Coping Behavior of Junior Physicians in Managing Conflict between Work and Family Roles

Aminah Ahmad

Department of Professional Development and Continuing Education,
Faculty of Educational Studies, Universiti Putra Malaysia, 43400 Serdang, Selangor, Malaysia
aminah@ace.upm.edu.my

Abstract: This study examined the extent of work-family conflict experienced by married female junior physicians and the coping behavior of the physicians in managing the conflict. The sample of this study consisted of married female physicians (with at least one child) aged 40 and below working in fourteen public hospitals in Malaysia. Data were gathered from a sample of 231 female junior physicians using self-administered questionnaires through the drop and collect method. The two major strategies used by the physicians were personal role redefinition which involved changing their own attitudes and perceptions of role expectations, and reactive role behavior which involved careful planning, scheduling and organizing their role activities, and working harder to meet all their role demands. The least frequently used strategy was structural role redefinition which entails an active attempt to deal directly with role senders and lessen the conflict by mutual agreement on a new set of expectations. Implications of the findings and suggestions for future research were discussed.
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1. Introduction

The proportion of employed professional women in Malaysia increased from 6.7 per cent in 2004 to 8.3 per cent in 2009 and slightly more than half (59.4 per cent) of the total employed women in 2009 were married (Department of Statistics, Malaysia, 2010). With the increase in the number of female professionals and the need to balance the demands of their work and family lives, married female professionals are more likely to experience work-family conflict involving incompatible demands. Among professionals, men spent more time in professional work and women more time in childcare and women perceived themselves as responsible for childcare activities at home (Bergman *et al.,* 2008). This illustrates that apart from paid work, female professionals, including female physicians, are mainly responsible for work at home and thus carried a double workload. With the double workload, the female physicians are more likely to experience conflict between work and family roles. Work-family conflict is a form of interrole conflict in which the role pressures from the work and family domains are mutually incompatible, such that participation in one role makes it more difficult to participate in the other (Greenhaus *et al.,* 1985). The experience of work-family conflict among female physicians have been reported by Aminah (2010, 2008).

To ease the strain of work-family conflict, coping strategies have been used. Lazarus and Folkman (1984) defined coping as the cognitive and behavioral efforts individuals use to manage taxing demands appraised as exceeding their personal resources. They suggest that coping has two main functions: the regulation of distressing emotions (emotion-focused coping) and doing something to positively change the problem causing the distress (problem-focused coping). Hall (1972) studied women's strategies for coping with role conflict and identified 16 strategies which were categorized into a three types of coping behavior for dealing with interrole conflict. Type I coping (structural role redefinition) involves an active attempt to deal directly with role senders and lessen the conflict by mutual agreement on a new set of expectations. One way of changing structural demands would be to relocate and share one's role tasks (house cleaning for example). Type II coping (personal role redefinition) involves changing one's personal concept of role demands received from others. It entails changing the expectations themselves. An example is setting priorities among and within roles, being sure that certain demands are always met (for example, the needs of sick children), while others have lower priority (such as lawn care). Type III coping (reactive role behavior) entails attempting to improve the quality of role performance with no attempt to change the structural or personal definition of one's roles. Implicit in coping through reactive role behavior is the assumption that one's role demands are unchangeable and that the person's main task is to find ways to meet them; this coping strategy involves a reactive orientation toward one's roles.

Other forms of coping strategies include segmentation, compensation and accommodation, where individuals limit their psychological and/or behavioral involvement in one sphere to satisfy the demands of the other (Edwards *et al.*, 2000). Boundary management work is another strategy that individuals engage in which involves principles and practices for creating, maintaining, and crossing borders between the two domains (Ashforth *et al.*, 2000; Clark, 2000).

Much of the research on coping with work-family conflict has used Hall's typology to conceptualize coping. A study of female married professionals with children in Hong Kong indicates that their major coping strategies are personal role redefinition and reactive role redefinition (Lo *et al.*, 2003). Others who have used Hall's typology include Kirchmeyer (1993) who investigated coping among Canadian managers and Matsui, Ohsawa and Onglatco (1995) among Japanese working women. Recently, Hsieh and Eggers (Hsieh *et al.*, 2010) explored the coping strategies used by North American lodging managers to resolve the conflict between their work and personal lives. They found that obtaining role support from inside role set, including support from family and employees, establishing priorities, and planning, scheduling, and organizing better were the most frequent coping strategies used by the lodging managers to resolve the conflict.

Rotondo and Kincaid (2008) studied four types of coping with work-family conflict using data collected as part of the National Survey of Midlife Development in the United States. The coping strategies studied include direct action and advice seeking (problem-focused) and positive thinking and cognitive reappraisal (emotion-focused). They found that the relationships between individual coping styles and conflict as well as facilitation were not uniform and varied depending on the source domain. Wentzel, Buys and Mostert (2009) investigated the strategies African secondary school educators use to deal with the interaction between their work and personal lives. Among the strategies reported were keeping work and personal life apart, acceptance of their teaching environment, planning ahead, and seeking for advice through communication. Niehm *et al* (2009) examined strategies employed by American family business managers to cope with overlapping work and family demands. They found that managers of surviving businesses were more likely to make adjustments by hiring temporary help for the business or home as part of their coping strategies. Meanwhile, Somech and Drach-Zahavy (2007) identified eight coping styles that employed parents used to deal with work-family conflict, labeled as super at home, good enough at home, delegation at home, priorities at home, super at work, good enough at work, delegation at work, and priorities at work.

Given the pertinence of work-family conflict experienced by working women and the modest attention paid to the coping strategies used to balance the demands of work and family roles among Asian women, particularly Malaysian professional women, the objectives of the present study are as follows: 1) to determine the extent of work-family conflict experienced by married female junior physicians, and 2) to examine the coping strategies used to handle the conflict using Hall's (1972) typology. Hall's typology continues to be widely used by researchers in studies of coping with work-family conflict. Therefore, the researcher adopted Hall's typology to investigate the coping strategies used by junior physicians to resolve conflicts between their work and family lives.

2. Method

2.1 Sample and Procedure

The sample of this present study consisted of married female physicians (with at least one child) aged 40 and below working in fourteen public hospitals (eleven state hospitals and three teaching hospitals) in Peninsular Malaysia. The age limit was established since physicians tend to have more work load at this stage of their career span and hence tend to experience greater work-family conflict. Data were collected from a sample of 231 female physicians using self-administered questionnaires through the drop and collect method. The questionnaire was first constructed in English language and then translated into Malay language and was validated by back-translation to ensure that both versions were equivalent. The questionnaire was administered in both the Malay and English languages and the physicians were given the alternative to choose either of the two languages.

2.2 Measurements

Work-family conflict was measured using an interrole conflict scale developed by Pleck *et al.* (1980). This scale consists of eight items based on the three most prevalent aspects of work interference with family, namely excessive work time, schedule conflict and fatigue or irritability. Responses were coded on a five-point scaled response options ranging from strongly disagree (1) to strongly agree (5). Examples of items are: "My work schedule often conflicts with my family life"; "My work takes up time that I would like to spend with my family". The reliability coefficient (alpha) of the work-family conflict scale was 0.83.

Coping was assessed using an adapted version of role-coping inventory by Hall and Hall

(1979). This inventory has 22 coping strategies or items for three types of coping -- structural role redefinition (Type I), personal role redefinition (Type II) and reactive role behavior (Type III). The response options for the items were five-point scales ranging from never (1) to nearly all the time (5). One of the items for Type II coping was deleted since it was inappropriate to the subjects based on content validation. Another item was deleted from the Type III coping scale because of lack of variance and low item-total correlation based on the reliability test via internal consistency. The inventory for this present study consisted of 20 items, 12 items for Type I, six for Type II and two items for Type III coping. The reliability coefficient (alpha) for Type I coping scale was 0.60, Type II, 0.69 and Type III, 0.74.

3. Results

Table 1 presents the characteristics of the respondents. The respondents' ranged from 25-40 years of age (M = 32.18, SD = 3.56) with 79.5% aged from 25-35. They had an average of 4.73 years of experience (SD = 3.26) and 69.4% had 5 years or less of experience in the present job. Majority (74.4%) of the physicians in this study had 1 to 2 children (M = 2.08, SD = 1.12). The mean score for work-family conflict on a five point scale was 3.34 (SD = 0.81), and Type I coping was 3.18 (SD = 0.41), Type II coping was 3.85 (SD = 0.45) and Type III coping was 3.75 (SD = 0.66).

Table 1: Characteristics of Respondents

Characteristic		Frequency	(%)	Mean	SD
Age (years)				32.18	3.56
	25 - 30	87	39.7		
	31 - 35	87	39.7		
	36 - 40	45	20.6		
Work experience (years)				4.73	3.26
	≤ 5	152	69.4		
	6 - 10	53	24.2		
	11 -15	13	5.9		
	≥ 16	1	0.5		
Number of children				2.08	1.12
	1 - 2	172	74.4		
	3 – 4	51	22.1		
	≥ 5	8	3.5		

In managing the work-family conflict, the Type II coping (personal role redefinition) with a mean of 3.85 (SD = 0.45) was most frequently used by the women whereas the least frequently used strategy was Type I coping (structural role redefinition) with a mean of 3.18 (SD = 0.54) (Table 2). Table 3 presents the t values for the difference in the use of coping type in managing the work-family conflict. There were significant differences in the use of Type I and Type II, as well as Type I and Type III coping. The means for Type II and Type III coping were also significantly different.

Table 2: Means And Standard Deviations Of Work-Family Conflict And Coping Types

Variable	M	SD
Work-Family Conflict	3.66	0.54
Type I Coping (Structural Role Redefinition)	3.18	0.41
Type II Coping (Personal Role Redefinition)	3.85	0.45
Type III Coping (Reactive Role Behavior)	3.75	0.66

Table 3: Differences In The Use Of Coping Types

Type of Coping	df	t	p
Type I and Type II	215	-18.53	0.00
Type I and Type III	224	-12.17	0.00
Type II and Type III	224	2.78	0.01

4. Discussions

Overall, the two major strategies used by the physicians are Type II coping (personal role redefinition) and Type III coping (reactive role behavior) to manage their conflict. Similar findings were reported by Lo *et al.* (2003) in their study among female married professionals in Hong Kong. In this present study, among the three types of coping, Type II coping (personal role redefinition) was the most frequently adopted strategy. Type II coping involves changing the person's perceptions of his or her role demands rather than attempting to change the environment. In other words, the women in this study tended to be involved less in redefining the expectations held by other people and negotiating a new set of expectations from their role senders as would be the case with Type I coping. Instead, the women tried to change the perceived role by seeing their own behavior or the external expectations in a different light. By doing so, they attempted to reduce the amount of conflict actually experienced. Compromising as a way of reducing strain and making an individual's lifestyle manageable is a common behavioral response (Skinner *et al.*, 1991). Domestic overload, for instance, may be managed through compromise by deliberately lowering standards.

The second most frequently adopted coping strategy was Type III coping (reactive role behavior). The reactive role behavior involves attempts to meet all the role demands experienced. These strategies probably present considerable strain on the women's

energies since they involve attempting to do everything demanded, rather than attempting to reduce demands. Since the assumption is that all role expectations must be met, the women engaged in careful planning, scheduling and organizing of their role activities, and working harder to meet all their role demands. The study conducted by Skinner and McCubbin (1991) found that one of the coping strategies that women in dual employed families commonly used was maximizing efficiency and organization to meet the demands of work and family roles. Although Type III coping is thought to be less effective (Hall, 1972), the attempt to be a "super mother" appears to be a common strategy among married women.

Type I coping (structural role redefinition) was the least frequently adopted coping strategy among the women. It involves redefining the expectations held by other people so that fewer conflicting demands are placed upon the person and a new set of role behaviors is expected from that person by members of the role set. Such coping requires communicating with one's role senders and negotiating a new set of expectations which will be mutually agreed upon. This means changing the received role as opposed to changing the perceived role alone, as would be the case with Type II coping. The lack of help obtained from family members in reducing work load and resolving conflict suggests that the redistribution of roles within the family to match increased role responsibilities outside the home has not been widely practiced.

The less frequent use of Type I coping could, to a certain extent, be due to the notion that Type I coping seems more directly related to long-term conflict reduction and satisfaction than Type II or Type III coping. More convincingly, the literature on sex role socialization indicates that the universal culture, through what Bem and Bem (1971) call a non-conscious ideology, rewards more reactive, less confronting and less aggressive coping in women of all ages. A study by Long (1989) found that sex-role socialization relates to differences in coping and occupational strain among working women, while a study by Somech and Drach-Zahavy (2007) found that gender role ideology moderates the relationship between coping behaviors and work-family conflict.

Several limitations of this study should be noted. First, this is a descriptive survey research, which reports the extent of work-family conflict experienced and the coping strategies. The effectiveness of the different types of strategies used has not been addressed. Second, a significant limitation of the present investigation is the limited sample size utilized for this study. The results reported here may only be generalized to female junior physicians meeting the selection criteria (married and aged 40 years and below) in the fourteen public hospitals in Malaysia, but any assumption of external validity beyond that is cautioned. Third, the inferences drawn from this study are limited by self-reported and cross-sectional characteristics of the data.

The experience of work-family conflict among employees suggests the need for organizations to facilitate the development of individual coping strategies through human resource development programs. Training programs could be initiated to help employees identify the effective coping strategy, and thereafter intensify the use of such strategy. The importance of family-supportive work culture which is sensitive to employees' family needs has been emphasized by Aminah and Zoharah (2010). Facilities such as reliable dependent-care center, including childcare center, and family leave would help junior physicians at this life stage cope with the conflict more effectively, besides the individual coping strategies that they adopt. There is a need to review the ratio between physicians and patients that has a great implication on work-family conflict. The excessive work that junior physicians have to perform has been emphasized by Aminah (2010), Shaufelli *et al*. (2009) and Lingard *et al*. (2006). The working hours of physicians, the weekly frequency of on-calls and the total number of hours that physicians have to spend on on-call duties should be reassessed. Limiting on-call frequency and hours may be more likely to reduce the level of work-family conflict experienced.

Future research efforts should seek to expand this study and identify effective coping strategies for managing conflict between work and family roles. The use of qualitative research would help to further our understanding of how employees can effectively cope with work-family conflict.

Corresponding Author:
Aminah Ahmad
Department of Professional Development and Continuing Education,
Faculty of Educational Studies,
Universiti Putra Malaysia,
43400 Serdang, Selangor, Malaysia
aminah@ace.upm.edu.my

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