family conflict, job satisfaction and spousal support: An exploratory study of nurses' experience. *Curationis*, 31(1), 38–44.
206. Pejtersen, J. H., Kristensen, T. S., Borg, V., & Bjorner, J. B. (2010). The second version of the Copenhagen Psychosocial Questionnaire. *Scandinavian Journal of Public Health*, 38(3_suppl), 8–24.
207. Pennbrant, S., & Dåderman, A. (2021). Job demands, work engagement and job turnover intentions among registered nurses: Explained by work-family private life inference. *Work*, 68(4), 1157–1169.
208. Perry-Jenkins, M., Repetti, R. L., & Crouter, A. C. (2000). Work and family in the 1990s. *Journal of Marriage and Family*, 62(4), 981–998.
209. Peter, R., & Sharma, S. K. (2022). National nursing and midwifery commission bill: Hopes and challenges. *Journal of Medical Evidence*, 3(1), 55–59.
210. Peters, V. P., De Rijk, A. E., & Boumans, N. P. (2009). Nurses' satisfaction with shiftwork and associations with work, home and health characteristics: A survey in the Netherlands. *Journal of Advanced Nursing*, 65(12), 2689–2700.
211. Philip, J., & Cherian, V. (2020). Factors affecting the psychological well-being of health care workers during an epidemic: A thematic review. *Indian Journal of Psychological Medicine*, 42(4), 323–333.
212. Pien, L.-C., Cheng, W.-J., Chou, K.-R., & Lin, L.-C. (2021). Effect of work–family conflict, psychological job demand, and job control on the health status of nurses. *International Journal of Environmental Research and Public Health*, 18(7), 3540.
213. Pisanti, R., van der Doef, M., Maes, S., Lazzari, D., & Bertini, M. (2011). Job characteristics, organizational conditions, and distress/well-being among Italian and Dutch nurses: A cross-national comparison. *International Journal of Nursing Studies*, 48(7), 829–837.
214. Pisarski, A., Lawrence, S. A., Bohle, P., & Brook, C. (2008). Organizational influences on the work life conflict and health of shiftworkers. *Applied Ergonomics*, 39(5), 580–588.
215. Podsakoff, P., MacKenzie, S., Lee, J.-Y., & Podsakoff, N. (2003). Common Method Biases in Behavioral Research: A Critical Review of the Literature and Recommended Remedies. *The Journal of Applied Psychology*, 88, 879–903. <https://doi.org/10.1037/0021-9010.88.5.879>
216. Powell, G., & Greenhaus, J. (2006). Is the opposite of positive negative?: Untangling the complex relationship between work-family enrichment and conflict. *Career Development International*, 11, 650–659. <https://doi.org/10.1108/13620430610713508>
217. Powell, G. N., & Greenhaus, J. H. (2010). Sex, Gender, and Decisions at the Family → Work Interface. *Journal of Management*, 36(4), 1011–1039. <https://doi.org/10.1177/0149206309350774>

218. Premchandran, R., & Priyadarshi, P. (2020). Work-family enrichment: evidence from India on source attribution. *International Journal of Manpower*, 41(8), 1269-1285.
219. Rafferty, A.-M., Ball, J., & Aiken, L. H. (2001). Are teamwork and professional autonomy compatible, and do they result in improved hospital care? *BMJ Quality & Safety*, 10(suppl 2), ii32–ii37.
220. Raina, M., Cho, E., & Singh, K. (2020). Toward contextual understanding: antecedents of work-family interface in India. *South Asian Journal of Business Studies*, 9(3), 339-356.
221. Rani, C., Kaur, R., & Goel, P. (2022). Work-Life Balance of Nurses and Its Antecedents: A Systematic. *Orissa Journal of Commerce*, 43(2).
222. Rashmi, K., & Kataria, A. (2023). The mediating role of work-life balance on the relationship between job resources and job satisfaction: perspectives from Indian nursing professionals. *International Journal of Organizational Analysis*, 31(5), 1316-1342.
223. Raso, R. (2019). Evaluations: Monotonous or meaningful? *Nurse Management*, 50(4), 6.
224. Rastogi, A., Syed, S., Bansal, A., Ramalingam, A., Sharma, T., Kumar, V., George, M., & Varshney, M. (2021). Knowledge, attitude, and practice toward prevention and management of COVID-19 among Indian nurses: A cross-sectional study. *Journal of Applied Sciences and Clinical Practice*, 2(1), 14–21.
225. Rastogi, M., Rangnekar, S., & Rastogi, R. (2017). Work–family enrichment in India: Validation of work–family enrichment scale. *Global Business Review*, 18(6), 1568-1579.
226. Rastogi, M., & Saikia, A. (2019). Determinants of work engagement among nurses in Northeast India. *Journal of Health Management*, 21(4), 559-570.
227. Reghunathan, N. (2019). Work-Family Conflict amongst Dual Earner Professional Nurses. *Nursing Journal of India*, 110(1), 29-33.
228. Rhoades, L., & Eisenberger, R. (2002). Perceived organizational support: A review of the literature. *Journal of Applied Psychology*, 87(4), 698.
229. Riedl, E. M., & Thomas, J. (2019). The moderating role of work pressure on the relationships between emotional demands and tension, exhaustion, and work engagement: An experience sampling study among nurses. *European Journal of Work and Organizational Psychology*, 28(3), 414–429.
230. Romate, J., & Rajkumar, E. (2022). Exploring the experiences, psychological well-being and needs of frontline healthcare workers of government hospitals in India: A qualitative study. *Humanities and Social Sciences Communications*, 9(1), 1–21.
231. Russo, M., & Buonocore, F. (2012). The relationship between work-family enrichment and nurse turnover. *Journal of Managerial Psychology*, 27(3), 216–236.
232. Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68.
233. Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, 69(4), 719.
234. Scanlan, J. N., & Still, M. (2019). Relationships between burnout, turnover intention, job satisfaction, job demands and job resources for mental health personnel in an Australian mental health service. *BMC Health Services Research*, 19(1), 1–11.
235. Schaufeli, W. B., & Bakker, A. B. (2004). Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study. *Journal of Organizational Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior*, 25(3), 293–315.
236. Schwarz, N., & Clore, G. L. (1983). Mood, misattribution, and judgments of well-being: Informative and directive functions of affective states. *Journal of Personality and Social Psychology*, 45(3), 513.
237. Schwarz, N., & Clore, G. L. (2003). Mood as information: 20 years later. *Psychological Inquiry*, 14(3–4), 296–303.
238. SECRETARIAT, L. S., & DELHI, N. (2021). LEGISLATIVE NOTE.
239. Sekaran, U., & Bougie, R. (2019). Research methods for business. John Wiley & Sons, Incorporated.
240. Shah, R. A. (2015). Work-life balance and gender: A study of professionals in India. *Review of Management*, 5(1/2), 5–18.

241. Shanafelt, T., Ripp, J., & Trockel, M. (2020). Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic. *Jama*, 323(21), 2133–2134.
242. Sharma, J., Dhar, R. L., & Tyagi, A. (2016). Stress as a mediator between work–family conflict and psychological health among the nursing staff: Moderating role of emotional intelligence. *Applied Nursing Research*, 30, 268–275.
243. Sharma, M. M., Sharma, M. D. K., Parashar, A., Sevak, M. S., Vyas, M. H., Kalal, M. N., & others. (2022). Telenursing a boon for healthcare in India: A scoping Review.
244. Sharma, S. (2022). *Nursing Research and Statistics-E-Book*. Elsevier Health Sciences.
245. Sharma, S. K., Thakur, K., & Peter, P. P. R. (2020). Status of nurses in India: Current situation analysis and strategies to improve. *Journal of Medical Evidence*, 1(2), 147–152.
246. Shockley, K. M., & Singla, N. (2011). Reconsidering work—Family interactions and satisfaction: A meta-analysis. *Journal of Management*, 37(3), 861–886.
247. Shore, L. M., & Tetrick, L. E. (1991). A construct validity study of the survey of perceived organizational support. *Journal of Applied Psychology*, 76(5), 637.
248. Shore, L. M., & Wayne, S. J. (1993). Commitment and employee behavior: Comparison of affective commitment and continuance commitment with perceived organizational support. *Journal of Applied Psychology*, 78(5), 774.
249. Simha, A., F. Elloy, D., & Huang, H.-C. (2014). The moderated relationship between job burnout and organizational cynicism. *Management Decision*, 52(3), 482–504.
250. Singh, R. G. (2013). Factors explaining job satisfaction among hospital employees. *OPUS: HR Journal*, 4(1), 30.
251. Sinha, S. (2017). Multiple roles of working women and psychological well-being. *Industrial psychiatry journal*, 26(2), 171-177.
252. Siu, O. L., Bakker, A. B., Brough, P., Lu, C., Wang, H., Kalliath, T., O’Driscoll, M., Lu, J., & Timms, C. (2015). A three-wave study of antecedents of work–family enrichment: The roles of social resources and affect. *Stress and Health*, 31(4), 306–314.
253. Skinner, N., Elton, J., Auer, J., & Pocock, B. (2014). Understanding and managing work–life interaction across the life course: a qualitative study. *Asia Pacific Journal of Human Resources*, 52(1), 93-109.
254. Søvdal, L. E., Naslund, J. A., Kousoulis, A. A., Saxena, S., Qoronfleh, M. W., Grobler, C., & Münter, L. (2021). Prioritizing the mental health and well-being of healthcare workers: An urgent global public health priority. *Frontiers in Public Health*, 9, 679397.
255. Sowmini, C., & De Vries, R. (2009). A cross cultural review of the ethical issues in dementia care in Kerala, India and The Netherlands. *International Journal of Geriatric Psychiatry: A Journal of the Psychiatry of Late Life and Allied Sciences*, 24(4), 329–334.
256. Spector, P. E., Zhou, Z. E., & Che, X. X. (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. *International Journal of Nursing Studies*, 51(1), 72–84.
257. Steger, M. F., Dik, B. J., & Duffy, R. D. (2012). Measuring meaningful work: The work and meaning inventory (WAMI). *Journal of Career Assessment*, 20(3), 322–337.
258. Stiglbauer, B., & Kovacs, C. (2018). The more, the better? Curvilinear effects of job autonomy on well-being from vitamin model and PE-fit theory perspectives. *Journal of Occupational Health Psychology*, 23(4), 520.
259. Sulosaari, V., Unal, E., & Cinar, F. I. (2022). The effectiveness of mindfulness-based interventions on the psychological well-being of nurses: A systematic review. *Applied Nursing Research*, 64, 151565.
260. Suresh, H. (2013). Perception to the Subjects Learnt in the Undergraduate Nursing Program among Students of a Selected College. *International Journal of Nursing Education*, 5(1), 71.
261. Tang, G., Kwan, H. K., Zhang, D., & Zhu, Z. (2016). Work–family effects of servant leadership: The roles of emotional exhaustion and personal learning. *Journal of Business Ethics*, 137, 285–297.
262. Tang, S., Siu, O., & Cheung, F. (2014). A study of work–family enrichment among Chinese employees: The mediating role between work support and job satisfaction. *Applied Psychology*, 63(1), 130–150.

263. Terry, D. J., Nielsen, M., & Perchard, L. (1993). Effects of work stress on psychological well-being and job satisfaction: The stress-buffering role of social support. *Australian Journal of Psychology*, 45(3), 168–175.
264. Thapa, D. R., Subedi, M., Ekström-Bergström, A., Areskoug Josefsson, K., & Krettek, A. (2022). Facilitators for and barriers to nurses' work-related health-a qualitative study. *BMC nursing*, 21(1), 218.
265. Theorell, T., & Karasek, R. A. (1996). Current issues relating to psychosocial job strain and cardiovascular disease research. *Journal of Occupational Health Psychology*, 1(1), 9.
266. Timmons, S., Evans, C., & Nair, S. (2016). The development of the nursing profession in a globalised context: A qualitative case study in Kerala, India. *Social Science & Medicine*, 166, 41–48.
267. Tone Innstrand, S., Melbye Langballe, E., Arild Espnes, G., Falkum, E., & GjerlØ w Aasland, O. (2008). Positive and negative work–family interaction and burnout: A longitudinal study of reciprocal relations. *Work & Stress*, 22(1), 1–15.
268. Trinkoff, A. M., Lipscomb, J. A., Geiger-Brown, J., Storr, C. L., & Brady, B. A. (2003). Perceived physical demands and reported musculoskeletal problems in registered nurses. *American Journal of Preventive Medicine*, 24(3), 270–275.
269. Tsaor, S.-H., & Tang, Y.-Y. (2012). Job stress and well-being of female employees in hospitality: The role of regulatory leisure coping styles. *International Journal of Hospitality Management*, 31(4), 1038–1044.
270. Tschan, F., Huguenin, M., Seelandt, J., Semmer, N. K., Keller, S., Nuoffer, J.-M., Candinas, D., & Beldi, G. (2014). Teamwork reduces physiological stress in junior surgeons. *British Journal of Surgery*, 101(S5), 8.
271. Tyler, P., & Cushway, D. (1992). Stress, coping and mental well-being in hospital nurses. *Stress Medicine*, 8(2), 91–98.
272. Van Bogaert, P., Clarke, S., Roelant, E., Meulemans, H., & Van de Heyning, P. (2010). Impacts of unit-level nurse practice environment and burnout on nurse-reported outcomes: A multilevel modelling approach. *Journal of Clinical Nursing*, 19(11–12), 1664–1674.
273. Van Bogaert, P., Kowalski, C., Weeks, S. M., Clarke, S. P., & others. (2013). The relationship between nurse practice environment, nurse work characteristics, burnout and job outcome and quality of nursing care: A cross-sectional survey. *International Journal of Nursing Studies*, 50(12), 1667–1677.
274. Van Bogaert, P., Timmermans, O., Weeks, S. M., van Heusden, D., Wouters, K., & Franck, E. (2014). Nursing unit teams matter: Impact of unit-level nurse practice environment, nurse work characteristics, and burnout on nurse reported job outcomes, and quality of care, and patient adverse events—A cross-sectional survey. *International Journal of Nursing Studies*, 51(8), 1123–1134.
275. van Daalen, G., Willemsen, T. M., Sanders, K., & van Veldhoven, M. J. (2009). Emotional exhaustion and mental health problems among employees doing “people work”: The impact of job demands, job resources and family-to-work conflict. *International Archives of Occupational and Environmental Health*, 82, 291–303.
276. Van der Doef, M., & Maes, S. (1999). The job demand-control (-support) model and psychological well-being: A review of 20 years of empirical research. *Work & Stress*, 13(2), 87–114.
277. Venkatraman, N. (1989). The concept of fit in strategy research: Toward verbal and statistical correspondence. *Academy of Management Review*, 14(3), 423–444.
278. Vermaak, C. (2016). The development and empirical evaluation of a psychological well-being at work structural model for geriatric care staff (Doctoral dissertation, Stellenbosch: Stellenbosch University).
279. Viertiö, S., Kiviruusu, O., Piirtola, M., Kaprio, J., Korhonen, T., Marttunen, M., & Suvisaari, J. (2021). Factors contributing to psychological distress in the working population, with a special reference to gender difference. *BMC Public Health*, 21, 1–17.
280. Vogt, K., Hakanen, J. J., Jenny, G. J., & Bauer, G. F. (2016). Sense of coherence and the motivational process of the job-demands–resources model. *Journal of Occupational Health Psychology*, 21(2), 194.

281. Voydanoff, P. (2004). The Effects of Work Demands and Resources on Work-to-Family Conflict and Facilitation. *Journal of Marriage and Family*, 66, 398–412.
<https://doi.org/10.1111/j.1741-3737.2004.00028.x>
282. Walton-Roberts, M. (2015). Femininity, mobility and family fears: Indian international student migration and transnational parental control. *Journal of Cultural Geography*, 32(1), 68–82.
283. Wayne, J. H., Grzywacz, J. G., Carlson, D. S., & Kacmar, K. M. (2007a). Work–family facilitation: A theoretical explanation and model of primary antecedents and consequences. *Human Resource Management Review*, 17(1), 63–76.
<https://doi.org/10.1016/j.hrmr.2007.01.002>
284. Wayne, J. H., Grzywacz, J. G., Carlson, D. S., & Kacmar, K. M. (2007b). Work–family facilitation: A theoretical explanation and model of primary antecedents and consequences. *Human Resource Management Review*, 17(1), 63–76.
<https://doi.org/10.1016/j.hrmr.2007.01.002>
285. Wei, H., King, A., Jiang, Y., Sewell, K. A., & Lake, D. M. (2020). The impact of nurse leadership styles on nurse burnout: A systematic literature review. *Nurse Leader*, 18(5), 439–450.
286. Westman, M., Etzion, D., & Danon, E. (2001). Job insecurity and crossover of burnout in married couples. *Journal of Organizational Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior*, 22(5), 467–481.
287. Williams, A., Franche, R.-L., Ibrahim, S., Mustard, C. A., & Layton, F. R. (2006). Examining the relationship between work-family spillover and sleep quality. *Journal of Occupational Health Psychology*, 11(1), 27.
288. Wrzesniewski, A., & Dutton, J. E. (2001). Crafting a job: Revisioning employees as active crafters of their work. *Academy of Management Review*, 26(2), 179–201.
289. Yildiz, B., Yildiz, H., & Ayaz Arda, O. (2021). Relationship between work–family conflict and turnover intention in nurses: A meta-analytic review. *Journal of Advanced Nursing*, 77(8), 3317–3330.
290. Zaresani, A., & Scott, A. (2020). Does digital health technology improve physicians’ job satisfaction and work–life balance? A cross-sectional national survey and regression analysis using an instrumental variable. *BMJ Open*, 10(12), e041690.
291. Zedeck, S., & Mosier, K. L. (1990). Work in the family and employing organization. *American Psychologist*, 45(2), 240.

10 APPENDICES

10.1 Appendix 1: Questionnaire

Your Age (in years)		
Your Marital Status		
a) Married	b) Single	
Your Seniority Level		
a) Junior Scale	b) Senior Scale	
Your Education Qualification		
a) Post Graduate	b) Graduate	c) Pre- Graduate

Job Demands						
Rate the statements on a five-point scale of 1-5 as given under:						
1= Never 2= Rarely, 3= Sometimes, 4= Often, 5= Always.						
Quantitative demands		1	2	3	4	5
1	Is your workload unevenly distributed so it piles up?					
2	How often do you not have time to complete all your work tasks?					
3	Do you get behind with your work?					
4	Do you have enough time for your work tasks?					
Emotional Demands		1	2	3	4	5
5	Does your work put you in emotionally disturbing situations?					
6	Do you have to relate to other people's personal problems as part of your work?					
7	Is your work emotionally demanding?					
8	Do you get emotionally involved in your work?					
Cognitive Demands		1	2	3	4	5
10	Does your work need your undivided attention?					
11	Do you have to keep track of more than one process at once?					
12	Do you have to concentrate all the time to watch for things going wrong?					
13	Do you have to react quickly to prevent problems arising?					

Job Resources						
Perceived Organizational Support						
Rate the statements on a five-point scale of 1-5 as: 1= Strongly Disagree, 2= Disagree, 3= Neither agree nor disagree, 4= Agree, 5=Strongly Agree						
14	The hospital values my contribution to its well-being					
15	The hospital strongly considers my goals and values					
16	The hospital really cares about my well-being.					
17	The hospital is willing to help me when I need a special favour.					
18	The hospital shows very little concern for me					
19	The hospital takes pride in my accomplishments at work					
Perceived Co-worker Support						

	Rate the statements on a five-point scale of 1-5 as: Response scale: 1 = not at all, 2 = just a little, 3 = moderate amount, 4 = quite a lot, 5 = a great deal.					
	To what extent can you	1	2	3	4	5
20	Count on your colleagues to listen to you when you need to talk about problems at work?					
21	Count on your colleagues to back you up at work?					
22	Count on your colleagues to help you with a difficult task at work?					
23	Really count on your colleagues to help you in a crisis situation at work, even though they would have to go out of their way to do so?					
	Job Autonomy					
	Rate the statements on a five-point scale of 1-5 as: 1= Strongly Disagree, 2= Disagree, 3= Neither agree nor disagree, 4= Agree, 5=Strongly Agree	1	2	3	4	5
24	I have the freedom to decide what I do on my job					
25	It is basically my own responsibility to decide how my job gets done					
26	I have a lot of say about what happens on my job					
	Work-Family Conflict					
	Rate the statements on a five-point scale of 1-5 as: 1= Strongly Disagree, 2= Disagree, 3= Neither agree nor disagree, 4= Agree, 5=Strongly Agree	1	2	3	4	5
27	The demands of my work interfere with my home and family life.					
28	The amount of time my job takes up makes it difficult to fulfil family responsibilities.					
29	Things I want to do at home do not get done because of the demands my job puts on me.					
30	My job produces strain that makes it difficult to fulfil family duties.					
31	Due to work-related duties, I have to make changes to my plans for family activities.					
32	The demands of my family or spouse/partner interfere with work-related activities.					
33	I have to put off doing things at work because of demands on my time at home.					
34	Things I want to do at work don't get done because of the demands of my family or spouse/partner.					
35	My home life interferes with my responsibilities at work such as getting to work on time, accomplishing daily tasks, and working overtime.					
36	Family-related strain interferes with my ability to perform job-related duties.					

	Work-Family Enrichment					
	Rate the statements on a five-point scale of 1-5 as: 1= Strongly Disagree, 2= Disagree, 3= Neither agree nor disagree, 4= Agree, 5=Strongly Agree	1	2	3	4	5
	My involvement in my work					
37	Helps me to understand different viewpoints and this helps me be a better family member					
38	Helps me to gain knowledge and this helps me be a better family member					
39	Helps me acquire skills and this helps me be a better family member					
40	Puts me in a good mood and this helps me be a better family member					
41	Makes me feel happy and this helps me be a better family member					

42	Makes me cheerful and this helps me be a better family member Work to family capital					
43	Helps me feel personally fulfilled and this helps me be a better family member					
44	Provides me with a sense of accomplishment and this helps me be a better family member					
45	Provides me with a sense of success and this helps me be a better family member					
	My involvement in my family					
46	Helps me to gain knowledge and this helps me be a better worker					
47	Helps me acquire skills and this helps me be a better worker					
48	Helps me expand my knowledge of new things and this helps me be a better worker Family to work affect					
49	Puts me in a good mood and this helps me be a better worker					
50	Makes me feel happy and this helps me be a better worker					
51	Makes me cheerful and this helps me be a better worker					
52	Requires me to avoid wasting time at work and this helps me be a better worker					
53	Encourages me to use my work time in a focused manner and this helps me be a better worker					
54	Causes me to be more focused at work and this helps me be a better worker					

	Psychological Well-being					
	Rate the statements on a five-point scale of 1-5 as: 1= Strongly Disagree, 2= Disagree, 3= Neither agree nor disagree, 4= Agree, 5=Strongly Agree	1	2	3	4	5
55	I like most parts of my personality.					
56	When I look at the story of my life, I am pleased with how things have turned out so far.					
57	Some people wander aimlessly through life, but I am not one of them.					
58	The demands of everyday life often get me down.					
59	In many ways I feel disappointed about my achievements in life.					
60	Maintaining close relationships has been difficult and frustrating for me.					
61	I live life one day at a time and don't really think about the future.					
62	In general, I feel I am in charge of the situation in which I live.					
63	I am good at managing the responsibilities of daily life.					
64	I sometimes feel as if I've done all there is to do in life.					
65	For me, life has been a continuous process of learning, changing, and growth.					
66	I think it is important to have new experiences that challenge how I think about myself and the world.					
67	People would describe me as a giving person, willing to share my time with others.					
68	I gave up trying to make big improvements or changes in my life a long time ago					
69	I tend to be influenced by people with strong opinions					
70	I have not experienced many warm and trusting relationships with others.					

71	I have confidence in my own opinions, even if they are different from the way most other people think.					
72	I judge myself by what I think is important, not by the values of what others think is important.					

10.2 Appendix 2: District wise list of health institutions in Jammu and Kashmir

<i>UT of Jammu & Kashmir</i>								
<i>Kashmir Division</i>								
<i>Name of District</i>	<i>DHs</i>	<i>CHCs</i>	<i>PHCs</i>	<i>NTPHC</i>	<i>MAC</i>	<i>SC</i>	<i>New SCs</i>	<i>Total</i>
<i>Anantnag</i>	1	5	26	14	9	114	36	205
<i>Bandipora</i>	1	3	8	5	3	42	36	98
<i>Baramulla</i>	1	6	33	21	12	125	82	280
<i>Budgam</i>	1	9	40	10	4	110	45	219
<i>Ganderbal</i>	1	1	15	4	1	42	21	85
<i>Kulgam</i>	1	3	19	9	9	82	42	165
<i>Kupwara</i>	1	7	33	6	42	154	63	306
<i>Pulwama</i>	1	3	20	16	4	85	18	147
<i>Shopian</i>	1	2	6	9	7	40	15	94
<i>Srinagar</i>	1	1	14	15	2	61	0	115
Total	10	40	214	109	93	855	358	1714
<i>Jammu Division</i>								
<i>Doda</i>	1	3	13	20	30	75	69	211
<i>Jammu</i>	1	8	33	12	10	193	29	286
<i>Kathua</i>	1	5	24	11	12	136	54	243
<i>Kishtwar</i>	1	1	7	9	18	39	36	111
<i>Poonch</i>	1	3	17	15	10	102	37	185
<i>Rajouri</i>	1	7	22	15	11	140	70	266
<i>Ramban</i>	1	3	9	10	15	39	39	116
<i>Reasi</i>	1	2	12	10	9	64	39	137
<i>Samba</i>	1	3	11	2	3	74	13	107
<i>Udhampur</i>	1	2	21	14	15	97	44	194
Total	10	37	169	118	133	959	430	1856
UT Total	20	77	383	227	226	1814	788	3570

Source: Own editing (2023)

10.3 Appendix 3: Sample distribution across different healthcare institutions

<i>Name of the Institution</i>	<i>Questionnaires distributed</i>	<i>Questionnaires collected</i>	<i>Response rate</i>
SKIMS	372	228	61.29
SMHS	63	41	65.08
GMCH	55	33	60
SMGS	49	31	63.27
SSH	37	22	59.46
Lalla Ded Hospital	36	26	72.22
GB Panth	31	18	58.06
MCH	24	21	87.5
Bone & Joint Hospital	20	12	60
Super Speciality Hospital	19	11	57.89
Chest Disease Hospital	17	6	35.29
Psychiatric Hospital Jammu	12	9	75
Psychiatric Hospital Srinagar	11	6	54.55
CDH	10	6	60
Maternity Home Sanat Nagar	8	0	0
GMC	7	0	0
DH Kishtwar	7	1	14.29
DH Kathua	6	0	0
Chittaranjan Mobile Hospital	5	1	20
DH Poonch	5	0	0
SDH Nowshera	5	2	40
CHC Surankote	4	0	0
Total	803	474	59.03

Source: Own editing (2023)

10.4 Appendix 4: Factor loadings as found in CFA and Deleted items.

Factor Loadings of the variables							
<i>Quantitative Demands</i>				<i>Work Family conflict</i>			
QD1	QD2	QD3	QD4	WFC1	WFC2	WFC3	WFC5
0.85	0.78	0.77	0.74	0.79	0.88	0.64	0.67
<i>Emotional Demands</i>				WFC7	WFC8	WFC9	WFC10
ED1	ED2	ED3	ED4	0.65	0.67	0.72	0.74
0.89	0.8	0.72	0.62	<i>Work Family Enrichment</i>			
<i>Cognitive Demands</i>				WFE1	WFE2	WFE3	WFE4
CD1	CD2	CD3	CD4	0.92	0.76	0.82	0.73
0.83	0.75	0.72	0.83	WFE5	WFE6	WFE9	WFE10
<i>Perceived organizational Support</i>				0.74f	0.69	0.67	0.65
POS1	POS2	POS3	POS4	WFE12	WFE14	WFE15	WFE16
0.85	0.62	0.61	0.76	0.63	0.65	0.65	0.63
POS5	POS6			WFE17	WFE18		
0.84	0.76			0.65	0.77		
<i>Perceived coworker Support</i>				<i>Psychological Well-being</i>			
PCS1	PCS2	PCS3	PCS4	PWB1	PWB2	PWB3	PWB4
0.88	0.68	0.69	0.85	0.9	0.81	0.75	0.61
<i>Job Autonomy</i>				PWB5	PWB6	PWB8	PWB9
JA1	JA2	JA3		0.63	0.63	0.63	0.72
0.73	0.8	0.92		PWB10	PWB13	PWB14	PWB15
				0.73	0.76	0.69	0.68
				PWB16	PWB17	PWB18	
				0.66	0.79	0.89	

Source: Own editing (2023)

Item	Description
WFC 4	My job produces strain that makes it difficult to fulfil family duties.
WFC6	The demands of my family or spouse/partner interfere with work-related activities.
WFE7	My job helps me feel personally fulfilled, and this helps me be a better family member.
WFE8	My job provides me with a sense of accomplishment, and this helps me be a better family member.
WFE11	My job helps me acquire skills, and this helps me be a better worker.
WFE13	My job puts me in a good mood, and this helps me be a better worker.
PWB7	I live life one day at a time and don't really think about the future.
PWB11	For me, life has been a continuous process of learning, changing, and growth.
PWB12	I think it is important to have new experiences that challenge how I think about myself and the world.

Source: Own editing (2023)

10.5 Appendix 5: Results of T-Test on Caste divide and Rural-Urban divide

Param		Var		Mean	t-val	p-val	Param		Var		Mean	t-val	p-val
Caste	N (%)	QD	U	2.7	-2.023	0.04	Setting	N (%)	QD	R	2.59	-7.288	0
			L	2.91						U	3.34		
Upper Caste	168 (39.7)	ED	U	3.1	-1.412	0.159	Rural	288 (68)	ED	R	3.09	-2.858	0.004
			L	3.24						U	3.39		
		CD	U	3.22	-2.607	0.009			CD	R	3.18	-6.262	0
			L	3.47						U	3.78		
Lower Caste	255 (60.3)	POS	U	3.64	0.603	0.547	Urban	135 (32)	POS	R	3.75	5.527	0
			L	3.59						U	3.32		
		PCS	U	3.71	2.816	0.005			PCS	R	3.63	2.149	0.032
			L	3.48						U	3.45		
T-Test for perception of stued variables across the caste divide		JA	U	3.07	3.37	0.001	T-Test for perception of studied variables across the geographical divide		JA	R	3.06	5.521	0
			L	2.82						U	2.63		
		WFC	U	2.93	-3.035	0.003			WFC	R	2.87	-8.034	0
			L	3.22						U	3.62		
		WFE	U	3.78	2.65	0.008			WFE	R	3.8	5.84	0
			L	3.61						U	3.42		
		PWB	U	3.55	6.054	0			PWB	R	3.58	14.073	0
			L	3.05						U	2.54		

Source: Own editing (2023)

10.6 Appendix 6: Qualitative studies from which the interviews are collected

Study	Sample	Location	Source
Study 1	15 interviewees (nurses, educators, officials)	Kerala, India	(Timmons et al., 2016)
Study 2	16 nurses	Tamil Nadu, South India	(Joseph et al., 2023)
Study 3	44 participants in 6 focus groups	Kolkata, India	(Dasgupta, 2014)
Study 4	19 registered nurses	Kathmandu Valley, Nepal	(Thapa et al., 2022)
Study 5	17 MHPs	North India	(Aggarwal & Sriram, 2018)
Study 6	2 focus groups (8-10 workers per group)	Delhi, India	(M. S. George et al., 2017)

Source: Own editing (2024)

List of Publications



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Doctoral School: Károly Ihrig Doctoral School of Management and Business
MTMT ID: 10076915

List of publications related to the dissertation

Articles, studies (8)

1. **Khateeb, F. R.:** Absenteeism Among Nurses: A Bibliometric Analysis of the Past 25 Years of Research.
Management and Labour Studies. 49 (3), 527-554, 2024. ISSN: 0258-042X.
DOI: <http://dx.doi.org/10.1177/0258042X231214848>
2. **Khateeb, F. R.:** Caught in the Crossfire: How Work-Family Conflict Affects the Lives of Married Nurses in India.
SEISENSE Journal of Management. 6 (1), 58-73, 2023. EISSN: 2617-5770.
DOI: <http://dx.doi.org/10.33215/sjom.v6i1.886>
3. **Khateeb, F. R.:** From strain to synergy: investigating the positive aspects of work-family interface among Indian doctors.
Management Matters. 20 (2), 185-204, 2023. ISSN: 2279-0187.
DOI: <http://dx.doi.org/10.1108/MANM-06-2023-0023>
4. **Khateeb, F. R.:** Work-Family Symbiosis in Nurses: Work-Family Positive Spillover in Female Nurses in North India.
MDIM Journal of Management Review and Practice. 1, 1-20, 2023. EISSN: 2582-7774.
DOI: <http://dx.doi.org/10.1177/mjmrp.231195485>
5. **Khateeb, F. R.:** Analysis of Work-Life Conflict Construct in Case of Telework: A Case Study of Teachers From Kashmir Valley (India) During Covid-19 Pandemic.
SEA: Practical Application of Science. 9 (26), 143-154, 2021. EISSN: 2360-2554.
6. Boros, J., **Khateeb, F. R.**, Kun, A. I.: Research and development career plans and work-life balance: Evidence from a survey among Hungarian Ph.D. students.
In: Módszertani újítások és kutatások a szakképzés és a felsőoktatás területén : X. Trefort Ágoston Szakképzés- és Felsőoktatás-pedagógiai Konferencia Tanulmánykötet. Szerk.: Simonics István, Holik Ildikó, Tomory Ibolya, Óbuda University, Budapest, 128-140, 2021.
ISBN: 9789634492399
7. **Khateeb, F. R.:** Work life balance - a review of theories, definitions and policies.
Cross-Cultural Management Journal. 23 (1), 27-55, 2021. ISSN: 2286-0452.



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8. **Khateeb, F. R.:** Review of fieldwork of major theories based on work life balance.
Cross-Cultural Management Journal. 22 (2), 123-143, 2020. ISSN: 2286-0452.

List of other publications

Articles, studies (1)

9. **Khateeb, F. R., Nabi, T.:** Green human resource management: a review of two decades of research.
Management Research and Practice. 15 (2), 43-64, 2023. ISSN: 2067-2462.
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