# Chapter 1

## Introduction

### 1.1 Chapter overview

This chapter shall cover the overview of this research, the motivation as well as the need of the study.

1.2 Theoretical overview

Over the years there has been increased research in the field of women in the workplace (Frone, Russell, & Cooper, 1992a; Gutek, Repetti, & Silver, 1988). This is due to the fact that more and more women are entering the field of work due to increase in the number of single parent families, increase in dual earners families, as well as increase in families who have to take care of the elders (Netemeyer, Boles & McMurrian, 1996). Furthermore, since traditionally women have a primary responsibility in the family, their involvement in this role is thought to affect their work performance (Gutek et al, 1988). However, more and more women are finding themselves employed in jobs that traditionally were not accessible to them, thus women are breaking the stereotypes barriers (Riska & Wegar, 1993; Scheiber, 1987).

Over the years it has been documented that more and more women are entering the medical field (ibid). Walker (1999) reported that little research has been conducted on the experiences of women doctors within the South African context. The large number of women entering this profession is sufficient reason to give them attention. Not only do these women experience stressors experienced by doctors but they also face stressors that are specifically related to their gender roles. It has been documented in literature that female doctors report high levels of depression. It has also been shown that there is a high rate of suicide cases among women in the medical field as compared to women in general (Cartwright, 1987; Firth-Cozens & Payne, 1987, & Scheiber, 1987). According to Route (1999) little is known about the stressors experienced by general practitioners as research has produced contradictory results. Since the 1960's women have increased in general practice and are predicted to dominate it (Pringle, 1998). This field is thought to be one of exclusion from advanced medical practice, and there is a struggle to remain part of the medical field

(ibid.). These professionals find themselves on call frequently and dealing with all sorts of emergencies. Pringle (1998) went on to report that the women in the general medical field find themselves in 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 rank of general practice and are often referred to as second class citizens amongst doctors in practice. Moreover, this they have been regarded as 'failures' against masculine benchmarks of success (ibid.). Thus the stress that these women face may be due to working in a prejudiced, non-supportive environment, which does not accept a women's place in the profession (Cartwright, 1987). Basically 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 no time for themselves and their families (Porter, Howie, & Levinson, 1987). As a result they may experience work overload and role strain, a result of the felt difficulty of meeting two or more significant role obligations, that is, bargaining between occupational and traditional gender roles (Cartwright, 1987; Mandelbaum, 1981; Richardsen & Burke, 1993).

The conflict between work and family roles as well as its management is becoming a large area of study and poses a challenge to individuals as well as organizations (Adams, King, & King, 1996; Frone, 2000; Frone, Russell, & Cooper, 1992a; Gutek, Searle, & Klepa, 1991; & Kossek & Ozeki, 1998). This is the field of work/occupational stress. Psychologists who are interested in this field have acknowledged that work stress and family stress interact (Lazarus, 1999). This implies that a worker must be viewed as a whole comprising of other roles as well, and that there is a spillover between work and family stress (ibid.). Researchers have conceptualized this spill over between work and family as work-family conflict (WFC) (Frone et al, 1992a; & Gutek, et al, 1991). According to Adams et al (1996) research in the field of occupational stress regarding the relationship between work and family has proceeded along the following lines (1) work-family conflict where it was argued that conflict between the work and family domain can be a source of stress that influences important psychological and physical outcomes, and the relevant examples are: job and life satisfaction as well as job burnout, respectively (2) the

impact of social support, for example, the presence of social support can have a positive impact on one's general health. Researchers like Adams et al (1996) argued that there is a small number of research projects that have actually focused on the integration between these two lines of research (Greenhaus, 1988; Jackson, Zedeck, & Summers, 1985) as cited in Adams et al (1996). As a result these researchers maintained that researches have failed to give the accurate view of the whole interface since they only provide a glimpse of either the positive or the negative aspects of the work and family interface. With specific reference to women in the medical field, Walker (1999) reported that even though there is a growing area of research into these women, most research seems to have focused on the stressors or problems that these women face as well as statistics of women entering the medical field. Thus there is total exclusion in research of how these women handle their stressors, in other words their resilience.

Within the field of medical science there is a view that all disorders have a specific course and much medical research is directed at determining what factors cause a particular disease (Neihorf & Scheider, 1993). That is a science of pathogenesis that presupposes that health is best promoted by identifying and preventing the cause of a disease (Cowley & Billings, 1999). However, the concept of *Salutogenesis* takes an opposite stance in that it emphasizes the importance of starting from how health is created and maintained, rather than focusing on the negative aspect of illness and disorder (ibid.). This shift from pathogenesis to Salutogenesis reemphasizes the biopsychosocial model for the explanation of health - vice the World Health Organization - definition rather than chiefly for understanding diseases (Levenstein, 1994). According to Brown (2002) the World Health Organization defined health as a state of complete physical, mental and social well-being.

The father of the salutogenic paradigm is Aaron Antonovsky (Antonovsky, 1979). Through his intensive work on how humans cope with stress he developed the sense of coherence (SOC) concept, which he defined as:

A global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (a) the stimuli deriving from one 's internal and external environments, in the course of living are structured, predictable and

explicable (b) the resources are available to one to meet the demands posed by this stimuli, and (c) these demands are challenges, worthy of investment and engagement (Antonovsky, 1987:19)

Schafer (1992) mentioned that research in the salutogenic orientation has emphasised health promotion and stress management for wellness, perhaps in that it successfully explains why people cope with stress (Cairns, 2001). In line with this is the concept of coping resources. It is a fact that people face a variety of stressors and experiences that affect their mental, emotional, social, physical, and spiritual well-being. Of most importance is how they cope with these to help them maintain health, prevent diseases and recover from illnesses (Hall, 1997). Thus coping resources can be said to be useful in helping individuals deal with their stressful environment. These resources are said to be able to help individuals to deal with stressors more effectively. Hammer and Marting (1988) defined these coping resources as those resources that are inherent in individuals that help them to deal with stressors in a more effective way, to experience fewer or lesser intense symptoms upon exposure to a stressor, as well as recovering faster from this exposure.

In keeping with the concepts discussed above, the current research explores the work-family conflict, sense of coherence, coping resources and job satisfaction amongst women general practitioners. Various points were highlighted in this chapter, subtly giving hint to motivation and need for doing this research. Looking within the South African context little research has been done with specific focus on women doctors. The little research that has been done seems to focus only on the stressors experienced by these women and has failed to focus on their resilience as well as the satisfaction that they derive from doing their job. Where resilience and stressors might be studied as independent entities by contrast this research integrates the two, and thus giving a more comprehensible picture to these women's experiences. Schafer (1992) mentioned that research in the salutogenic orientation has emphasized health promotion and stress management for wellness and the knowledge that has been gained from this research is believed will contribute to research on health promotion.

## 1.3 Aims of the study

The aims of this research are to explore how women general practitioners experience work-family conflict, their coping resources as well as the implications on their level of job satisfaction.

## 1.4 Research report outline

The next chapter in this report will review the literature on women doctor's experience of work-family conflict, sense of coherence, coping resources and job satisfaction. The concepts of stress and coping will be reviewed in order to lay the basis or theoretical framework for the investigated variables in this research. Chapter Three will outline the aims, questions as well as the hypothesis raised in this study. Chapter Four outlines the methods used to collect and analyze data as well as the scales used in this research. Chapter five presents the results of the study. The sixth chapter will discuss the findings of the study in detail, limitations and recommendations. This is followed by Chapter seven, which outlines conclusions arising from the study.