A STUDY OF WORK-FAMILY CONFLICT IN RELATION TO SOCIAL SUPPORT AND OPTIMISM AMONG DOCTORS

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ABSTRACT

The present study deals with assessing work-family conflict in relation to social support and optimism. The data was collected from 75 doctors working in a premier hospital in Chandigarh, India. Three standardized questionnaires i.e. Work-family conflict Scale by Kopelman, Greenhaus and Connolly (1983), Social Support Scale by Caplan et al. (1975) and Optimism Scale by Scheier & Carver (1985) were used for the study. It was hypothesized that no significant relationship exists between work-family conflict, social support and optimism; and no significant difference exists between the three variables based on socio-demographic variables (i.e., gender, marital status, living alone or with the family and hours of work). The results showed that there exists a negative relationship of work-family conflict with social support and optimism. Moreover, there was a significant difference in work-family conflict with regard to hours of work; but insignificant differences in gender, marital status and living alone or with the family among doctors. Significant difference in social support with regard to doctors who live alone and who live with their families and hours of work, but insignificant difference in gender and marital status was observed. Also, significant difference was found in optimism with regard to doctors who live alone and who live with their families, whereas insignificant difference in gender, marital status and hours of work was observed.

KEYWORDS

Optimism, Social Support and Work-Family Conflict.

1. INTRODUCTION

Conflict refers to a condition in which an individual has to make a choice between two mutually inclusive or incompatible choices, that is, the choices overlap and therefore, one is chosen over the other or at the cost of the other. Thus, work-family conflict can be defined as an inter-role

conflict in which a person is unable to cope with two incompatible roles i.e., his role at work and his role in family. Work-family conflict has become an integral part of any professional's life in today's world. Long hours of work, over demanding professions, tumultuous economic situation, lack of job security, lack of social support especially due to disintegration of joint family system and many more reasons make matters worse by adding to the ever increasing work-family conflict. Work-family conflict affects almost every working individual, however, in certain professions, work-family conflict is inevitable. One such profession is the medical profession. Therefore, the present study is aimed at studying work-family conflict in relation to social support and optimism among doctors.

1.1. Work-Family Conflict

Greenhaus & Beutell (1985, p. 77) defined work-family conflict as "a form of inter-role conflict in which the role pressures from work and family domains are mutually incompatible in some respect". Work-life and family-life are interrelated and interdependent, therefore, tend to interfere and affect each other, either positively or negatively. When negatively affected it is called work-family conflict as hindrance in the achievement of one domain is affected by the other domain. For example, sudden illness of a family member would demand for delaying office work *(Frone et al., 1992a)* or when work is taken home intervenes with the family time.

1.2. Social Support

In the simplest language social support means support/help/assistance provided by society or different units of society. It is the support rendered by family, friends, relatives, superiors, coworkers and society in general in the form of emotions, tangible support, information, companionship etc. (*Schaefer, Coyne, and Lazarus, 1981*). In other words social support is the perception and might or might not be a reality of being loved, cared for and supported by other people and society.

Albrecht and Adelman (1987) has defined social support as "verbal and nonverbal communication between recipients and providers that reduces uncertainty about the situation, the self, the other, or the relationship, and functions to enhance a perception of personal control in one's life experience" (p. 19). *Shumaker and Brownell (1984)* defined social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well being of the recipient". Whereas, *House (1981)* defined it as

"the demonstration of emotional concern, the provision of instrumental aid, information, and/or appraisal".

1.3. Optimism

In general optimism refers to a tendency of seeing the glass "half full" of water as opposed to half empty. It is a characteristic way of always perceiving the best in everything and everyone. It is being most hopeful in all possible situations and believing that the best would come out of it. Optimism is an attitude towards life which helps to see the world as a better and happy place and also a belief that whatever happens, happens for good. It is the opposite of pessimism.

Scheier and Craver (1985) defined Optimism as "the global generalized tendency to believe that one will generally experience good versus bad outcomes in life". It is a disposition to take a bright and hopeful view of things. *Tiger (1979)* defined optimism as "a mood or attitude associated with an expectation about the social or material future, one which the evaluator regards as socially desirable, to his/her advantage, or for his/her pleasure" (as cited in *Peterson 2000).*

Therefore, optimism is not just an attitude but a way of life which has numerous benefits such as superior health, greater achievement, persistence, emotional health, increased longevity, less stress, resilience etc. People who have optimistic outlook in life will often see more opportunities than those who are pessimistic. Optimists put problems behind them and take a positive view of life. Optimism prevents people from giving up hope and becoming insensitive or apathetic.

2. REVIEW OF LITERATURE AND HYPOTHESES

2.1. Work-Family Conflict

Nowadays maintaining a balance between responsibilities at work and at home has become a great challenge for employees. Therefore, importance of studying WFC lies in the fact that happy employees mean happy organizations. Moreover, it is closely linked with increased levels of stress, absenteeism, turnover, lower performance, satisfaction and poor physical and mental health. Several studies support this notion, for instance, *Kinnunen et al (2006)* revealed the association between WFC and health related problems; (*Lapierre & Allen, 2006*), talked about depression and anxiety levels; and *Hill (2005)* showed the negative impact of WFC on overall satisfaction with life.

Earlier, work-family conflict measure was unidirectional i.e., how work interferes with family life, but now researchers are also trying to look the other way round i.e., how families can interfere with work (*Duxbury, Higgins & Mills, 1992).* Both directions of WFC should be considered and the three forms of WFC, i.e., 'time-based conflict', 'strain-based conflict', and 'behavior-based conflict' must be analyzed for an accurate measure. Time-based conflict refers to the conflict arising when time devoted to one role interferes with another role. Strain-based conflict refers to the conflict arising when strain/stress in one role interferes with another role. Whereas, behavior-based conflict refers to the conflict arising due to incompatible behaviors between two roles (*Frone, Russell, & Cooper, 1992a).*

The gender differences play an important role in work-family role systems and are a major reason for work-family conflict, *Pleck (1977). Hall (1972)* revealed in his study that women who play multiple roles might experience more role conflict. Married working women have to fulfill a dual role i.e., responsibilities at work and home that leads to more work-family conflict and have a negative effect on managing their jobs. Many studies supported that females face more conflicts as compared to males, for example, *Burley (1995), Gutek et al., (1991), Duxbury and Higgins (1991), Higgins Duxbury and Lee (1994).* Further, studies also suggest from which domain women face more problems as compared to men i.e., *Jaros et al. (1993)* revealed that in case of family domain, women face more conflict as compared to men, whereas, in case of work domain men face more conflict as compared to women. Similar results were achieved by *Hochschild and Machung (1989)* and *Staines and Pleck (1983).* In contrary to the above studies, *Rehman and Waheed, (2012)* found no significant gender differences in work-family conflict among faculty members. Besides gender, work family conflict is linked with work domain pressures i.e., number of working hours per week and family domain pressures like the spouse time in paid work *(Voydanoff, 1988).*

2.2. Work-Family Conflict and Social Support

A large number of studies support the notion that work-family conflict is a key antecedent of work and life effectiveness and is related to positive and negative consequences at work and home, for example, *Kossek & Ozeki, 1998, Allen et al, 2000; Eby et al, 2005).* Also the lack of social support at workplace is one of the most likely factors to impact work-to-family conflict *(Frone, Russell & Cooper, 1992a).*

The type of support also affects the intensity of conflict as showed in a study by *Ahmad, (1996). Albrecht and Adelman 1987, Cohen and Wills 1985)* revealed that support from family and friends can lead to a wide range of psychological outcomes. Moreover, the time spent on family activities positively relate to family-to-work conflict *(Frone et al., 1997 and Gutek et al., 1991)*. However, hours spent at home and at work have a positive relationship with family-to-work conflict and work-to-family conflict respectively *(Frone, Yardley et al. 1997; and Netemeyer et al. 1996).* Conversely, *Carlson and Perrewe (1999)* showed that support from family have a negative relationship with work-family conflict. *Caplan et al, (1975)* opined that social support can be derived from different sources at work i.e., supervisor and co-workers and outside the work i.e., from family and friends. *Ray and Miller (1994)* suggested that these different sources of social support work in unique ways to deal with the work-family conflict and relieve strain. Moreover, research indicates that married working women have a higher vulnerability to work-family conflict and adversely affects their health and well-being. *Daalen et al. (2006)* revealed the relationship between gender differences and the sources from which social support is received and their effectiveness in reducing work-family conflict.

2.3. Work-Family Conflict and Optimism

Optimism is a generalized tendency to expect positive outcomes and a belief that "good rather than bad things will happen in a person's life" *(Scheier & Carver, 1993). Hassan, (2010)* in an exploratory study found that there were minor gender differences between the mean scores on optimism, self-confidence and work engagement. Thus, the findings suggested that on average men tend to have higher optimism and self-confidence in comparison to women. *Dyson, (2006)* in a study found negative relationship between optimism and work-family conflict. Marital status positively correlated with optimism i.e., individuals who were married or were living with a partner were more optimistic, satisfied with their life and family than those who were not married or were living alone and not with a partner. Moreover, the number of children also correlated positively with optimism.

However, limited empirical research on work-family conflict in relation to social support and optimism points to the need for such a study.

2.4. Objectives of the Study

1. *To examine Work-Family Conflict among Doctors with regard to socio-demographic variables.*

2. *To examine Social Support among Doctors with regard to socio-demographic variables.*
3. *To examine Optimism among Doctors with regard to socio-demographic variables.*
4. *To study the relationship between Work-Family Conflict and Social Support among doctors.*
5. *To study the relationship between Work-Family Conflict and Optimism among doctors.*

2.5. Hypotheses of the Study

H_o1. "There exists no significant difference in Work-Family Conflict among Doctors with regard to socio-demographic variables".

- *H_o 1.1. 'There exists no significant difference in work-family conflict among male and female doctors'.*
- *H_o 1.2. 'There exists no significant difference in work-family conflict among married and unmarried doctors'.*
- *H_o 1.3. 'There exists no significant difference in work-family conflict among doctors living alone and living with family'.*
- *H_o 1.4. 'There exists no significant difference in work-family conflict among doctors working below 12 hours and working 12 hours and above'.*

H_o2. "There exists no significant difference in Social Support among Doctors with regard to socio-demographic variables".

- *H_o 1.1. 'There exists no significant difference in social support among male and female doctors'.*
- *H_o 1.2. 'There exists no significant difference in social support among married and unmarried doctors'.*
- *H_o 1.3. 'There exists no significant difference in social support among doctors living alone and living with family'.*
- *H_o 1.4. 'There exists no significant difference in social support among doctors working below 12 hours and working 12 hours and above'.*

H_o3. "There exists no significant difference in Optimism among Doctors with regard to socio-demographic variables".

- *H_o 1.1. 'There exists no significant difference in optimism among male and female doctors'.*
- *H_o 1.2. 'There exists no significant difference in optimism among married and unmarried doctors'.*
- *H_o 1.3. 'There exists no significant difference in optimism among doctors living alone and living with family'.*
- *H_o 1.4. 'There exists no significant difference in optimism among doctors working below 12 hours and working 12 hours and above'.*

H_o4. "There exists no significant relationship between Work-Family Conflict and Social Support among Doctors".

H_o5. "There exists no significant relationship between Work-Family Conflict and Optimism among Doctors".

3. RESEARCH MEHODOLOGY

3.1. Sample and Procedure

The present study is descriptive in nature and utilizes the survey technique. A sample of 75 Doctors from a premier hospital in Chandigarh was collected through snowball sampling technique. The respondents were given self-administered questionnaires and necessary instructions. They were assured that the results and other information would be kept strictly confidential and used for research purpose only. After the administration of the questionnaires, scoring was done for further statistical analysis.

3.2. Instruments

1. Work-Family Conflict Scale*:* The Work-Family Conflict Scale developed by *Kopelman, Greenhaus and Connolly, 1983,* uses eight items to assess the extent of the inter-role conflict that occurs between work and family roles (work-family conflict). Coefficient alpha values ranged from .78 to .90.

***2.* Social Support Scale:** The Social Support Scale developed by *Caplan et al., 1975,* includes subscales that describe the support available from co-workers, supervisor, spouse and

family/friends as perceived by an employee. Coefficient alpha for the supervisor support subscale ranged from .86 to .91*;* co-worker support was .79.

***3.* Optimism Scale- Life Orientation Test-Revised**: The Life Orientation Test (LOT) developed by *Scheier & Carver, 1985*, has been one of the most popular instruments used to measure dispositional optimism. A revised version of the scale LOT-Revised (LOT-R) was subsequently developed *(Scheier, Carver, and Bridges, 1994).* This revised test has proven to have considerable overlap with the original LOT. The LOT-R is briefer than the original (6 coded items, 3 framed in each direction). LOT-R has Cronbach alpha values in the range of high .70s to low .80s showing a good internal consistency.

4. ANALYSIS OF RESULTS

For the analysis, Mean, SD, t-values and Pearson's Product Moment coefficient of correlation were computed.

4.1. Analysis of Work-Family Conflict Scores

H_o 1. "There exists no significant difference in work-family conflict among doctors with regard to socio-demographic variables".

Table 1. Means, SDs and t-values of Work-Family Conflict and Socio-demographic variables

S. No.	Variables		N	Mean	SD	t-value	Sig.
1.	Gender	Male	49	28.49	7.185	1.766	.082
		Female	26	25.46	6.837		
2.	Marital Status	Married	25	27.00	6.770	0.374	.710
		Unmarried	50	27.66	7.417		
3.	Living	Alone	54	27.31	7.020	0.241	.810
		With Family	21	27.76	7.707		
4.	Hours Of Work	Below 12 Hours	29	24.38	6.790	3.102**	.003
		12 Hours & above	46	29.37	6.780		

*** Significant at 0.01 level.*

H_o1.1. 'There exists no significant difference in work-family conflict among male and female doctors'.

Table 1 reveals that t-value (1.766) was not found significant, even at 0.05 level of confidence, implying no significant difference in work-family conflict among male and female doctors. Thus, hypothesis 1.1 was accepted.

H_o 1.2. 'There exists no significant difference in work-family conflict among married and unmarried doctors'.

Table 1 reveals that t-value (0.374) was not found significant, even at 0.05 level of confidence, implying no significant difference in work-family conflict among married and unmarried doctors. Thus, hypothesis 1.2 was accepted.

H_o 1.3. 'There exists no significant difference in work-family conflict among doctors living alone and living with family'.

Table 1 reveals that t-value (0.241) was not found significant, even at 0.05 level of confidence, implying no significant difference in work-family conflict among doctors living alone and living with family. Thus, hypothesis 1.3 was accepted.

H_o 1.4. 'There exists no significant difference in work-family conflict among doctors working below 12 hours and working 12 hours and above'.

Table 1 reveals that t-value (3.102) was found significant at 0.01 level of confidence, implying a significant difference in work-family conflict among doctors working below 12 hours and working 12 hours and above. Thus, hypothesis 1.4 was rejected.

Therefore, Hypothesis 1 i.e., "There exists no significant difference in work-family conflict among doctors with regard to socio-demographic variables i.e., gender, marital status and living alone or with the family" was accepted.

4.2. Analysis of Social Support Scores

H_o 2. "There exists no significant difference in Social Support among Doctors with regard to socio-demographic variables".

Table 2. Means, SDs and t-value of Social Support and Socio-demographic variables

S. No.	Variables		N	Mean	SD	t-value	Sig.
1.	Gender	Male	49	34.96	7.379	0.910	.366
		Female	26	36.46	5.523		
2.	Marital Status	Married	25	36.88	6.894	1.267	.209
		Unmarried	50	34.78	6.701		
3.	Living	Alone	54	34.33	6.768	2.420*	.018
		With Family	21	38.43	6.055		
4.	Hours Of Work	Below 12 Hours	29	37.69	5.727	2.301*	.024
		12 Hours & above	46	34.09	7.096		

**Significant at 0.05 level.*

H_o 2.1. 'There exists no significant difference in Social Support among male and female doctors'.

Table 2 reveals that t-value (0.910) was not found significant, even at 0.05 level of confidence, implying no significant difference in social support among male and female doctors. Thus, hypothesis 2.1 was accepted.

H_o 2.2. 'There exists no significant difference in Social Support among married and unmarried doctors'.

Table 2 reveals that t-value (1.267) was not found significant, even at 0.05 level of confidence, implying no significant difference in social support among married and unmarried doctors. Thus, hypothesis 2.2 was accepted.

H_o 2.3. 'There exists no significant difference in Social Support among doctors living alone and living with family'.

Table 2 reveals that t-value (2.420) was found significant at 0.05 level of confidence, implying a significant difference in social support among doctors living alone and living with family. Thus, hypothesis 2.3 was rejected.

H_o2.4. 'There exists no significant difference in Social Support among doctors working below 12 hours and working 12 hours and above'.

Table 2 reveals that t-value (2.301) was found significant at 0.05 level of confidence, implying a significant difference in social support among doctors working below 12 hours and working 12 hours and above. Thus, hypothesis 2.4 was rejected.

Therefore, Hypothesis 2 i.e., *"*There exists no significant difference in Social Support among Doctors with regard to socio-demographic variables i.e., gender and marital status" was accepted.

4.3. Analysis of Optimism Scores

H_o 3. "There exists no significant difference in Optimism among Doctors with regard to socio-demographic variables".

Table 3. Means, SDs and t-value of Optimism and Socio-demographic variables

S. No.	Variables		N	Mean	SD	t-value	Sig.
1.	Gender	Male	49	15.61	3.610	0.376	.708
		Female	26	15.23	5.109		
2.	Marital Status	Married	25	15.40	4.924	0.117	.907
		Unmarried	50	15.52	3.766		
3.	Living	Alone	54	14.81	3.861	2.283*	.025
		With Family	21	17.19	4.501		
4.	Hours Of Work	Below 12 Hours	29	14.86	4.406	1.022	.310
		12 Hours & above	46	15.87	3.998		

**Significant at 0.05 level.*

H_o 3.1. 'There exists no significant difference in Optimism among male and female doctors'.

Table 3 reveals that t-value (0.376) was not found significant, even at 0.05 level of confidence, implying no significant difference in Optimism among male and female doctors. Thus, hypothesis 3.1 was accepted.

H_o 3.2. 'There exists no significant difference in Optimism among married and unmarried doctors'.

Table 3 reveals that t-value (0.117) was not found significant, even at 0.05 level of confidence, implying no significant difference in Optimism among married and unmarried doctors. Thus, hypothesis 3.2 was accepted.

H_o 3.3. 'There exists no significant difference in Optimism among doctors living alone and living with family'.

Table 3 reveals that t-value (2.283) was found significant at 0.05 level of confidence, implying a significant difference in Optimism among doctors living alone and living with family. Thus, hypothesis 3.3 was rejected.

H_o 3.4. 'There exists no significant difference in Optimism among doctors working below 12 hours and working 12 hours and above'.

Table 3 reveals that t-value (1.022) was not found significant, even at 0.05 level of confidence, implying no significant difference in Optimism among doctors working below 12 hours and working 12 hours and above. Thus, hypothesis 3.4 was accepted.

Therefore, Hypothesis 3 i.e., "There exists no significant difference in Optimism among Doctors with regard to socio-demographic variables i.e., gender, marital status and hours of work" was accepted.

4.4. Relationship between Work-Family Conflict and Social Support

H_o 4. "There exists no significant relationship between Work-Family Conflict and Social Support among Doctors".

Table 4. Pearson's Product Moment Coefficient of Correlation between Work-Family Conflict and Social Support.

Variables	N	'r'	Sig.
Work Family Conflict	75	-0.192	.098
Social Support	75		

Table 4 reveals that correlation (-0.192) was not found significant even at 0.05 level of confidence, implying no significant relationship between Work-Family Conflict and Social Support among Doctors. But there exists an indirect and negative relationship between Work-Family Conflict and Social Support among doctors. Thus, hypothesis 4 was accepted.

4.5. Relationship between Work-Family Conflict and Optimism

H_o 5. "There exists no significant relationship between Work-Family Conflict and Optimism among Doctors".

Table 5. Pearson's Product Moment Coefficient of Correlation between Work-Family Conflict and Optimism.

Variables	N	'r'	Sig.
Work Family Conflict	75	-0.159	.174
Optimism	75		

Table 5 reveals that correlation (-0.159) was not found significant even at 0.05 level of confidence, implying no significant relationship between Work-Family Conflict and Optimism among Doctors. But there exists an indirect and negative relationship between Work-Family Conflict and Optimism among doctors. Thus, hypothesis 5 was accepted.

5. DISCUSSION OF RESULTS

The study aimed at comparing the levels of work family conflict, social support and optimism among doctors of a premier medical institute in Chandigarh. A sample of 75 doctors both males and females were carefully studied using 3 different questionnaires i.e., Work-Family Conflict, Social Support and Optimism, utilizing the survey technique. After the scoring and administration of the scales, statistical analysis i.e., means, standard deviations, t-values and correlations were computed for work family conflict, social support and optimism. The entire sample was divided into different groups i.e., gender, marital status, whether they were living alone or with family and hours of work. Five hypotheses were laid down for this purpose. Hypothesis 1 i.e., "There exists no significant difference in Work-Family Conflict among Doctors with regard to socio-demographic variables i.e., gender, marital status and living alone or with the family" was accepted. The results reveal that no significant difference exists between the levels of Work-Family Conflict among male and female doctors; among married or unmarried doctors and doctors living alone or with their families. However, the level of Work-Family Conflict was significantly different in case of hours of work ($p<0.01$) i.e., there exists a significant difference in the mean scores of doctors whose work shift is less than 12 hours and of those whose work shift is 12 hours or more. As the hours of work increase, the conflict between work and family also increases, it becomes increasing difficult for any individual to be able to

balance family with work when work is taking more than 12 hours a day. Work is possible only at the cost of family thus leading to greater conflict between the two. The results could be validated with similar results obtained in studies done in the past i.e. Long hours of work greatly influence the work family conflict as there exists a positive relationship between hours of working and WFC *(Frone et al. 1997, Judge Boudreau and Brets, 1994).* Whereas, no significant gender differences for WFC were found among the faculty members *(Rehman and Waheed, 2012).* On the contrary, *Burley (1995), Gutek et al., (1991), Duxbury and Higgins (1991),* found that females face more conflict in family than men. Moreover, *Jaros et al. (1993)* revealed that in the family domain females face more conflict than males, whereas, in the work domain males face more conflict than females.

Hypothesis 2 i.e., "There exists no significant difference in Social Support among Doctors with regard to socio-demographic variables i.e., gender and marital status" was accepted. The results show that there exists no significant difference between the mean scores on social support among male and female doctors; and married and unmarried doctors, which implies that gender and marital status do not affect the perception of the support one gets from its social network. However, the level of social support significantly differs in case of whether a doctor is living alone or with family, and the social support in case of hours of work i.e. when it is below 12 hours and when its 12 hours or more also significantly differ. The mean scores show that the doctors who live with their families have better social support as compared to those living alone. Moreover, the doctors who work for less than 12 hours a day have better social support as compared to doctors working for more than 12 hours a day. The results could be validated by similar results obtained in studies done in the past; for example, employees believe that the support from the organization helps them to perform better, even in stressful situations *(Rhoades & Eisenberger, 2002).* Moreover, support from one's supervisor was better related to less work strain rather than getting support from other external sources *(Fenlason & Beehr, 1994).*

Hypothesis 3 i.e., "There exists no significant difference in Optimism among Doctors with regard to socio-demographic variables i.e., gender, marital status and hours of work" was accepted. The results reveal that no significant difference exists between the levels of Optimism among male and female doctors; married and unmarried doctors; and doctors working for less than 12 hours and doctors working for more than 12 hours a day. However, the level of Optimism is significantly different among doctors living alone or with their families. Doctors who live with

their families are more optimistic and get higher support from their families than the doctors living alone, as the family support makes them more hopeful and positive in life. Also, the doctors who work for fewer hours, spend more time with their family and friends, get more support than those who work for longer hours. The results could be further validated as similar results have been obtained in studies done in the past. For example, *Sitz and Poche, (2006)* found no strong relationship between gender and optimism. *Dyson, (2006)* showed that people who were married or living with a partner were less affected by FWC and were more likely to be optimistic, more satisfied with their life and family as compared to those not married or were living without a partner.

Hypothesis 4 i.e., "There exists no significant relationship between Work-Family Conflict and Social Support among Doctors" was accepted. The results show that coefficient of correlation (-0.192) was not significant, but there was an indirect and negative relationship between the levels of Work Family Conflict and Social Support, that is, higher the Social Support, lower would be the Work Family Conflict and vice versa. However, the relationship is negative, though it is not significant ($p > 0.05$). Similar findings were obtained in the study by *Frone, Russell & Cooper, (1992a)* depicting the impact of social support on work-family conflict.

Hypothesis 5 i.e., "There exists no significant relationship between Work-Family Conflict and Optimism among Doctors" was accepted. The results show that coefficient of correlation (-0.159) was not significant, but there was an indirect and negative relationship between the levels of Work Family Conflict and optimism, i.e., higher the optimism, lower would be the WFC and vice versa. However, the relationship is negative, though it is not significant ($p>0.05$). Similar findings were obtained in the study by *Dyson (2006)* who found that optimism was negatively associated with work- family conflict i.e., lower optimism leads to work-family conflict.

6. CONCLUSION

Thus, it can be concluded that the reasons behind such insignificant results might be small size of the sample, lack of randomization of data, attitude of the respondents etc. Moreover, certain personality traits and some qualities of the profession seem to have an impact. For example, the participant doctors were comparatively young and thus enthusiastic and well prepared for the demands of their profession, many of these doctors belonged to the family of doctors and thus were already used to the lifestyle. Furthermore, their attitude towards their work is very positive,

as nowadays any job especially private or job in an MNC can be more hectic, and almost as demanding as the job of a doctor in many cases. Medical profession can be very gratifying as one serves mankind and it is considered as a noble profession. This satisfaction and also the job security these doctors enjoy go a long way in making them strive for better and carry on in spite of high work family conflict and low social support. These reasons are not exhaustive but suggestive, further research is required for reaching to a conclusion and making the study valid and to generalize it to a bigger population.

7. LIMITATIONS AND RECOMMENDATIONS

The present research study is delimited in the following ways i.e. sample is selected from only one hospital of Chandigarh and only three variables namely, work-family conflict, social support and optimism were studied. Therefore, it is recommended that for further research, the sample could be selected from different hospitals. Moreover, with a larger sample comparative study of employees from different occupations could be conducted. Other factors affecting and mediating between work-family conflict, social support and optimism could also be studied.

8. IMPLICATIONS OF THE STUDY

The findings of the study can help the hospital administration and policy makers to understand the importance of work-family conflict, social support and optimism for the doctors. Thus, after recognizing the level of work-family conflict, social support, appropriate steps should be taken by hospital administration for reducing conflict, developing and enhancing support among medical professionals. Different kinds of experiences, exposures, trainings, medical facilities, reinforcements, positive and supportive environment etc. could go a long way in improving overall satisfaction, physical and mental growth and development of the doctors. Therefore, reduced work-family conflict, strong social support and optimism would help doctors to achieve better performance, increased satisfaction, healthy and positive life, thereby, leading to overall individual and organizational growth and development.

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