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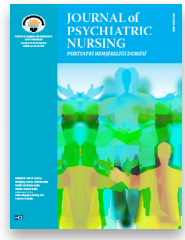

Original Article

The relationship between work-family conflict, organizational silence and social support in nurses at a university hospital

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Abstract

Objectives: This study aimed to determine the effect of nurses' organizational silence on work-family conflict and perceived social support.

Methods: In this cross-sectional descriptive study, the samples consisted of 329 randomly chosen nurses who worked at a university hospital in Istanbul, Turkey. Data were collected by means of questionnaires. Organizational Silence Causality Scale, Multidimensional Perceived Social Support Scale (MSPSS), Work-Family Life Conflict Scale (WFCTS), and Personal Information Form were used. Linear Regression Analysis (Backward) was used to analyze the factors affecting the subscales of Pearson Correlation Analysis and Spearman Correlation Analysis, as well as the WFCTS, Work to Family Conflict (WFC) and Family to Work Conflict (FWC) subscales. Significance was assessed at $p<0.01$ and $p<0.05$ levels.

Results: 49.2% of the nurses participating in the research are younger than 30 years, 95.7% are women, 64.4% are undergraduate and 56.8% have bachelor degrees. Nurses perceive WFC more. There is generally a weak negative relationship between WFCTS and MSPSS scores, which is positive between nurses' silence behavior and nurses' WFC, FWC and Total Work and Family Conflicts. MSPSS and Organizational Silence affect WFCTS scores. The modeled independent variables had a 19% effect on the FWC, a 7.7% effect on the WFC, and a 13% effect on the WFCTS.

Conclusion: It is possible to reduce nurses' sense of social support, take measures to reduce the causes of organizational silence, initiatives and work-family conflict.

Keywords: Nursing; silence; social support; work-family conflict.

The growing shortage of nurses is a global issue. Work-family conflict was defined as one of six variables (work-family conflict, perceptions of autonomy, attachment to work, importance of working to the individual, interpersonal relationships at work, and supervisor- subordinate relationship) found to influence a nurses' intentions to continue their career.[1] The role theory suggests that work-family conflict is a form of inter-role conflict in which pressures from work and family domains are mutually incompatible in some respect.[2] The role theory advocates that individuals have multiple roles, but involvement in each role is limited by time. Time-based conflict occurs when time contributed to one role inhibits participation in another role. Individuals cannot balance work and family life as they are involved in multiple roles. They find it difficult to comply with expectations arising from one role when they attempt to meet the demands of the other role.[3] The theory of Role Strain suggests that individuals have limited stores of physical energy, time and psychological resources. Consequently, responsibilities from multiple work and family roles compete for these resources. Time and energy spent in one role reduces the amount of time that can be allocated to the other role.[2,4] Based on the role theory, the crossover effect refers to a situation where pressures related to the work role have an unfavorable or stressful impact on the family role; and

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the pressures of the family role have an unfavorable impact on the work role. As the work-family conflict has many negative outcomes both for the individual and the organization, the predictors of work-family conflict should be recognized.

Predictors of work-family conflict can be grouped as working environment, family environment and demographic characteristics.[3,5–8] These predictors are associated with both sub-scales of Work-Family Life Conflict Scale: Work to Family Conflict (WFC) and Family to Work Conflict (FWC). WFC is defined as conflict that arises due to work responsibilities interfering with family responsibilities. FWC occurs when responsibilities associated with family roles interfere with work demands.[9] High work–family conflict has a negative impact on an employee's physical and mental health, and psychological well-being. Additionally, it has detrimental effects on occupational life and job satisfaction, affects job performance, reduces organizational commitment, occupational effectiveness, and increases work stress.[4,6,7,10–21] Reducing nurses' work-family conflict can potentially attract qualified individuals into the profession and increase retention.[6]

Nurses' social well-being is closely related to individual, organizational, and social factors. Social well-being supported by these factors can benefit nurses in the form of satisfaction, motivation, self-confidence, self-esteem, hope, and success within individual and social interactions. They also can enjoy greater job satisfaction, psychological well-being, and lower level of psychological burnout and desensitization.[10,21–24] Social support reduces FWC and WFC, work stress, and the negative effects of conflict on work performance. Providing sufficient social support to nurses can enhance their professional ability and hence increase the quality of patient care.[12,22,25–27] Social support is the leading factor in perceived stress factors. It affects the probability of perceiving a situation as stressful including work-family conflicts.[27] The social support that an individual receives both in a working or nonworking environment should be evaluated to better understand the effect of conflict of roles on the general stress of the individual.[27] Both working and nonworking social support is assumed to be a resource for decreasing conflicts between the work and family roles of individuals.

Organizational silence was described as a collective-level phenomenon characterized by the widespread withholding of information, opinions, or concerns by employees about work-related problems or issues.[28] In recent years, organizational silence in nursing has been frequently discussed in various studies and is a very common phenomenon among nurses.[29] Nurses comprise a 24-hour monitoring system in hospitals for early diagnosis and medical intervention.[30] Silence of nurses on patients' safety issues may trigger medical mistakes and negatively affect patient and organizational outcomes.[31] An organizational climate where healthcare employees can talk without restraint about inferior patient care and unsafe practices is crucial.[32] Silence concerning risks and errors may lead to critical problems, especially in the healthcare sector. Furthermore, this practice may undermine needed improvements in the patient care delivery system. Nurses who believe that administrators do not recognize their concerns or exclude them from hospital decisions may not come forward to administrators with their ideas and recommendations on patient safety.[31,32]

Knowingly or unknowingly, administrators contribute to organizational silence which has negative effects on the organization and its' employees. These negative effects can include; reduced cooperation efforts, decrease in morale and performance, physical and psychological withdrawal, feelings of helplessness, leaving the job, and sabotage, etc. Suppressing critical communication or not sharing information on purpose may increase an employee's stress level and psychological problems. In addition, the feeling of being unable to talk about problems and express opinions openly may lead to poor job satisfaction, commitment and motivation. The threat to the psychological well-being of employees may lead to feeling unappreciated and cause cognitive disharmony. Employees may have difficulty adapting to changes in the organization along with a decline in morale, commitment and motivation. Employees will have a decreased interest in organizational transformation activities, obstruct organizational learning, and experience a decline in quality of work. If employee silence is commonplace within the organization, intellectual poverty appears, mistakes are overlooked and administrators lack critical information.[28,33–36] The spillover model suggests that family-based stress or work-based stress can initiate a stress reaction among team members who share the same working environment.[37] Silence on a single issue in the organization can spread to silence on a number of issues.[38] It was noted that the silence experience of an individual in an organization may spread to other individuals as well. Correspondingly, silence which is associated with organizational and personal issues may spread to family life and affect work-family conflict.

One theory this study is based on is the Conservation of Resources Theory (COR). According to this theory, individuals seek to acquire, maintain, invest and develop biological, cognitive, and social resources. These resources include objects, constraints, personal characteristics, energy, and other valuable things. Likewise, they may use intermediary resources to acquire valuable goals. Work resources are defined as physical, psychological, social or organizational dimensions of a job that promote personal development and growth. These resources should reduce job demands and related physiological and psychological costs as well as maintain operations to reach necessary work goals. Individuals experience psychological stress when their resources are lost, threatened or insufficient resources are accessible even though they have invested their own resources. Individuals with more desirable resources are less affected from the decline or losses in resources than individuals with less desirable resources. In case of resource loss, individuals implement protective strategies for the remaining resources with a defensive behavior to adapt to the new con-

ditions. Failure to adapt causes negative functional and emotional outcomes and a reduction in the number of invested resources.[39–42] In Ng and Feldman study (2012), the meta-analytic findings provide support for a negative relationship between workplace stress and voice behavior and a positive relationship between voice behavior and performance outcomes. COR theory proposes that employees will be less likely to engage in voice behavior when they perceive their organizational environment as stressful.[43] The silence behavior of employees used while protecting their resources because of stress in the work environment can also spread to other employees leading to performance problems. In addition, trying to improve their performance to protect their resources may deplete family time and energy resulting in work-family conflict. A work-family conflict also occurs when employees do not participate in silence behavior in order to protect their resources. Owning less resources reflect work stress in their family life.

Organizational silence is common in nurses,[29] however its relation with work-family conflict has not been analyzed in relevant literature. There are existing studies indicating that social support affects work-family conflict. Therefore, in this study, perceived social support (significant other, family, spouse) and organizational silence were chosen as the predictors of work-family conflict. This study aimed to determine if there is a relation between work-family conflict and organizational silence of nurses and their perceived social support. It is important to examine the relation between work-family conflict with silence behavior of nurses and their perceived social support. Attention to this issue is fundamental for the health and development of both individuals and organizations. This study will contribute to scientific information as a starting point for future studies to eliminate or reduce work-family conflict. This study aimed to address the following questions:

1. Is there a relation between perceived social support and work-family conflict?
2. Is there a relation between organization silence and work-family conflict?

Materials and Method

Research Design and Sample

This research was descriptive and correlational.

The study population consisted of 1000 nurses at Istanbul Faculty of Medicine Hospital in Istanbul (Turkey). The power analysis was conducted through a 5% type 1 error, 50% p-value, a 10% type 2 errors, and 10% sampling error. The minimum number of nurses was calculated as 263 (The power analysis was 90%). Considering the possibility of a 30% loss, 350 nurses were selected using the randomized sampling method and were included in the study sample. The study data was obtained from the questionnaire forms completed by the 329 nurses.

The Implications of the Study

The Ethical Approval of the study was received from the Ethical Committee of Istanbul Faculty of Medicine Hospital (2011/1812-606). Prior to data collection, the nurses were informed of the purpose of the study. The nurses who agreed to participate in this study were given a questionnaire form to complete and return. Five of the 350 questionnaire forms were not returned and 16 were incomplete. These 21 questionnaires were not considered for further evaluation.

Data collection was conducted between September and November 2013. The research analysis was conducted by a professional statistician and statistical consulting was received from two experts.

Statistical Analyses

Statistical analysis was performed using the NCSS (Number Cruncher Statistical System) 2007 (Kaysville, Utah, USA) software package. Descriptive statistical methods were used to analyze the survey data (mean, standard deviation, median, frequency, ratio, minimum, and maximum), Student's t-test was used to analyze normally distributed quantitative data with two group comparisons, and Mann Whitney U test was used to compare non-normal variables of two groups. One-way ANOVA test was used for statistical evaluation of at least three normally distributed groups. Tukey's HSD test was used to determine significant differences between the cases in which the assumption of homogeneity of variance was met. Games-Howell test was used for cases in which the assumption of homogeneity of variance was not met. The Kruskal-Wallis test was used for comparing non-normal variables for more than two groups, and the Mann-Whitney U test was used to assess whether two independent groups are significantly different from each other. The Pearson correlation coefficient and the Spearman correlation coefficient were used to measure the strength of the relationship between variables. The Linear Regression Analysis (Backward) was used in the analysis to find the predictive factors of the Work-Family Conflict Scale sub-scale and total scale scores. The significance level was assessed to $p<0.01$ and $p<0.05$. The Work-Family Conflict Scale and its sub-scales were accepted as dependent variables, while other variables were accepted as independent variables.

Data Collection Tools

The Organizational Silence Scale: The Organizational Silence Scale was developed by Çakıcı[34] (2008). The Organizational Silence Scale consists of three sub-scales, the issues of silence, the reasons for remaining silent and perceptional consequences of the silence. These sub-scales of reasons for remaining silent were used in this study. Higher scores indicate higher perceived silence, lower scores indicate lower perceived silence. Each aspect for remaining silent is adapted to a 5 point Likert scale, 1 being totally ineffective and 5 being very effective. It is further evaluated with five sub-scales: Admin-

istrative and Organizational Reasons, for example: "Individuals, who spoke plainly, were treated unfairly or subject to ill-treatment", "Mistrust towards the administrators". Fears about Work, for example: "The opinion that informers of the problems are not treated well, fear of unemployment or dismissal" Lack of experience, for example: "Lack of a formal mechanism that facilitates open speech such as being new to the job or being young", "The concern that ignorance and inexperience are noticed". Fear of Isolation, for example: "Negative reactions of the administrators towards negative feedback, Fear of being called a trouble maker or complainer". Fear of Relationship Damage, for example: "The thought that the administrators would not like them", "Fear of losing support)" There is no cut-off score for scale. In this study, the reliability value of the scale was measured as 0.77-0.97.

Multidimensional Scale of Perceived Social Support (MSPSS); The scale was developed by Zimet et al. in 1988, and adapted to Turkish by Eker et al.[44] (2001). The MSPSS is a brief self-reporting questionnaire with 12 items that subjectively measure perceived social support using three subscales: Family subscale, Friends subscale and Significant Others subscale. A Likert scale of 1-7 is used with 1 being strongly disagree and 7 being strongly agree. The sub-scales and total scale are independently evaluated. A high observed total mean score indicates high levels of perceived social support. There is no cut-off score for scale. In this study, the reliability value of the scale was measured as 0.91.

The Work-Family Conflict Scale; was developed by Netemeyer, Boles and McMurrian in 1996, and adapted to Turkish by Efeoğlu[9] (2006). The Work-Family Conflict Scale (WFCTS) consisted of two sub-scales as Work-Family Conflict (WFC) and Family-Work Conflict (FWC). Both subscales adopted a 5-point Likert scale and determine the status of the conflict with judicial sentences, 1 denotes strongly disagree and 5 strongly agree. The scale is evaluated as WFC, FWC, and WFCTS. Lower scores indicate lower conflict, likewise, higher scores indicate higher conflict. There is no cut-off score for the scale. In this study, the reliability value of the scale is 0.92. The Cronbach's α reliability coefficients of the scales and item-total correlations are presented on Table 2.

Personal Information Form; includes six-questions prepared by researchers to obtain introductory information on nurses (age, gender, marital status, educational status, working years in the profession, working years in the institution). These variables used as previous studies indicated that sociodemographic characteristics may change work-family conflict.[10,17,45–47]

Results

This study was conducted with 329 nurses, of which 95.7% were female and 4.3% were male (n=14). The mean age of the participants was 32.60±9.04 years (Min=2, Max=59). Sociodemographic information of the participants is presented in Table 1. The mean and standard deviation values of the scales were given in Table 2. The results indicating differences in total score of the Work-Family Conflict Scale (WFCTS) and sub-scale scores for gender, marital status and education status were presented in Table 3. There was no difference in work-family conflict among nurses based on gender and education status. In terms of marital status, single nurses reported higher Work-Family Conflict (WFC) than married nurses (Table 3). The relationship between the variables used in this study were presented in Table 4. It was found that age, working years in the profession, and working years in the organization were negatively correlated with the scores of WFC and WFCTS (Table 4). It was found that WFCTS and its sub-scales were positively correlated with organizational silence and negatively correlated with perceived social support (Table 4). Regression analysis (Table 5) was used to test the predictive effects of Organizational Silence and Perceived Social Support. Additionally, it was used to test age, gender, education status, marital status, and working years in the profession. Furthermore, regression analysis (Table 5) was used in the organization on the WFCTS and its sub-scales of FWC and WFC.

Table 1. Sociodemographic characteristics of nurses (n=329)

Variables	n	%
Education		
High-school	21	6.4
Associate degree	67	20.4
Undergraduate	212	64.4
Graduate	29	8.8
Marital status		
Married	142	43.2
Single	187	56.8
Gender		
Female	315	95.7
Male	14	4.3

The explanatory power (R^2) of the model indicates the effect of independent variables on the FWC sub-scale score and was found as 0.193, and the model was significant (F=12.816; p<0.001). As a result of the analysis, the study ended in the 10th stage. This model included administrative and organizational reasons, lack of experience, family support, gender (F), and working years in the profession. The variable of gender (F) showed the highest effect in the model.

R^2 of the model indicates the effect of independent variables on the WFC sub-scale score and was found as 0.077, and the model was significant (F=13.625; p<0.01). As a result of the analysis conducted on the effects of independent variables on WFC, the study ended in the 12th stage. The model included lack of experience and family support. The sub-scale score of lack of experience showed the highest effect in the model.

R^2 of the model indicates the effect of independent variables

Table 2. Descriptive statistics of study variables (n=329)

Variables	Number of statements	Cronbach α	Mean±Standard deviation
Reasons of organizational silence			
Administrative and organizational reasons	13	0.96	37.03±13.67
Fears about work	6	0.90	14.36±5.70
Lack of experience	4	0.80	9.02±3.37
Fear of isolation	4	0.86	12.00±4.10
Fear of relationship damage	3	0.85	8.50±3.21
Work-family life conflict			
Work-family conflict	5	0.94	13.82±6.68
Family-work conflict	5	0.93	9.93±5.71
Work-Family Conflict Total Scale	10	0.92	23.75±10.63
Perceived social support			
Support by significant other	4	0.94	20.46±8.30
Family support	4	0.92	24.36±5.65
Friend support	4	0.91	22.67±5.88
Perceived Social Support Total Scale	12	0.91	67.49±15.91

Table 3. Evaluation of Work-Family Conflict Scale Sub-scale and total scores for gender, marital status and education status

Variables	Work-Family Conflict		Family-Work Conflict		Work-Family Conflict Total Scale	
	Mean±SD	Min-Max (Median)	Mean±SD	Min-Max (Median)	Mean±SD	Min-Max (Median)
Gender						
Female (n=315)	13.92±6.68	5-25 (13)	9.90±5.74	5-25 (9)	23.82±10.59	10-50 (24)
Male (n=14)	11.71±6.68	5-23 (11)	10.43±5.21	5-20 (10)	22.14±11.69	10-43 (22)
p	[c]0.228		[a]0.573		[c]0.564	
Marital status						
Married (n=142)	12.63±6.42	5-25 (12)	9.35±5.24	5-25 (8)	21.97±10.18	10-50 (21)
Single (n=187)	14.73±6.74	5-25 (15)	10.37±6.03	5-25 (9)	25.10±10.79	10-50 (24)
p	[c]0.004**		[a]0.160		[c]0.008**	
Education status						
Vocational school of health services (n=21)	13.90±6.66	5-25 (14)	10.19±5.14	5-21 (10)	24.10±8.59	10-38 (25)
Associate degree (n=67)	12.16±7.12	5-25 (11)	9.51±5.82	5-25 (8)	21.67±11.74	10-50 (20)
Undergraduate (n=212)	14.46±6.46	5-25 (14)	10.07±5.72	5-25 (9)	24.53±10.27	10-50 (24.5)
Graduate (n=29)	12.97±6.83	5-25 (11)	9.66±6.08	5-25 (7)	22.62±11.60	10-50 (20)
p	[b]0.088		[d]0.659		[b]0.257	

**p<.01. [a]Mann-Whitney U Test; [b]One Way Anova Test; [c]Student t-test; [d]Kruskal Wallis Test. SS: Standard deviation; Min: Minimum; Max: Maximum.

on the WFCTS, and was found as 0.134, and the model was statistically significant (F=16.802; p<0.01). As a result of the analysis conducted on the effects of independent variables on WFCTS score, the study ended in the 13th stage. The model included administrative and organizational reasons, family support, and working years in the profession. The sub-scale score of family support showed the highest effect in the model.

Discussion

This study aimed to determine the relationship between work-family conflict of nurses with organizational silence and their perceived social support. The study findings indicated that administrative and organizational reasons, lack of experience, poor family support, working years in the profession, and being a female are predictive factors for a high-level family-work

Table 4. Relationships between study variables (n=329)

Sociodemographic variables		Reasons of organizational silence					Perceived social support			Work-family life conflict		
		Administrative and organizational reasons	Fears about work	Lack of experience	Fear of isolation	Fear of relationship damage	Support by significant other	Family support	Friend support	Perceived Social Support Total Scale	Work-family conflict	Family-work conflict	Work-Family Conflict Total Scale
Age	[e]r	-.097	-.085	-.138	-.124	-.094	-.101[f]	-.012[f]	.005[f]	-.083f	-.174	-.058[f]	-.130
	p	.078	.122	.012*	.024*	.090	.066	.825	.927	.133	.002**	.294	.018*
Working years in the profession	[f]r	-.098	-.112	-.153	-.120	-.106	-.073	.008	.035	-.047	-.202	-.076	-.176
	p	.077	.043*	.005**	.029*	.055	.187	.889	.525	.398	.001**	.167	.001**
Working years in the organization	[f]r	-.099	-.096	-.081	-.097	-.080	-.042	.028	.034	-.025	-.204	-.070	-.172
	p	.074	.081	.141	.078	.147	.446	.614	.534	.651	.001**	.205	.002**
Support by significant others	[f]r	-.109	-.112	-.032	-.165	-.119							
	p	.048*	.042*	.016*	.003**	.030*							
Family support	[f]r	-.204	-.217	-.229	-.193	-.173	.454						
	p	.000**	.000**	.000**	.000**	.002**	.000**						
Friend support	[f]r	-.240	-.221	-.197	-.151	-.163	.449	.562					
	p	.000**	.000**	.000**	.006**	.003**	.000**	.000**					
Perceived Social Support Total Scale	[f]r	-.172	-.166	-.187	-.172	-.151	.880	.681	.749				
	p	.002**	.002**	.001**	.002**	.006**	.000**	.000**	.000**				
Work-family conflict	[f]r	.347	.240	.329	.243	.305	-.112	-.194	-.175	-.149			
	p	.000**	.000**	.006**	.000**	.000**	.043*	.000**	.001**	.007**			
Family-work conflict	fr	.145	.189	.213	.151	.176	-.100	-.231	-.198	-.159	.477		
	p	.008**	.001**	.000**	.006**	.001**	.069	.000**	.000**	.004**	.000**		
Work-Family Conflict Total Scale	fr	.313	.264	.208	.242	.294	-.122	-.230	-.206	-.172	.905	.779	
	p	.000**	.000**	.000**	.000**	.000**	.027*	.000**	.000**	.002**	.000**	.000**	

*p<.05; **p<.01; [e]r=Pearson's Correlation Coefficient; [f]Spearman's Correlation Coefficient.

conflict (FWC). Lack of experience and family support are less predictive of work-family conflict (WFC). Work-family and organizational reasons, lack of experience, family support, and working years in the profession are less predictive on work-family conflict total scale score (WFCTS).

As the age of nurses increases the WFCTS score decreases. However, the regression analysis suggested that age is not predictive of work and family conflict. Lambert et al.[46] (2015) found a negative correlation between work-family conflict and age. It was determined that there is a negative correlation between working years in the organization and work-family conflict. As the working years of nurses in the organization increases, the scores of WFC and WFCTS decreases. However, regression analysis results indicated that the working years of nurses in the organization did not have any effect on work-family conflict. A negative correlation was found between working years in the profession and WFC and WFCTS scores. Regression analysis indicated that working years in the profession had negative effects on FWC and WFCTS scores.

In this study, Student-t test indicated that there was no difference between WFC, FWC, and WFCTS scores of nurses according to gender (Table 3). However, it was observed that the gender variable predicted FWC when it was included in the regression analysis. The literature suggested different results such that men's exposure to work and family conflict is less than women's[4] and work-family conflict is not associated with gender.[46] It also suggests FWC does not differ in terms of gender, but WFC is higher in women than men,[47] female nurses feel WFC more than male nurses and male nurses feel FWC more than female nurses.[45] Drummond (2016) indicated that family support was associated with lower work–family conflict for women. The regression analysis suggested that as a gender variable, being a female has negative effect only on FWC. The social role theory of gender differences suggests that work is the primary domain of men while home and family are primary domains of women. According to the social role theory of gender differences, women in our society are expected to fulfill their primary roles in families and their roles in the workplace as secondary in order to have a career. As women have possibly accepted this role model, they may perceive less FWC. In the

Table 5. Regression analysis results for work-family conflict scores of variables and their relations

Model		Unstandardized Coefficients		95.0% Confidence Interval for B	
		B	p	Lower Bound	Upper Bound
10	a. Dependent Variable: Family-Work Conflict score				
	Administrative and organizational reasons	.151	.001**	.073	.229
	Lack of experience	-.353	.010*	-.623	-.084
	Family support	-.161	.008**	-.281	-.042
	Gender (female)	-3.670	.031*	-6.997	-.343
	Working years in profession	-.137	.001**	-.208	-.065
14	a. Dependent Variable: Work-Life Conflict score				
	Lack of experience	. 274	.003**	.095	.454
	Family support	-.205	.001**	-.312	-.098
13	a. Dependent Variable: Work-Family Conflict Total Scale Score				
	Administrative and organizational reasons	.196	.001**	.116	.277
	Family support	-.348	.001**	-.543	-.154
	Working years in profession	-.149	.012*	-.265	-.033

*p<.05; **p<.01.

future, re-visiting this issue with studies including equal number of female and male nurses will be beneficial. The regression analysis indicated that there is no effect of marital status on work family conflict. However, WFC and WFCTS scores showed differences in terms of marital status, but there was no difference in FWC scores. Single nurses experience WFC and WFCTS more than married nurses. Aras and Karakiraz[48] (2013) reported a difference in work-family conflict in terms of marital status, married people experience more conflicts than single people. The assumption being that as married nurses have more social support resources, they have less WFC and WFCTS compared with single nurses. A supportive work-family organizational culture for the employees with family responsibilities leads to less strain and discomfort associated with work and family roles.[49] In this study, no difference was found in WFCTS, WFC, and FWC in terms of education level. The regression analysis suggested that education level of nurses did not have any effect on work-family conflict. Lambert et al.[46] (2015) reported that work-family conflict is not associated with education levels. In Turkey, there is no difference in tasks, duties, and responsibilities among nurses from different education levels (high school, associate degree, undergraduate, and graduate), leading to this result.

Although Byron[8] (2005) reported that work-domain variables relate more to WFC than FWC and nonworking-domain variables relate more to FWC than to WFC. In our study sub-scales of organizational silence affected FWC (administrative and organizational reasons, lack of experience), WFC (lack of experience) and WFCTS (administrative and organizational reasons) in the same direction. No national or international study was found regarding the relation between organizational silence and work-family conflict. But, there are studies regarding social support from family members and supervisors leading to the reduction of WFC and FWC which affect employee behaviors.[50] Ng and Feldman[43] (2012) indicated that employees who reported high levels of organizational, social, and work stress used less voice behavior and preferred to be silent to protect their personal resources and improve their work future. Ng and Feldman (2012) suggested that individuals keep their silence to maintain resources due to increased stress. Unwillingness to share information, verbalize, and give feedback has a potential to negatively affect trust, morale and motivation of employees.[36] As shown, these issues may affect work family conflict. Studies regarding the relation between silence and family-work conflict may be repeated using different secondary variables.

Examining the perceived social support indicated that it negatively affected FWC, WFC, and WFCTS total scores. The results were similar with other studies[24,25,27] as the perceived social support is negatively correlated with family-work conflict. In our study, different from previous studies,[51,52] the family support affects both the WFCTS score and also WFC and FWC sub-scales. There are studies demonstrating that family support and husband support are negatively related with WFC[50] in women.[4] In our study, different from other studies,[4,25–27] no relationship was found for perceived husband or significant other support with any sub-scales of work-family conflict. Supervisory nurses should support nurses in their professional roles as they try to perform various work and family roles. They should develop strategies to improve work-related psycholog-

ical well-being as well as their general level of welfare.[22] Providing supportive work environments underlining a culture of open communication in an ethical working climate will be beneficial in reducing work-family conflict.

The Limitations of the Study

The limitations of this study include the fact that a single hospital was studied, most of the participants were female, and the overall study was the result of a self-questionnaire form. Although the findings were obtained from nurses who worked in one of the largest university hospitals in Turkey, it was conducted in the only university hospital in a province in Turkey. Therefore, the study findings cannot be generalized for all nurses.

Conclusion

Our study suggests that to promote job satisfaction and well-being without work and family conflict family support should be increased, family oriented policies in hospitals should be improved, and organizational silence in hospitals should be addressed. The assumption is that both hospital administrators and nurses can benefit from the findings of this study. The reduction in nurses' work-family conflicts may increase retention. In addition, decreasing the likelihood of nurses' acquiring mental and physical problems as a result of work and family conflict, a positive work environment should be provided for nurse retention. In this regard, administration approved psychiatric nurse consultations and conflict resolution would prove beneficial. The psychiatric liaison nurses can encourage general nurses to express themselves on work-stress, problem solving, and establish and maintain nurse support groups.

The following suggestions capitalize on the statements included in the sub-scales of organizational silence (administrative and organizational reasons, lack of experience) that affects work-family conflict. Work-family conflict can be reduced by addressing the organizational reasons of silence such as supporting the culture of open communication in the hospital. Promoting the idea that administration is interested, paying attention and keeping their promises ensures a feeling of trust, and empowers communication between administrators and nurses. Establishing a working culture that supports open communication and expanding the firm structure of the hierarchy may reduce work-family conflict. Dissolving the perception that individuals who speak openly are treated unfairly, and establishing a formal process facilitating open communication may also reduce work-family conflict. Nurses who lack confidence speaking openly, such as inexperienced workers, may have the sense that certain topics are only a concern of administration. Similarly, they may have concerns that lack of knowledge and inexperience are noticed. This can be avoided by providing education and consultancy so that work family life conflict may be diminished for inexperienced nurses.

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