Research Paper

The Effect of a Family-centered Program to Manage Domestic Roles on Marital Satisfaction in Female Nurses

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ABSTRACT

Background: Marital satisfaction is vital for the continuation of married life, and one of the factors negatively affecting this satisfaction is women's employment in stressful positions, especially in families where the division of domestic tasks is traditionally based on gender. This study was conducted to determine the effect of a family-centered program to manage domestic roles on marital satisfaction in female nurses.

Methods: This quasi-experimental study was conducted with a pre-test-post-test design with a control group and a two-month follow-up. The study population consisted of married female nurses working in two hospitals in Zabol City, Iran. Based on the determined sample size, this study was conducted on 50 female nurses and their husbands, who were randomly divided into the trial (25 couples) and control (25 couples) groups. Data were collected using Carlson's work-family conflict scale (WFCS) and the enrich marital satisfaction questionnaire (1998). The trial group received a family-centered educational-supportive program to empower them in performing domestic roles and was compared to the control group after a two-month follow-up. Data were analyzed in SPSS software version 20 using the chi-square and independent tests for parametric data and Mann-Whitney's U test for nonparametric data, at the significance level of $P<0.05$.

Results: The mean score of marital satisfaction was significantly higher in the trial group compared to the control group after the intervention ($P<0.05$).

Conclusion: The educational-supportive program for family management based on family-centered care decreased work-family conflict (WFC) in female nurses and led to improvements in marital satisfaction.

Keywords: Education, Family-centered care, Marriage, Satisfaction, Work-family conflict

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1. Introduction

Marital satisfaction is the individual's general assessment of marriage and a reflection of marital function and happiness [1] and is considered one of the objectives of marriage [2]. Evidence shows that marital satisfaction has a major effect on the physical and mental health of couples and children [3] and it is essential to continue marital life. The feeling of marital satisfaction in each couple refers to their coordination and adaptation to their spouse in organizing marital life, coordination in spending leisure time, the division of domestic tasks, interaction and communication with each other, sexual relationships, and expressing feelings toward one another [4]. Among the many factors that reduce marital satisfaction, women's employment is the most influential [5]. This factor is likely to cause work-family conflicts (WFC), especially in stressful jobs, [6] such as nursing which has a heavy workload and is based on shift, [7] and more especially in women with families in which domestic task division is performed in a traditional way [8] and housework and motherhood are considered an inevitable responsibility for them. Moreover, based on research findings, occupational stress acts as the 1st context in which marital conflict occurs [4]. One of the main reasons for female nurses to leave their service is the inability to balance between domestic roles and job responsibilities [9].

Conversely, an adequate ability to perform domestic roles and the spouses' mutual understanding of family expectations and functions are among the factors affecting marital satisfaction [4]. Moreover, enjoying the time spent with the family [10] and the spouse's support and participation in activities through a two-way relationship [11, 12] can eliminate the negative effects of stressors on marital satisfaction and WFC [4, 13] and even increase job satisfaction [13] by reducing stress and increasing mental strength. According to Fowers, men tend to rate their marriage more positively and are more satisfied with their marital life compared to women [14]. Nonetheless, their satisfaction also reduces when they do most of the housework [15].

While many studies have examined the factors affecting marital satisfaction and the effect of interventions to improve it such as training life skills [16], sexual relationships [17], lifestyle choices [18], conflict resolution [19], and marital communication skills training [20]; however, fewer studies have paid attention to assess the effect of interventions on strategies for family characteristics, such as family members' support [21], traditional gender role attitudes [22] and the traditional division of household labor, which are associated with conflict and reduced marital satisfaction, if the division of household labor is not agreed upon couples [23]. Negligence of men in fulfilling their spousal duties under the factor of masculine authority and dominance can even be considered domestic violence. And its prevention requires family education and counseling to improve interactions and marital satisfaction [24].

In medical sciences, and especially in nursing, a family-centered care strategy is often used to implement medical interventions which are used to improve family members' ability to perform the role of patient caregiver, especially for children [25]. This approach also seems to be useful in improving the marital satisfaction of the parents of children with bipolar disorder [26]. While the effect of this method on increasing marital satisfaction through the husband's participation in domestic roles has not been investigated as one of the known factors to reduce marital satisfaction. Therefore, this study was conducted to determine the effect of an educational-supportive program to manage domestic roles based on a family-centered approach with the participation of husbands on marital satisfaction in female nurses in Zabol City, which is a city in Iran with a largely traditional culture in terms of the division of domestic tasks [24].

2. Methods

The present interventional study was conducted with a pre-test-post-test design and with a control group in Zabol City, Iran. The study population included married female nurses working in two hospitals in Zabol City (about 240 people). Based on Abedini et al.'s study [26] and considering potential attrition of 15%, the sample size per group was determined as 25 nurses based on the following formula who participate in the intervention with their spouses (25 couples=50 individuals).

After receiving approval from the Ethics Council of Gonabad University of Medical Sciences (Code: IR.GMU.REC.1395.47), 50 married female nurses working in two hospitals in Zabol (25 nurses from each hospital) were screened based on the inclusion criteria who participated in the intervention with their husbands (100 people).

A multistage random sampling method was used in the study. The participants were divided into two control and trial groups according to their hospitals. The study's goals were explained to the participants and written informed consent was obtained. The participants were

asked to fill out Carlson's Work-Family Conflict Scale (WFCS) before the intervention (in the sampling stage) and the enrich marital satisfaction questionnaire before and after the intervention. The trial group (nurses with their husbands) received a family-centered educational-supportive program to empower them in performing domestic roles. Group training was provided in eight 1.5-hour sessions. The educational content of the public sessions included familiarization with the difficulties of the nursing profession, focusing on female nurses, introducing four dimensions of the family structure (communication, power, and decision-making, family's role, values and norms based on Friedman's structural-functional model), [27] the features of a healthy family, introducing strategies to control WFC and skills training and practice to manage work-family roles (including time management, stress management, self-management, assessment of the couples' chosen strategies, and ensuring their joint satisfaction and the practicability and compatibility of the strategies with their family-cultural conditions). The two-month follow-up was carried out after the training stage, during which questions were answered and guidance was provided over the phone.

Inclusion criteria for women nurses in both groups

The study inclusion criteria consisted of working in one of the hospitals at the time of sampling, being married and living with the spouse, age between 25 and 35 years, with a practical nurse diploma or an associate, bachelor's or master's degree in nursing, having one or two children under ten years of age, a work history less than ten years, being a native of Zabol City, score≥50 in the 18-item Carlson's WFCS, no addiction or mental disorders in themselves or their husbands, being in a monogamous marriage and the husband not opposing his wife's employment, and willingness to cooperate in the study.

The exclusion criteria for both groups

The exclusion criteria included unwillingness to continue cooperation and absence in more than two educational sessions.

Outcome measures

In this study, marital satisfaction was assessed using enrich marital satisfaction questionnaire, the Persian version short-form (47-item). The reliability of the short form has been confirmed with Cronbach's alpha of 0.95. The minimum score is 47 points and the maximum is 235. The validity and reliability of this tool have been confirmed in a study conducted by Seraj in Iran [28].

WFC was assessed by the 18-item Persian version of the WFCS by Carlson (2000). A higher score indicates more conflict. The reliability of this form has been confirmed with Cronbach's alpha of 0.84 [29].

Statistical analysis

The data collected were entered into SPSS software version 20. The Kolmogorov-Smirnov test was used to determine the normality of data distribution. Parametric data were analyzed by unpaired t test and chi-square test and nonparametric data were analyzed using the Mann-Whitney U test. The results were statistically significant with a $P<0.05$.

3. Results

According to Table 1, no significant differences were observed between the two groups, except in the variable of spouse's occupation regarding the demographic details.

As shown in Table 2, after the intervention, the mean score of marital satisfaction in the trial group increased ($P=0.001$) because the score increased significantly from moderate to high in the trial group.

Table 3 presents the mean scores of components of marital satisfaction that increased in trial group after intervention ($P<0.001$).

4. Discussion

The present study was conducted to assess the effect of a family-centered program to manage domestic roles on marital satisfaction in female nurses. According to the results, the program significantly increased marital satisfaction and its components in female nurses and the hypothesis that the educational program increases marital satisfaction was confirmed. Another study has also noted a positive relationship between marital satisfaction and the management of domestic roles in working women, especially nurses [30].

This study sought to gain the husbands' emotional and instrumental support through a family-centered program so that by introducing the nursing profession to them and talking about its stressful nature, the spouses of female nurses better understand the difficult work conditions of their spouses. Another study confirmed the effect of both spouses' awareness of each other's needs as a factor affecting marital satisfaction [31]. The family also provides peace of mind and mental security by controlling the members' emotions and establishing close emotional relationships [32, 33] and thus leading to a sense of self-efficacy.

Table 1. Comparing demographic details in the trial and control groups

Variables		No. (%)		P*
		Trial Group	Control Group	
Age (y)	30 and below	15(60)	17(68)	0.56
	Over 30	10(40)	8(32)	
Service history	Less than 5 years	14(56)	15(60)	0.77
	5 years and above	11(44)	10(40)	
Number of children	1	14(56)	16(64)	0.56
	2 or 3	11(44)	9(36)	
Spouse's occupation	Employee	16(64)	9(36)	0.05
	Self-employed	9(36)	16(64)	
Spouse's education	High school diploma and associate degree	12(48)	11(44)	0.78
	Bachelor's degree and above	13(52)	14(56)	

* X^2

Table 2. The mean score of marital satisfaction in the trial and control groups before and after the intervention

Marital Satisfaction		Mean±SD	t	df	P
Before the intervention	Trial	150.68±21.97	0.76	48	0.45
	Control	155.52±23.29			
After the intervention	Trial	173.56±17.28	3.53	48	0.001
	Control	154±21.62			

Table 3. A comparison of the trial and control groups in terms of the differences in the scores of the components of marital satisfaction before and after the intervention

Component	Group	Mean Rank	Mann-Whitney's U	Z	P
Personality issues	Trial	36.40	40	-5.47	<0.001
	Control	14.60			
Conflict resolution	Trial	36.08	48	-5.66	<0.001
	Control	14.92			
Financial management	Trial	34.78	80.5	-4.87	<0.001
	Control	16.22			
Sexual relationship	Trial	34.84	79	-4.85	<0.001
	Control	16.16			
Marriage and children	Trial	34.44	89	-4.73	<0.001
	Control	16.56			
Family and friends	Trial	35.26	68.5	-4.96	<0.001
	Control	15.74			
Religious orientation	Trial	35.04	74	-4.83	<0.001
	Control	15.96			

In this study, we also sought to familiarize the participants with dimensions, including communication, power and decision-making, roles and values in the family as well as the features of a healthy and balanced family in these dimensions based on psychological, cultural, and religious recommendations [34] so that they can find more self-awareness about their behavior and families gain more knowledge about the ways to correct them. In another study, cognitive-behavioral training had positive effects on marital satisfaction. This method is based on learning and cognitive principles and emphasizes on what the family thinks and behaves and recommends positive thinking and the distraction of interpretations from conflicting situations [35].

In this study, the difficulty of managing domestic roles about care duties and performing household chores for female nurses without help from their husbands, its consequences for the health of women and their families, and its effect on their work conditions of them were explained and put to group discussion. A study conducted in Turkey has also shown that in two-breadwinner families, the men's participation in roles, such as taking care of the children, which is traditionally defined as a gendered role for women, reduces WFC and increases marital satisfaction [36].

Other issues discussed included broadening supporters and offering more forms of social support through encouraging participation and asking for others' assistance and delegating affairs, such as taking care of family members to other people and paying for their services as well as prioritizing the duties at hand, which are also recommended in another article [37].

In the dimension of effective communication within the family and conflict resolution, the importance of using listening techniques and avoiding prejudgments, and clarifying messages were also explained. In other studies, marital conflict resolution [38] and communication training for both spouses were effective in improving marital satisfaction.

The spouses were trained and practiced the skills needed to control role conflicts and better-performing family roles, such as stress management and its techniques, including positive thinking, relaxation techniques and exercise, time management and parent=child relationship management in a busy life, and also self-management, and its techniques. Other studies have occasionally used these techniques alone or in combination to improve marital satisfaction [39].

The limitations include not separately assessing the men in terms of the trained variables in cognitive, emotional, and skills areas, especially regarding social support and marital satisfaction.

5. Conclusion

This study showed comprehensive educational support program for family management with a family-centered approach and practicable content appears to have improved marital satisfaction and its subscales. Therefore, it is recommended to use this program in similar conditions.

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Ethics Committee of Gonabad University of Medical Science (Code: IR.GMU.REC.1399.209).

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Authors' contributions

Conceptualization: Shahla Khosravan, Anis Jor and Leila Sadegh Moghadam; Analyzing, and modeling the data: Seyed Behnam Mazloum Shahri; Drafting the manuscript: Shahla Khosravan and Anis Jor; Final approval: all authors. All authors had full access to all data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Conflict of interest

The authors declared no conflict of interest.

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