



Double Burden of Professional and Domestic Roles: Work-Family Conflict, Workload, and Job Stress as Predictors of Performance among Female Healthcare Workers in Hospitals

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Article Info:

Article history:

Received: June 23, 2026

Revised: August 11, 2026

Accepted: August 14, 2026

Available Online: August 22, 2026

Keywords:

Employee Performance; Women's
Health Workers; Work-Family
Conflict; Work Stress; Workload



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Abstract

Background: Female healthcare workers in Indonesia face dual demands from professional and domestic roles, which may affect their work performance.

Objective: This study examines the simultaneous and partial effects of work-family conflict (WFC), workload, and work stress on the performance of female healthcare workers, drawing on Role Conflict Theory, Conservation of Resources Theory, and Job Demands-Resources Theory.

Methods: A quantitative cross-sectional survey was conducted among 130 female healthcare workers in hospitals in Kuningan Regency, West Java, selected through purposive sampling. Data were collected using a seven-point Likert-scale questionnaire and analyzed using multiple linear regression.

Results: WFC and work stress had positive and significant effects on performance, with coefficients of 0.374 ($p=0.014$) and 0.146 ($p=0.022$), respectively. In contrast, workload had a negative and significant effect ($B=-0.397$; $p=0.001$) and was the strongest predictor based on its standardized coefficient ($\beta=-0.298$). Simultaneously, WFC, workload, and work stress significantly affected performance ($F=22.687$; $p<0.001$), explaining 35.1% of its variance ($R^2=0.351$).

Conclusion: The findings indicate that work pressure does not uniformly impair performance in the collectivist Indonesian context. WFC and work stress may function as performance-enhancing factors when supported by adaptive and professional conditions, whereas workload remains a critical constraint requiring organizational intervention. These findings highlight the importance of culturally sensitive human resource policies that prioritize workload management while providing appropriate support for female healthcare workers.

To cite this article: Masruroh, R., Prayudi, D., Budiman, A., Oktaviani, W., & Alvian, D. (2026). Double burden of professional and domestic roles: Work-family conflict, workload, and job stress as predictors of performance among female healthcare workers in hospitals. *INKUBIS: Jurnal Ekonomi dan Bisnis*, 8(3), 1850-1859. <https://doi.org/10.59261/inkubis.v8i3.396>

INTRODUCTION

The problem of global health workers is now not just a matter of shortage of personnel or budget limitations (Darzi & Evans, 2016; Walton-Roberts, 2023). Behind these numbers, there is a more fundamental problem: the fatigue experienced by people who have to cope with the demands of hard clinical work every day while fulfilling obligations as family members. Mohr et al. (2025) noted that annual burnout rates among United States healthcare workers ranged from

30.4% to 39.8% over six years of observation, with primary care physicians reaching the highest figure in 2022. The OECD report (2024) reinforces these findings: nearly 40% of doctors under the age of 55 in ten member countries report symptoms of burnout, and this condition is most commonly found among nurses and midwives. Babapour et al. (2022) show that work stress in nurses not only impacts their own quality of life, but directly affects the quality of services patients receive. In Indonesia, this pressure is compounded by cultural norms that place women as the main ones in charge of family affairs. As a result, female healthcare workers may experience a substantial double burden, particularly in regional hospital settings.

This double burden persists despite health workforce policies implemented at both national and global levels. The WHO Global Health Workforce Strategy 2030 highlights gender equity and occupational wellbeing as priority pillars, yet implementation gaps remain, especially in low- and middle-income country contexts (WHO, 2016). In Indonesia, the 2019 Health Law mandates occupational health protection for healthcare workers, but implementation remains inconsistent at the district hospital level (Kemenkes RI, 2020). These conditions indicate the need to examine not only the prevalence of work-related pressures but also how work-family conflict (WFC), workload, and work stress translate into employee performance. This issue is particularly relevant in Indonesia because collectivist family norms may shape how female healthcare workers respond to competing work and family demands.

To explain these relationships, this study draws on three complementary theoretical perspectives. Role Conflict Theory Greenhaus & Beutell (1985) explains that WFC arises when demands associated with work and family roles are incompatible because of limited time, energy, and attention. WFC can occur through time-based, strain-based, and behavior-based conflict. Hetrick et al. (2023), through a meta-analysis of 65 studies, demonstrated that these dimensions may have different consequences, indicating the importance of examining WFC as a multidimensional role-related pressure. Conservation of Resources (COR) Theory Hobfoll (1989) further explains that individuals seek to protect and maintain valued resources such as time, energy, and social support. Under certain conditions, resource threats associated with role conflict may stimulate compensatory effort rather than simply reduce performance (Huang et al., 2024). Meanwhile, Job Demands-Resources (JD-R) Theory Bakker et al. (2023) explains that job demands can impair performance when they continuously exceed employees' recovery capacity, whereas manageable or challenging demands may stimulate motivation and productivity. Together, these perspectives provide a framework for examining why WFC, workload, and work stress may not necessarily have uniformly negative relationships with performance.

Previous studies provide evidence that the relationships among these variables are not entirely consistent. In Indonesia, Ratnaningsih et al. (2023) found that work-family dynamics differ from those commonly reported in Western contexts, partly because family interdependence and support are embedded in everyday social relationships. Similarly, Yao et al. (2024), examining 646 married female nurses in China, found that respondents with higher WFC could also demonstrate stronger work engagement. Brzykcy et al. (2024) further showed through a three-wave study that the consequences of WFC depend partly on the duration and dynamics of the conflict over time. These findings suggest that WFC should not automatically be interpreted as a determinant of poorer performance in every cultural setting.

Workload and work stress require different explanations. Workload in this study is measured through physical, mental, psychological, overload, and task-density dimensions, consistent with the concept of job demands in JD-R Theory. When workload exceeds employees' capacity to recover, concentration, clinical judgment, and performance may decline (Barpanda & Saraswathy, 2023). Yousef et al. (2024) found that this burden may be particularly difficult for female healthcare workers because domestic responsibilities can limit recovery after working hours. In contrast, work stress may have either detrimental or motivating consequences depending on its intensity and nature. La Torre et al. (2021) found that moderate work pressure was associated with better work ability among healthcare workers, while Ari (2025) reported that higher stress among nurses was not necessarily accompanied by a proportional decline in performance. These findings indicate that the effects of work stress may depend on how employees experience and manage occupational demands.

A synthesis of the literature therefore reveals three important gaps. First, previous studies

frequently examine WFC, workload, and work stress separately, limiting understanding of their simultaneous contribution to employee performance (Sohal et al., 2025). Second, empirical evidence from female healthcare workers in Indonesian regional hospitals remains limited, despite the combination of shift work, resource constraints, and strong family interdependence that characterizes this context (Ratnaningsih et al., 2023). Third, the assumption that all forms of work pressure uniformly reduce performance requires further empirical examination because COR and JD-R perspectives allow for different responses depending on available resources and the nature of the demand. Accordingly, empirical evidence from a collectivist healthcare context is needed to determine whether the relationships identified in predominantly Western settings are similarly observed among Indonesian female healthcare workers.

Based on these gaps, this study aims to analyze the simultaneous and partial effects of work-family conflict, workload, and work stress on the performance of female healthcare workers in hospitals in Kuningan Regency, West Java. The study contributes empirical evidence from an Indonesian regional hospital context and extends the application of Role Conflict Theory, COR Theory, and JD-R Theory by examining their explanatory relevance in a collectivist cultural setting. Practically, the findings are expected to provide evidence for hospital administrators and health policymakers in developing differentiated human resource interventions: structural workload management, supportive approaches to WFC, and appropriate management of work stress.

Based on the theoretical framework and research gaps, the hypotheses are formulated as follows:

1. H1: Work-family conflict (WFC), workload, and work stress simultaneously have a significant effect on the performance of female healthcare workers.
2. H2: Work-family conflict (WFC) has a significant partial effect on the performance of female healthcare workers.
3. H3: Workload has a significant partial effect on the performance of female healthcare workers.
4. H4: Work stress has a significant partial effect on the performance of female healthcare workers.

METHOD

This study used a quantitative approach with a cross-sectional survey design. This approach was chosen because it allowed efficient testing of predictive relationships between variables at a single point in time, with a moderate sample size, and produced generalizable estimates (Creswell & Creswell, 2017). Multiple linear regression was chosen because it was consistent with the model structure in this study, namely three independent variables that directly predicted one dependent variable without involving a mediation or moderation variable, and because all required classical assumptions were met (Hair et al., 2019). Overall, this study integrated the perspectives of HR management, organizational psychology, and occupational health.

The research population consisted of all female health workers who were actively serving in hospitals in Kuningan Regency, West Java, Indonesia. Due to the lack of up-to-date centralized registration data, the population size could not be definitively determined. Therefore, the sample was selected using purposive sampling with three inclusion criteria: female, married and/or having children, and having worked for more than two years. These criteria were designed to ensure that all respondents truly occupied dual roles, as this was an essential requirement for WFC to be measured meaningfully. The sample size of 130 respondents met the guidelines of Hair et al. (2019), which set a minimum ratio of 5:1 between the number of respondents and the indicators ($26 \text{ indicators} \times 5 = 130$), while exceeding the minimum recommended threshold for multiple regression analysis (Sugiyono, 2023).

Data were collected through a structured questionnaire using a seven-point Likert scale (1 = strongly disagree; 7 = strongly agree). The seven-point scale was chosen because it produced a wider variance of responses and higher psychometric sensitivity compared with the five-point scale, while reducing respondents' tendency to choose a middle score (Hair et al., 2019). Each variable was measured using indicators drawn from established frameworks: WFC was measured

through three indicators, namely time-based, strain-based, and behavior-based conflict (Greenhaus & Beutell, 1985); workload was measured through five indicators, including physical, mental, and psychological conditions, excessive load, and task density; work stress was measured through nine indicators covering the dimensions of uncertainty and organizational demands (Budiasa, 2021); and performance was measured through nine indicators, including quantity, quality, efficiency, discipline, initiative, precision, leadership, honesty, and creativity (Afandi, 2018).

Data analysis was carried out in three stages using SPSS 23. The first stage was instrument testing, which included a validity test using Pearson correlation (calculated r compared with r table; $df=128$; $\alpha=0.05$; r table=0.1723) and a reliability test using Cronbach's Alpha with a minimum threshold of 0.60 (Ghazali, 2018). The second stage was classical assumption testing: residual normality was tested using the One-Sample Kolmogorov-Smirnov test (normal if Asymp. Sig. > 0.05), multicollinearity was tested using Tolerance (>0.10) and VIF (<10) values, and heteroscedasticity was tested using the Glejser test (no heteroscedasticity if Sig. > 0.05). The third stage included multiple linear regression analysis, the coefficient of determination (R^2), the partial t-test (t table=1.978; $df=126$; $\alpha=0.05$ two-tailed), and the simultaneous F-test (F table=2.68; $df_1=3$; $df_2=126$; $\alpha=0.05$).

RESULTS AND DISCUSSION

Results

This section consists of two interrelated sub-sections. The first sub-section presents the results sequentially, starting from instrument testing, descriptive overview, classical assumption examination, to hypothesis testing with the resulting regression equation, namely $Y = 53.556 + 0.374X_1 - 0.397X_2 + 0.146X_3$. The second sub-section reviews the meaning behind each finding, both from a theoretical and practical perspective, and links it to relevant international literature.

Validity and Reliability Test Results

Table 1

Summarizes The Results of The Instrument Test for The Four Research Variables

Variable	r count (min-max)	r table (n=130)	Validity	Cronbach's Alpha
Work-Family Conflict (X1)	0,401–0,673	0,1723	Valid	0.788 (Reliable)
Workload (x2)	0,418–0,741	0,1723	Valid	0.795 (Reliable)
Work Stress (X3)	0,401–0,745	0,1723	Valid	0.900 (Reliable)
Employee Performance (Y)	0,402–0,723	0,1723	Valid	0.893 (Reliable)

Source: Primary data processed with SPSS 23 (2025). Note: r table ($df=128$; $\alpha=0.05$) = 0.1723; reliable instrument if Cronbach's Alpha > 0.60 (Ghazali, 2018)

All statement items produce a calculated r value that exceeds r table=0.1723, so that all of them are declared valid. Cronbach's Alpha values range from 0.788 for WFC to 0.900 for work stress, well beyond the minimum threshold of 0.60 and even meet the more stringent standard of 0.70 commonly used in management research (Hair et al., 2019). The highest reliability of the work stress construct suggests that the nine indicators measure a single construct that is highly consistent, while validating the adequacy of this instrument for the context of health workers.

Descriptive Analysis

Before testing the hypothesis, Table 2 first presents an overview of the four variables to provide an initial understanding of the conditions actually experienced by the respondents.

Table 2

Descriptive Statistics and Research Variable Criteria

Variable	N	Min	Max	Red	Std. Dev.	Criterion (%)	Categories
Work-Family Conflict (X1)	130	4	21	15,16	9,831	72%	High
Workload (x2)	130	5	35	22,70	8,951	65%	Medium

Work Stress (X3)	130	9	63	44,42	14,621	70,5%	High
Employee Performance (Y)	130	33	63	56,68	5,350	89,9%	High

Source: Primary data processed with SPSS 23 (2025). Criterion: Low (0–33%); Moderate (34–67%); High (68–100%). Actual score calculated: $\% = (\text{Actual Score} / \text{Ideal Score}) \times 100\%$

The data in Table 2 show some interesting patterns to observe. Performance was in the very high category (89.9%), with an average of 56.68 out of a maximum score of 63. When searched by indicator, accuracy was the most prominent dimension (score 849), while creativity was at the lowest position (799). This pattern reflects the character of the clinical profession that demands more procedural precision than innovation, as identified by Ari (2025) in the context of a high-risk work environment

WFC is in the high category (72%), indicating that most respondents have real difficulty balancing work and family demands. This condition is in line with the findings of Yao et al. (2024) that married female nurses are indeed more susceptible to experiencing high WFC, given the unpredictable nature of clinical work and irregular shift systems. Work stress is also in the high category (70.5%), with the indicator of employee personality problems as the highest source of stress (score 662) and the demands of formal roles as the lowest (607). This pattern suggests that the pressure most respondents feel does not come from the orders of their superiors or the rules of the system, but from the standards they set for their own work. In contrast to the previous two variables, workload was only in the medium category (65%), with the overload indicator recording the highest score (603) and the lowest task density (566).

There are interesting patterns to observe before formal testing is carried out. WFC and work stress are both in the high category, but performance is very high, while the workload is only moderate. This pattern provides early clues that role conflict and work pressure do not seem to work in the same way as the physical burden of work. Whether this conjecture is confirmed by the data will be seen in the results of the next regression analysis.

Classic Assumption Test

The normality test with the Kolmogorov-Smirnov One-Sample yielded an Asymp. Sig. (2-tailed) value = 0.200 > 0.05, so that the residual was declared to be normally distributed. Table 3 summarizes the results of the multicollinearity and heteroscedasticity tests simultaneously.

Table 3

Multicollinearity and Heteroscedasticity Test Results

Variable	Tolerance	VIF	Status MK	Sig. Glejser	Status HK
Work-Family Conflict (X1)	0,725	1,379	Free	0,055	Free
Workload (x2)	0,660	1,516	Free	0,062	Free
Work Stress (X3)	0,659	1,517	Free	0,096	Free

Source: Primary data processed with SPSS 23 (2025). MK = Multicollinearity (free if Tolerance > 0.10 and VIF < 10). HK = Heteroscedasticity (free if Sig. Glejser > 0.05)

The Tolerance values for all three variables ranged from 0.659–0.725, all above 0.10. The VIF value ranges from 1,379–1,517, well below the 10 limit. Both measures indicate the absence of multicollinearity problems. The Glejser test yielded significance values between 0.055–0.096, all above 0.05, so the model was declared free of heteroscedasticity. With the fulfillment of all classical assumptions, regression coefficient estimation meets the criteria of Best Linear Unbiased Estimators (BLUE) and can be used for statistical inference (Ghazali, 2018).

Hypothesis Testing through Multiple Linear Regression

Table 4 presents the results of multiple linear regression analysis and partial t-tests for each predictor variable.

Table 4

Results of Multiple Linear Regression Analysis and t-Test (Partial)

Variable	B	β (Std.)	t count	t table	Sig.	Verdict
Constant	53,556	—	—	—	—	—

WFC (X1)	0,374	0,215	2,496	1,978	0,014	H2 ✓
Workload (x2)	-0,397	-0,298	-3,535	1,978	0,001	H3 ✓
Work Stress (X3)	0,146	0,201	2,316	1,978	0,022	H4 ✓

Source: Primary data processed with SPSS 23 (2025). Note: t table (df=126; $\alpha=0.05$ two-tailed) = 1.978; ✓ = data-supported hypothesis

The regression equation $Y = 53.556 + 0.374X_1 - 0.397X_2 + 0.146X_3$ contains some information that needs to be read carefully. Constant 53.556 shows that respondents already have a strong baseline performance level before all three predictors are taken into account. WFC produces a positive coefficient ($B=0.374$; $\beta=0.215$; $t=2.496$; $\text{sig.}=0.014$), which means that every increase in one unit of WFC is actually related to an increase in performance of 0.374 units, contrary to initial assumptions. The workload produced the largest negative coefficient among the three variables ($B=-0.397$; $\beta=-0.298$; $t=-3.535$; $\text{sig.}=0.001$), which made it the most powerful factor in suppressing performance. While work stress produces a positive coefficient ($B=0.146$; $\beta=0.201$; $t=2.316$; $\text{sig.}=0.022$), which also contradicts the initial hypothesis that was assumed to be negative

Table 5

Coefficient of Determination (R^2) and Simultaneous F Test

Indicator	Value	F Table	F count	Sig.
R	0,592	—	—	—
R^2 (R Square)	0,351	—	—	—
Adjusted R^2	0,336	—	—	—
Simultaneous F Test	—	2,68	22,687	0,000

Source: Primary data processed with SPSS 23 (2025). Note: F table (df1=3; ff2=126; $\alpha=0.05$) = 2.68

The value of $R=0.592$ indicates that the relationship between the three predictors and performance is quite strong. The value of $R^2=0.351$ means that WFC, workload, and work stress together were able to explain 35.1% of the variation in the performance of female health workers, while the remaining 64.9% were influenced by other factors not included in this study model. The F test results in a calculated $F = 22.687$, well above the F of the table = 2.68, with a significance value of 0.000. This result means that H1 is accepted, namely all three variables simultaneously have a significant effect on performance.

Discussion

Work-Family Conflict and Performance: When Role Conflict Becomes a Motivator

The finding that WFC had a positive and significant effect on performance ($B=0.374$; $t=2.496$; $p=0.014$) was the most surprising finding in the study. So far, the WFC literature has almost uniformly assumed that conflicts between work roles and family inevitably weaken performance. That assumption was formed from studies that mostly involved samples from Western individualistic societies, in which the boundaries between work and family roles were drawn more firmly.

A different perspective emerged when COR Theory Hobfoll (1989) was applied to the context of collectivist culture. In a society that places the family at the center of identity and motivation like Indonesia, threats to role resources can trigger the opposite response: individuals work more organized and focused during working hours, so that family responsibilities can still be fulfilled after returning home. The survey data support this statement is shown by the two highest performance indicators in this study, namely rigor and work discipline, which are intuitively consistent with the work pattern of a person who manages time very carefully because he is aware of his limitations.

Yao et al. (2024) found an identical pattern in 646 married female nurses in China: those with the highest WFC showed the most intense work engagement. Fan et al. (2024) proved through longitudinal studies that a person who experiences WFC but still has strong support from his or her family tends to feel more positive at work and produce better performance. Such

support has indeed become a natural part of life in a society that upholds togetherness. Brzykcy et al. (2024) add a relevant time perspective: those who have lived with high levels of WFC for a long time tend to develop a self-regulation capacity that eventually becomes an advantage at work. Given that 84% of the respondents in this study had a working period of 2–5 years, such an adaptation period is very likely to have already taken place

Workload and Performance Degradation: An Uncompensated Depletion Process

In contrast to the other two variables, workload had a negative and significant effect on performance ($B=-0.397$; $t=-3.535$; $p=0.001$), a finding that is in line with most of the existing literature and is also the most important to consider in organizational management. With the highest standard beta value among the three variables ($|\beta|=0.298$), workload proved to be the most powerful factor in suppressing performance. This can be explained through the JD-R Theory (Bakker et al., 2023): when the demands of work continue to accumulate and exceed a person's ability to recover, their physical energy and thinking ability will be slowly depleted

Although the workload in aggregate was only in the medium category (65%), the overload indicator recorded the highest score (603). This suggests that the problem is not in the volume of daily tasks, but rather in occasional spikes in intensity that exceed normal capacity, a condition that Barpanda & Saraswathy (2023) refer to as quantitative overload, which was shown to be related to decreased clinical performance in 14 of the 15 studies they reviewed. Yousef et al. (2024) added a critical gender dimension, for female nurses, the negative effects of workload are more difficult to counteract by organizational support, female nurses after their working hours do not really rest because household chores are waiting. This is what distinguishes workload from WFC and work stress, WFC and work stress still give a person room to adapt, while excessive workload drains energy and mind to such an extent that even the inner spirit is not enough to keep up.

Work Stress as a Performance Driver: Evidence of Eustress Mechanisms in the Clinical Profession

Work stress had a positive and significant effect on performance ($B=0.146$; $t=2.316$; $p=0.022$). Although the effect was the least among the three predictors, this finding is the most theoretically interesting because it contradicts initial assumptions. Seyle (1975) has long shown that not all stress is destructive. The pressure that comes within tolerable limits can sharpen focus, reinforce a sense of responsibility, and encourage a person to work more earnestly. La Torre et al. (2021) prove this in clinical settings, where healthcare workers who work under

The descriptive data show interesting findings. The highest source of stress does not come from the demands of formal roles from the outside (score 607), but from internal personality factors (score 662). This suggests that the pressure that respondents feel the most comes from the high standards they set for their work. Within the framework of JD-R Theory, pressures rooted in internalized professional values tend to encourage morale, not drain energy (Bakker et al., 2023). Ari (2025) confirms this: although nurses bear higher stress than other professions, their decline in performance is not commensurate with the amount of stress they endure, a sign that facing repeated stress in the long term actually forms resilience that helps them stay productive. Wang et al. (2024) added that when WFC and work stress are present together, they can reinforce each other's involvement at work, and this effect may also explain why these two variables had a positive impact on performance in this study.

Policy Implications and Research Limitations

These three findings carry different policy implications for each variable. Since workloads have proven to be the most consistent to weaken performance, the most urgent step is to conduct regular, data-driven workload audits. This audit needs to specifically take into account the domestic burden that has been invisible but real for women health workers, and the results can be used as a basis for establishing a more proportionate nurse-patient ratio and a fairer task-sharing system. For WFC, what is needed is not an effort to eliminate the conflict itself, because in a culture that upholds togetherness, role conflicts do not always have to be avoided. What is more important is to provide support so that these conflicts can be lived better, for example through

flexible work scheduling, a forum for sharing experiences between fellow health workers, and easy access to childcare services.

Regarding work stress, what needs to be done is not to eliminate pressure completely, because reasonable pressure has been proven to boost performance. What is more appropriate is to create working conditions that make pressure still feel like a challenge, not a depressing burden. This can be achieved through regular performance feedback, clarity of expectations from superiors, and sincere recognition of the contributions that have been made. The overall direction of this policy is in line with the OECD's recommendations (2024) which encourage every country to build a health human resource system that is more sensitive to the needs of women health workers

These three limitations of research need to be openly acknowledged. First, cross-sectional design does not allow us to determine the direction of causality: whether it is WFC that drives performance, or whether it is precisely high performance that makes one better able to cope with role conflicts. To answer this question, a longitudinal study with a minimum of three measurement points is needed, as has been applied by (Brzykcy et al., 2024). Second, a sample limited to one district in West Java affects the extent to which these findings can be generalized to the context of other hospitals that have different resource characteristics, work culture, and demographic composition. Third, the work stress instruments used did not explicitly distinguish between challenge stressors and hindrance stressors. This distinction is important, because the eustress mechanism found in this study only applies to the first type of stress. The development of more differentiated instruments will allow for more careful testing on future research.

Novelty and Research Contributions

Based on all the findings and discussions that have been described, this study produces three main novelties that need to be affirmed: The first novelty is empirical evidence that Role Conflict Theory does not always produce the same predictions when applied outside the context of Western culture. In a society that upholds the value of family togetherness, WFC, which has been considered to be certain to weaken performance, has proven to be the opposite: it encourages a person to work more seriously as a form of responsibility for both roles at once. These findings suggest that theories that have been built on the experience of Western societies need to be retested when applied in different contexts, and this study provides one of the empirical pieces of evidence to support these efforts.

The second novelty is evidence that the mechanism of eustress is really valid in the context of the clinical profession. Stress stemming from self-set professional standards has been proven to boost morale. These findings deepen our understanding of when and under what conditions work pressure has a positive impact on performance. The third novelty is the finding that of the three variables studied, only workloads consistently and without exception degrade performance. Unlike WFC and work stress which can still boost work morale under certain conditions, excessive workload drains energy and mind in such a way that it cannot be overcome with motivation from within alone. Overall, these three novelties together show that the culture in which one works plays an important role in determining how work pressure impacts performance, so research in the field of HR management needs to more carefully consider the cultural context before generalizing findings from one society to another.

CONCLUSION

This study demonstrates that work-family conflict (WFC), workload, and work stress do not have uniform effects on the performance of female healthcare workers. WFC and work stress were found to have positive and significant effects on performance, whereas workload had a negative and significant effect and was the strongest predictor among the three variables. Simultaneously, the three variables significantly affected performance and explained 35.1% of its variance ($F=22.687$; $R^2=0.351$; $p<0.001$). These findings indicate that, in the Indonesian collectivist context, WFC and work stress may be associated with adaptive work responses, while excessive workload remains a critical constraint on employee performance.

The findings contribute empirically to the application of Role Conflict Theory, Conservation of Resources Theory, and Job Demands-Resources Theory in an Indonesian regional

healthcare context. From a practical perspective, hospital management should prioritize data-driven workload management while providing supportive arrangements for employees facing WFC and work stress. However, the cross-sectional design, the focus on hospitals in a single district, and the absence of differentiated measures for challenge and hindrance stressors limit causal interpretation and generalizability. Future research should employ longitudinal designs across multiple regions and examine contextual factors such as organizational support, schedule flexibility, and family support to clarify the conditions under which WFC and work stress may contribute to performance.

ACKNOWLEDGEMENT

The authors express sincere gratitude to the management and staff of hospitals in Kuningan Regency, West Java, who generously permitted access to conduct this research and facilitated the data collection process. Appreciation is also extended to all 130 female healthcare workers who volunteered their time and candid responses as respondents. This research received no external funding.

AUTHOR CONTRIBUTION STATEMENT

Rina Masruroh: Conceptualization, Methodology, Data Curation, Formal Analysis, and Writing – Original Draft. Deri Prayudi: Supervision, Validation, and manuscript preparation. Aris Budiman: Data Collection and manuscript preparation. Winda Oktaviani: Data Collection and manuscript preparation. Dini Alvian: Data Collection and manuscript preparation. All authors have read and approved the final manuscript.

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