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Work – family conflict, sense of coherence,coping resources and job satisfaction amongst women general practitioners

Mulaudzi, Tshifhiwa Ruth

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Chapter 2

LITERATURE REVIEW

Conceptualization of the research

2.1 Introduction

In this chapter the concepts of stress and coping are going to be introduced along with the other investigated concepts in this study, they are: Gender and work, work-family conflict (WFC), sense of coherence (SOC), coping resources, and job satisfaction. The stress and coping concepts are discussed in order to form the basis of understanding the latter mentioned investigated concepts.

2.1.1 The stress concept

The concept of stress is reported to be one that is difficult to define despite a great deal of research that has gone into it (Brannon & Feist, 1997; Monat & Lazarus, 1991; Rice, 1998). Over the years it has seen a number of definitions due to researchers' lack of agreement on a unified definition (Monat & Lazarus, 1991). According to Rice (1998) in recent years there has been three definitions that have been used where stress is seen as (1) A physical force – this is a physical force approach which suggests that an external event places severe pressure on an individual and all that the individual is left with is to try and survive (2) A subjective emotional tension – this is a psychological approach which suggests that stress is an internal psychic struggle which an individual expresses as overwhelming and is perceived as threatening and harmful (3) A bodily arousal – this is a physiological approach and it was suggested by Hans Selye. Selye (1947) as cited in (Rice, 1998) defined stress as "the non-specific response of the body to any demand made upon it". From this definition stress could be seen as either negative or positive (ibid.). However, the three definitions have been integrated and a fourth definition was proposed (Rice, 1998).

The integrated model for defining stress was proposed by Richard Lazarus and his colleagues (ibid.). Lazarus and Folkman (1984) defined stress as:

" a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well being" (p.19).

According to Brannon & Feist (1997) this definition of stress takes a transactional position towards stress. This implies that stress refers to a relationship between an individual and the environment. Secondly, the key to this relationship is how the person appraises the situation and the situation must be perceived as challenging, harmful and threatening to the person, that is, a choice between a challenge and a threat.

The topic of work stress falls within the field of social psychology. Psychologists who are interested in work stress acknowledge that work stress and family stress interact (Lazarus, 1999). This interface between work and family has been conceptualized as work-family conflict and it is this concept that will be viewed as a stressor amongst women general practitioners.

2.1.2 Work stress

The impact of job related stress has been well documented (Cooper, Dewe, & O' Driscol, 2001; Di Salvo, Lubbers, Rossi & Lewis, 1995; Fletcher, 1988; Frone, Russell & Cooper, 1995; Gutek, Repetti & Silver, 1988; & Spielberger & Reheiser, 1995). According to Fried, Rowland, & Ferris (1984) as cited in Di Salvo et al, (1995) work related stress has generally been seen to be a result of an imbalance between environmental demands and individual capabilities. Work related stress is said to have adverse effects on productivity, absenteeism, worker turnover, and employee health and well being. In addition, these effects have clear-cut direct costs to employers (Spielberger & Reheiser, 1995). As a result there has been a growing concern over the consequences of job stress for both employees and organizations and the proof of these lies in the increase research on occupational stress (ibid). Of importance to note is that even though there is an increase in research concerning occupational stress, the conceptual definition seems to differ from study to study and there are various models that have been proposed, including the widely cited: Interactional (Cooper et al, 2001), the Person-Environment Fit (Spielberger & Reheiser, 1995) and the more contemporary one, Lazarus Transactional Process theory (Lazarus, 1995).

The Interactional approach is a cause and effect approach that focuses on the statistical interaction between stimulus and response, this implies that the perceived presence of certain work conditions may be associated with a number of stress

responses (Cooper et al, 2001). It has been criticized based on the fact that focusing on the interaction between two variables implies that attempts to explain complexities of such a relationship are limited to "structural manipulation"(p. 11), that is, the influence of a third moderator (ibid). Lazarus (1990) as cited in Cooper et al, (2001) reported that this approach does not fully provide a sufficient framework to facilitate a full understanding of the stress process. However, he maintained that its importance lies in the fact that it draws attention to the separate constructs that play a significant role in understanding stress (ibid).

From the Person-Environment Fit theory occupational stress is defined in terms of the job characteristics that pose a threat to the individual because of lack of fit between the employee's abilities and job demands (French & Caplan, 1972) as cited in Spielberger and Reheiser (1995). Research support for this approach has been reported in that it seems to be a better predictor of job strain[1] than either person or environment variables separately. However it has been criticized for not yielding a highly focused approach (ibid). This implies that there is little in the way of empirical evidence that support this mode due to problems in clarifying the exact nature of misfit and appropriately measuring the constructs involved (Cooper et al, 2001). According to Cooper et al, (2001) contemporary approaches to understanding work stress are based on the transactional process perspective and that job related stressors have built upon this perspective. These theoretical approaches "emphasize the importance of thoroughly exploring the nature and scope of environmental factors that have a potential to create strain for the individuals in the workplace" (ibid, p. 27).

Cartwright and Cooper (1997) in Cooper et al (2001) differentiated a number of primary work related stressors: (1) Factors intrinsic to the job itself (2) Roles in the organization (3) Relationships at work, such as those with supervisors, colleagues and subordinates (4) Career development issues (5) Organizational factors, including the structure and climate of the organization as well as its culture and political environment (6) and lastly, the home-work interface. Frone et al, (1995) reported that even though there was an increase in work related stress research, the limitation of these research was that they failed to view workers from the broader context of other

[1] Refers to the individual's physical (e.g. fatigue), psychological (e.g. job dissatisfaction) and behavioural (e.g. absenteeism) responses to stressors (Cooper et al, 2001).

life domains, for example, family. As observed from the above report of the environmental sources of strain in the workplace it seems to be another source of stressor and as such worthy to be studied.

Lazarus (1999) reported that clinicians have come to recognize that job stress and family stress do not exist independently or in isolation but that they interact substantially. This is because work and family represents two of the most important aspects of an adult's life (Frone, Russell, & Cooper, 1992a). Moreover, there have been changes in family structures, more women entering the world of work, and technological changes that has made it easier for job tasks to be performed in a variety of locations and as a result blurring the boundaries between job and family life. Consequently, these create the potential for conflict to occur between work and non-work roles (Cooper et al, 2001). This is what has come to be known as inter-role conflict which has been defined as "the simultaneous occurrence of two or more sets of role pressures such that compliance with one would make more difficult the compliance with the other" (Kahn, Wolfe, Quinn & Snoek, 1964: 19).

The results of this have been that over the years where research has traditionally studied family and work as independent entities, it has now begun to focus on the interface between both these roles. In other words the questions that are now being asked are 'what is the impact of work life on family life and what is the impact of family life on work life?' (Frone et al, 1992a). This is due to the fact that the expectations of these two roles are rarely compatible (Netemeyer, Boles & McMurrian, 1996). Lazarus (1999) reported that there is a "spillover" between work and family stress. It is this spillover that researchers have come to conceptualize as work-family conflict (WFC) and a construct under investigation in this study (Frone et al, 1992; Gutek et al, 1991). This conflict has been reported to have an impact on important things like job satisfaction, burnout, turnover, and in addition to these it has been found that there exist a relationship between this conflict and psychiatric disorders (Frone, 2000; Frone, Russell, & Cooper, 1997; Lambert, Hogan, & Barton, 2002; Netemeyer et al, 1996; Noor, 2004; O'Driscol, Brough, & Kalliate, 2004). A more detailed discussion on this conflict will follow.

2.1.2.1. Work family conflict

As already mentioned, researchers have come to realize the importance of studying the interface that exists between work and non-work roles and that is what has contributed to the existence of the WFC construct. As one goes through the literature one observes that this construct has gone through a number of makeovers in terms of its definition (Duxbury & Higgins, 1991; Frone et al, 1992a; Greenhaus & Beutel, 1985; Gutek et al, 1991; Netemeyer et al, 1996). However the acceptable definition seems to have its basis on Kahn's (1964) original work, cited in Duxbury & Higgins (1991); Greenhaus & Beutel (1985); Krause (2003). Based on the above the widely accepted definition of WFC seems to be the following:

"A form of interrole conflict in which the role pressures from the work and family domains are mutually incompatible in some respect. That is, participation in the work (family) role is made more difficult by virtue of participation in the family (work) role" (p.77).

This definition implies that WFC arises when the demands of participation in the work (family[2]) domain are incompatible with the demands of participation in the family (work) domain. It also implies that the conflict that arises from these demands can have an important effect on the quality of both work and family life (Adams et al, 1996). Frone et al (1992a) reported that the WFC concept reflects the goodness of fit or perhaps a lack thereof between an individual's work and family life. It occurs when one's efforts to try and fulfill work role demands interferes with one's ability to fulfill family demands and vice-versa (Greenhaus & Beutel, 1985). Krause (2003) reported that within this definition of WFC lies the idea that it is a complex construct, which has multiple forms and operates in multiple domains. Several sources of WFC have been written about in literature (Frone et al, 1992a; Greenhaus & Beutel, 1985; Gutek et al, 1991; and Netemeyer et al, 1996). However there are certain main elements that are seen as the basic source of WFC, they are: general role demands (this refers to responsibilities, requirements, expectations, duties, and commitments associated with a certain role), strain that results from a certain role as well as time that one devotes to a certain role (Netemeyer et al, 1996).

[2] The use of brackets implies that each domain can be used interchangeably, i.e., vice-versa

Looking into the early research of this WFC construct literature reveals that previous research has relied almost exclusively on studying the conflict that arise when work interferes with family to the total exclusion of researching what happens when family interferes with work (Frone et al, 1992a & Krause, 2003). This early approach was criticized because it was felt that it would be less likely to provide a holistic, useful, conceptual basis for understanding the interface between work and family if these two domains are studied individually (Krause, 2003). Based on this recent research on WFC has taken an integrative approach in conceptualizing the work-family interface (Frone et al, 1992a; Gutek et al, 1991; Krause, 2003). Contemporary researchers have come to conceptualize WFC as having two components, that is, it is dual in nature (Adams et al, 1996; Frone et al, 1992; Gutek et al, 1991; Kossek & Ozeki, 1998; Netemeyer et al, 1996).

Gutek et al, (1991) were among the first researchers to conceive WFC as being dual in nature. They proposed that WFC has two components: family interference with work (FIW) and work interference with family (WIF). Duxbury and Higgins (1991) reported that it is hard to synthesize the literature on WFC as different terminologies has been used to describe the same constructs. Going through the literature concerning the dual nature of the WFC reveals that these terminologies have been used loosely if not interchangeably (Frone 2000; Frone et al, 1992a; Frone, Russell, & Cooper, 1992b; Gutek et al, 1991; Netemeyer et al, 1996). In other research the two components of WFC, that is, WIF and FIW have also been referred to as W$\rightarrow$F or WFC and F$\rightarrow$W or FWC simultaneously. The above mentioned symbols serve to emphasize the dual nature of the WFC where work (W) is seen to interfere with the family (F) domain and this is expressed over the literature as W$\rightarrow$F, WIF or WFC. Where family domain is seen to interfere with work domain the illustration is F$\rightarrow$W, FIW or FWC (ibid, Krause, 2003). More than just being dual in nature, the WFC construct has been conceptualized to be bi-directional in nature, that is, they distinguish between work interfering with family W$\rightarrow$F and family interfering with work F$\rightarrow$W (Frone 2000; Frone et al, 1992). Furthermore, over the years research has supported the bi-directional nature of WFC (Duxbury & Higgins, 1991; Frone, 2000; Frone et al, 1992; Gutek et al, 1991; Netemeyer et al, 1996). To avoid confusion in this research the bi-directional or direction of interference of WFC will be illustrated,

as W→F for work interfering with family and F→W for family interfering with work. The use of WIF and FIW will be discarded, the use of WFC will refer to a more general nature of the conflict that exists between the two domains.

It has been reported that W→F seems to exist more than F→W (Frone et al, 1992a; Gutek et al, 1991; Kossek & Ozeki, 1998; Netemeyer & Boles, 1992). In their study Kossek and Ozzeki (1998) found that there was a more negative relationship between W→F and job satisfaction than between F→W and job satisfaction. In their study of permeability between work and family boundaries, Frone et al, (1992b) also found evidence that W→F boundaries are less permeable when compared to F→W boundaries. This implies that it is hard to compromise the demands of work domain as opposed to compromising the demands of family domain. It thus seems that W→F has a more detrimental effect on the family domain than family has on the work domain (Krause, 2003). In trying to understand why there is more occurrence of W→F than F→W Gutek et al (1991) offered the following explanations: that it might be easier to estimate time spent on work activities than on family activities, people spend more time in work activities than family activities, and lastly it might be easier to adjust family schedules than work schedules.

Gutek et al (1991) proposed two frameworks in an attempt to understand the work-family conflict, the rational view as well as the gender role view. According to the rational view the amount of conflict one perceives increases when the number of hours one devotes to both work and family domains increases. In other words the moment one domain demands more hours than the other, there will be conflict in that domain. This suggests that if more hours are spent at work, W→F will be experienced and conversely if more hours are spent in the family, F→W will be experienced. The gender role view on the other hand maintains that gender is directly related to the perceived work-family conflict, and moderates the relationship between hours spent in paid and family work and perceived work-family conflict (ibid). From this perspective gender affects perceived work-family conflict. Thus additional hours in one's sex role domain are felt as less of an imposition by the role holder than additional hours of work in the domain traditionally associated with the other sex (ibid). In females this implies that when they spend many hours at work they will

report W→F, but also when they spend many hours at home they'll report W→F. With males on the other hand, when more hours are spent at home they will report F→W and when more hours are spent at work they will still report F→W. These researchers concluded that the level of perceived work-family conflict is not simply different from the number of hours expended, but it differs in a manner consistent with role expectations. Interestingly, there was no support for the gender role view in their study (ibid).

Greenhaus and Beutel (1985) outlined three important forms of WFC: time based conflict, strain based conflict, and behaviour based conflict. Time based conflict arise because individuals have limited resources in terms of time, energy and membership from different roles (for example work) or demands thereof might make it extremely difficult to comply with the demands of the family role. A closer look into this form of conflict reveals that it taps into the rational approach of understanding WFC as proposed by Gutek et al, (1991). Following the time based conflict is the strain based conflict. This conflict occurs when the strain that is created by a family role affects the performance of the work role and vice-versa. An example of this would be when an employee withdraws or is irritable with family members (Burley, 1995 cited in Cooper et al, 2001). Cooper et al, (2001) maintained that strains of family life may carry over into the work context though there has been only a few supporting studies of this impact (Higgins & Duxbury, 1992 as cited in Cooper et al, 2001). Lastly, it is the behavioural-based conflict. This is the type of conflict that arise due to conflict between one's role norms and expectations (Cooper et al, 2001). Thus the attitudes, values and the behaviours that are expected in one role may be incompatible with those required in another role (ibid). An example of this will be a black African woman who works as a manager. At work she might be expected to be assertive, driven, ambitious and basically to speak her mind. However, in her family context with her in laws this behaviour may cause conflict.

Research indicates that WFC is a significant source of strain for both men and women but there is a debate regarding gender differences (Cooper et al, 2001; Duxbury & Higgins, 1991; Frone, 2000; Frone et al, 1992a; Frone et al, 1992b; Gutek et al, 1991; Higgins, Duxbury, & Lee, 1994). This gender debate seems to have arisen from the

work of Pleck (1977) who proposed that there is gender difference in the boundaries of work-family interface as cited in Frone et al (1992b). However there seems to be mixed reports concerning gender and WFC. Frone et al (1992b) found no evidence to support Pleck's hypothesis concerning gender difference. In other words there was no difference in the way men and women experienced WFC. Higgins et al (1994) reported that women experienced more WFC compared to men only in their earlier life cycle stage and that as they mature they experience same level of WFC as men. Parasuraman and Simmers (2001) found that men reported more WFC as compared to women. Cooper et al (2001) reported that research that has tried to differentiate between F→W and W→F in terms of gender has revealed no clear-cut evidence for gender difference. Thus research results have been inconsistent and there is no unified confirmation of gender differences both in terms of the level and direction of WFC (ibid).

Cooper et al, (2001) reported that what is clear and evident is that men and women do have different experiences. Parasuraman and Simmers (2001) reported that women are more family involved and committed to the home than men, and that perhaps they have learnt more adaptable ways of coping. However, this juggling was reported to come at a price, as women were more likely to report life stress. What also remains clear is that women are generally perceived to be the ones struggling more to juggle work and family demands than men (Krause, 2003).

2.2 Coping

Just like stress, the concept of coping has received much attention both from a lay and scientific perspective, however an adequate system for defining the coping process is still missing (Monat & Lazarus, 1991). This concept is reported to be located in two different theoretical literatures, that is, the literature based on animal experimentation and the other from ego psychology (ibid.). The animal model implies a learned behavior to avoid, lower, or neutralize a dangerous condition. This approach has been criticized for being too simplistic and not including an integral part of human functioning, which is basic human cognition and emotion (ibid.). The psychoanalytic ego psychology on the other hand defines coping as those thoughts and behavior that are realistic and flexible, which are used to reduce stress (ibid.). Monat and Lazarus

(1991) criticized this approach because it suggests that some forms of coping are more successful than others and argued rather that judgment about coping should be made contextually.

Where traditionally the concept of coping was seen in terms of traits and styles, Lazarus and Folkman (1991) chose to approach this concept from a process point of view. They chose to define this concept as

"Cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p.210).

According to Kleinke (1998) this definition has three defining key features: coping involves a certain amount of effort and planning, it does not assume that the outcome of coping response will be positive, and it emphasizes that the coping process takes place over time. Kleinke (1998) maintained that coping is a process in which one uses flexibility to respond with skills and strategies that best fit the demands of the situation.

In trying to understand the coping process, Lazarus and Folkman (1984) mentioned that there are two types of appraisals: primary and secondary appraisal. In primary appraisal, the individual decides if potential stressors or challenges place them in danger. If the individual decides that they are not in danger then the process of coping will stop. However if the individual perceive that there is a threat or danger, they move to the process of secondary appraisal. In this process the individual will assess whether anything can be done about the perceived danger or not. If something can be done, an action can be taken. This involves individual's evaluation of their coping resources and options available for dealing with the challenge or threat (Brown, 2002).

As mentioned earlier, some researchers have chosen to study coping as active, ongoing strategies in particular stress situations, whereas others emphasize general coping traits, styles or dispositions (Monat & Lazarus, 1991). Those who focus on coping strategies observe those behaviours adopted by individuals given stressful situations and then infer the coping process implied by the behaviours. Monat and

Lazarus (1991) mentioned that this approach has been largely neglected. The coping as dispositions approach assumes that the type of coping mechanism adopted is consistent with one's personality or pattern of interacting.

In this research coping will be viewed as the strategies that one utilizes during stress and this will be based on an argument focusing on coping resources and sense of coherence. As mentioned by Monat and Lazarus (1991) the concept of coping should be viewed in terms of an outcome separate from coping, in other words the coping process does not guarantee a positive outcome. Based on this, the outcome of this research will be job satisfaction.

Furthermore, a question was raised earlier on whether all coping mechanisms are effective, this thesis will also argue that some coping mechanisms are more effective than others and this will be based on various coping resources being measured against job satisfaction and work-family conflict. Thus it will be argued that given a stressful situation, in this case high levels of WFC, any coping resource might be effective in reducing or eliminating this stress level but the degree of effectiveness will differ as will be seen by levels of job satisfaction.

2.2.1 Coping resources

As mentioned earlier, we are all subjected to stress at one point in our lives. Antonovsky (1979) sought to know that given the reality of the existence of stressors what resources we have available in ourselves that enables us to cope with the stressors. He reported that the answer might lie in what he called the generalised resistance resources (GRRs). Madhoo (1999) reported that individuals possess a variety of coping resources that enables them to deal with stressors. Thus from the above it can be deduced that stress exists when the demands from the environment exceeds an individual's coping resources (Rice, 1998).

However, it seems as if different researchers have defined these resources in different ways (Schafer, 1996). Nonetheless, what seems common is that researchers seem to start from a point that we all possess coping resources, and that the differences lie in the effectiveness of the resources used given a specific stressor. The following section is based on Hammer and Marting's (1988) conceptualisation of coping resources. The

reason for doing this is that their instrument for assessing coping resources was used in this research.

Hammer and Marting (1988) defined coping resources as those resources inherent in individuals that enable them to handle stressors more effectively, to experience fewer or less intense symptoms upon exposure to a stressor, or to recover faster from that exposure. They viewed this definition as consistent with current conceptions of resources that emphasize the mediating role resources play in the coping process (Mulaudzi, 2002). Hammer and Marting's (1988) definition is expanded upon in that resources are viewed as predispositions that may be derived from genetic factors, environmental influence and learned relationships.

Hammer and Marting (1988) conceptualised resources into five domains. These domains were summarised by Hall (1997) as follows:

1. Cognitive resources: the extent to which an individual maintains a positive sense of self-worth, a positive outlook towards others, and optimism about self in general.
2. Social resources: the degree to which individuals are in close personal social networks that can provide a source of support in times of stress.
3. Emotional resources: the degree to which people can identify and express their emotions.
4. Spiritual and philosophical resources: the degree to which a person's interactions with the world are grounded in a set of values. A clear set of values or strong philosophical position may help an individual cope with stress by providing a basis for understanding life events, and a set of guidelines for action when under stress.
5. Physical resources: the degree to which a person engages in health promoting behaviours that may improve the ability to cope with the physical consequences of stress.

The coping resources of the population of interest in this study will be assessed according to these five domains of coping resources. This conceptualisation of coping resources assumes that individuals have a wide variety of coping resources. A closer look at these resources reveals that there seem to be a link to the transactional model

in the conceptualisation of these coping resources, in other words they involve a relationship between an individual and the environment. Thus this conceptualisation seems to build up on what Lazarus and Folkman (1984) proposed on their conceptualisation of stress, as a result emphasizing that stress exists when the demands from the environment exceeds an individual's coping resources (Rice, 1998).

2.2.2 Sense of coherence (SOC)

In the late 1960's while working with his colleagues Antonovsky (1979) was struck with an idea:

"If two people were confronted by an identical stressor…but one had the wherewithal to successfully meet the challenge and the other did not, how could this situation best be conceptualised?" (p.3).

Fuelled by a concrete experience of having observed Israeli women who had been to the concentration camps, and yet most of them were judged to be in good emotional health, he set on to discover the creation of health. Antonovsky (1987) wondered…"to have gone through the most unimaginable horror of the camp, followed by years of being a displaced person, and then to have re-established one's life in a country which witnessed three wars…and still be in reasonable health…" (p.xi).

This line of thinking led to the question of *Salutogenesis*- the study of the origins of health (Antonovsky, 1979, 1987). Having noticed that the study of pathogenesis still dominated the medical research, Antonovsky sought to be different. He was uncomfortable with the idea of pathogenesis based on the following reasons: (1) It does not view an individual holistically, that is, it does not take into account how an individual subjectively interpret their illness (2) It has a "magic-bullet" approach for all illnesses (Antonovsky, 1979, p.37) to the total exclusion of multiple causation (3) The approach is dichotomous postulating that an individual is either sick or well instead of being multidimensional in its view. This is where the approach of Salutogenesis sought to be different. Instead of viewing the state of health in a dichotomous manner, the approach conceptualised health as being a state of continuum between two poles, the health-illness continuum, or *the ease / dis-ease*

continuum. However he felt that these two poles were only "heuristic devices" and not reality based since there could never be an absolute state of health or an absolute state of illness. Antonovsky sought to answer the mystery of survival, to understand the mystery of why some people go through pain and suffering and still manage to leave meaningful lives. Based on the health-illness continuum he sought to find the factors that push the person to the health end of the continuum.

Given the fact that we are all subjected to stress at one point in our lives Antonovsky (1979) wondered what the resources are that enable us to relieve the tension that comes with these stressors. He reported that the answer lay in what he called the generalised resistance resources (GRRs). These are any characteristics of a person or a group or the environment that can be applied to meet all the demands as well as to relieve the tension that comes with the stressors (ibid). He felt that these resources play a huge role in pushing an individual towards the *health / ease* end or the healthy end of the continuum. In his earlier work three kinds of GRRs were identified (Antonovsky, 1979) but later on a number of them were identified and these include: (1) Physical and biochemical – refers to those factors in our bodies that boost our immune system and nervous system. (2) Artifactual material – refers to the accumulation of wealth and material resources, for example, money, clothing, food, and power. (3) Cognitive and emotional – refers to knowledge intelligence and ego identity (4) Valuative-attitudinal – those factors in an individual that enable them to cope, that is, coping style of a person. (5) Interpersonal-Relational – this refers to social support. (6) Macrosociocultural – refers to what an individual has internalised from their given culture. He further mentioned that these GRRs serve specific functions, to avoid stressors as well as to manage the tension that arises out of stressors that are being experienced (Antonovsky, 1979).

Of importance for Antonovsky was seeing or looking for the commonalities in all these GRRs. He saw all these GRRs as characteristics of a system that is effective either in avoiding or combating a wide variety of stressors (ibid.). According to Antonovsky (1987) these GRRs aid us as humans to make sense of the stressors that we constantly come in contact with in our everyday life. These GRRs determine the extent to which we come to have a generalised, pervasive orientation, which he termed the sense of coherence (SOC) (Antonovsky, 1979 & 1987).

Originally the SOC concept was defined as:

"…a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there's high probability that things will work out as well as can be reasonably expected" (Antonovsky, 1979, p.123).

The SOC is perceptual and has both cognitive and affective components. It is a crucial element in an individual's personality structure. It is dynamic in that it is shaped and reinforced throughout one's life. When one is confronted with a stressor, if they have high level of SOC they will perceive the stressor as meaningful. They will be able to stay in contact with reality while having faith that things will turn out as well as can be expected (ibid.). This concept involves one's participation in the process of shaping the outcome. In addition, when confronted with a stressor an individual will have the capacity to activate a wide variety of GRRs to prevent tension from being turned into full-blown stress (ibid.). In later years Antonovsky (1987) proposed that the SOC had three defining keys. It is oriented towards a life development process and involves three major components: (a) *comprehensibility* of the forces at work in the environment, which Antonovsky (1987) defined as the sense that internal and external environment are structured, predictable, and explicable. It is a way of seeing the world as predictable and comprehensible. In other words it refers to the extent to which one perceives the stimuli that confront one as making cognitive sense. A person high in comprehensibility expects that the stimuli they will encounter will be orderable and explicable (b) *manageability* – sense that one has the resources available for dealing with stressors and (c) *meaningfulness* which is the cognitive and emotional perception of stressors' importance – and was defined as the belief that these stimuli demands are challenging and worthy of personal investments (Flannery & Flannery, 1990). It refers to the extent to which one feels that life makes sense emotionally, that problems are worth investing energy in, are worthy of commitment and engagement, and are challenges not burdens. Based on the above Antonovsky (1987) modified the original definition to be defined as follows:

"a global orientation that expresses the extent to which one has a pervasive, enduring yet dynamic feeling of confidence that (1) the stimuli deriving from one's internal and

external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to meet the demands posed by the stimuli; and (3) these demands are challenges worthy of investment and engagement" (p.19).

Thus putting it all together one can say that SOC refers to an orientation that enables an individual to perceive stressors as comprehensible, manageable and meaningful and thus better equipped to deal with the stressor. According to Jooste (2001) this concept refers to a dispositional orientation that is indicative of physical and psychological health, as it is inextricably involved in adaptive coping in stressful situations. Thus pushing an individual into the health ease continuum of the health pole. The SOC measures how well an individual copes with his or her life and is seen as an important indicator of how a person handles life stressors. This has implications for their general level of health (Fox, 2000). There seem to be a debate on whether sense of coherence is a coping style or not (Antonovsky & Sagy, 1986; Bowman, 1996 & 1997). According to Antonovsky and Sagy (1986), sense of coherence can be viewed as a coping style as it enables one to see one's life as more or less ordered, predictable, and manageable. Antonovsky (1987) likened his SOC to other coping styles such as Kobasa's (1979) concept of hardiness[3] & Boyce, Schaefer & Uitti 's (1985) sense of permanence[4]. Bowman (1996, 1997) on the other hand viewed sense of coherence to be an underlying worldview that allows one to develop more active and adaptive strategies when dealing with stress. Thus it seems SOC underlies coping strategies or coping styles.

2.2.2.1 Development of the SOC

According to Antonovsky (1979) life experiences are an important element in shaping one's SOC. This is due to the fact that from the time we are born we are constantly going through challenging situations, stress, tensions and resolutions. If these experiences are characterised by consistency, participation in shaping outcome, and an underload-overload balance of stimuli then our perception of the world will be coherent and predictable (ibid.). This, according to Antonovsky is a crucial element for a strong SOC. Moreover, if a strong SOC is to develop one has to experience a

[3] This refers to a personality style where individuals do not shy away from a challenge, have a strong sense of commitment and control (Kobasa, 1979 as cited in Antonovsky, 1987)

[4] A coping style which involves the belief or perception that certain valued and central elements of life are stable and enduring (Boyce et al, 1985 as cited in Antonovsky, 1987)

measure of frustration and punishment in early life. According to Antonovsky & Sagy (1986) a person's SOC is tentative in childhood but moves towards the process of becoming definitive in adolescence. According to Antonovsky and Sagy (1986) young adolescents are expected to have a weaker sense of coherence than older adolescents. SOC has been reported to be affected by the stability of the community in which the adolescent lives (Antonovsky & Sagy, 1986).

In young adulthood the process of anticipatory socialisation is completed and one can hold one's own in the particular society or culture. There is more predictability and consistency in one's life at this stage. Antonovsky (1987) believed that it is in this stage of life that one's position in the SOC continuum becomes fixed. Thus it seems that one's level of SOC will be determined by one's sense of ego identity. Perhaps it will then make sense why for example, early adolescents have a lower level of SOC as compared to the late adolescents. It is widely known that adolescence is a stage where youngsters battle with finding their identities in society and that by early adulthood the sense of identity start to stabilise (Erikson, 1982). By the third decade of life an individual has committed himself to an identity as well as being exposed to a life experience and as such has more or less come to view the world as comprehensible, manageable, and meaningful (Antonovsky, 1987). Once the domains of SOC are dynamically stabilised in the first three decades of life, the individual SOC is not expected to change (Antonovsky, 1979, 1987; Frankenhoff, 1996). If it does, the changes will be minor, in other words, the SOC is not highly displaced (Antonovsky, 1979).

2.2.2.2 SOC and culture

According to Antonovsky (1987) one's culture as well as ethnic background is decisive in determining or engendering the strengths and weaknesses of one's level of SOC. He suggested that many different cultural paths may result in similar levels of SOC, and that there may be different cultural paths in the development of SOC. In other words factors that contribute to the strength of one's SOC might differ from culture to culture even though they might have same levels of SOC. Bowman (1997) in her study of Anglo Americans and Native Americans found that the different pathways to SOC might be the results of different ethnic backgrounds between groups as well differences in environment, and religion. There has been few studies done on

SOC and culture, and more research is needed in this area (Bowman, 1996, 1997). What evidence there is however supports that Antonovsky's early hypothesis (1987) about SOC and culture seems to hold true.

2.3 Job satisfaction

According to Spector (1997) the job satisfaction variable is the most widely studied within organizations. This is argued to be due to the fact that management is concerned with the physical and psychological well being of their employees (Cassim, 2000; and Kirkpatrick, 1998). This variable is seen as very important on business effectiveness and contributes to employee turnover and companies reputation (Spector 1997). Biesheuvel (1984) reported that job satisfaction increases motivation and that the satisfied worker will be dedicated to a greater work effort. Spector (1997) highlighted a number of reasons why it is important to study job satisfaction: (1) Job satisfaction reflects good treatment of people, that is they are being treated fairly and with respect (2) Job satisfaction is a good indicator of one's emotional well being (3) Job satisfaction can lead to employees behaving in certain ways that might impact on the organization (4) It can reflect on organization functioning. Perhaps at this point a definition of job satisfaction is needed.

Slabbert (1987) maintained that a single definition of job satisfaction is still missing. Looking at the history of the development of this concept one discovers that it has been defined from different perspectives. Spector (1997) reported that job satisfaction has been viewed from the need fulfilment perspective, an example of this will be Brooke, Russell, & Price (1988), Kahn (1991), Locke (1976, 1983). Locke (1976, 1983) proposed that job satisfaction is the results of the perceived relationship between an individual's needs, what the job entails and the resulting feelings thereof. Thus it seems from this definition that job satisfaction has both cognitive and affective components. Furthermore, from this approach job satisfaction is seen to be the degree of fit that exists between an employee's needs (physical and psychological) and the things that the work provides. This view of job satisfaction has also been supported by Scarpello & Vandenburge (1992). However, it seems this approach has been discouraged due to the fact that most researchers seem to focus more on cognitive processes than needs (Spector, 1997). Another perspective is that of viewing job satisfaction as an affective/attitudinal concept (ibid.). Based on this latter

perspective Spector (1997) defined job satisfaction in terms of the affect/attitude that one might have about their jobs, in other words the extent to which people like or dislike their jobs.

From the above two proposed perspectives what seems to be common is that job satisfaction is seen as having an emotional/affective component. Based on the above it is proposed that job satisfaction is an affective as well as an attitudinal response that one experiences towards their job that probably results from the degree of fit between an employee's needs and what the job has to offer. Spector (1997) maintained that this feeling or this affective experience is related to various facets of the job and they include: appreciation, communication, co-workers, fringe benefits, job conditions, nature of the work itself, organization itself, organization policies and procedures, pay, personal growth, promotion opportunities, recognition, security, and supervision. Thus going back to the definition and what the job has to offer one can assume that these facets are what the job has to offer.

2.3.1 Sources of job satisfaction

According to Muchinsky (1993) a number of theories exist concerning causal factors of job satisfaction but none of them have had large empirical support. As a result, Cassim (2000) concluded that job satisfaction is a complex phenomenon with multiple causal factors and that no theory has been successful in incorporating all of them but that each theory only explains a piece of a puzzle (Muchinsky 1993). With that in mind a discussion on various approaches to understanding antecedents of job satisfaction will now follow. This will be based on Spector (1997). He proposed antecedents in terms of two categories: environmental antecedents (this refers to the job environment and the factors associated with it) and individual factors.

2.3.1.1 Environmental antecedents

Environmental factors that are thought to be sources of job satisfaction are listed as follows: Job characteristics (The job characteristics like skill variety, task significance, and tasks that people are doing must be experienced as satisfactory to them); Organizational constraints (this refers to those conditions in the job environment that interfere with employees performance of their job); Role variables (a set of behaviour required from an employee must be well defined); work-family

conflict; pay; job stress; workload; control (refers to amount of freedom given to an employee to make decisions independently); and work schedules. All these factors are reported to have an impact on the level of satisfaction that an employee might have about their jobs.

2.3.1.2 Personal antecedents

According to Spector (1997) the above refers to those factors that an employee brings to the job, for example, their prior job experience as well as their personality. Basically what Spector (1997) proposed is that an individual's personality will have an impact on the level of job satisfaction. In other words, if there is a high degree of match between job characteristics and person characteristics there will be high levels of job satisfaction.

A closer look at these antecedent factors reveals that they can also be categorized into extrinsic and intrinsic factors respectively. According to Mulinge and Mueller (1998) as cited in (Vallabh, 2000). Extrinsic factors refer to those factors that are the by products of work and intrinsic factors relate to an employee's internal state of fulfilment (ibid.).

2.3.2 Effects of job satisfaction

The effects of job satisfaction have been widely cited both on an international level (Burke & Mckeen, 1995; Koeske et al, 1994; Spector, 1997; Weiss, 1990) and in South African research (Cassim, 2000; Fox, 2000; Kirkpatrick, 1998; Vallabh, 2000). Many employee behaviour and outcome have been hypothesised to be related to job satisfaction (Spector, 1997). This variable has been found to have an impact on turnover; organisational commitment, productivity and absenteeism; health, life satisfaction and quality of life (burnout); job performance; organizational citizenship behaviour (being altruistic and compliant) (Adams, King, & Adams, 1996; Burke & Mckeen, 1995; Koeske et al, 1994; Spector, 1997; Weiss, 1990).

For those individuals who are concerned with promoting health amongst employees, the above-mentioned discussion is good enough reason why concepts like job satisfaction warrant to be studied.

2.4 Gender and work

Traditional ideologies have always proposed the belief that men and women have different natures and as a result the roles that they play in society are also different (Korabik, 1999). Thus it was naturally accepted that men should be seen in the labour force and women in the domestic force, bearing and rearing children (Hunter College 1983 as cited in Korabik, 1999). However, from the 20th century, the development in technology and industries within the western society seems to have freed women from these traditional ideologies (ibid.). The results of these have been more women spending more time in paid work than in domestic work (Powell 1993 as cited in Korabik, 1999) and thus leading to changes in societal gender role prescriptions (Korabik, 1999).

In most countries the role of women in the workplace seems to be expanding (Powell, 1999). Over the years the number of women entering the labour market seems to be on the increase. According to International Labour Office (1986, 1999) as cited in Powell (1999) the number of women entering the labour force increased by 9% in diverse countries. As the rapid changes in technology took place accelerating the pace of work, as well as the emergence of the single parent families and dual earner families, the number of women in the workplace continued to expand (Cooper & Lewis, 1999). Furthermore, the proportion of women entering non-traditional jobs seems to have tripled between 1970 and 1998 and these trends seem to apply in almost every country (Powell, 1999). This of course might still be on the increase as the years advance. With specific reference to South Africa, Lehohla (2002) reported that between the period of 1995 and 2001 there was a rapid increase in number of women employed as compared to men in South Africa. Lehohla (2002) maintained that in 1995 23% of African women were employed and that this figure rose to 35% in 2001. In 1995 40% of Coloured women were employed and this rose to 43% in 2001; 32% rose to 36% amongst Indians; and lastly 43% rose to 49% amongst whites (ibid).

What seems ironic is that despite these trends women in the workplace are still discriminated against. Powell (1999) reported that the economic status of women is still much lower than that of men despite the fact that they might be doing the same jobs.

However, these trends have not come at no cost. Cooper and Lewis (1999) reported that these changes have had an impact on the institution of family. The long hours that are demanded from the job has made family life difficult to sustain. Despite the changing nature of traditional roles women are still reported to be more family involved than men (even though men are now perceived to be offering a helping hand in the running of the household) and these trends have also come at a cost for them as they juggle to balance work and family (Duxbury & Higgins, 1991).

2.4.1 Women and medicine

"Since the beginning of time, women have been healers. Female healers, including the hedge-witches and nuns in mediaeval times, the sangomas of Southern Africa, the curanderas of New Mexico and shamans in native healing rituals, have impacted the history of the ancient and the new worlds. Today, women are continuing this great medical legacy…" (Brian, 2001: 174).

The number of women choosing to enter the medical profession as a career is on the rise (Brian, 2001; Chidambaram, 1993; Gautam, 2001; Pringle, 1998). In 1960, 6% of women were doctors, in 2000 they comprised about a third of the whole physicians population and 50% of students in medical school were women (Gautam, 2001). More specifically, within the South African context the trend also seem to hold. From the year 1963 to 1994 the percentage of women doctors had increased from 10.5% to 19.7% (Walker, 1999). In 1993 the number of women graduating from South African medical schools had risen by 36% (ibid.). These trends are on the increase as more women are choosing medicine as a career (Gautam, 2001). The American Medical Association (AMA) predicted that by 2010 30% of all physicians would be women (Brian, 2001). The following statistics were obtained through personal communication (Information Technology Department: 2005, 31 May) from the Health Professional Council of South Africa indicating the number of general practitioners in South Africa[5]. This seemed most accurate, as all medical practitioners are required to register with this council before they can practice. On the 31 May 2005 the following statistics were reported:

[5] The statistics are updated once every three months, thus the figures indicates the number of medical practitioners registered as from the period 8 November 2004 – 31 May 2005

Province	Male	Female	Total	% Male	% Female
W. Cape	3979	1471	5450	73.0	27.0
E. Cape	1272	341	1613	78.9	21.1
Free State	1046	322	1368	76.5	23.5
Gauteng	6896	2593	9489	72.7	27.3
KZN	3446	919	4365	78.9	21.1
Mpumalanga	751	166	917	81.9	18.1
N. West	660	175	835	79.0	21.0
N. Cape	297	79	376	79.0	21.0
Limpopo	752	169	921	81.7	18.3
Total	19 099	6235	25 334	75.4	24.6

It should also be noted that 842 GP's had foreign addresses, and 236 of these are females. This implies that they are currently residing overseas. Thus 28% of those medical practitioners who have emigrated are females.

The figures indicate that even though the number of women medical practitioners is reported to be on the increase, they are still low compared to the male medical practitioners. Women in this field have come a long way. A brief history about women in medicine will follow. It is unfortunate however that the professionalisation of medicine in the South African context is under researched, thus the following will mostly be based on international research (Walker, 1999).

2.4.1.1 Early medical women

It was through nursing and midwifery that women first entered the world of medicine (Pringle, 1998). As women began to work outside the domestic force, they first entered the world of work through other women's homes working as midwives, nurses, and teachers, amongst others (Riska & Wegar, 1993). Most medical schools were closed to women (Pringle, 1998). Any woman who wanted to study medicine had to be apprenticed by a male doctor and that came with sexual exploitation, as a result unless trained by a family member few had access to medical training (ibid.). The few who did get access were treated as "odd" characters (ibid.). They had to deal with men's and society's objections about women practicing medicine which was based on the argument that they are biologically unsuited to practice medicine (Walker, 1999). In this instance it was believed that higher education would be detrimental to their reproductive systems. In addition to this, those women who gained access to training had to deal with being ridiculed, hostility from other medical students and persistent refusal by medical staff to accept women in on their committees, as well as the examining bodies (Pringle, 1998).

The establishment of separate medical schools facilitated entrance of more women in the field of medicine since women's applications into mainstream medical schools was met with rejection (Pringle, 1998; Walker, 1999). These medical schools served important functions: (1) They allowed more women to be trained as opposed to being limited to the quota system (Pringle, 1998); (2) These women could then practice in a non-threatening and non-judgmental environment (Walker, 1999); (3) This then gave these women some sense of a critical mass as well as the opportunity to boost their self-esteem through mutual support and a sense of togetherness (Pringle, 1998); (4) These schools provided a useful teaching experience which otherwise these women would not have got in other medical institutions (Walker, 1999); and lastly Santili (1990:318) as cited in Walker (1999) reported that the institutions served as springboards for many of the "health and welfare reform policies that women physicians were dominant in bringing to the attention of the medical community".

Many of these women chose the field of medicine because of their high regards for independence and those who were married wanted financial independence and to combine family and career (Pringle, 1998). Thus it does seem that the battle of trying

to balance work and family is not a modern phenomenon. Interestingly the majority of these women were single, almost suggesting that they could not have it both ways, that is, be working women at the same time fulfilling their traditional gender roles.

Having overcome educational barriers another battle for women doctors began. They had great difficulty getting appointments in hospitals or even establishing practices (Pringle, 1998). For those who did get appointments their practices were limited to children and women (Pringle, 1998; Riska & Wegar, 1993). Opportunities came during World War One but again restricted after the war. Pringle (1998) reported that by the outbreak of World War Two the number of women doctors had steadily increased but were restricted to women's hospitals. The only way that they could be accepted was to continue exhibiting 'lady-like' qualities, for example, not directly challenging men and continuing to fulfill their roles as women consistent with the norm (ibid.). They became known as compassionate healers.

By the end of World War Two the 1944 Goodenough report – the first national review of medical report – as cited in Pringle (1998) argued that both genders should have equal opportunities to enter into medical schools. This resulted in the closing down of separate medical schools and women could be accepted into mainstream medical school. However, this came with its own problems as "hostility shifted from sex to sexuality" and the women were judged to be either masculine or sexless (Pringle, 1998:30). Furthermore they were facing anxieties concerning marriage and their sexual attractiveness. Those women who did marry while having a career faced hostility about having it all (ibid.). It was around 1960's that women doctors made their presence felt in the field of general practice and they also began to specialize (ibid.).

The first woman ever to be awarded her medical degree was Elizabeth Blackwell in 1849 in the United States (Pringle, 1998; Walker, 1999). Women's entry into medicine in South Africa happened some seventy odd years ago after this first woman completed her training. Thus South Africa lagged behind. Women started practicing medicine in the twentieth century and it was only in the 1920's that they began to move into this profession in large numbers (Walker, 1999). Due to their entering medicine late, their struggles were different compared to international women doctors.

The South African women doctors entered this field with ease, the key difference being that only white women were allowed to enter this field. Within this profession women were seen as weak and wasting their time (ibid.). Even though they were accepted into the medical field with ease they still had to face ridicule, as it was still perceived to be a man's job. Their classes were separated as it was felt that they could not be taught, for example, anatomy of men while sitting with men. It was only in the 1960's that men and women were combined to study anatomy together (ibid.). For these medical women in South Africa practice was restricted to hospitals and specializing was difficult to get in (ibid). Furthermore married woman were barred from practicing in the public sector (ibid). It was through the foundation of South African Society of Medical Women that women doctors began to fight against these forms of discrimination (ibid). Thus it seems the struggles for medical women in South Africa concerned racism and sexism.

Walker (1999) wrote that the field of medicine in South Africa has always been and remain highly racialised. The first black women doctor in South Africa graduated in 1942 and it was only in the 1980's that the medical schools opened their doors to black women (Wynchank, 2004).

These medical women have come a long way and they have come to be accepted in the field of medicine and its specialties. This seems to be due to the fact that women doctors contribute more than men to underprivileged areas. In addition to this, it is reported that more patients are seeking women doctors and the World Health Organization (WHO) reported that women doctors play a far greater role than men in delivering health care than most countries (Riska & Wegar, 1993). Women doctors are in high demand since they are perceived as family people who understand family problems (Pringle, 1998). On a last note, perhaps it should be argued that women have been accepted into the medical field simply because they can do the job. Now that the history of medical women has been introduced, the next section will focus on the stressors that women medical practitioners encounter.

2.5. Women general practitioners (GP's) and stress

Since the 1960's women have increased in general practice and are predicted to dominate it (Pringle, 1998). Route (1999) reported that there have been several studies

published about general practitioners and stress, however there's little known about stressors experienced by women general practitioners in particular. The field of general practice is said to be one of exclusion from advanced medical practice, and there is a struggle to remain part of medical field at all (Pringle, 1998). These professionals find themselves on call 24 hours, 7 days a week, and deal with all sorts of emergencies. Pringle (1998) went on to report that these women find themselves in a subordinate position, patronized by medical specialists, and may struggle to carve out a distinct identity for themselves. Women in general practice have been written about as the proletariat of the medical world who keep the lowest ranks of general practice. They are often referred to as second-class citizens amongst doctors in practice, and have been regarded as 'failures' against masculine benchmarks of success. In addition to this they are reported to usually be unequal partners against their partners (usually male) (Elston, 1993; Pringle, 1998). Thus the stress that these women experience may be due to having to work in a prejudiced, non-supportive environment which does not accept a women's place in the profession (Cartwright, 1987). They are often subjected to exploitation financially, and their domestic commitments may be used to exclude them from decision making (Pringle, 1998). It has been reported that these women experience more stressors than any other professionals in the field of medicine (Pringle, 1998; Riska & Wegar, 1993; Richardsen & Burke, 1993).

General practitioners are seen as having little time for themselves or their families (Porter, Howie & Levinson, 1987). These professionals experience work overload, feel that there is a lack of time, and even experience periods of exhaustion (Cartwright, 1987). They may also experience role strain, a result of the felt difficulty of meeting two or more significant role obligations, in other words bargaining between occupational and traditional gender roles (Richardsen & Burke, 1993; Cartwright, 1987; Mandelbaum, 1981). Furthermore, one source of stressor that seems underreported is the role ambiguity (Pringle, 1998). Women doctors are perceived to be more understanding and as such they usually end up being a 'psychologist', and a 'social worker' and this is said to be taxing. Over and above this there is a complaint by some male doctors that they see fewer patients due to their spending more time with patients. Other women GP's complain about this role expectation of being

'understanding' as they feel it undermines the fact that they are doctors first before anything else (ibid).

Studies that have been done on women GP's and stress seem to reveal a variety of results. In an early study, Porter et al, (1987) reported GP stressors to be due to job ambiguity, periods of exhaustion, not having enough time and social stressors. It also seems that relationships with work colleagues can also be a source of stressor, although this is specific to group practice (Elston, 1993). Firth-Cozens (1999) reported that women GP's experience difficult relationships with their senior partners, which sometimes tend to be abusive. Issues pertaining to maternity leave cover, duty hours, and holidays need to be negotiated amongst partners. Women general practitioners have been reported to complain about these because they feel that they are dependent on the goodwill of their partners (often males). Also they feel exploited by their partners as far as "…any recognition of women's domestic responsibilities are concerned" (Pringle, 1998: 45). As a result of these women GP's are reported to opt for single-handed/solo private practice (Pringle, 1998). Ironically the women who opt for single-handed/ solo private practices are more stressed than the ones in group private practices (ibid.).

In a review of studies done on women GP's Route (1999) found that the following contribute to their stressors: administrative work, interruptions and patient demands, working environment and communication, work-home conflict and social life, administration and goal achievement, problems with patients, and fund holding. Howie and Porter (1999) reported the following to be sources of stressors: pressures associated with seeing patients, being on call at night, and work-family conflict. From the above it can be concluded that it seems as if the organizational aspects of the job, patient care, working environment and the work-home interface are the main or common stressors.

What does remain clear is that these women experience a tremendous amount of stress and it seems to be both work and family related, again confirming that these two domains are not easy to separate. Firth-Cozens (1999) reported that a greater proportion of doctors are more sick/impaired than the average population. A high rate of stress, depression and alcoholism is reported to exist among doctors and women

GP's are reported to be more vulnerable (ibid.). Certainly Pringle (1998) reported that women GP's are said to have an increased rate of suicide and cirrhosis of the liver compared to other doctors (Porter et al, 1987). More recently Firth-Cozens (1999) reported a high comorbidity between depression and alcoholism amongst women GP's. Also of importance is the impact of these stressors. Porter et al (1987) reported that a higher rate of stressors was related to a higher rate of fatigue, tension, low self-esteem, and psychiatric disorders. Poor patient care, abuse of patients, and eventually burnout has also been reported (Firth-Cozens, 1999; Gautam, 2001).

It does seem that the effects not only are detrimental on the GP's themselves but also on their patients. Thus the stressors that these women experience cannot be undermined especially given the fact that these individuals are playing an important role in socioeconomically deprived areas, and they play a far greater role than men in health care in most countries (Brian, 2001) and as such are entrusted with many lives.

As noted by Walker (1999) South African women in the medical field are largely unresearched, and in fact this researcher was only able to cite a Cape Town based project, which was still ongoing, investigating problematic areas for women doctors. The preliminary results of this project indicated that medical women in South Africa are faced with: lower earnings due to discriminatory practices, working long hours on end without sleep; lack of part-time training opportunities and rewarding jobs; no helpful provisions made for dealing with pregnancies, lack of proper supervising; lack of child care facilities at work; and more men perceived to be in power within the medical political hierarchy (Walker, 1999). Thus it seems there are some similarities when compared to international trends. The following section will explore coping resources that these medical practitioners use.

2.6 Women GP's and coping resources

As mentioned earlier in the literature some researchers have come to study coping as strategies that individuals adopt in stressful situations, whereas others view it in terms of particular traits. This research emphasizes coping in terms of strategies that women GP's adopt in dealing with their above discussed stress.

Maintaining a balance between the multiple roles that women GP's are faced with is a difficult issue (Brian, 2001), and their work environment is reported to offer few support (Gautam, 2001). Howie & Porter (1999) reported that over the years a number of strategies have been developed to tackle some of the stressors as well as providing GP's with effective coping strategies. As mentioned earlier there is a spill over between work and family and research indicates that it is hard to separate these domains. Of interest is to note that research on coping resources suggest coping strategies that emphasize separating work and family, implying a mental effort not to be preoccupied with work while at home and vice-versa, as well as not bringing work home and vice-versa (Gautam, 2001).

Carter & West (1999) emphasized the importance of sharing the burden through teamwork. This not only offers them support but also enable them to share challenging and complex demands. Gautam (2001) suggested that women doctors need to monitor their stress levels, as this will allow them to address it productively. In terms of work, the following was suggested: they must learn to manage their times effectively by setting priorities about what needs to be done; they must take control of working hours by scheduling breaks and days off; they must lobby effectively for work equity policies, parental leave policies, child care, amongst others; they must use their colleagues for support and share stresses and successes with them. In terms of home the following was suggested (ibid): Before going home they must first mentally prepare themselves for it by engaging in relaxation skills for a few minutes; they must not take work home as this allows them to give their family undivided attention; they must ask for help when it comes to housework; they must take care to maintain emotional attachment to their partners; they must make friends outside their job environment; they must learn to manage their finances, and to be aware of their negative attitude that maintains their level of stress. On a personal level Gautam (2001) reported the following: doctors must learn to take care of their own needs as well as to set limits. Hardy and Barkham (1999) suggested psychotherapeutic interventions as an effective way of managing stressors amongst mental health practitioners, and that they can generally be offered either in the form of prevention (stress management training) or treatment (counselling).

A closer look at all the above-suggested coping strategies reveals that they tap into the coping resources domains mentioned earlier thus indicating the effectiveness of using the CRI instrument as a measure for assessing coping strategies.

2.7 Women GP's and job satisfaction

Pringle (1998) used the term 'success' to refer to satisfaction that these women derive from their lives. Kirkpatrick (1998) reported job satisfaction as a global construct made up of separate factors or dimensions. Within the human service profession those factors include "opportunities for helping people", "feelings of success as a professional", and the amount of authority given to do the job. Based on the work of Marks (1987) as cited in Pringle (1998) women GP's reported satisfaction as coming from the character of interpersonal contacts and the ability to be helpful. Thus satisfaction came with little concern for external recognition. Interestingly more recently Gautam (2001) reported that women doctors generally report being satisfied with their jobs but that if given a choice many reported that they would choose a different job. There are factors that are reported to affect these women's level of job satisfaction. Female doctors who reported feeling in control of their environment and low prevalence of sexual harassment generally report high levels of job satisfaction (Brian, 2001). On the other hand women who have families, that is, have children or are married tend to report lower job satisfaction due to high levels of WFC (ibid.). The following have generally been reported to contribute to job satisfaction among women doctors:

- Having enough time for family and personal life
- Enjoying high esteem in the public view
- Positive relationships with co-workers and patients
- Financial security

Thus it seems as if prestige, financial rewards and the psychosocial aspects of work contribute to job satisfaction (Brian, 2001; Richardsen; Burke, 1993). In a study conducted by Route (1999) being older in this profession seemed to be associated with job satisfaction. In other words; older respondents experienced more job satisfaction as opposed to younger ones. Probably they have learned effective ways of coping and have adjusted to the job or alternatively the average has increased due to those who were not satisfied leaving to find alternative employment.

Porter et al, (1987) reported that low job satisfaction amongst GP's was related to higher rate of prescription of medication with adverse side effects, misdiagnosis, increase complaints from patients, and negative feelings towards patients, for example, frustration. Interestingly doctors who reported low job satisfaction also reported high rates of non-compliance amongst their patients (Firth-Cozens, 1999). Low job satisfaction is also reported to contribute to poor physical health amongst GP's (ibid.).

Looking at the integration of the above mentioned variables, it seems that research exploring the relationship between work-family conflict and job satisfaction is widely cited (Boles, Howard, Donofrio, 2001; Lambert et al, 2004; Noor, 2004; O' Driscoll et al, 2004). What has come out of this research is that it is widely accepted that a negative relationship exists between job satisfaction and work-family conflict. However, what researchers do not seem to agree on is the directional nature of the interference of the WFC, that is, whether W→F occurs more than F→W or whether F→W occurs more than W→F. In their earlier study with working woman Gutek et al, (1991) reported more W→F than F→W as having more impact on working women's well being. Boles et al, (2001); Kossek & Ozeki (1998) also reported similar results in their study. In her research with working mothers Noor (2004) reported more F→W than W→F as having more impact on job satisfaction. Noor (2004) maintained that this was due to the fact that mothers face dilemmas of wanting to be good mothers yet at the same time wanting to be good employees. At the same time having to acknowledge that the rewards of the work role are utilised for the well-being of the family. This was supported by a recent longitudinal study by O' Driscol et al (2004) who reported a consistent negative relationship between F→W and job satisfaction over time.

With specific reference to doctors Swanson, Power, & Simpson (1998) reported that many studies have linked work-family conflict with job dissatisfaction amongst female doctors. These researchers conducted a study in Scotland amongst doctors comparing the impact of W→F and F→W. The results of this study indicated that on a general level regardless of gender and field of speciality the doctors reported high W→F as opposed to F→W (ibid). Interestingly, compared to specialists/consultants,

general practitioners reported higher levels of stress in the home-work interface regardless of gender, specifically they reported high F→W scores as opposed to W→F. Thus confirming the asymmetric permeability of work and home roles (Frone et al, 1992b). However, these researchers reported that despite the high levels of WFC for these investigated doctors women generally reported high levels of job satisfaction compared to their male counterpart (Swanson, et al, 1998). Thus research results investigating the relationship between job satisfaction and work-family conflict reveals a variety of results.

Summary

The previous chapters up to the current one provided a framework as well as to give insight into the world of women doctors. In other words, their stressors, how they cope with them as well as the satisfaction they derive from their job. This was done by introducing the reader into the stress and coping concepts, which form the conceptualisation of this research. The stressor for these women was viewed as work-family conflict and the coping resources as well as the sense of coherence are viewed as these women's coping mechanisms. Lastly the job satisfaction was discussed as the outcome that is based on the coping mechanism. The next section will focus on the current research by exploring the aims of this research, methodology which was followed for this research, analysis and results, as well as the discussion and conclusions that arose from the results.