Chapter II

Conceptual Framework
CHAPTER II

CONCEPTUAL FRAMEWORK

The present study focuses on the conceptual framework of understanding the dynamics of work life balance and life satisfaction of critical care nurses. Women workforce constitutes a significant percentage of the total work force in any critical care nursing. Employers expect employees to invest themselves fully in their professions. Hence long hours of work, travel, after-office hour’s socialization, out-station training etc have become the norm of the day. Work/life balance has become a major issue in the world of work but both work and family is sought to achieve balance. For many female, the work life balance is one of life’s greatest challenges. This chapter provides the theoretical background of health care, hospitals, nursing, critical care nursing, work life balance and intricate on the subject of apprehension life satisfaction.

2.1. HEALTH CARE SECTOR

“Physicians, Nurses, Medical Technicians and Other Scientific Occupations will become to Rival the IT Sector within the Next Decade”

- India Vision 2020 Report

Health service industries provide a continuous service around the clock for the benefit of all citizens in any country. Health service personnel is responsible for provision of health care through application of medical science knowledge, skill and expertise in meeting the health needs of all people within each country. It is therefore expected that a healthy and psychologically balanced workforce provides health care. Health care providers are bound to work shift-work as a health need for a number of people worldwide. Nurses as health care providers are obliged to work during the day and night to cater for the needs of the sick people. This can only be possible if nurses work during the 24 hours of the day. Over the years, the private sector in India has gained a significant presence in all the sub-segments of medical education and training, medical technology and diagnostics, pharmaceutical manufacture and sale, hospital construction and ancillary services, and also the provisioning of medical care (NCMH, 2005).
2.1.1. Infrastructure

The Indian healthcare industry is highly fragmented and dominated by private players. Issues in regard to public and private health infrastructure are different and both of them need attention but in different ways. Rural public infrastructure must remain in mainstay for wider access to health care for all without imposing undue burden on them. Infrastructure is the base for health care services. There is tremendous demand for tertiary care hospitals and specialty hospitals in India. The infrastructure of hospitals in both public and private should be improved. There is a gap between the availability of the beds and required beds in the hospital in India.

Figure 1: Health Care Infrastructure


Developing countries, which contain a large proportion of the world’s population, generally do not have enough hospitals, equipment, and trained staff to handle the volume of persons who need care. Several patients cannot use public facilities since they are not located nearby. Most of the people choose private hospitals and nursing homes, although they are costly compared to the public sector. Government authorities have failed in monitoring the cost and quality of care delivered by private providers.
2.1.2. Healthcare Boom in India

Health care as a promising sector have attracted private investors to hospital care delivery. However infectious diseases like tuberculosis are still taking their toll, degenerative diseases are becoming a major health concern in India. Cancers, diabetes cardiovascular diseases, and coronary heart disease are on the rise. These diseases require proper medical and hospital care. It was estimated that spending on in-patient care accounts for 47 percent of total private healthcare spending because of lifestyle diseases (CII-McKinsey, 2002).

A massive boom in private hospitals is changing the nation's health delivery landscape beyond recognition. Trends that have been observed are that most of the healthcare players have been setting up additional facilities to cater critical care or super specialty healthcare. Some leading hospital players are very aggressive on raising funds for their expansions. India is also witnessing growth of advanced diagnostic equipments and excellent infrastructure. The economic growth of the last fifteen years has also meant that an increasing part of India's population can afford to spend more on healthcare. There are many reasons for the health care boom in India like:

- Strong Indian economy
- Increasing options for healthcare financing / mediclaim & medical tourism
- Increasing demand from within the county & healthcare delivery
- Hi-tech laboratory & pharmaceuticals etc.

2.1.3. Current Scenario

ASA & Associates Health care sectors in India (2008): Challenges & opportunities reports that healthcare sectors current scenarios are:

- Good healthcare available only in metros the others lack in infrastructure
- 85 per cent private sector establishments have less than 25 beds
- Private sector accounts for 82 per cent of all out-patient visits
- Speciality and superspeciality hospitals account for 2 per cent of total institutes
- Inadequate remuneration for public hospital staff
2.2. HOSPITAL

Hospitals are institutions that is built, staffed, and equipped for the diagnosis of disease; for the treatment, both medical and surgical, of the sick and the injured; and for their housing during this process. The word hospital is derived from the word "hopes" which means a guest. This is quite true for a patient leaves his home and comes to the hospital as a guest for brief periods of stay. Even more than a guest he is worried and sick as such he needs more care and attention than a guest would receive. Besides the patients there are the workers like doctors, superintends, critical care nurses, other nurses, technicians, different class servants and other members of the health team.

2.2.1. Ownership

The health care service in India has various dimensions. Multiple systems, various ownership patterns and different kinds of delivery structures make up a complex plurality that makes the development of an organized system difficult. Allopathy, ayurveda, homoeopathy, unani and siddha among others are different systems of medicine available in the country. However, allopathy is the dominant system of medicine worldwide.

As regards ownership, while the broad characterization could be made as public and private, there are various intricacies involved. The public sector ownership is divided between central and state governments, and municipal and panchayath local governments. The facilities include teaching hospitals, secondary level hospitals, first level referral hospitals (community health centers’ [CHCs] or rural hospitals), dispensaries, primary health centers’ (PHCs) and sub centers’, and health posts. Apart from this there are public facilities for selected occupational groups like the Employees State Insurance Scheme (ESIS), defense, Central Government Health Scheme (CGHS), railways, post and telegraph, mines etc.

Private ownership is of two kinds, for-profit and not-for-profit. The former could be self-employed or individual ownership or various other forms of ownership like partnership, cooperative or corporate. The not-for-profit variety is usually a Trust or a Society, many of these also being called non-government organizations (NGOs). These again could be teaching hospitals, hospitals and nursing homes of various sizes providing a variety of care, clinics and dispensaries, and diagnostic facilities.
2.2.2. Growth of Hospitals

While the demand for hospital care is rising, public and private hospitals are too few and their geographic distribution too skewed to meet such demand. With 35 beds per hospital, the average number of beds per hospital is small compared to China (50 beds/hospital) and Brazil (75 beds/hospital) (CII-McKinsey, 2002). According to the National Family Health Survey (NFHS-2004), 68 percent of people surveyed do not use public hospitals and dispensaries because they feel their quality is poor. Due to the lower cost of procedures, India has become an attractive destination for medical tourism.

**Figure 2: India cost advantage**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>US</th>
<th>Thailand</th>
<th>India</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Surgery</td>
<td>40,000</td>
<td>7,500</td>
<td>6,000</td>
<td>23,000</td>
</tr>
<tr>
<td>Bone Marrow Transplant</td>
<td>2,50,000</td>
<td>------</td>
<td>26,000</td>
<td>1,50,000</td>
</tr>
<tr>
<td>Liver Transplant</td>
<td>3,00,000</td>
<td>------</td>
<td>69,000</td>
<td>2,00,000</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>20,000</td>
<td>8,000</td>
<td>6,000</td>
<td>12,000</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>20,000</td>
<td>3,500</td>
<td>2,000</td>
<td>10,000</td>
</tr>
</tbody>
</table>

Source: ASA & Associates Health care sectors in India (2008):

The demand for hospital services has been consistently soaring in the country, with every class of the society demanding better quality and standards of healthcare. However, only about 20% of healthcare services are being provided by public sector, with the remaining being provided by the private sector (MHFW, 2007). Public sector focus is mainly on prevention and elimination of infectious diseases and accessibility of basic healthcare facilities to the rural and urban masses. According to National Family Health Survey (2007), the private medical sector remains the primary source of health care for 70% of households in urban areas and 63% of households in rural areas. Numerous reasons for relying on private rather than public sector at the national level is poor quality of care in public sector, distance of public sector facility, long wait times and inconvenient hours of operation.
2.3. NURSING PROFESSION

"Nursing encompasses an art, a humanistic orientation, a feeling for the value of the individual, and an intuitive sense of ethics, and of the appropriateness of action taken."

-Myrtle Aydelotte

Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations (American Nurses Association -ANA). Survival of the human race is inextricably intertwined with the development of nursing.

The word nurse evolved from the Latin word nutritious, which means nourishing. Nursing is not only an applied science; it is also an art, which provides skillful care for the sick in appropriate relationship with the patient, family, physician and with others who have related responsibilities. Skillful nursing care embraces the whole person, body, mind and soul, his physical, mental, social and spiritual well-being.

Nursing as a holistic approach is one of the greatest of humanitarian services and all people whether ill or well, rich or poor, literate or illiterate, young or old, at work or at play, in or out of hospital, are in some way or other, directly or indirectly closely associated with it. Nursing is a healthcare profession focused on the care of individuals, families, and communities so they may attain, maintain, or recover optimal health and quality of life from conception to death (Snodgrass, 2004).

Nursing was viewed during the 17th century as a very low job in the social hierarchy. It was not until Florence Nightingale, well educated woman from a middle class family, became a nurse and improved it drastically that people began to accept nursing as a reputable profession. The doctor makes some key decisions about the diagnosis, treatment, and medication, and it is the nurse’s role to administer that care on an ongoing basis to ensure successful recuperation of the patient. Nursing has continued to develop in this latter sense, although the idea of nourishing in broadest sense refers in modern nursing to promoting quality of life (Radcliffe, 2009). Even though nurse’s work is firm, it is apparent that the critical care nurse’s work is still more complicated than any other nurses working in other units.
2.4. CRITICAL - CARE UNIT (CCU)

“It is not how much you do but how much love you put in the doing”

-Mother Theresa

A Critical-Care Unit (CCU), Intensive-Care Unit (ICU), Intensive-Therapy Unit/Intensive-Treatment Unit (ITU), & High Dependency Units (HDU) are a specialized department in a hospital that provides intensive-care medicine. The term intensive care has been defined by the Intensive Care Society (ICS) as: a service for patients who have potentially recoverable conditions, who can benefit from more detailed observation and invasive treatment than can be provided safely in an ordinary ward or high-dependency area. Many hospitals also have designated intensive-care areas for certain specialties of medicine, depending on the needs and resources of the hospital. Critical care services are atypical in the wide heterogeneity of their patients.

Critical care is provided by multi-professional teams of highly experienced and professional physicians, nurses, respiratory care technicians, pharmacists and other allied health professionals who use their unique expertise, ability to interpret important therapeutic information, access to highly sophisticated equipment and the services of support personnel to provide care that leads to the best outcome for the patient. Patients are rarely admitted directly to the critical care unit. Rather, they are usually admitted from the emergency room, or surgical area where they are first given care and stabilized.

The continuum of critical care begins at the moment of illness or injury and continues throughout the patient's hospitalization, treatment and subsequent recovery. An ICU is a specially staffed and equipped, separate and self-contained section of a hospital for the management of patients with life-threatening or potentially life-threatening, and reversible or potentially reversible, organ failure.

An ICU also provides specialist expertise and facilities for the support of patients, utilizing the skills of medical, nursing and other staff trained and experienced in the management of critically ill patients. Critical care unit is usually reserved for patients with threatened or established organ failure, often arising as a result or complication of an acute illness or trauma, or as a predictable phase in a planned treatment programme.
2.4.1. Historical recognition of critical care as specialty

“Nurses dispense comfort, compassion, and caring without even a prescription”

-Val Saintsbury

Critical care evolved from an historical recognition that the needs of patients with acute, life-threatening illness or injury could be better treated if they were grouped into specific areas of the hospital. Critical care evolves from the need to care for post-operative patients away from the general ward. In 1854, Florence Nightingale left for the Crimean War, where triage was used to separate seriously wounded soldiers from the less-seriously wounded. Until recently, it was reported that Nightingale reduced mortality from 40% to 2% on the battlefield. Although this was not the case, her experiences during the war formed the foundation for her later discovery of the importance of sanitary conditions in hospitals, a critical component of intensive care.

In 1947-1948, the polio epidemic raged through Europe and the United States, resulting in a breakthrough in the treatment of patients dying from respiratory paralysis. Critical care nursing is highly technical and is generally considered beyond the level of a new graduate. Critical care unit is usually reserved for patients with threatened or established organ failure, often arising as a result or complication of an acute illness or trauma, or as a predictable phase in a planned treatment programme. Thus critical care encapsulates intensive care, high-dependency care and any other care with higher observational requirements than those available on a general ward.

Critical care units are characterized by complicated machinery, high noise level, and physical contact with blood, vomitus, time pressure, infection hazards, and unpredictable emergencies. Critical care nurses could be referred to as the “guardians of humanity” and the “sentinels of society,” with good reason. A life in nursing, although comfortable, will not make a millionaire, but it will provide steady, worthwhile, satisfying employment for those with the moral strength, smarts, stamina, and savvy. Critical care areas are usually defined as intensive care, postoperative recovery, burn, emergency care, and telemetry units. Thus critical care encapsulates intensive care, high-dependency care and any other care with higher observational requirements than those available on a general ward.
2.4.2. **Evolution of critical care in India**

In 1923, what could be claimed as the first intensive care unit (ICU), a small facility for post-operative neurosurgical patients was opened at the Johns Hopkins Hospital in Baltimore, USA. The patterns of medical problems seen in Indian intensive care unit (ICUs) are dissimilar to those seen elsewhere. Critical care practices in India have evolved significantly over the past two decades. Critical care medicine is a brand of medicine concerned with the provision of life support for critically ill patients.

Critical care initially began as a service in major hospitals, but with the formation of the Indian Society of Critical Care Medicine, the development of this specialty has been very rapid, and its association has played a great role in the growth of critical care in India. The coronary care units were developed in the early to mid-1970s. Around the same time Dr. Farokh E Udwadia, developed the first respiratory care unit in two hospitals of Mumbai- a community hospital and a private one. The most major achievement of these units was not only to bring down the mortality of tetanus, but also to open the eyes of society to the need for critical care services.

The patterns of medical problems seen in Indian intensive care units are dissimilar to those seen elsewhere. These also change with the categories of the hospital. A number of tropical infections such as malaria, leptospirosis, tuberculosis, etc. form a significant proportion of the patients. Even today, the mortality from severe sepsis in our country is very high. Throughout this chapter, the term ‘critical care’ will be used to refer collectively to both intensive care and high-dependency care. It is important that the critical care nurse understands the peculiar nature of the patient's stay in the hospital and make the physical, mental and social environment conducive to recovery.

Critical care nurses make important patient care decisions under conditions in which there is no certainty concerning events and outcomes every day. Thus the role of critical care nurses at the intensive care unit or high dependency units will vary depending on their expertise, facilities and support services, as well as the severity of illnesses and number of patients admitted. Nurses working in critical care units could be referred to as the” life savers”, “guardians of humanity” and the “sentinels of society,” with good reason of patients care.
2.4.3. Critical care Vs Emergency medicine

Critical care refers exclusively to the treatment of patients who suffer from life-threatening conditions. Emergency room physicians and nurses treat patients who suffer from relatively minor emergencies like mild attack, sprained ankles, broken arms to those with major problems including heart attack, knife or gunshot wounds or drug overdoses. In the emergency department, physicians and nurses stabilize patients and transport them to the intensive care units or other area of the hospital for further treatment. Thus the long-term management of critically ill and injured patients is provided by critical care professionals, often in the intensive care units. Working as a critical care nurse requires more training and hard work in order to be and stay competent within the field.

2.4.4. Types of Critical Care Units

a. General intensive care units (ICU)

Most intensive care units are general and take both medical and surgical patients with a range of underlying diseases. Many hospitals have many specialized high-dependency units, while others will admit high-dependency patients into intensive care beds. In much the same way, coronary care beds are sometimes provided in the same unit (Dragsted L, Qvist J 1992). An intensive care unit should be able to manage all the common organ system failures and hence provide respiratory support (including mechanical ventilation), circulatory support and renal support and provide the full range of invasive monitoring required for such activity.

b. High-dependency care units (HDCU)

A high dependency unit is a specially staffed and equipped section of an intensive care complex that provides a level of care between intensive care and the general ward area and that typically patients admitted to high dependency units will have single organ failure and are at risk of developing complications. The high dependency unit may operate independently from the intensive care unit and may be specialty-specific. Specialized units also exist at intensive care unit level or at high dependency unit level, sometimes at combined units’ level depending upon the specific disease categories.
Specialized units deal with specific disease categories. The larger and more specialized hospitals will provide more specialized types of critical care as follows:

1. Neonatal intensive-care unit (NICU)
2. Special-Care Nursery (SCN)
3. Pediatric intensive-care unit (PICU)
4. Psychiatric intensive-care unit (PICU)
5. Coronary care unit (CCU)
6. Cardiac Surgery intensive-care unit (CSICU)
7. Cardiovascular intensive-care unit (CVICU)
8. Medical intensive-care unit (MICU)
9. Medical Surgical intensive-care unit (MSICU)
10. Surgical intensive-care unit (SICU)
11. Surgical intensive-therapy (SIT)
12. Overnight intensive recovery (OIR)
13. Neurotrauma intensive-care unit (NICU)
14. Neurointensive-care unit (NICU)
15. Burn wound intensive-care unit (BWICU)
16. Trauma Intensive-care Unit (TICU)
17. Surgical Trauma intensive-care unit (STICU)
18. Trauma-Neuro Critical Care (TNCC)
19. Respiratory intensive-care unit (RICU)
20. Geriatric intensive-care unit (GICU)
21. Mobile Intensive-Care Unit (MICU)
22. Post Anaesthesia Care Unit (PACU) etc.
2.4.5. Critical care nurses qualities

"To do what nobody else will do, a way that nobody else can do, in spite of all we go through; is to be a nurse."

-Rawsi Williams

It is hard work with numerous challenges, as well as rewards. It takes a very strong, smart individual to work in nursing and requires frequently working from the heart as well as the mind. It is important to realize that the critical care nurse’s accumulated knowledge extends beyond one’s basic level of nursing education. Critical care nursing requires a nurse to have additional skills. The critical care nurse needs to:

- Be well versed in advanced with excellent critical thinking skills.
- Ability to make sound clinical judgments
- Be adept and calm while treating patients in environments
- Quick decision-making skills under life-threatening conditions
- Stay abreast of changing advanced technology to preserve organ function
- Coordinate the care with multiple influencing factors
- Provide leadership in the management of care
- Coordinate the multiple disciplinary team and strong interpersonal skills.
- Ability to work collaboratively with patients, family members and health-care team.
- Flexibility in managing rapidly changing patient situations.
- Good communication to explain in proper manner to doctors, patients family and others
- Motivation and energy to learn and expand practice etc.

CCN’s need jobs where they can thrive and grow. Hospital administration should give good pay, work values, autonomy, delineation of tasks/duties, quality patient care conditions; sound organizational policies, support and structure to motivate retain the nurses.
2.4.6. The role of critical care nurses

Critical-care nurses rely upon a specialized body of knowledge, skills, and experience to provide care to patients, families and create environments that are healing, humane, and caring to critically ill patients. Foremost, the critical-care nurse is a patient advocate. Critical-care nurse’s practice in settings where patients require complex assessment, high intensity therapies and interventions, and continuous nursing vigilance, thus their main role are:

a. Improving patient outcomes

Critical care nurses can improve patient recovery by using patient-centered care, pro-active management and vigilance, coping with unpredictable events, and providing emotional support. Patients are helped by skilled and timely reduction of sedation, weaning from ventilation, physical rehabilitation, and psychological support. Thus, skilled critical care nursing will reduce the risk of complications, the number of critical care bed days and improve patient outcomes (Thorens et al 1995)

b. Observation

Critical care nurses must provide continuous observation of critically ill patients which will reduce a patient’s risk of precipitous deterioration, monitor their total dependence on support equipment and prevent their agitation or confusion leading to harm. Observation involves assimilation, interpretation and evaluation of information, including the patient’s physical and psychological response to interventions, changes in condition, the significance of monitored physiological parameters and the safe functioning of equipment. Only appropriately trained and experienced nurses can provide this comprehensive level of observation.

c. Communication

Critical care nurses provide information to patients, relatives and other members of the interdisciplinary team. Nurse’s roles should not include making up for a shortfall in administrative, clerical, technical and cleaning staff (Department of Health London (2001). The nurse caring for acute and critically ill patients evaluates patient’s progress toward attaining expected outcomes and communicate it to the required persons especially the family members who expects the words from the nurses.
d. Critical thinking

The critical care unit is a place of high patient acuity, complex pathologies, and multiple “unknowns.” These characteristics require nursing staff to display unique qualities and high levels of critical thinking. The qualities that make the critical care unit such an interesting place include:

- What kind of admissions will arrive today?
- When will they arrive?
- How acutely ill will they be?
- What signs/symptoms of pathologies will patients present with?
- How many will require immediate life-saving measures?
- What type and how many monitoring devices will the patient require?
- What level of understanding will patients and/or their family possess?

Often, these critically ill patients are unable to communicate their symptoms or their needs. Consequently, critical care nurses must be able to make decisions based on physical examinations, patient assessments, and data obtained through monitoring devices. Utilization and critical application of all these data will allow the critical care nurse to provide the best care to his or her patients (Shelley Cohen 2007).

e. Caregiver role of nurse at ICU

A caregiver’s knowledge of and attitudes about symptoms such as pain and fatigue may influence the patient. A caregiver who harbors fears of causing addiction, overdosing, or indirectly causing discomfort through side effects may guard the medication supply, limit its use, and under medicate the patient (Ferrell, et al 1995).

f. Counseling and Psychotherapy

Counseling and psychotherapy are designed to reduce distress by helping caregivers adjust psychologically to the demands of care giving with support, education, and problem-solving or coping skills. These interventions are typically to enhance morale, self-esteem, coping, and sense of control while reducing anxiety and depression.
2.5. WORK LIFE BALANCE

“Life is like riding a bicycle. To keep your balance, you must keep moving.”

- Albert Einstein

Balance as an English language is a complex word with a variety of meanings. As a noun, a balance is a set of scales, a weighing apparatus. If we use the scales, then balance occurs when there is “an equal distribution of weight or amount”. However balance also has a physical and psychological meaning as “stability of body or mind”. Balance has been put by Oxford English Dictionary as “to offset or compare; to equal or neutralize, to bring or come into equilibrium”. There is an unspoken normative assumption that balance is good.

Work-life balance begins with the concept of balance, now the balance to be done between work and life. Work can be initially defined as paid employment and includes extra unpaid hours, travelling time, break time and all the work related hours. In simple terms, “work” is normally conceived as including paid employment while “life” includes activities outside work. Clark (2000) defines balance as “satisfaction and good functioning at work and at home with a minimum of role conflict”.

Work-life balance has been defined as the sufficient time to meet commitments both at home and work as well as satisfying, healthy, and productive life that includes work, play, and love, that integrates a range of life activities with attention to self to personal and spiritual development; and that expresses a person’s unique wishes, interest and values. While the definition of work-life balance play besides love and work, much of the previous literature on work-life balance has focused on the work-family interface (Burke & Greenglass, 2001).

In the 1990s, the term “work-life balance” emerged and replaced discussions of “work and family”. This implies that work-life issues are no longer only just women’s issues or family issues but also the organizations issue and societal issue. Even though there are many researches in work life balance the link of it with the life satisfaction is still unexplored. Every one wants to have life satisfaction which is possible only with a balanced work life and family life. The increased interest in understanding the work-family interface stems from the demonstrated outcomes of work-family conflict on life satisfaction.
2.5.1. Conceptual clarity of work-life balance

The concept of work-life balance is that work and life are separate, the spheres are in conflict and that balance between the two spheres is sought. Not only is balance sought, the promise is that balance, once achieved, creates contentment (Jackson, 2002). Additionally, both poles of the balance-work and life/family are contested concepts. The term ‘life’ seems to equate to ‘non-paid-work’, an expansive grouping that can include such categories as family, friends, pets, leisure, recreation, unpaid home activity, caring for children, and love-motivated activities.

Generally, the Work-life balance debate assumes that individuals have too much rather than too little work. High-level long hour’s employees tend to explain why they accept schedules consisting of long or odd hours in terms of low-level employees tend to say that they need the money. The work-family conflict is an important concern for individuals and organizations alike because such conflict, as a source of stress, has been correlated with negative consequences, including reduced job as well as family satisfaction which can lead to reduced life satisfaction. Interference occurs when conflicting demands make it difficult to fulfill the requirements of multiple roles.

Consideration of individual life paths is also important for the organization to find the factors pressurize their work life balance. Work and family were viewed as women’s issues or social issues instead of business issues latter it became business issues when they were introduced into employment policy by human resource professionals in the late 1980s (Frame & Hartog, 2003).

Work/life debates are now concerned with the needs of those with family responsibilities as well as organizational needs. The increased interest in understanding the work/family interface stems from the demonstrated outcomes of work-family conflict on role and life satisfaction. The work life balance survey aims to measure how effectively organizations accommodate work life balance, by assessing employees’ awareness of work life balance policies and their comfort levels in using these policies. Work/life balance policies can assist employees achieving a balance between their work and personal commitments. This trend results in work-family conflict as women try to cope with conflicting demands of work and the family.
2.5.2. Models of Work life balance

There are typically eight main models used to explain the relationship between work and life outside work. First Greenhaus and Beutell (1985) defined work-family conflict as, “a form of inter role conflict in which the role pressures from the work and family domains are mutually incompatible in some respect” and reported that work-family conflict can be conceptualized and measured as (a) time-based, (b) strain-based, and (c) behavior-based.

Work-family conflict based on time occurs when responsibilities in one domain are difficult to fulfill because of the time spent in the other domain. Strain-based work-family conflict occurs when the psychological demands in one domain interfere with normal responsibilities and relationships in the other domain. These forces are generated or affected by organizational, family interpersonal relationship, and personal characteristics.

Zedeck and Mosier (1990) and O’Driscoll (1996) note that there are typically five main models used to explain the relationship between work and life outside work as segmentation model, spillover model, compensation model, instrumental model & conflict model. The segmentation model hypothesizes that work and non-work are two distinct domains of life that are lived quite separately and have no influence on each other. This appears to be offered as a theoretical possibility rather than a model with empirical support.

The second spillover model hypothesizes that one world can influence the other in either a positive or negative way. There is, of course, ample research to support this but as a proposition it is specified in such a general way as to have little value. We therefore need more detailed propositions about the nature, causes and consequences of spillover.

The third model is a compensation model which proposes that what may be lacking in one sphere, in terms of demands or satisfactions can be made up in the other. For example work may be routine and undemanding but this is compensated for by a major role in local community activities outside work. Compensation to both work and family was found to be a difficult task.
A fourth model is an instrumental model whereby activities in one sphere facilitate success in the other. The traditional example is the instrumental worker who will seek to maximize earnings, even at the price of undertaking a routine job and working long hours, to allow the purchase of a home or a car for a young family.

The fifth model is a conflict model which proposes that with high levels of demand in all spheres of life, some difficult choices have to be made and some conflicts and possibly some significant overload on an individual occur.

Further the sixth model is termed as border theory (Clark, 2000). It argues that people are daily border-crossers as they move between home and work. This opens up a rich vein of analysis of the nature of borders, their permeability, and the ease with which they can be managed or moved and so on.

The seventh models of work-life balance can also be enriched by the psychology of individual differences. For example, there has been some research on “workaholics” who are characterized as those who choose to work long hours even when they may not need to do so. More recently, Scott, Moore and Miceli (1997) have linked it to three relatively stable personality types, the achievement-oriented, the perfectionist and the compulsive-dependent

The understanding of these models will help the Effective work-life balance policies are valuable to businesses and organizations for a number of reasons, including (Sandep Aggarwal 2012):

- Reduced employees turnover rates
- Becoming a good employer or an employer of choice
- Increased return on investment in training as employees stay longer
- Reduced absenteeism and sick leave
- Improved morale & satisfaction
- Greater employees loyalty and commitment
- Improved productivity
2.5.3. History of work and family research in India

Mid 70s – mid 80s: Exploratory studies mainly on working women, preoccupied with changing status and roles of working women and societal perceptions of them. It appears from our review so far, that during the decade of mid-1970s to mid-1980s, there was a ‘disconnect’ between the various streams of research on work and family in India. There was one stream of research seemed to clearly indicate that as far as underprivileged sections of society were concerned, plight of working women was deteriorating, and nature of family organization was contributing to their deprivation. There were two things however that were in common across both streams of study. One was the observation of a dual burden borne by working women in India regardless of their class and status group that resulted in considerable stress and strain. The other was the absence of men from participant samples in these studies. In this decade as though the study of work and family in India was in fact the study of women, work and family.

Mid 80s – mid 90s: Inclusion of men in samples, results showed greater responsibility for family duties rested with women, women were more stressed. Clearly the ‘disconnect’ between research on work and family in different social science disciplines in India continued into this decade. The development was perversely contributing to the underdevelopment of women, and working status was no guarantee to more egalitarian relations within the family regardless of one’s class and socio-background.

Mid 90s – mid 2000: More studies on dual career as opposed to dual worker couples, no significant differences in conflict and stress for men and women, however sources of stress and conflict differed. One of the most significant events of this decade was liberalization and reform of the Indian economy in 1991. With this change in government policy, India became connected to a fast globalizing world. Research on work and family evolved accordingly but in the route that had been set so far.

2000 onwards: Some focus on organizational policies towards women, increasing concern about how the hospital sector is affecting work-life balance for ‘all’ employees.
Figure 3: The Evolution of work-life

2.5.4. Importance of Work life balance in Nursing

“A woman has to live her life, or live to repent not having lived it.”

-D.H. Lawrence

Work-life balance is about creating and maintaining supportive and healthy work environments, which will enable employees to have balance between work and personal responsibilities and thus strengthen employee loyalty and productivity. Work life balance problem is increasing over time due to high female participation rates, increasing single parent families, the predominance of the dual-earner family and emerging trends such as elder care. Balance is not getting easier rather becoming more complicated.

It is further exasperated with globalization, an aging population, and historically low unemployment, job security, support from one’s supervisor, support from co-workers, work demands or overload, work-role conflict, work-role ambiguity, job dissatisfaction, and extensive use of communication technology that blurs the boundaries between home and work. Today’s women have many competing responsibilities such as work, children, housework, volunteering, spouse and elderly parent care and this places stress on individuals, families and the communities in which they reside.

Work-life conflict is a serious problem that impacts workers, their employers and communities. The negative effects of work life conflict long work hours and highly stressful jobs not only hamper employees’ ability to harmonize work and family life but also are associated with health risks, weight gain and depression, sleep, marital dissatisfaction, job dissatisfaction & career satisfaction.

Kopelman et.al. (1983) found work-family conflict is an important concern for individuals and organizations alike because of its negative consequences leading to reduced job satisfaction as well as family satisfaction and hence to reduced life satisfaction. According to Adams et al. (1996), the relationship between work and family can significantly affect both job and life satisfaction. The level of involvement the individual assigns to work and family roles is associated with this relationship. According to them, positive balance suggests an equally high level of satisfaction with work and non-work roles while negative balance implies an equally low level of satisfaction with those roles. Adams et al. focus on balance and satisfaction.
2.5.5. Predominant originator of work/family Interference

“Being a woman is a terribly difficult task, since it consists principally in dealing with men.” - Joseph Conrad

Work and family were once described as “myths of the separate worlds” in which the two domains were independent of each other. This conceptualization changed with the introduction of the concept “asymmetrical permeable” boundaries between the work and family domains. The stressors and demands that originate in one domain intrude upon the other at a different level of intensity.

This study is designed to investigate the relationship between the bi-directional elements of work/life conflict on life satisfaction as mediated by the coping strategies. The work-family interface is bidirectional, that is, work can interfere with family and family can interfere with work. The bidirectional nature of the work-family interface is important because the consequences of the conflict are dependent on where the conflict originates from work or from family which differs from industry to industry. Frone et al. suggested that WFC and FWC are related through a bi-directional nature where one can affect the other. While these negative influences were consistently presented by majority researches of nursing.

2.5.5.1. Personal Characteristics

The personal characteristics include the demographic characteristics like age, education, experience, nature of job, marital status, and income.

2.5.5.2. Work and Home demands

A major predictor of behavioral involvement in both the family and work domains is time demands. As time demands in a domain increase, the level of behavioral involvement in that domain also increases, resulting in less behavioral involvement in the second domain, thus producing work-family conflict. It is also found that increased family involvement was associated with family-work interference, such that thoughts about family life while in the work domain interfered with work performance. Gaining a better understanding of the conflict arising from family life and work life and the satisfaction as outcomes of role conflict is an important area of concern with the increase in the participation of women in the work-force.
Work-family interference (Work factors)

Work can be initially defined as paid employment. Work-home interference is often defined as a form of inter-role conflict in which the role pressures from the work and family domains are mutually incompatible in some respect (Greenhaus & Beutell, 1985). Work interferes with family occurs when work demands and responsibilities make it more difficult to fulfill family role responsibilities. The values placed on these factors are based on how one perceives their own role and how these factors affect them in the family domain.

There are associations between the amount of time spent at work and work-to-family interference, career identity, work overload, financial need, organizational work hour expectations, non-job responsibilities, relationships with others, understaffing etc. The higher levels of work-to-family conflict reported by nurses often are a function of their longer work hours. Issues impacting on work-life balance in the workplace are outlined following:

- **Responsibility**

  Many employees felt a level of personal responsibility to meet deadlines and patients expectations, even if these expectations were often unable to be met by working standard hours. Many organizations view the ideal worker as one who is "committed to their work above all else (King, E., 2008).

- **Lack of staff**

  Operating with few staff is a common issue impacting on work-life balance. There is a 40-50 percent shortage of nursing personnel due to increasing demand for nurses, nursing services in the healthcare sector across the country and globally (Ravi. V, 2012).

- **Additional work hours**

  Most employees claimed to have worked additional hours at some time. There was general agreement that calls to undertake extra hours were acceptable as long as the employee had the option to refuse and requests were not constant. While systematic data on trends in the number of hours worked per day by nurses are lacking, anecdotal reports suggest that hospital staff nurses are working longer hours with few breaks and often little time for recovery between shifts (California Nurses Association, 2001).
Family- work interference (Home factors)

In simple terms, “family life” includes activities outside work. Baruch and Barnett found that there is a positive association between multiple roles and good mental health when a woman likes her job and likes her home life. The influences outside the workplace are many. The home demands like home duties, family responsibilities & care, relationship, maintaining standard of living, maintaining cost of living, caring family, spending time with family, going home on time etc influence the critical care nurses:

- **Home duties**
  
  Many felt that uncompleted tasks around the home were a constant pressure. As many of these tasks were on-going, most noted that there was always some task left unfinished. As these duties were also unpaid work, they were more easily left. Female participants also noted that having an unsupportive partner could exacerbate the pressure to complete these home duties. Also male expects women to undertake all home duties.

- **Relationship with relatives, friends & neighbours**

  Women felt that pressure to conform to certain stereotypical roles which contributed to work-life imbalance. Female participants noted some pressure as mother. Many had elderly or sick family members and relatives who required the support at home with tasks such as shopping or household duties (Karasek, 1979).

- **Family responsibilities and care for family members**

  Even though family provides immense joy and personal satisfaction, children, parent and life partner place some pressures on women nurses that impacted on work-life balance. Children were generally acknowledged as the top priority for every parent not exceptionally the critical care nurses (Dreher Dougherty, 2008).

- **Maintaining Cost of living**

  The monetary costs have been well known for a number of years by the hospital administrators but only a little has been done. Low salary was seen as issues that could increase the financial burden on individuals. Many researches are also evident that the pay for critical care nurses is not in par with their roles and workload (Pratibha P. Kane, 2009).
2.5.5.3. Shift work

Shift works are increasing in healthcare industries and work outside daytime hours is unavoidable. Shift works have often been introduced with little or no consideration of the risks to health and safety. Employers owe a legal duty of care to employees which include ensuring that health and safety. The employers treat all hours the same and pay for the work that is done in all shifts as same, they consider what is done and not when it is done. Some people work shift work and extended hours as a matter of economic necessity.

Studies have shown that shift-work can have negative impact on job performance, sleep, physical, emotional health, social life, family life, drug use and level of job-related stress. For nurses these negative effects have consequences not just for the individual, but also for the workplace as decreased alertness and reduced job performance could endanger human lives (Brown- DeGagne & Eskes, 1998). In general, the term ‘shift work’ is quite vague and includes any organization of working hours that differ from the traditional work period; sometimes it is a synonymous of irregular or odd working hours”(Costa, G.,2003).

Because shift workers are on the job in the evening or on weekends, or because they sleep during the day, they often miss out on social or family activities which the society and family expects from the critical care nurses. Child care or visits to the children’s school also can be a problem because of the work schedule. (Roger 1997). Nurses need jobs where they can thrive and grow. The hospital administration should give good pay, work values, autonomy, delineation of tasks, quality conditions; sound organizational policies, support and structure etc to motivate retain the nurses.

Plentiful researchers like Netemeyer, Boles, McMurrian (1996), Adams et al. (1996), Duxbury & Higgins (2001), E. Demerouti et al. (2001) Martins et al. (2002), Fisher-McAuley et al. (2003), Schieman et al. (2003), Grzywacz & Bass (2003), Sandhu & Mehta (2006), Pal & Saksvik (2007), Haar & Baroel (2008) and few more found that there exist work family interference. Thus based on the well-known researches it is proven that the main indicators of work family interference of critical care nurses are; work-family interference, family-work interference and shift work.
2.6. OUTCOMES OF WORK/FAMILY INTERFERENCE

Several models of work-family conflict have been proposed by different on the spillover of work-family conflict to different domains. The issues associated with balancing work and family are of paramount importance to individuals, the organizations that employ them, the families that care for them, the unions that represent them and governments concerned with global competitiveness, citizen well-being and national health. Thus, they point out that WLB is about achieving a satisfying quality of life, overall satisfaction with less stress in managing role demands. (Lewis et al. 2007).

Duxbury, L. Higgins, C. Lee and Mills (1991) “explore how the changing relationship between family and work affects organizations, families and employers. It must be noted that past researchers have suggested that work-family conflict and family-work conflict are two factors of one overall construct the present study treated work-family conflict as one overall construct. Thus, the purpose of the present study was to test a comprehensive model of consequences work family interference that examines:

- Individual-related consequences (physical health, work and family stress, depression, burnout, psychological strain, sleep disorder)
- Family-related outcomes (marital satisfaction, family satisfaction) and
- Work-related outcomes (job satisfaction, career satisfaction, commitment turnover intentions, absenteeism)

2.6.1. Individual Employee Outcomes

A thought provoking recent studies are related to occupational risk due to biological disruptions of shift work. The work life interference can disrupt many parts of a person’s life. Studies have shown the negative effect of work life interference on a person’s life tremendously. Work life interference can increase the risk for other disorders, such as major depression which can further negatively affect a person’s life, such as improper sleep, dreadful relationships outside work and work. Thus work life interference will have its impact on the physical health, psychological well being and sleep disorder of critical care nurses.
2.6.1.1. Physical Health

“When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied.”

-Herophilus

High levels of work-family conflict produce adverse physical health (Frone et al., 1997). The strain imposed by work-family conflict has also been linked to decreased appetite and energy levels, increased cholesterol levels and somatic coronary heart disease complaints. The effects of critical care work on pregnancy and menstruation increased risk of miscarriage, low birth weight and preterm births are also being increasing. The job nature of critical care nurse like responding & moving quickly in an emergency, closely seeing & monitoring of patients, thus are supposed to use hands, arms & legs freely without restrictions which cause exhaustion to them. Few symptoms of physical health effects considered in this study are;

**Gastrointestinal (GI) Disorders**

Gastrointestinal dysfunction is common in shift workers. Gastritis or other digestive disorder has been an explanation frequently given by shift workers for absenteeism and for switching to day work for health reasons. The causes are likely to be multiple, but diet, drinking alcohol, upset stomachs, constipation, and stomach ulcers and general stress have all been suggested, in addition to irregular meal times.

**Cardiovascular Morbidity**

The term "cardiovascular disease" (CVD) comprises, cerebrovascular diseases and diseases in larger arterias and veins, especially in the form of claudicatio intermittens. Ischaemic heart disease (IHD) or coronary heart disease (CHD) comprises myocardial infarction, angina pectoris, sudden death, cardiac failure, and cardiac arrhythmias.

**Cholesterol**

Shift work schedules among critical care nurses have been reported to have deleterious effects on biomarkers of cholesterol. Several studies suggest that shift work
may increase serum triglyceride and low density lipoproteins. The adverse effect of cholesterol leads to many other complications.

**Reproductive Health**

The relationship between shift work, irregular hours and various working conditions is associated with occupational fatigue factors, risk for premature birth although with low birth weight, but not preterm birth, slow fetal growth and increase the risk of preterm delivery and spontaneous abortion etc.

**Cancer**

There are comparatively few studies which do not suffer from major design defects, and which have considered these symptoms. The factors that may affect cancer risk, is found that those working rotating shifts had a significantly higher risk of prostate cancer than day workers, but there was no significant increase in risk for those on fixed night shifts.

**Musculoskeletal Disorders**

The term MSD covers any injury, damage or disorder of the joints or other tissues in the upper/lower limbs or the back. Trauma to an area (jerking movements, auto accidents, falls, fractures, sprains, dislocations, and direct blows to the muscle) also can cause musculoskeletal pain. Other causes of pain include postural strain, repetitive movements, overuse, and prolonged immobilization.

**Diabetes Mellitus**

Basal insulin secretion and glucose tolerance normally follow a circadian rhythm. Plasma insulin response to intravenous tolbutamide has been shown to peak early in the morning around 0400. Detailed attention to the type and amount of food eaten are also important elements in the clinical management of diabetes.

**Epilepsy**

Epilepsy is a common symptom and diverse set of chronic neurological disorders characterized by seizures. In many cases a cause cannot be identified; however, factors that are associated include brain trauma, strokes, brain cancer, and drug and alcohol misuse among others. Epileptic seizures result from abnormal, excessive or hyper synchronous neuronal activity in the brain. Epilepsy is usually controlled, but not cured, with medication.
Asthma

Asthma is a common chronic inflammatory disease of the airways characterized by variable and recurring symptoms, reversible airflow obstruction and bronchospasm. Common symptoms include wheezing, coughing, chest tightness, and shortness of breath. Asthma is thought to be caused by a combination of genetic and environmental factors. Circadian rhythms of airway resistance have been demonstrated by pulmonary function testing in normal and asthmatic subjects.

Other symptoms

The effects on health of critical care work are many. Changes in posture or poor body mechanics may bring about spinal alignment problems and muscle shortening, therefore causing other muscles to be misused and become painful. Many symptoms are also recorded earlier like frequent headaches, dizziness and chronic nausea. There are few studies which provide evidence for a greater tendency of leg swelling, blood clots in leg, varicose veins and knee pain because of continuous standing, lighting, carrying, pulling, bending for medicating, frequent walking for observation etc.

Work family interference has several health hazards. Those already suffering from digestive disorders, diabetes, heart diseases, face additional burdens etc found to increase. However working as nursing practitioner in critical care unit, an environment marked by high volumes of critical incidents, the researchers like Graeber et. al, (1978), Angersbach et al, (1980), Costa et.al, (1981), Rutenfranz et. al, (1985), Segawa K (1987), Simon, (1990), Spiegel K et.al, (1999), D. S. Rawat (2003) observed the negative effects on the physical health of nurses adversely affected by excruciating experiences in the critical care unit.

Findings of several researches demonstrate that nurses at critical care have complete eight hour work shift with few normal rest period, and have to tolerate the odors related to blood and other body fluids, at times they are wounded with needle stick also which will be painful for them. To reduce the risk of developing long-term physical health symptoms due to exposure to horrific events, all rescuers (including A&E nurses) should have access to strategies given by this study.
2.6.1.2. Psychological Health

“A cheerful heart is good medicine, but a crushed spirit dries up the bones”

-The Bible

Staff in the health care sector is particularly subjected to such mental health risks World Health Organization (WHO), 2004. The shift workers have been shown to experience a number of psychological disturbances and family dysfunctions, as a result of which there is a serious impact on the family and social life. The irregular work hours affect the worker, her spouse, children and whole family. According to the International Labour Organisation (ILO, 2005) psychosocial problems may result in illness, injury, stigmatization, isolation, and even death. Therefore, it is important and very useful to invest in mental health promotion in this sector.

The difficulties in psychological well-being are mainly due to an inharmonious relationship between work schedules of shift workers and those of other day workers.

According to the WHO (2009), mental health can be conceptualized as ‘a state of well-being in which the individual:

- realizes his or her own abilities;
- can cope with the normal stresses of life;
- can work productively and fruitfully;
- is able to make a contribution to his or her community

Mental health is the foundation for well-being and effective functioning for an individual, family, organization and for a community. Over the past two decades, there has been a growing belief that stress at work has undesirable effects, both on the health and safety of workers and effectiveness of their organizations. Psychological stress will be used as an indicator of psychological well-being resulting from work-family conflict in this research. Studies have found an association between work life conflict and psychological wellbeing as;

- Stress (Work Stress & Home Stress)
- Anxiety & Depression
Stress

The task of tending to the needs of the sick, the disabled, and the dying can be very stressful. Employees in the health industry face significant risks of "burnout" which involves emotional exhaustion, depersonalization and low productivity associated with feelings of low achievement (Thompson J-1989). The shift work job demands are most associated with emotional exhaustion. The resulting stress can show itself in reduced efficiency, lack of job satisfaction, fear of injury, absenteeism, turnover, illness, indifference, lack of creativity, and bad decisions. The research has identified sub-scales of workplace stressors and home stressors that might impact on nurses.

The work place stress factors are: not finishing work in time, backache due to long standing hours, shortage of staff, long work hours/ Overtime, dealing with emergencies, problematic patients, death of patient, needle stick injuries, exposure to infections, exposure to work-related violence or threats, lack of social support at work, ergonomic factors. The home stress factors: father/partner problematic; dependant relatives; sole earning member; need of crèche; no/low family support.

Anxiety & Depression

Many studies have found a relationship between shift work and anxiety, and between shift work and depression (Healy et al 1991). Depression is a condition in which a person feels discouraged, sad, hopeless, unmotivated, or disinterested in life in general. The disorders are two sides of the same coin. Over the past couple of years, clinicians and researchers alike have been moving toward a new conclusion: Depression and anxiety are not two disorders that coexist. They are two faces of one disorder. Whereas the world of mental health care, where exact diagnosis dictates treatment, anxiety and depression are regarded as two distinct disorders.

But in the world of real people, many suffer from both conditions. It just seems that some people with the vulnerability react with anxiety to life stressors. And some people, in addition, go beyond that to become depressed. Taking into account the worker's psychological well-being, this study includes the psychosocial stress factors like feeling tensed, worrying, hurting, dreaming bad, getting frightened, feeling panic, feeling dejected, getting frightened etc.

To summarize, the problem researched in this study evolved from the critical care nurses were exposed to a high frequency of critical incidents leading to high levels of psychological symptoms such as stress, anxiety & depression. The relationship between critical care nursing and the psychological well-being of the critical care nurse has been explored by different authors. Interventions would help them develop a more positive attitude toward their clients/patients, and reduce negative experiences of stress resulting from their caring role, reduce and fatigue, tiredness, anxiety and depression arising out of the critical nursing. The critical care nurses become hazard not only to themselves, but also to the patients, if they were not being regularly treated/looked after psychologically.

2.6.1.3. Sleep

“There is no medicine like hope, no incentive so great, and no tonic so powerful as expectation of something better tomorrow.”

-Orison Swett Marden

Sleep can be defined as a normal state of altered consciousness during which the body rests; it is characterized by decreased responsiveness to the environment, and a person can be aroused from it by external stimuli. Sleep is a basic human need related to both circadian rhythms and homeostatic mechanisms of the body. The suprachiasmatic nucleus in the anterior hypothalamus is located above the optic chiasm, this area receives input from the retina, which provides information about darkness & light and controls the production of melatonin, which is believed to be a potent sleep inducer. Working outside and inside the house formed two central domains in women’s life, and each domain contains its own duties which reduces them to allocate time for their sleep.
Normal Sleep Requirements & Patterns

Sleep duration and quality vary among persons of all age groups

- Infants - 16 Hours /Day
- Toddlers - 12 Hours /Day
- Preschoolers - 11 Hours /Day
- Schoolers - 9 - 10 hours /day
- Adolescents - 8 - 9 hours /day
- Adults - 6 - 8 hours /day

(Source: http://nursingplanet.com/pn/nursing_management_sleep_disorders.html).

The National Sleep Foundation polls have identified that women consider getting enough sleep as their lowest priorities (NSF, 2007). The arousal and wakefulness of sleep rely on the Reticular activating system (RAS) which is located in the brain stem. The sleep disorders like difficulty in initiating or maintaining sleep (insomnia) or by excessive sleepiness may arise predominantly from within the body (intrinsic), from external sources (extrinsic), or from disruption of circadian rhythm. A dyssomnias sleep pattern disturbance is given below:

(i) Intrinsic sleep disorders
   c. Sleep apnea syndrome (Karl Doghramji, 2008)
   d. Restless leg syndrome (Belenky, et.al, 2003)

(ii) Extrinsic sleep disorders
   e. Circadian rhythm sleep disorders (Belenky, et.al, 2003)
      - Inadequate sleep hygiene
      - Environmental sleep disorder
i. Intrinsic sleep disorders

Intrinsic sleep disorders originate from within the body or arise from causes within the body. Management of dyssomnias is complex. These are of four classifications as:

a. Insomnia:

It is the persistent difficulty in initiating or maintaining sleep. The difficulty does not respond readily to improved sleep habits or removal of precipitating factors. Insomnia is the inability to sleep or inability to sleep well at night. The total sleep time is often within normal range but is felt inadequate. Management of insomnia is complex. It is difficult to get sleep in places, other than their usual bedroom symptoms of insomnia are:

- Difficulty falling asleep/ having un refreshing sleep
- Waking up often during the night and having trouble going back to sleep
- Waking up too early in the morning
- Having at least one daytime problem such as fatigue, sleepiness, concentration,
- Accidents at work or while driving, etc.

b. Narcolepsy (Excessive daytime sleepiness):

Narcolepsy is a chronic sleep disorder that commonly begins during adolescence and is characterized by excessive daytime sleepiness with the occurrence of sleep attacks. Narcolepsy can run in families, but can occur in the absence of any family history as well. The critical care nurses also experiences disturbed nocturnal sleep and repeated episodes of almost irresistible daytime drowsiness followed by brief periods of sleep. Many critical care nurses reporting that they have fallen asleep at work, while driving/travelling or both.

c. Sleep apnea syndrome:

Sleep apnea is characterized by cessation of breathing for 10 seconds or longer occurring at least 5 times/hour. Sleep apnea is a common and potentially devastating sleep disorder. Apnea means "not breathing." Critical care nurses with sleep apnea actually close off their airway at night. Snoring indicates partial obstruction. Repeated micro arousals impair the normal sleep cycle leading to daytime sleepiness.
d. **Restless leg syndrome:**

Restless leg syndrome involves anything “crawling”, itching or tingling sensations of the leg while at rest and causes an almost irresistible urge to move. The syndrome is often most severe before sleep onset. Clients always have periodic limb movements during sleep. RLS is characterized by an intolerable, internal itching sensation occurring in the lower extremities that causes an almost irresistible urge to move the legs. The sensation is commonly described as a "creepy" or "crawly" sensation and is typically relieved by movement of the legs or walking around.

ii. **Extrinsic sleep disorders**

It encompasses a range of factors, from environmentally to chemically induced. Some environmental factors temporarily present during hospitalization. Extrinsic disorders originate or develop from causes outside the body. It is mainly because of inadequate sleep hygiene, behavioral pattern and environmental sleep disorders. Some environmental factors temporarily present in hospitals. In the general population, the Circadian rhythm sleep disorders such as *time zone change syndrome* and *shift work sleep disorder* are not uncommon.

External factors such as sleep schedules, light, noise, drugs, nicotine, alcohol and activity levels may cause disrupted sleep. It includes inadequate sleep hygiene and environmental sleep disorder. Environmental sleep disorders arise when the main sleep environment is not conducive to good quality sleep. The ideal sleep environment should be quiet, dark and comfortable. Costa (2003) cited research findings that indicate that shift work (particularly, night work) can lead in the short term to sleep difficulties.

Work/family interference is highly significant with sleep disorder. Work, family and shift work are related to shortened sleep and a greater need for recovery. Authors like Kogi & Ohta, (1975), Pilcher et al (1996), Fass et.al, (2000), Ayas (2003), Czeisler (2005), Hobson, (2007), Karl Doghramji (2008) Medical Center Health Services of Oklahoma (2011) and several others emphasized the importance of hygienic sleep for critical care nurse which otherwise cause the excessive day time sleepiness, restless leg syndrome, sleep apnea and insomnia as evident from several researches.
2.6.2. Family Outcomes

“Love is that condition in which the happiness of another person is essential to your own.”

- Robert A. Heinlein

Work-family interference is linked with reduced family and marital satisfaction. Generally, spending more time on the job is associated with an increase in work-spouse conflict which, in turn, is associated with less marital satisfaction. While some research indicates that wives' increased work hours were associated strongly with a greater likelihood of divorce. Various studies have found gender, as well as age and educational differences in satisfaction with family life (Kiecolt, 2003).

2.6.2.1. Marital satisfaction

Historically, the research on marital satisfaction has suffered from the use of ambiguous and overlapping terms. Over the years, researchers have used a variety of synonyms for marital satisfaction, including marital quality, marital success, adjustment, happiness, satisfaction, consensus, companionship and integration. Marital satisfaction is a distinct concept, and it is important to take a moment to define the term, marital satisfaction. According to the literature, marital satisfaction is the subjective evaluation of one’s experience in their marriage.

Marital happiness is the level of personal happiness an individual feels about his or her marriage. An individual’s personal evaluation of their marriage and the most similar to the concept of marital happiness because only the individual is able to say how happy or satisfied they are. Marital satisfaction is not (charismatest available at http://www.charismatest.com/research/4/what-is-marital-satisfaction);

- A quality of the relationship
- A measurement of the relationship
- Predictive of relationship success (i.e., stability).

Marital satisfaction is an amalgamation of both marital happiness and subjective condition which can only be described by the individual spouse. Work-spouse conflict occurs when the pressures from one role make it hard to be successful in the other role.
The ways to achieve and maintain a sufficient level of marital satisfaction assures marital success. Marital satisfaction is a unique measure because it refers to:

- Since marital satisfaction is subjective, no one else can tell you how satisfied you are with your marriage
- Marital satisfaction refers the condition of your marriage as you experience it &
- Marital satisfaction is a highly complex and personal experience.

Uniquely, marital satisfaction is a relatively stable attitude and attribute which reflects the individual’s overall evaluation of the relationship, needs, expectations and desires for the relationship. In a large-scale longitudinal study (White and Keith, 1990) shift work was found to reduce marital quality and increase the probability of divorce. The four key indicators of the quality of close/spousal relationships are (Spanier, 1976):

- the level of satisfaction with the relationship;
- the level of relationship cohesiveness (e.g. how often something is calmly discussed, stimulating exchange of ideas, how often there is shared laughter); and
- agreement and satisfaction with the expression of affection.

Moreover, shift work has an impact on all aspects of marital quality, marital happiness, marital interaction, disagreements, marital problems and sexual problems. Studies it was found that those who were martially satisfied had more problem-solving communication, more and better leisure time together, more effective communication, less conflict over childrearing, less sexual dissatisfaction and fewer financial disagreements. Thus this research aims at finding the marital satisfaction of married women nurses working in critical care units which covers the critical care nurses experience with their partner and describing their partner.
2.6.2.2. Family Satisfaction

“Happiness is when what you think, what you say, and what you do are in harmony.”

- Mahatma Gandhi

Family satisfaction refers to affective reactions to one’s family, reflecting the extent to which individuals have positive feelings about their family situation. Family satisfaction will be used as an indicator of non-work-related outcomes resulting from work-family conflict in this study. Various studies have found gender, as well as age and educational differences in satisfaction with family life (Kiecolt, 2003). Family satisfaction is one of the most widely researched areas in family-related outcomes and has generally been shown to increase as the amount of work-family conflict decreases (Allen et al., 2000). Other studies find that traditional roles promoting economic dependency, as well as the presence of children influence family satisfaction.

Existing literature equivocates influence of economic factors exert on happiness and satisfaction levels. Family satisfaction includes the nurse’s enthusiasm, enjoyment and the overall view and satisfaction about their family members. The quality of communication and the family experience also increases the family satisfaction. In more comprehensive studies it was found that those who were satisfied with family had more effective communication, more and better leisure time together. Age, education, number of children, religious attendance has also been associated with happiness and satisfaction.

Generally, spending more time on the job is associated with an increase in work family interference, which is associated with less marital & family satisfaction. Working unsociable hours in shift work has also been found to have an impact on intimate relationships. In studies carried by Locke, Harvey J. (1951), Spanier (1976), Chaya S. Piotrkowski (1979), Cowan et al., (1985), White & Keith (1990), Smith & Folkard (1993), Rogers & May (2003), Grosswold (2003), Brayfield & Rothe (1951), Chaya S. Piotrkowski (1979), Cramer (1998), Wilson (2002), Strazdins et.al (2003), Hill (2005) linked to workplace demands and expectations in family satisfaction. In more comprehensive studies it was found that those who were satisfied with family and spouse had more life satisfaction.
2.6.3. Organisational Outcomes

"I loved work and I loved pouring myself into the work, you know. It was the real life that I had trouble with.

-Roseanne Barr

Organizational satisfaction here includes the job satisfaction and the career satisfaction. Work family interference was found to be significantly negatively correlated with job satisfaction and positively correlated to career satisfaction. Women may prioritize their work and family roles differently. In particular, it is found that there is association between total job satisfaction and total life satisfaction and happiness, with a less strong, but significant association with self-rated anxiety.

The level of your satisfaction cannot be determined by anyone else other than the individual. Thus, whilst some authors have emphasized the workplace aspects in quality of working life, others have identified the relevance of personality factors, psychological well being, and broader concepts of happiness and life satisfaction. This study focuses on the two major aspects of an organizational satisfaction

2.6.3.1. Job Satisfaction

The concept of job satisfaction among critical care nurses is of an unprecedented importance given in the current job market. Satisfied nurses are more likely to stay not only in the field of nursing, but in the organization in which they are satisfied. Considering the significant nursing shortage, retention of nursing staff is absolutely vital to the healthcare industry especially in critical care nursing.

Nurses often work in unsatisfactory conditions with inadequate staffing and a shortage of basic supplies. In the 1980s and 1990s, many researchers have addressed on nurse job satisfaction. The understanding of nurse job satisfaction and its contributing variables are important for any health care organization to exist and prosper. Patient service will increase with improvement in policies, environment and the job satisfaction. Nursing managers should stay abreast of the current trends and factors that contribute to job satisfaction. High levels of job satisfaction may be sign of a good emotional and mental state of employees.
Research has suggested that one of the primary issues fueling the shortage is that many nurses are dissatisfied with their jobs and consequently leaving the profession. Issues related to organizational commitment and organizational support, such as unfair work conditions, autonomy, salary inequities, lack of employee support and cohesion should be addressed promptly and justly. Thus job satisfaction in critical care nursing should be of great concern to any organization. The lack of research addressing the factors that influence nurses’ job satisfaction is a problem because if nurse administrators do not know what the critical care nurses want, they cannot make changes to better satisfy the nurses.

A thorough understanding of nurses’ job satisfaction is extremely important to nursing administration. If nurse leaders comprehend what makes nurses satisfied, they can make changes to facilitate nurse satisfaction and therefore improve patient satisfaction and also employee retention. Nevertheless, the atmosphere in critical care units is not always conducive to sound working environments, which could have an adverse effect on job satisfaction.

Critical care nurse hold the majority of positions in most health care settings, and plays an important role in patients care and replacement is costly and time consuming, thus organization should focus on improvising their job satisfaction. Also High nurse turnover and vacancy rates are affecting access to health care. According to Thompson & Brown, (2002) job satisfaction includes job characteristics: job outcomes, job security, work schedules and salary. The dissatisfaction is often attributed to heavy workloads, leadership styles, motivation, inadequate training, and lack of respect (Lu, While and Barriball, 2005).

The cuts in benefits for nurses may give satisfaction or dissatisfaction to nurses working in critical care units. Thus job satisfaction was evaluated on several levels: at intrinsic level and extrinsic level (Lawler, E.E., & Porter, L.W, 1967). *Intrinsic characteristics include:* independence, group cohesion, characteristics of the organization, professional growth, and the *extrinsic characteristics include:* values such as, autonomy, salary, fringe benefits, and work schedules, are also considered to be important in job satisfaction.
2.6.3.2. Career Satisfaction

“Choose a job you like & you will never have to work a day in your life”

-Confucius

Career is defined by the Oxford English dictionary as a person’s course or progress through life. Career satisfaction represents an individual’s feelings of satisfaction or dissatisfaction with an entire career. Career satisfaction is an important variable in its own right because it summarizes feelings about a lifetime of work. Recent literature lays groundwork for a career satisfaction construct which is of growing concern for the field of critical care nursing where satisfaction with career plays a vital role.

Hall (1976) view career as ‘the entirety of work-related experiences and activities over the span of a person’s life’. Rein Lepnurm et.al. (2006) says that career satisfaction of specialists is affected by many variables ranging from family responsibilities, stress, quality of services and facilities, professional rewards, and how the work is organized. Researchers have begun to investigate the roots of career satisfaction. A similar scale used by Don Cowan, AMN Healthcare to find the career satisfaction of registered nurses has been used in this research. Research on career satisfaction may be of:

- To continue invest in practices that promote healthy workplaces
- Invest in leadership at all levels of practice and in all sectors of care
- Enhancing career satisfaction and interest
- Encourage positions in all care settings

2.7. COPING OF WORK-FAMILY INTERFERENCE

“Coping with the demands of everyday life would be exceedingly trying if one could arrive at solutions to problems only by actually performing possible options and suffering the consequences.”

-Albert Bandura

Research work-family conflict and other variables have examined some moderating role of certain variables. A moderator effect is obtained when the relationship between the predictor and criterion variables varies for different levels of some third variable (referred to as the ‘moderator’ variable). The moderators can affect relationships involving work-family conflict. Coping is a mediating construct. Boyd, et al. (2009) supports the idea of coping as a mediator. In other words, coping mediates the impact of work life conflict on individual, family and organizational outcomes.

Coping have a significant impact on individual, family and organizational outcomes for two potential reasons:

- Coping prevents a negative appraisal of work family interference and
- Coping may mediate the adverse impact of work family interference.

Critical care nurses have enough coping strategies to deal with the problem of work life conflict. It is the responsibility of every critical care nurses to use some strategy to reduce their work family interference and organization should also help the critical care nurses to overcome the effect of work family interference. Thus the two major coping strategies to reduce the effect of work family interference are the individual coping strategies and organizational coping strategies.

2.7.1. Individual Coping mechanism

Coping is the mobilization of individual’s biological, social and psychological responses in order to effectively deal with stressors and various hazards of an individual and their life satisfaction. There is increasing awareness of the benefits of providing more flexible HR strategies reflecting increasing recognition of the fact that work and other life commitments cannot easily be separated Grover & Crooker (1995).
When the coping skills are not adequate the stress may lead to illness and eventual death. Coping refers to behaviour that protects people from being psychologically harmed by problematic social experience. Coping is useful because it helps in reduction of challenges, threats and frustration and thereby protecting the individual by:

- Health promotion
- Sleep management
- Stress management
- Positive Attitude
- Seeking Advice
- Prioritizing work
- Facing job performance
- Maintaining good relationship with others

2.7.2. **Organizational Coping mechanism**

Successfully achieving work-life balance will ultimately create a more satisfied workforce that contributes to productivity and success in the workplace. Employers can facilitate work life balance with many schemes that can attract women employees and satisfy their needs. Some of the schemes are: perceived flexibility, work environment, supportive management, supports offered by organization, refuse overtime, facilities for child care, financial planning services for employees who need them, work sharing, part-time employment, leave plans to suit employee's needs, subsidized food plans, insurance plans, counseling services for problems like managing work and the home, rest rooms, food preparation services, realistic workloads etc.

Work/family balance is often associated with providing a workplace that enables employees to balance their work and family commitments, and ensuring that those with family responsibilities have equal opportunities for employment, rewards, advancement and development while at the same time ensuring that personal performance and organizational productivity requirements are met. Coping is useful because it helps in reduction of challenges, threats and frustration and thereby protecting the individual.
2.7.3. **Intervention Strategies**

Organization implementing intervention will assist their employee to balance their work & personal lives enhancing life satisfaction. Whether the introduction of work life balance strategies is effective in reducing work/family conflict is uncertain; it may simply improve employee attitudes towards the organization. Organization must initiate some intervention and changes in the existing intervention strategies suitable to the critical care nurses related to work schedule as providing optimal rest breaks, Reduce physical workload at night, avoid quick shift changes, plan some free weekends etc. environment modification as lighting, attention to temperature, optimize workplace facilities, minimize noise & provide counseling/ nurse development program (NDP)about night work, health tips, career opportunities, maintenance of good relationship with partner and others etc.


2.8. LIFE SATISFACTION

“You will never be happy if you continue to search for what happiness consists of. You will never live if you are looking for the meaning of life.”

- Albert Camus

In the 1960's, life-satisfaction became a common topic in research. Satisfaction is a state of mind. It is an evaluative appraisal of something. Life-satisfaction is the degree to which a person positively evaluates the overall quality of his/her life as a whole. Life satisfaction is an overall assessment of feelings and attitudes about one’s life at a particular point in time ranging from negative to positive. Life satisfaction is a more complex concept than the attainment of goals or the feeling good about oneself. Life satisfaction and the prospect of critical care nurses are well likely to be important for all hospitals and nurses.

King et.al., (2006) developed a definition that encompasses both the subjective component and the narrative component of meaning in life. In his viewed as "Lives may be experienced as meaningful when they are felt to have significance beyond the trivial or momentary, or to have purpose, or to have a coherence that transcends chaos". Life satisfaction is one among a range of concepts that is assumed to reflect the conditions of ‘a good life’. Subjective well-being also provides the theoretical context for the definition of life satisfaction applied in the thesis. Deeper insight into these factors can contribute to a better understanding life satisfaction by balancing work and family effectively.

Research in social cognition supports temporal components in suggesting that life satisfaction judgments are based on the relevant information available to the individual at the time the judgment is made. Household income, caring responsibilities, housework and voluntary activities has a significant impact on life satisfaction and also add to working time even if this work is unpaid. It is noteworthy that working women dedicate fewer hours to caring & educating children and to cooking and housework in comparison with the hours spent in paid work are high which leaves little free time for this unpaid work. Due to its importance to organizational outcomes, contend that satisfaction may be the most extensively researched topic in the history of industrial and organizational psychology (Brooks, 2008).
2.8.1. Conceptual clarity of life satisfaction

“I choose not to think of my life as surviving, but coping.”

-Lorna Luft

Diener (1984) defined life satisfaction as “a cognitive judgmental global evaluation of one’s life. It may be influenced by affect but is not itself a direct measure of emotion”. The definition highlights the subjective well-being and evaluation of life satisfaction involves a judgmental process that differs from that involved when reporting affect as it requires a conscious, cognitive assessment of life circumstances and a comparison of these to a subjectively set standard (Pavot & Diener, 1993).

Pavot and Diener (1993) contend that life satisfaction judgments are comprised of three temporal components:

1) long-term influences, which include personality and stable life circumstances;
2) moderate-term influences, which include current life events and cognitive interpretations; and
3) short-term influences, like current mood and immediately salient life events.

A greater amount of discrepancy between the set standard and one’s actual standing means less happiness. There are different perspectives on the judgmental process of life satisfaction. Life satisfaction, by definition, is unique to the individual determining it. Although there is some agreement about the important qualities influencing life satisfaction (e.g., health and successful relationships, sleep), individuals ultimately determine these factors for themselves and assign a value to them (Diener, et al., 1985).

Research has been conducted on the negative (i.e., inverse) relationship between satisfaction and work/life conflict (Ford, Heinen & Langkamer, 2007). Kossek and Ozekis (1998) stated in their meta-analysis of studies on the relationship between work/life conflict and satisfaction that “regardless of the type of measure used (bidirectional work-family conflict, work to family, family to work), a consistent negative relationship exists among all forms of work-family conflict and life satisfaction”.

60
Pavot & Diener (2008) says life satisfaction is a “distinct construct representing the cognitive and global evaluation of the quality of one’s life as a whole”. Shin and Johnson (1978) defined life satisfaction as “a global assessment of a person’s quality of life according to his chosen criteria. Life satisfaction judgments therefore depend on the standards individuals have set for themselves. Life satisfaction is an amalgamation of individual, family and organizational satisfaction, the span of work and family domains. Since life-satisfaction cannot be inferred from overt behavior, it has been read off their inner consciousness by questioning.

The correlations between life satisfaction and various domains are indicative of a causal influence of those domains on life satisfaction. The outcomes of work/family interference such as the individual, family and organisational outcomes must change in to satisfactions as the individual satisfaction, family satisfaction and organisational satisfaction which are the major determinants of life satisfaction. The dissatisfaction with individual life, family life and organizational life will make one’s life dissatisfied. The work family interference outcomes can be made in to satisfiers with some mediating intervention strategies given by the organisations.

Life satisfaction can be viewed as a general construct made up of multiple domains and the sum of satisfaction with specific life domains (e.g., job, marital, family) or if an overall positive life satisfaction results in satisfaction with specific life domains. More specifically, an individual’s assessment of his/her satisfaction is based on an assessment of satisfaction in a relatively small number of domains. Veenhoven (1991) said that “Life satisfaction is conceived as the degree to which an individual judges the overall quality of his life-as-a-whole favorably”.

Life satisfaction can be influenced but not controlled. Life satisfaction, by definition, is unique to the individual determining it. Each philosophy which attempts to influence life satisfaction has to been:

1. Adapted to a specific situation (environment)
2. Tied to specific risks
3. Exposed to contingency
2.8.2. **Main Effects of work/life conflict on life satisfaction**

Nurses in critical care play the major role in health care industry and are the first ones who are thought about when we talk about critical health care and thus it is necessary that their needs have to be taken care, which would lead to high quality nursing care. The management support is also an indicator for favorable treatment, patient satisfaction, employee’s satisfaction and long term survival and success of the hospital.

More importantly, work and family roles can produce significant impact on life satisfaction. Conversely, if a person successfully manages his or her multiple roles, these roles may enrich his or her life. Availability of good work life balance leads to increased intake of skilled nurses, reduces turnover, increases job satisfaction level, commitment, dedication and positive health care provisions at large.

Hospitals must facilitate employees to achieve a certain level of work-life balance could go far in increasing employee work and life satisfaction and hence the value of services delivered to patients. Organizations and academia must give serious attention to the relationships between work and family roles and how these two domains affect other elements such as the individual life satisfaction. Critically, for many organizations, helping employees to balance work and family maybe be useful strategies for attracting and retaining capable employees.

Allen, et al. (2000) in their meta-analysis, notes that work/life conflict has “dysfunctional and socially costly effects on individual work life, home life and general well-being and health”. Therefore, the relationship between work/life conflict and life satisfaction has received a considerable amount of attention in the research literature. Not only is life satisfaction most strongly statistically related to work/life conflict.

Pavot & Diener, (1993), says life satisfaction is a cognitive, global evaluation of an individual’s life as a whole.”. Pavot & Diener (2008) viewed Life satisfaction as a “constituent component of SWB” Their life satisfaction is a “distinct construct representing the cognitive and global evaluation of the quality of one’s life as a whole”.

With the exception of two studies in the early 1980s (Beutell & Greenhaus, 1982; Cooke & Rousseau, 1984) concluded that individuals who report increasingly higher levels of work/life conflict also report lower levels of overall life satisfaction.
2.8.3. Domain of Life Satisfaction

It is of further importance to note that while the consequences of conflict are different depending upon the domain (i.e., work or family) where the conflict originates, conflict behaves in a reciprocal nature and can actually have an additive, compounding effect on life satisfaction. Life satisfaction results in satisfaction with specific domains. Majority of research into satisfaction has the goal of answering the question of “what gives life satisfaction. For the purpose of this study, a focus on the history of work/life conflict as an antecedent variable is of greater value. Work/family interference has been examined as an antecedent of:

1. Individual consequences - Physical and mental health outcomes (e.g., Burke & Greenglass 1999; Frone, et al., 1997; Frone 2000; Schmidt, Colligan, & Fitzgerald 1980);
2. Family consequences (e.g., Bedeian, et al., 1988; Parasuraman, Greenhaus, & Granrose 1992); and
3. Organizational consequences (e.g., Bedeian, et al., 1988; Bruck, Allen, & Spector 2002; Greenhaus, Parasuraman, & Collins 2001);

While multiple researchers maintain that in order to appropriately study life satisfaction, individuals are usually satisfied when their needs are being met, and when the individual’s expectations and desires are being satisfied. Since life-satisfaction cannot be inferred from explicit behavior, we have to read off inner consciousness by questioning to find the roles of mediators in the relationship between work/life conflict and life satisfaction.

2.8.4. Study focus on Life Satisfaction

The life satisfaction in this research is the structure (purusarthas) is taken from Hinduism and is based on a three thousand years old experience. Insofar it can be regarded as a result of anthropology: There are two traditions in the empirical research for satisfaction are:

- The sociological tradition uses the term “quality of life”
- The psychological tradition uses the term “well-being”
Life satisfaction was initially valued as objective living conditions. At the beginning the sociological research concentrated on social and economic indicators. Later research concentrated on the subjective (psychological) valuation of living conditions called “well-being”. Changes in the subjective valuation don’t necessarily reflect changes of the objective living conditions. Subjective life satisfaction measures assessed cognitive appraisals of the quality of life experiences. It is the valuation of life as a whole, rather than particular aspects of it. The following table connects the purusartha with above determinants of quality of life and well-being which gives the life satisfaction.

<table>
<thead>
<tr>
<th>Purusartha</th>
<th>Satisfaction</th>
<th>Determinants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kama</strong></td>
<td>Family satisfaction</td>
<td>▪ Family life ▪ Marital life</td>
</tr>
<tr>
<td>Love and desire</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Artha</strong></td>
<td>Organizational satisfaction</td>
<td>▪ Environment ▪ Job satisfaction ▪ Career satisfaction</td>
</tr>
<tr>
<td>Power and wealth</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dharma</strong></td>
<td>Non-work satisfaction</td>
<td>▪ Community life ▪ Religious activities ▪ Freedom</td>
</tr>
<tr>
<td>Compliance with the laws of society and nature</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Moksha</strong></td>
<td>Individual satisfaction</td>
<td>▪ Physical health ▪ Psychological health ▪ Sleep</td>
</tr>
<tr>
<td>Liberation from suffering</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: http://www.socrethics.com/Folder2/Controllability.htm

Life satisfaction is defined in this paper as the individual perception and satisfaction of above determinants. In this study the term *kama* means love and desire is used in a non-commercial sense, i.e. for married and unmarried couples. The importance of similarity and complementarily may depend on the stage of the relationship. The *Artha* means power & well-being is used in organizational level. In many areas of organizational life a dominant roleprocures more job satisfaction and career satisfaction.
Life satisfaction may result from a kind of appreciation which is not reflected in material terms. The *Dharma* means compliance with the laws of society and nature which are the non work outside activities which includes the satisfaction with the participation in the religious activities, community activities etc. The *Moksha* means liberation from suffering includes physical health, psychological health and sleep of critical care nurses.

Finally, and perhaps most important, utilizing life satisfaction as the dependent variable of interest allows for individual respondents to individually determine not only the criteria, but its importance, in determining his/her overall level of satisfaction. This study will specifically examine the different magnitudes of affect of work/life conflict on life satisfaction. Life satisfaction is an amalgamation of individual, family and organizational satisfaction, and therefore spans both the work and family domains. Thus the three broad view of this research on life satisfaction are individual satisfaction, family satisfaction and organizational satisfaction.

### 2.8.4.1. Individual Satisfaction

Determining not only what makes people, but also how many people are, satisfied personally and with work has become an ongoing stream of research for both academics and practitioners. Fredrickson (1998) contends that positive emotions serve the specific purpose of expanding the breadth and depth of an individual’s personal resource. Satisfied individuals have longer, healthier lives and tend to have more satisfying social relationships. Further, these findings are self reinforcing because healthy social contact is essential to satisfaction, and satisfied people tend to have stronger and more supportive family and friendships, which results in greater psychological benefits.

#### a. Physical health issues

While income is undoubtedly an important factor influencing people’s standard of living and quality of life, other elements such as enjoying good health and a favorable family life remain at the heart of life satisfaction for most people. The survey on literature demonstrates that ‘good health’ is regarded by most people as a key element, if not the most important element, for good quality of life (Delhey, 2004). Friedman (2001) states that since coping are positively related to an individual’s health and well-being, it is necessary in dealing with the stressors related to role incompatibility or conflict.
b. Mental health

The survey underlines the significant time that people, both in and outside employment, spend on maintaining family contacts, on care responsibilities and on household work are the main factors workers reported problems in reconciling their family responsibilities with the demands of employment. In recent years, the burden of illness associated with poor mental health has received increasing attention. People with mental health problems are among the most likely to be outside employment and to face multiple difficulties in their daily lives (Angersbach et al., 1980).

c. Sleep

The adverse effects of sleep loss on human performance are widespread throughout industries that require shift work. Even when actual sleep episodes do not occur, the underlying physiological state of sleepiness can lead to deterioration in performance capability. Shift work can lead to a host of problems attributed to the disturbances of the circadian system in some people. Sleep problems due to shift work can be impaired with physical & psychological health and disturbed social & domestic life which causes displeasure and dissatisfaction in life Bruck D, Pisani DL (1995).

2.8.4.2. Family satisfaction

Family life is at the core of daily experiences for the majority of people and, not surprisingly, the quality of family relationships is regarded as most important for quality of life. In recent years research on quality of family life and factors influencing family has increased. This interest reflects mounting concern about the challenges for the maintenance of family ties and the difficulties that families face in raising children as well as caring for adult family members and spouse.

Attention to family issues has also intensified with growing awareness of family problems and rapidly changing life expectancy. Schimmack (2008) illustrates this relationship with the following example: “an individual with high marital satisfaction has high life satisfaction because his or her marital satisfaction is an important aspect of his or her satisfaction with life as a whole”. Voydanoff (2002) contend that coping mediates the relationship between the work/family interface and various outcomes, including satisfaction.
2.8.4.3. Organization satisfaction

An individual’s overall life satisfaction should be of significant importance to organizations as well. Individuals who are satisfied with their work will be enjoying a greater chunk of their lives than people who can’t stand their jobs. Due to the amount of time individuals spend at work, high levels of job satisfaction tend to reinforce an individual’s personal satisfaction, thereby resulting in a greater level of life satisfaction overall. Kopelman et al. (1983) found that work-to-family conflict was negatively related to family satisfaction. Researchers found that individual perceptions of satisfaction served as a predictor of work performance. In addition to earning potential and higher work performance, satisfied individuals tend to have:

1. Higher levels of work attendance (Scott & Taylor, 1985; Smith, 1977);
2. Lower turnover (Hom & Kinicki, 2001; Wright & Bonett, 2007);
3. Increased likelihood to postpone retirement (Hanisch & Hulin, 1990)
4. Better organizational financial outcomes (Harter, Schmidt, & Hayes, 2002);
5. Withstand in same job (Biswas-Diener, 2008)

Job satisfaction provides a measure of job-specific affect, whereas career satisfaction represents an individual’s feelings of satisfaction or dissatisfaction with an entire career. Almost all surveyed nurses see the shortage in the future as a catalyst for increasing stress on nurses, lowering patient care quality, and causing nurses to leave the profession. High nurse turnover and vacancy rates are affecting access to health care.

Haar (2006) suggests that “despite high interest, few studies have sought to examine how employees cope with work/life conflict occurring both from the workplace and the home”. Coping success is determined not only by the strategy, but also the situation to which it is applied. Coping is very essential to have life satisfaction and not exist in a vacuum. Yet coping processes are a type of adaptation that requires effort on the part of the individual and organization. Also strategies are used when an individual perceives that she can change the situation strategies tend to be used more frequently when the individual believes it will change and therefore makes a cognitive choice to make the needed of changes.
2.8.5. Measurement of Life Satisfaction

Perhaps the most widely used type of measures to assess life satisfaction is by asking questions like ‘How satisfied are you with your life? This type of question tries to appeal more reflective and evaluative aspects in considering one’s life. Shin and Johnson (1978) defined life satisfaction as ‘a global assessment of a person’s quality of life according to his chosen criteria’. Life satisfaction judgments therefore depend on the standards individuals have set for themselves. Diener, Emmons, Larsen and Griffin developed the Satisfaction with Life Scale (SWLS; 1985), a self-report questionnaire that asks respondents to rate five statements concerning their present satisfaction with life (e.g., ‘So far, I have gotten the important things I want in life’) on a 7-point scale. Another version of the SWLS, the Temporal Satisfaction with Life Scale (Pavot, Diener, & Suh, 1998), assesses respondents’ past, present, and future life satisfaction by asking them to rate 15 statements.

In the 1960's, life-satisfaction became a common topic in survey research. This development was accompanied by a critical discussion regarding the validity of survey questions about life satisfaction. It was even doubted that life-satisfaction could be measured adequately by means of standard interviews or questionnaires. Steady physiological correlates have not been discovered, and the modern understanding of higher mental functioning does not suggest that they ever will be. Nor have any overt behaviours been found to be consistently linked to inner enjoyment of life. Like most attitudinal phenomena, life-satisfaction is only partially reflected in behaviour.

Likewise, non-verbal behaviours such as frequent smiling or enthusiastic movements appear to be only modestly related to self-report of life-satisfaction. Consequently, estimates of someone's life-satisfaction by his peers are often wrong. Suicidal behaviour is probably more indicative of life dissatisfaction than any other behaviour. Almost all people who attempt or commit suicide are dissatisfied with both work and family life. However, not all dissatisfied people resort to suicide. Since life-satisfaction cannot be inferred from overt behaviour, we have to read off inner consciousness by questioning.
The literature on life-satisfaction can be summarized by means of the questions that arise if one follows the utilitarian lead of creating greater satisfaction for a greater number of people. If everyone is satisfied with life, then there is little need to search for ways in which levels of satisfaction can be improved. Prior research has suggested that there is a negative relationship between work/family conflict and life satisfaction. However, Kossek and Ozeki (1998) point out that the nature and strength of this relationship varies widely. Allen et al. (2000) argued that the relationship between work/family conflict and life satisfaction suggest that undetected moderator variables may be involved. In this section, a variety of studies that examine the relationship between work family conflict and life satisfaction will be reviewed.


WLB is the successful integration of an individual’s life and work. Thus, Lewis et al. (2007) point out that WLB is about achieving a satisfying quality of life, overall satisfaction with less stress in managing role demands. This is a study on women who have broken the shackles of the past, who are walking along an untraced path. Research is focused on assessment of work/family interference of critical care nurses and cognitive evaluation of their life. It is hoped that the findings of this study will stimulate further research and will also provide at least a beacon of light in policy formulations in future. Further in-depth theoretical conceptions are attempted in the following chapter by reviewing and exploring earlier related studies for enhanced understanding of the various aspects related to the study.