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Navigating Multiple Roles: Physicians Married to Non-Physician Professionals

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LOMA LINDA UNIVERSITY
School of Science and Technology
in conjunction with the
Faculty of Graduate Studies

Navigating Multiple Roles: Physicians Married to Non-Physician Professionals

by

Carlene Olivia Fider

A Dissertation submitted in partial satisfaction of
the requirements for the degree of
Doctor of Philosophy in Family Studies

June 2011

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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ABSTRACT OF THE DISSERTATION

Navigating Multiple Roles: Physicians Married to Non-Physician Professionals

By

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Doctor of Philosophy, Graduate Program in Family Studies

Loma Linda University, June 2011

Dr. Curtis A. Fox, Chairperson

A qualitative study of the lived experiences of dual career couples in which one partner is a physician is being proposed to fulfill the requirements for a Doctor of Philosophy degree in Family Studies. The study will look specifically at how these couples manage the role expectations and demands from the home front as well as from the work front. The study will also investigate how these couples create time for the dyad considering the demands of both careers. While dual career couples have their distinct features, physician families that have dual career attachments have been under studied in regard to the impact their work has on their marriage, and there is need for more empirical research that addresses this and other issues. The proposed study will add to the empirical literature and will have implications for future research, theory, and practice, as well as for work-life policy issues for physicians.

CHAPTER ONE

INTRODUCTION

The present study seeks to examine gender-based division of occupational and domestic workload in a sample of dual career marriages in which at least one partner is a medical doctor. The study will also look at the relationship between workload, stress and satisfaction in the home/work interface, and how these aspects combine to predict conflict in marital relationships. With the influx of women into the field of medicine and the necessity for both partners to work outside of the home, this study will be able to shed light on the challenges faced by couples in which both partners work in professions that require a certain level of education and commitment.

This study is crucial to the profession of medicine as well as to family scholars for four significant reasons. First, the current literature on medical marriages frequently employs quantitative methods and very often focuses on the doctor and his wife. Second, there has been an increase in the number of professional couples (US Census, 2003) and getting a glimpse into the lives of medical marriages will inform other studies that are geared toward professional couples as well as professional families. Third, it is crucial to uncover the differences in the lived experiences of male physicians versus female physicians in regard to work/family stress. Though the challenges they face at work may be similar, having the added responsibility of caring for a family may compound their already busy lives. Finally, this study may help influence work/family policy and may provide empirical data, which may influence medical marriages in which both partners work outside of the home.

Over the past few years, sociologists and other social scientists have been interested in the processes by which humans choose partners (Bracher & Santow, 1998; Harknett, 2008; Liefbroer, Gerritsen, & Gierveld, 1994; Lichter, Zhenchao, & Mellott, 2006). The trend has commonly been that people marry either within their group, referred to as endogamy, or they marry persons with whom they share similar status, also referred to as homogamy (Kalmijn, 1998). More and more professional endogamous and homogamous couples are appearing (Kalmijn, 1998). Past research gives a number of reasons for this phenomenon of the dual career marriage. Dual career marriages, in which both partners pursue a professional career, offer a window onto the changing landscape of gender relations and roles.

In the span of a single generation, the family in which both parents work outside the home has gone from being the exception to becoming the rule. In 1985 the US Department of Labor reported that both husband and wife worked in 64% of married couple families with children under the age of 18. The data further reports that half of the mothers with children under 3 were in the workforce, up from one third in 1975 (Bureau of the Census, 1981).

The number of dual career couples is growing at an extraordinary rate in the United States (US Census, 2003). Half of the American workforce is women, and an increasing number of these women are mothers of young children (US Census, 2003). Additionally, as more women enter the workforce, they are earning higher degrees, securing more work today, not because they have to, but because they want to, especially among career women. An increasing number of women are pursuing careers rather than jobs. For example, in 1970, women earned 7% of all medical degrees and 5% of all law

degrees; in 1985, 28% of medical degrees and 37% of law degrees were awarded to women (U.S. Department of Education, 1985).

The majority of professional women who marry, tend to marry men who also have professional careers (Epstein, 1971). Thus, as the number of women pursuing professional careers continues to rise, the number of dual career marriages is expected to rise also. Before 1970, marriages in which the wife, as well as the husband, pursued careers were exceptional, and even viewed as a peculiar phenomenon (U.S. Department of Education, 1985). A review of the popular press, as well as scholarly literature, suggests that today dual career marriages occupy center stage in the drama of changing gender roles (Adler, Adler, Ahrons, Perlmutter, Staples, & Warren, 1989; Bryson & Bryson, 1980; Butler & Paisley, 1980; Epstein, 1971; Matthews & Matthews, 1980; Monk-Turner & Turner, 1987).

It should be understood that there are couples in which both partners work outside of the home, however, the couple may not be considered a dual career couple. The distinction between a dual career couple and a dual earner couple is that a career requires a high level of commitment to a particular occupation that has a developmental sequence (Rapoport & Rapoport, 1976), and typically necessitates having at least a bachelor's degree. Men and women in careers expect to advance in their company or organization over a period of time. They are dedicated to their professions and quite often personally identify with their work.

As such, when both a husband and wife have careers, they are known as a dual career couple. The issues that face a dual career couple are different and more complex than those of traditional married couples or even a dual earner couple (Pixley, 2009).

Dual career couples must wrestle with the dilemmas of how to support each other's career development, while juggling childcare, housekeeping, and their personal relationship. If one member is offered a promotion that requires moving out of state, the dual career couple faces the conflict of whose career comes first.

With regard to childcare and housekeeping, a dual career couple may struggle with dividing chores in such a way that one partner does not seem to be doing more than the other. Many couples strive for egalitarian roles and this is one dilemma that a dual career couple is likely to face (Aldous, 1982; Cherpas, 1985). Even though both husband and wife work full time, studies have shown that the wife still carries the burden of childcare and housekeeping (Hall & Hall, 1975; Pixley, 2009). It may be a challenge for a dual career couple to change social standards that they have lived with all of their lives. However, an unequal division of labor at home, often leads to fatigue on the part of one spouse, and can result in conflict for the couple (Pixley, 2009; Yogen, 1981).

Despite the apparent challenges, many dual career couples report that two careers enhance their personal relationship (Costa & Kahn, 2000; Pixley, 2009). Both husbands and wives report that it is very rewarding to be married to someone who is interesting, intelligent, driven, and powerful (Pixley, 2009). As one can image, the time commitment to career and family is heavy, and often the marriage relationship is the last attended to, after work, children, and housekeeping. Therefore, many dual career couples have a high level of conflict that goes unresolved due to fatigue and lack of time to talk (Costa & Kahn, 2000; Pixley, 2009). Due to the combined pressures of being a parent, a spouse, a professional and needing time for self, it is not uncommon for marital quality to be an issue that professional couples are concerned about.

Marital quality has been defined as a global evaluation of one's marriage (Bradbury & Fincham, 1990). When used by stress researchers, the construct of marital quality has been used as an indicator of general dyadic success. Marital quality has provided a common point of interest to researchers as it relates to stress-related outcomes such as health, well-being, psychological distress, and marital stability (Kluwer, 2000). This study examines marital quality in dual career marriages from the perspective of stress and coping theory, which posits that stress is a process that ultimately has both personal and relational consequences (Lazarus & Folkman, 1984). This theoretical stance has served as a foundation for past research dealing with role strain, coping, and distress in dual-career couples (i.e., Guelzow, Bird, & Koball, 1995). Few reviewed studies, however, have examined evaluations of marital quality as an outcome of the stress process, influenced by how dual career couples experience and handle chronic stressors such as role overload.

From the perspective of stress and coping theory, cognitive appraisals or perceptions modify or enhance the severity of experienced stress and influence coping responses (Lazarus & Folkman, 1987; Pearlin & McCall, 1990). In this study, perceptions of role overload are viewed as initiating the stress process. Role overload, as part of role strain, occurs as dual career partners attempt to satisfy the demands of multiple roles, which consistently and relentlessly compete for sparse time resources (Haas, 1999; Pearlin & Schooler, 1978). While role overload alone may not directly affect partners' marital quality, how they appraise and respond to these potential threats within the context of their marital relationship does have implications for marital quality (Fraenkel & Wilson, 2000; Pearlin, Lieberman, Menaghan, & Mullan, 1981). Once activated,

partner perceptions of overload trigger examination of coping resources, informing partners of possible options in their repertoire of coping strategies. Selection and use of individual coping strategies then affect partners' engagement of relationship enhancing interactions, termed relational coping resources. More specifically, employment of individual coping strategies is expected to reduce the negative impact of role overload and concomitantly allow partners more time to engage relational coping resources such as marital maintenance behaviors and cooperative negotiation strategies. These actions will, in turn, influence more positive evaluations of overall marital quality (Fraenkel & Wilson, 2000).

Objectives of Current Study

It is necessary to take a look at the purpose and focus of the current study. The study has a number of objectives. The present study will give a rich description of gender differences in perceived stress and satisfaction between home and work, and perceived role conflict for doctors in dual-marriages, comparing male and female doctors. The division of occupational and domestic workload in these relationships will be considered. Previous studies have suggested that the majority of such relationships are likely to be organized along traditional gender lines, with the female, even if she is the physician, adapting occupational roles to accommodate domestic responsibilities (Garvey & Tuason, 1979; Myerson, 1990; Nelson, 1978).

Secondly, the perception of the challenges associated with multiple role demands, home and work stress and satisfaction will be discussed; paying close attention to the accounts given by male doctors while having an ear for the experiences of female

doctors. It is anticipated that there will be a positive association between role quantity or workload associated with domestic/occupational roles, stress, and conflict within relationships. Furthermore, role complexity, specifically the role of parent, is expected to influence the perception of greater stress in the home/work interface. To investigate the impact of role complexity, the voices of physician parents will be analyzed while considering the shared experiences of non-parents. This will also hold true for parents with children living at home and parents whose children have left home.

Job satisfaction, which has been defined as the extent of satisfaction derived at the workplace, and life satisfaction, which is the extent of satisfaction derived from various facets of life, other than the job, will also be assessed and their impact on marital quality will be addressed. Both are likely to have an impact on the stresses experienced by handling the multiple roles of parent, spouse and career person, also termed multiple role stress.

The following chapters will discuss issues that are pertinent to the proposed dissertation research. Chapter two will look at the theoretical framework and the key concepts of the study and how this theory has been employed in current studies. The third chapter will present a comprehensive review of the current literature on dual career couples, the challenges they face, and the status of the medical marriage. The final chapter, is dedicated to an in-depth review of the methodology that will be used in the study. Areas such as inclusion criteria, data collection, and coding processes will be discussed.

CHAPTER TWO

CONCEPTUAL FRAMEWORK

The issue of work/family related stressors have been surveyed over the past few years. Changes in the economy, technology, and indeed the family have resulted in an increased participation of women in the workforce (Vannoy & Dubeck, 1998). These changes have had an impact on the structure of work and family life and the ways in which each influences the other (Vannoy & Dubeck, 1998). The impact of such changes has resulted in greater interest in work/family life by researchers and practitioners. A survey of the literature shows the use of multiple theoretical orientations. Stress theory has been employed as a conceptual framework from which to view these changes (Yogen, 1981). Other social scientists (Hill, 2005; Nakonezny & Denton, 2008) have viewed these changes through the lens of social exchange theory, while others have chosen conflict theory as the framework that guides their work (Broderick, 1993). Fewer studies have been grounded in ecological systems theory (Voydanoff, 2002), or family resilience theory (Grzywacz & Bass, 2003; Patterson, 2002), and even less have used traditional sex role theory and applied it to the work/family role system (Pleck, 1977). The multiple lenses have created a literature that, at best, appears to be less cohesive with regard to theoretical orientation. In this study, structural functionalism will be used. It appears to be a useful orientation because of the concepts and assumptions endemic to the theory. These will be discussed in the following paragraphs.

Theoretical Framework

The single greatest contributor of structural functionalism is Talcott Parsons (1951). Parsons believed that behavior is driven by our efforts to conform to the moral code of society. These codes function to constrain human behavior in ways that promote the common good. Structural functionalism views society as an organism that is built on order, interrelation, and balance among parts as a means of maintaining the smooth functioning of the whole. In order for a society to survive, subsystems must operate in ways that promote the maintenance of society as a whole.

At the heart of structural functionalism are three major aspects of society (Parsons, 1951). Firstly, norms and values are considered to be the basis of society. Secondly, social order based on unspoken agreements between groups and organizations is inherent in social structures. Finally, social change is seen as occurring in a slow and orderly fashion. Proponents of structural functionalists acknowledge that change is sometimes necessary to correct social dysfunctions; however, they propose that change must occur slowly so that people and institutions can have time to adapt.

There are key terms associated with structural functionalism that require special attention. These are structure, function, instrumental, expressive, equilibrium, structural-strain, dysfunction. Structure has been defined as status-roles, or positions, that are usually arranged in a hierarchical fashion (Murdock, 1949). Just as social structures such as governments contribute to the smooth functioning of society, individuals must fill a set of positions, or status-roles, to make families function smoothly.

Along with structure, function is an important principle in the discussion of structural functionalism. Function has been defined as a complex series of activities

directed towards meeting a need or needs of the system (Merton, 1957). In terms of families, one thinks of the services that families provide to and for society. The functions of the family then serves to enhance the survival of society at larger. One can best understand the purpose of any organization by examining what it does, or its functions. Society, therefore, develops institutions and patterns in order to maintain itself and keep it running efficiently.

Instrumental roles are roles that are required for survival. Structural functionalists view men as holding the instrumental role in families while women hold the expressive role of caregiver (Winton, 1995). This gender division of roles is closely tied to equilibrium, which is the assumption that any human system will resist change once things are functioning smoothly (Kingsbury & Scanzoni, 1993). Change is a necessary part of life and often comes gradually. As such, family members function best when things are in balance. Parsons felt that equilibrium is best achieved when members of a family system share the same values and goals and when they carry out differentiated roles (Winton, 1995).

A sixth concept involved in structural functionalism is that of structural-strain. When rapid social change occurs, social problems often arise. Structural-strains inspire adaptation or reform in social systems in order to keep society running, but the system remains relatively stable. Winton (1995) suggests that disorder occurs because of conflict between the parts that make up society, and therefore balance and peace must be restored.

Dysfunction is the final concept of structural functionalism that is necessary to define. Dysfunction is closely linked to structural-strain, but it is not always a derivative of structural-strain (Winton, 1995). Structural functionalists further point out that there

are times when social systems do not operate ideally. In such instances, the dysfunctions of a given system act as a way of improving its smooth functioning (Winton, 1995).

It is not necessary to discuss the assumptions of structural functionalism. There are seven assumptions inherent in structural functionalism (Parsons, 1951). These assumptions focus on social units such as the society, the community, the family, and the individual as levels of analysis. The first assumption of structural functionalism states that systems have interdependence of parts. Social units are therefore held together by cooperation and orderliness. Rules and regulations are therefore developed to maintain order within subsystems and serve to protect individuals and families alike.

The second assumption of structural functionalism is linked closely to the first and states that systems tend toward equilibrium. It is a fact that societies and social units work best when they function smoothly as an organism, with all parts working toward the correct functioning of the system. The maintenance of equilibrium is necessary for the any system to run effortlessly (Kingsbury & Scanzoni, 1993).

In addition to the maintenance of equilibrium, a third assumption of structural functionalism states that systems can be either static or involved in an ordered process of change. This assumption asserts that there is no middle ground (Merton, 1957), as systems either move toward change or stay where they feel comfortable. The fourth assumption of structural functionalism seems to be an extension of the above assumptions as it involves the impact that one part of a system has on the other parts. In other words the nature of one part of the system has an impact on the form that the other parts can take (Murdock, 1949). This is understood since systems are either static or in motion. As

such, if one part of a family system is in turmoil over a mother working outside of the home, it is likely that other parts of the system will begin to demonstrate conflict as well.

The idea that systems maintain boundaries within their environments is the fifth assumption of structural functionalism. This suggests that if one or more parts of a system conflict with others, adaptations must result (Merton, 1957). Boundaries are necessary in order for the system to maintain equilibrium and not allow other external forces to influence the system. In a sense, rules act as boundaries as they state what is acceptable and what is not. (Kingsbury & Scanzoni, 1993)

Allocation and integration are important aspects of the sixth assumption of structural functionalism as they are necessary the maintenance of equilibrium within a system. The division of labor and positions helps maintain balance; each part interrelates to create efficiency and harmony. Parsons concluded that the best way to do this was for husbands and wives to play certain roles (Parsons, 1951). He suggested that within families, males need to be instrumental, which means that they are the ones who should provide for the family. As such, their abilities should be focused on meeting the physical needs of the members in terms of food, shelter, education, and income. In contrast, females are to be expressive, meaning that they meet the emotional needs of family members by being nurturing and smoothing out problems in relationships. There is a biological aspect to Parson's explanation of instrumental and expressive roles. Due to the biological imperatives of motherhood, it is felt that women are predisposed to emotional, nurturing, and 'indoor' work, whereas the greater physical strength of men more often leads them into the provider role.

The seventh and final assumption is that systems strive to achieve self-maintenance. This process involves boundary control and adjusting (Winton, 1995). In essence, family systems carry out their functions and maintain internal equilibrium in a relatively autonomous manner. This is important because families are constantly in conflict with societal norms. The ability to self-maintain is necessary so that the family can serve a particular function, which may involve social change.

Theory Applied to Medical Marriages

The investigation of this theoretical orientation revealed that structural functionalism is a very useful tool when employing qualitative research (Herman-Kinney & Verschaeve, 2003). Since the focus of structural functionalism is based on behavior being driven by our efforts to conform to the moral code of society, and qualitative research is useful in describing the lived experiences of research participants within the context of their society, they compliment each other well. The proposed study will employ a qualitative research design involving a structured, in-depth interview, which will be discussed in chapter four. When investigating medical marriages through the lens of structural functionalism we see that the structure is the backbone of the proper function of every system.

Structural functionalism will assist in explaining what happens when the mother becomes a part of the paid workforce and the role changes that ensue (MacDermid, Roy, & Zvonkovic, 2005). As noted earlier, structural functionalists hold that the father is the one who should work while the mother should be the nurturer and caregiver. With couples in this proposed study, the mother also works outside of the home and this may

upset the delicate structure of the family resulting in disequilibrium (MacDermid, Roy, & Zvonkovic, 2005; Winton, 1995). If this is the situation, both partners must adapt to maintain their own. Structures are learned from ones family of origin, and play a major part in teaching what is acceptable and what is not. It is highly probable then, that the being involved in multiple roles may be easier for some couples and not others. Since no two people were raised alike, differences in their family systems can create conflict in intimate relationships. For example, in a medical marriage one partner may have grown up witnessing a considerable amount of parental involvement from both their parents, while the other partner's experience may have been different. Consequently, this can result in conflicts that directly relate to the parenting subsystem.

As Rank and LeCroy (1983) note, when people move from one social structure to another, and as they navigate the family life cycle, changes occur. These changes are a direct result of structural functionalism. Due to the changing nature of values in society striving toward equilibrium may be a constant task of dual career couples. Dual career marriages in which one spouse is a physician experience conflicts that may not be present in similar non-physician marriages (Garvey & Tuason, 1979). Some of the issues that such families are faced with include work-to-family spillover, role conflict, role strain, and identity issues. In addition, many female physicians have to cope with the reality of the second shift.

A well-established finding in the literature regarding work and stress is that stress from work can and does interfere with one's family life (Pleck, 1977; Pleck, 1999). This spillover, as it is referred to, is often the result of psychological carryover of strain from the workplace to one's family life, and it is often compounded by factors associated with

the time required to perform work and family roles (Pleck, 1977; Pleck, 1999). The result of this bi-directional spillover has been termed work/family conflict. When individuals perform multiple roles (e.g., employee, spouse, and parent), they are likely to experience interrole conflict, which places demands on their time, energy, and commitment (Greenhaus & Beutell, 1985). Exhaustion, the intensity of the requirements of ones job, and other job stressors can spill over into family life and affect the marital satisfaction of couples (Mauno & Kinnunen, 1999). Pleck (1999) indicates that work stress can have a deleterious impact not just on a marriage, but also on other aspects of family life.

Role strain exists when there are difficulties in performing a given role (Greenhaus & Beutell, 1985) due to additional obligations and commitments. This is likely to result in role conflict. Persons who hold multiple roles are left feeling pulled in varying directions, as time spent on activities within one role could not be devoted to activities within another role (Greenhaus & Beutell, 1985). It is here that role conflict arises. When one views this through structural functionalism, we see how it is easy for such a person to feel overwhelmed due to the structures and functions attached to being a good physician as well as a good parent. Until the couple is able to achieve an acceptable level of self-maintainance, there will be conflict.

In addition to the above, many physician families must also learn to deal with identity issues and cope with the second shift (Hochschild, 2003). Rapoport and Rapoport (1976) note that there is likely to be an identity dilemma in dual career families that arise from the conflict that arises when early gender-role socialization and the current practices of their work collide. In the medical family, the male, despite his profession, is still the one thought of as the one who is to be successful in work. The female in the relationship

is still thought to be more domestic (Byron, Byron, & Johnson, 1978). If the female in a medical marriage is the physician, she is still expected to be the one who is mostly responsible for care of the home and the children. This is a function of society due to the concept of interpretive and expressive roles.

This leads to another important issue to be addressed in medical marriages; the not so subtle impact of gender. Structural functionalists view men and women as having biologically, predetermined roles (Parsons, 1951). The role of men is that of family provider, while women are responsible for emotional family work (Kingsbury & Scanzoni, 1993). A more modern view of structural functionalism would state that changes in roles have affected family equilibrium. Thus, families must identify new ways to adapt within the structure of their systems.

In the past few decades, women have continued to define who they are in interaction with one another rather than primarily based on interaction with men (Charon, 2004). The influx of women into the field of medicine is once subtle yet powerful indicators that society recognizes that male and female are far more socially defined categories than biologically created ones. With the use of structural functionalism, this study will attempt to describe how physicians and their spouses react to work/family issues. Dysfunction is thought to arise when roles collide. Dual career couples, however, must continually, reconstruct roles in order to maintain equilibrium. As structural functionalism states, in order for these couples to function well, they cannot be static, but must move against the structures of society in an effort to self-maintain and work.

The current study is therefore interested in how couples adapt to the changes in their structure, since if one or more parts of a system conflicts with others, adaptations

will have to be made. In addition, this current study is interested in the impact of economics. Early structural functionalists found that when mother's worked, this destabilized the female and was a threat to the quality of child rearing (Kingsbury & Scanzoni, 1993). However, structural functionalism tends to look to outside forces, particularly economics, to explain change. Social structures affect and impact how people view their worth and influence how they develop a sense of who they are. The profession of medicine is a prestigious one that has high financial rewards. Female or male medical doctors may then realize that their economic contribution to the family is significant and this may have a bearing on the structure of the family. In the same way, the title of professional couple is likely to require adaptation. These are some issues that this study will attempt to address through the lens of structural functionalism.

Structural functionalism is an appropriate theory to use with dual career marriages in which one partner is a physician and the other is a non-physician professional. This framework can assist in looking at the functions or roles within the family, while being sensitive to gender roles (MacDermid, et al., 2005; Winton, 1995). In addition, structural functionalism helps to identify and describe the roles and conflicts that may occur in a family (Barnett & Hyde, 2001; Winton, 1995). Finally, structural functionalism allows families to choose who will fill the various roles in the home and how the family will work toward self-maintenance (MacDermid, Roy, & Zvonkovic, 2005).

CHAPTER THREE

REVIEW OF LITERATURE

Sociologists have been studying marriages for 35 years before psychologists or other social scientists became interested in the topic. Louis Terman and his colleagues (1938) wrote the first published study on marriage. Since then, the study of relationships has been of interest to many social scientists and the numbers of published articles has steadily increased. Gottman (1989; 1992) is widely known for his contribution to clinical and empirical literature on the dynamics of marriages, including interaction, marriage dissolution, marital satisfaction, and other marital processes. With the study of marriage came an interest in the varying aspects of relationships. Issues such as mate selection (Parker, 1979), marital happiness and satisfaction (Terman, Bittenweiser, Fergusson, Johnson, & Wilson, 1938), divorce (Gottman, 1993), marriage and health (Burman, & Margolin, 1992), inter racial marriages (Larry, 1963), dual career and dual earner marriages (Rapoport & Rapoport, 1971), marriage timing (Oppenheimer, 1988) and same gender marriages (Eskridge, 1993) have also been investigated and reinvestigated.

Although much has been written about marriages, it must be noted that there is not typical relationship as marriage customs, roles, and expectations are largely based on ones ethnic and racial origin, religion, age of marriage, culture in which one was raised, and whom one married. This researcher must also consider one's medical specialty, and where and when one studied medicine (Myers, 1994) as these too will affect how one approaches marriage. This chapter will address the following concerns; the demands and accommodations made by professional families then specifically the demands and accommodations made in families where at least one spouse is a medical doctor.

The marital satisfaction and stability among professional families has occupied the attention of researchers. Professional families are exposed to stressors that challenge the quality and satisfaction of their marriage. One such professional group is medical doctors. The proposed study is salient as Sotile and Sotile (2000) note that 50 per cent of medical students in the United States marry while in medical school. As such, it is necessary to examine the phenomenon of professional families, and specifically professional families in which one partner is a physician. The roles of caregiver and breadwinner are shared in a dual career family. Depending on the circumstances of the moment, the demands of each role changes, and for many couples, this is an ongoing tug-of-war and shifting of plans.

The empirical study of dual career families is a new area, having its birth in the late 1960s (Thomas, Albrecht & White, 1984). Since then, a wealth of empirical literature on this topic has emerged. Between 1950 and 1980, the number of married women who were members of the labor force more than doubled from 21.6% to 50.2% (US Office of the President, 1981). This has resulted in an increase in the number of dual career couples in the ensuing years. In 1996, dual career couples comprised 60 percent of all marriages (Catalyst Study, 1998). In addition, a significant portion of the U.S. labor force finds economic independence, security, and satisfaction in the family's second income.

Defining the Dual career Lifestyle

The term dual career was first coined in 1969 by a European academic couple (Rapoport & Rapoport 1969; Rapoport & Rapoport 1971). Since then this term has become quite established, and other expressions such as coupled careers (Bernasco

1994), conjoint career couple (Adler et al. 1989) and coordinated career couple (Butler & Paisley 1980) have been introduced. Conjoint career couple and coordinated career couple, unlike coupled careers, refer to couples where both partners pursue careers in the same field or whose work activities overlap (Butler & Paisley 1980), and who are, therefore, professional colleagues in addition to being partners (Adler et al. 1989). According to Rapoport and Rapoport (1969, 1971), dual career couples differ from dual earner families or dual earner couples in one unique way. In dual career couples, both partners pursue an occupational career in which their jobs are characterized by high professional standards, a high degree of commitment, and a developmental sequence. Johnson, Kaplan, and Tusek (1979) discuss other characteristics that are implied in this lifestyle, including high levels of career responsibility, economic rewards, social prestige, and personal investment of time and energy on the part of both partners. Conversely, one partner in a dual earner couple has a career while the other holds an employment without career prospects and/or aspirations, or both may have jobs that do not require specific education and training. Other expressions used to describe dual earner families or couples are two paycheck families, and dual worker families (Eby 1997; Sekaran 1986; Taylor & Lounsbury 1988). The rationale for such a distinction between dual career and dual earner couples is that a number of problems are particularly relevant to the situation when both partners pursue careers. These problems can be classified into two areas: geographical mobility and family responsibilities – which, not only but to a higher degree affect careers of women more than careers of men in dual career couples.

Roos and Gatta (1999) conducted a study that supports the notion that for women, holding a terminal degree does increase income, it does so less for women than for men.

The general reason behind this very well established fact is often attributed to gender differences in career paths. Different attitudes toward work and the struggle to balance work and family responsibilities, but also gender segregation of occupations and discrimination might hinder women in their quest to attain the highest positions, compared to their male counterparts who have comparable backgrounds and education (Stroh & Reilly 1999: 310). Particularly for women in academia, there is strong evidence that married faculty women receive less prestigious positions and institutional rewards than do their male counterparts (Monk-Turner & Turner 1987).

Research suggests that women tend to enter homogeneous (Ferber & Huber 1979) or hypergamy (Marwell, Rosenfeld, & Spilerman, 1979) marriages meaning they are inclined to marry men of higher or at least not lower status. As has been noted before, the majority of professional women are married to men who are also pursuing careers. Since many of these couples meet during graduate school, the probability of being in the same field increases (Monk-Turner & Turner, 1987). In addition, quite frequently women have older partners who are thus ahead on the vocational ladder (Bryson & Bryson, 1980; Gappa, 1980; Matthews & Matthews, 1980; McNeil & Sher, 2001). This may assist in explaining the dynamics of professional couples.

A dual career couple operates without a “wife,” that is without a person who stays home to manage the home and care for the children. Traditionally it is the wife/mother who accepts this responsibility for the home. One of the major changes which has occurred in the American family in the 20th century is the transition from homemaker to career person for many women, and this change has made role strain a fact of life for the American family (Killian, 1952).

The number of couples currently pursuing this lifestyle is difficult to determine since career involvement is a more important determinant than income. What is relatively certain, however, is that the number of couples is increasing and will continue to do so in the decade ahead (Johnson, Kaplan, & Tusel, 1979). The fact that married women are going to work and working more consistently than ever before is undeniable. Extension professionals have an opportunity to help individuals meet the challenges and cope with the stress so that they can enjoy the positive aspects of the dual career lifestyle.

Characteristics of the Dual career Marriage

The pioneering research that has explored dual career families was conducted by the Catalyst Organization, a nonprofit research organization that is associated with the National Council for Research on Women and works with businesses to advance women. The 1998 Catalyst study entitled *Two Careers, One Marriage* is based on the responses of close to one thousand dual career earners. For the study, Catalyst conducted in-depth interviews with both members of 25 dual career couples, comprising a roughly representative distribution in terms of age, geographic location, and presence of children. Telephone surveys were also conducted which lasted for 20-minutes and were held with 802 randomly selected members of dual career marriages.

This research suggests that the number of dual career couples is growing at a phenomenal rate in the United States. Half of the American workforce is women, and an increasing number of these women are mothers of young children (Catalyst Study, 1998). Additionally, as more women enter the workforce, they are becoming better-educated and taking professional and executive positions. Many women work today, not because they

have to, but because they want to, especially among career women (Catalyst, 1998).

According to the Catalyst study a two-career marriage, which is used interchangeably with dual career couple or a dual career family, offers couples the benefits of economic independence and career control. The data also show that 67% of the 802 male and female survey respondents agreed that having a working spouse gave them the freedom to leave their jobs if they were not satisfied. The results also suggest that men (52%) were almost as likely as women (65%) to say that having a working spouse had a positive impact on their careers. Further, 58% of women and 73% of the men surveyed indicated that they were satisfied with their ability to balance work and home responsibilities.

The issues that face a dual career couple are different and more complex than those of traditional married couples (Dickerson & Hester, 1984; Poloma & Garland, 1971). Dual career couples must wrestle with the dilemmas of how to support each other's career development, while juggling childcare, housekeeping, and their marital relationship. Regarding the issue of childcare and housekeeping, a dual career couple may struggle with dividing chores equally (Poloma & Garland, 1971). Even though both husband and wife work full time, studies have shown that the wife still carries the burden of childcare and housekeeping (Dickerson & Hester, 1984; Bryson, Bryson & Johnson, 1987, Holmstrom, 1972; Rapoport & Rapoport, 1971; Weingarten, 1978). It may be difficult for a dual career couple to change social standards that they have lived with all of their lives. However, an unequal division of labor at home, often leads to fatigue on the part of the wife, and conflict for the couple.

On the positive side, many dual career couples report that two careers enhance

their personal relationship (Catalyst Study, 1998). Both husbands and wives report that it is very rewarding to be married to someone who is interesting, intelligent and powerful. Yet the time commitment to career and family is heavy, and often the marriage relationship is the last attended to, after work, children and housekeeping. Therefore many dual career couples have a high level of conflict that goes unresolved due to fatigue and lack of time to talk.

Challenges Faced by Dual career Couples

Dual career couples are faced with a unique set of challenges, many of which relate to role expectations, work role conflicts, and family role conflicts (Dickerson & Hester, 1984). According to Dickerson and Hester (1981) it is not uncommon that a woman who tries to combine a career and a family may soon be reminded that she is flaunting the socially accepted norms. This places her in a situation that can be considered to be no-win. These further note that the qualities associated with the role of wife-mother (nurturance, emotionality, responsiveness to people rather than ideas) are seen to be incompatible with those qualities associated with success in the occupational sphere (independence, rationality, and assertiveness).

Dickerson and Hester (1981) proposed that the man in a dual career marriage is also likely to encounter his share of struggles. The definition of masculine and feminine roles as he has been socialized to understand them are now different. The majority of men grow up expecting to be the head of a household, to be the one who earns the money and has the power. For the most part, men are not socialized or educated to fill roles that require skills in child rearing or homemaking. Even if a man has such skills, he may

perceive that devoting a great deal of time and emotional energy to domestic activities may negatively affect his career, particularly if he is competing with other men who do not have similar family roles (Dickerson & Hester, 1984).

Challenges arising from coping with two careers in one household are evident. The result of trying to juggle two careers may be that each individual is less competitive in terms of his or her own career advancement (Hansen, 1991). Each partner in the dyad has to make compromises for the other partner's career, and the net result is often that each ends up with a little less (Hansen, 1991). The home environment is a special challenge to the dual career couple as two people try to meet the demands of careers and build a family life together. Maintaining a home and a family can be taxing for even the most committed and energetic marriage partners.

It appears that most couples try to share the domestic load (Thomas, Albrecht, & White, 1984). Thomas, Albrecht, and White (1984) conducted a study involving 34 professional couples, in which they found that marital satisfaction was not compromised in the majority of the couples when the husband was the main source of income for the family. Contrary to this, Hardesty and Betz (1908) found that couples were more likely to report better marital stability when the husband's income was greater than the wife's. The results of their findings also indicate that marital satisfaction decreased as the income of the wife increased. This research also found that as the career aspirations of the woman increased, there was an increase in role conflict with negatively impacted marital satisfaction. More than half the women in the study (71%) stated that their husband's career took precedence and it was noted that husbands were supportive of their wives when they were pursuing more traditional feminine careers like nursing and teaching. In

the same study, fewer husbands were supportive if their wife became a lawyer, and executive or had a doctorate degree.

The standards in dual career family are voluntarily lowered, as some tasks may be eliminated or redistributed to domestic help, children, or spouses (Stains, Pleck, Shepard, & O'Conner, 1978). Even so, the fact remains that in the majority of dual career families, the responsibility for the domestic sphere lies with the wife. Even highly educated professional women retain that responsibility (Thomas, Albrecht, & White, 1984).

Marital Satisfaction and Dual career Couples

Terms such as marital satisfaction, marital happiness, and marital adjustment continue to be used interchangeably with marital quality (Kluwer, 2000). Some researchers agree that these concepts are highly interrelated (Norton, 1983). Several theoretical and explanatory models of marital quality have been postulated over the past two decades (Karney & Bradbury, 1995; Rusbult, 1983), yet there has been criticism that these models have not been well grounded in theory (Fincham, Beach, & Kemp-Fincham, 1997).

Research on the processes involved in maintaining marital happiness in intact couples is sparse (Dindia & Canary, 1993). Generally speaking, both men and women find benefits in being married, as such marriage is associated with happiness both genders (Gove & Zeiss, 1987). Studies gauging marital quality or satisfaction, for the most part have tended to report that the members in a couple are satisfied, as opposed to dissatisfied in their marriages (Heyman, Sayers, & Bellack, 1994; Norton, 1983). There are a number of speculations that have been put forth to attempt to explain why partners report high

marital satisfaction in spite of the elevated divorce rates in the United States (Weigel & Ballard-Reisch, 1999). The first possible explanation directly relates to social desirability and response bias (Kluwer, 2000). In addition, it might be more socially permissible to report distress in particular aspects of one's relationship such as household chores or division of labor (Kluwer et al., 1996; Blair, 1993; Sutor, 1991; Ferree, 1990), rather than to report dissatisfaction with one's partner or the relationship itself.

A second reason for the results of current research on marital satisfaction could be that, perhaps, couples who are interested in marital research choose to participate in such studies (Hunsley, Vito, & Pinsent, 1996). As a result when they are asked about issues that relate to marital satisfaction and other similar constructs, their responses more be more positive or they may also be more likely to actively work on their relationship, thus being considered more socially desirable.

Reports of high levels of marital happiness among couples has been shown to be directly related to one's physiological predisposition to place their marriage in a positive light as this increases their ability to adjust to changes (Johnson & Booth, 1998). Overall, persons who contribute to empirical literature by being part of research projects tend to possess a more positive view of marriage and married life (Russel & Wells, 1992). What is of interest then is the possible conceptual frameworks of marital quality. In dual career families where higher levels of stress are present on each partner as well as the couple, looking at marital happiness is of particular importance. Research suggests that in such couples, though they have little time left at the end of the day to devote to their spouse, marital quality is reported to be comparatively high (Silberstein, 1992; Stoltz-Loike, 1992). Additional research has also found positive relationships between careers and

marital quality among both men and women (Gilbert, 1985; Voydanoff, 1987; Yogeve, 1982).

These findings are of interest as literature and logic hints toward the negative relationship between stress and marital quality (Bradbury, Cohan, & Karney, 1998), which would appear to put couples experiencing greater levels of stress at greater risk for poorer marital quality. Research by Lagerfeld (1998) provides evidence that work demands can lead to a sense of decreased ability to cope well. Studies exploring stress outcomes in marriages, however, have often focused on major life events, such as birth or death of children or partners with terminal illnesses or major medical conditions, as stressors (Kluwer, 2000). This proposed study will add to the knowledge in the area of marital research by examining the day to day stress of role overload for dual career partners. Social science researchers and have paid little attention to the ways in which time impacts intimate relationships (Fraenkel & Wilson, 2000). The time constraints inherent to dual career couples and the ways in which partners cope with stressors on an individual level as well as on a relational level, all serve to contribute to existing literature on marriages.

For the past 50 years researchers interested in investigating marital relationships have focused on factors that predict the dissolution of marriage (Alfred-Cooper, 1998). Couples in the first (Kurdek, 1998) or last (Glenn, 1998), stages of marriage have denominated research samples with only a sparse presentation of middle-stage marriages, which is a time when many couples raising young children experience greater stress and have less time and energy to invest in the marital relationship (Belsky & Kelly, 1994; Cowan & Cowan, 1997). This present study will present a unique angle as it incorporates

couples from varying stages of dual career marriages. The study further seeks to explain how partners can also function well in spite of the constraints of role overload, utilizing individual coping strategies and becoming allies as they create a healthy shared belief system which allows them to consciously reclaim time and allocate it appropriately to the marriage, with positive outcomes for marital quality.

Changes in and Status of the Medical Marriage

A medical marriage is one in which or of both partners are medical doctors (Myers, 1986; Myers, 1994; Sotile & Sotile, 2000). The textbook medical marriage includes a physician who is devoted to his practice and his wife homemaker wife who lovingly and caringly wears the title of domestic goddess proudly. The thought of being married to a successful medical doctor gives this wife personal gratification and the fact that she is a 'good wife and mother'. What society didn't know was that many of the women behind the white picket fences and well-manicured lawns were not as happy as they professed to be (Fine, 1981; Sotile & Sotile, 2000). The late 1970's saw an increase the voice of wives of physicians as they described their marriages as cold, dictatorial, over bearing, and lonely.

The picture perfect wife has shifted in the past few decades as over sixty percent of spouses of physicians are gainfully employed outside the home (Myers, 1984; Sotile & Sotile, 2000). These women now face different challenges as they are forced to juggle responsibilities of being a wife, a mother, and a career woman. This is what a professional family is; one in which both partners work outside the home in professions that require a certain level of education and personal commitment. One form of

professional families are those in which one member is a physician and the other has a career that he or she is dedicated and committed to, and which involves a certain level of education.

Sotile and Soitle (2000) mention that between 1980 and 1997 medical marriages have changed, as there has been a significant increase in the number of women who attend and graduate from medical school. Sotile and Sotile (2000) further state that if a female physician does not marry another physician she is considerably more likely to marry a man who is a professional. No matter how self-motivated and driven he is, it is likely that he will struggle with his form of the 'physician wife' syndrome (Sotile & Soitle, 2000). It is probable that his career will take a back seat to hers in regard to prestige, status, and income. This may be met by over compensation on the part of his wife, which leaves her feeling spent and over burdened.

The challenges of being in a medical marriage are many, however, before delving into the world of physician couples I will review the literature on male and female physicians and their experience of marriage. It is necessary to take a look at the differing challenges of male and female physicians so that one can have a deeper understanding of the intricacies of their lives. Prior to that, let's take a brief look at dual physician couples and the dynamics of such relationships.

In dual physician couples it is typical that the husband's medical career will take precedence over his the medical practice of his wife (Fine, 1981; Sotile & Soitle, 2000). In light of this, married female physicians with children choose specialties that have less time demanding, thus scarifying their profession for their husbands. Women who do this don't frequently see this as an issue associated with bargaining, but see it as a way of

being supportive of their spouse, since, after all, it is her responsibility to be submissive and cooperative (Glick & Borus, 1984). In this regard, a married females physician career affects her family life and her family life has an impact on her career.

When investigating dual physician couples and comparing them with other professional couples, wives are the ones who assume over 80 percent of the responsibilities associated with the household and childcare (McGoldrick, Anderson, & Walsh, 1989). The post feminist United States still does not see women as equal to men in all areas. Taffel (1994) reported findings from a study of 3000 randomly selected men and women conducted by the Family and Work Institute that suggests that women consistently are five times more likely to cook and do the family shopping, and eleven times more likely to be engaged in cleaning around the home. One very interesting finding from this study was that the findings were true for younger women as much as older women, though the younger women in the study contributed to half or more of the household income.

Women in dual physician marriages and other professional marriages have the task of managing a productive and demanding profession in addition to being the CEO of their homes. In a study consisting of 1,420 obstetrician-gynecologists working at Johns Hopkins University (Wiseman & Teitelbaum, 1987) it was discovered that these married female physician worked about 7.5 fewer hours per week than male physicians with the same specialty. Despite this, they were still working, on average, in excess of sixty hours per week while being in charge of over fifty percent of home affairs. Another study conducted by Sobecks, Justice, Hinze, et al (1999) proposes that in spite of the profession of the husband, female physicians will work between forty-two and forty-nine hours in

their careers even though many of them would have made altered their careers as a means of meeting the family needs.

There is disagreement in the literature regarding the level of satisfaction and stability in doctors' marriages (Myers, 1994; Sotile & Sotile, 2000). Some commentators contend that medical marriage of male physicians is not less satisfying than that of other professionals (Wiseman & Teitelbaum, 1987). Lewis (1993) paints a very positive picture of the medical marriage. In their study of 747 physicians (85% were male) they linked high levels of marital satisfaction to very efficient family functioning.

Lewis (1993) also advocates that the male physician marriage is not prone to dissatisfaction. In their study they found that physicians who attest to having high levels of marital satisfaction associated it with high work satisfaction, low work stress, and fewer psychiatric symptoms. Physician wives in the same study indicated that marital satisfaction is proportionally tied to the success of the medical practice. Interestingly, work hours and the absence or presence of vacation were not determinants of the marital quality, where there is contentment with the practice. Lewis (1993) attributes the different representation of marital dysfunction in the literature to sampling difference and the assessment instruments use for the evaluations.

Warde, Moonesinghe, Allen, and Gelberg (1999) compared marital satisfaction between male and female physicians with children. In their study, male physicians appeared to have greater marital satisfaction than female physicians. According to Warde et al. high levels of marital satisfaction was associated with two primary factors: helpful and cooperative partner and the low levels of role (responsibility) conflict. Role conflict that Warde et al define as "the perceived frustration resulting from the competing

demands of career, marriage, and family” (162) was higher among female physicians than their male counterparts. Female physicians who are parents are more prone to experience role conflict than their male colleagues. This is primarily because the determinant variables are very long work hours, scheduling, work that exacts physical and psychological demands, disparity in division of home responsibilities, and challenges of caring for children (Warde, Moonesinghe, Allen & Gelberg, 1999). Overall, lower levels of role conflict have been seen to be positively associated with high levels of marital satisfaction for male physicians.

Myers (1994) in his study of 130 medical student or physician couples that he has interacted with as a psychiatrist has noted many challenges that are associated with being a physician. From his experience working with married physicians he notes the following issues that are typical for many male physicians: communication difficulties, overwork, alcohol use, self-medication, under diagnosed depression, sexual problems, and violence. In regard to female doctors, Myers (1994) suggests that delay in seeking help, guilt, self-image problems, impaired assertiveness in marital communication, role strain, husbands with unmet needs, and problems with intimacy and sexuality are some of the issues faced. In addition to these many female physicians are not allowed to have emotional needs, may have husbands who feel belittled, may resent doing all the worry work of the marriage, may have a husband who is under or unemployed, maybe be depressed, or may feel like an imposter. Let's explore some of these issues.

Concerns surrounding communication are not indigenous to physician marriages, however, it is an issue that has been discussed in the literature. In a study of male physicians, Myers (1994) notes that they mention having communication difficulties. In

general, women more than men have the propensity to share feelings and initiate soul-searching conversations (Garvey & Tuason, 1979). Wives of physicians report feeling a deep sense of loneliness in their marriage as many physician husbands fail to initiate and engage in 'meaningless' conversation or refrain from sharing thoughts and feelings (Krell & Miles, 1976). It must be understood that many male doctors have compulsive personality traits (Krell & Miles, 1976). The profession of medicine requires them to be moral, orderly, conscientious and portray a certain level of perfectionism (Garvey & Tuason, 1979). What is interesting is that these traits often morph into like rigidity and becoming emotionally distant that can hinder a relationship.

Another complaint of the wives of physicians is that their husbands tend to overwork. Overworking and or workaholism are interestingly willingly adopted into our society and there are those who reward and praise those who suffer from an addiction to work. Men who do work overtime so that their family can be provided for are considered heroes, however, this can prove to be quite a complicated issue, as the individual may only be looking after their family, and trying to meet all their needs.

Research suggests that an increasing number of physician wives find employment outside of the home (Myers, 1994). This is due to three main factors. Firstly, there may be economic necessity; secondly, wives may work outside of the home because of personal needs; and finally, due to their own careers. While financial security is a desired goal, yet there are wives of physicians who feel that overworking is a main contributor to marital discord (Myers, 1994).

Married male physicians, more than their female counterparts suffer from alcohol abuse and issues related to self-medication. Work related stress that leads to excessive

alcohol use coupled with the availability of medicine creates a toxic environment for ones marriage. For some male physicians, alcohol use occurs as a result of wanting to unwind following a long day at work, and then intensifies when he begins drinking excessively as a past time. It is not uncommon for this habit to create friction in his marriage (Vaillant, Brighton, & McAurthur, 1970; Wallot & Lambert, 1984). On occasion, alcohol and drugs that are being used as methods of coping can result in violent outbreaks that are directed to members of the physicians' immediate family; namely his wife and or children.

Another issue that male physicians present with involved problems with intimacy and sex. The major concerns are sexual desire disorder, sexual arousal disorder, orgasm disorder, and extramarital affairs. Researchers suggest that male physicians' may expel a considerable amount of energy at work and possibly other physical activities like sports that render them tired when they go home. Sometimes, hidden behind the physician who is so tired from a long day on the wards is a sexual disorder. A hectic patient load and a sixty hours workweek may be covers for the lack of desire that he has. And since intimate time frequently leads to sex he may avoid alone time at all costs (Myers, 1992). As far as extramarital affairs go some may be prompted by convenience (Myers, 1992) while other affairs have been triggered by the unfortunate fact that the physicians wife may be insistent on asking him to be more involved with the matters of the family when he arrives home (Myers, 1992). This could be interpreted as nagging and he may long for just someone who will cater to his needs and not make any requests of him (Myers, 1992).

The concerns that plague male physicians marriages may not always be comparable to those experienced by female physicians in their marriages, nonetheless

they are still significant. Myers (1994) notes that female doctors were not common until the 1970's. Even with the introduction of females into medical programs, women were still excluded from many in-depth studies conducted on physicians. As such, many publications focused primarily on the physician and his wife. Common marital problems of female physicians should not be overlooked. Myers (1984) studied the currently literature on married female physicians and discovered that the main challenges they faced involved delayed help seeking, self-blaming coupled with feelings of guilt, ambiguity in self-image, being passive in marital communication, role strain, unmet needs in husbands, bilateral competitiveness, and problems with intimacy and sexuality.

Female physicians reasons for delaying seeking help in their marriages is directly related to the fact that she likely has commitments to her work, her children, the home, her extended family, and her community (which may include her church). All these present barriers that may prevent her from taking care of her marriage as she would like. She may deny that her marriage is unhappy or may figure that once some of her responsibilities lift she can give more of her time and attention to her marriage. In an attempt to maintain the appearance of doing it all, she may avoid seeking help.

More than male physicians, female physicians have severe feelings of guilt. It is the tendency for many women (including women who are medical doctors) to wear a superwoman cape. This suggests that they can successfully handle any and all circumstances. Guilt for the female physician, however, is different in that many of them feel anxiety and display depressive symptoms but they cannot pin point what could trigger either (Myers, 1984). Quite often, female physicians with children are the ones who fair the worst in regard to marital happiness (Myers, 1992). Potee, Gerber, and

Ickovics (1999) conducted a study in on female physicians and found that female physicians without children were more likely to be in surgical specialties, less likely to be in primary care, and more likely to work full-time than were their female colleagues who had children. Is it the female physicians with children that are more likely to experience overwhelming guilt.

In addition to the immense feelings of guilt female physicians feel, many of them also have difficulty feeling secure in their marriages (Myers, 1992). This may stem from the fact that by and large women in medicine were misunderstood and stereotyped (Myers, 1986a). Such women entered a male dominant profession and as such were not viewed as being a typical, traditional woman. Such a woman had to be a 'real man' in order to survive in the medical world. In the event that the female was attractive she was rarely taken seriously or she was thought to be sleeping her way through medical school (Myers, 1986b). Some women in the medical profession, until the 1970's, where subjected to harassment but said and did nothing mostly because they figured that they would have to endure such treatment if they wanted to make it in medicine as a woman. Insecurities regarding self-image pervaded for many women who, though competent, were unable to assert themselves at work as well as at home. This lack of self-confidence and negative self-image affected marital happiness (Myers, 1986b).

The insecurity associated with work has been seen to reoccur in the marriage of some female physicians (Myers, 1986a). Researchers suggest that timidity in marital communication can be another issues that plagues female physicians (Myers, 1986b). Quite often female physicians are able to be forthright and upfront with their patients and colleagues, however, they are more passive with their spouses and fail to articulate their

needs and wants. In her marriage, the female physician may be less able to speak with conviction for a number of reasons outlined by Myers (1994). Most of her inability to convey her feelings in her marriage may be as a result of a general sense of inadequacy in relationships with men, possible depression that alters one's sense of self, an unwarranted need to be a 'good wife and mother', and or a husband who may be unapproachable and controlling.

One researcher notes that one of the biggest reasons that female physicians suffer from lack of assertiveness in their marriages because they, consciously or unconsciously, do not want to make their husbands feels insignificant (Lorber, 1984). Many female physicians are married to men who were raised in traditional homes where mothers didn't work outside of the home but rather did everything domestic. Such husbands may be verbal about the lack of 'femaleness' of their wives creating an uncomfortable situation for her. This may result in the physician wife's need to become a domestic goddess and fulfill all the duties that fit the script of a traditional wife and mother (Myers 1986b). The guilt associated with not being able to do it all may leave her feeling that she needs to concede to her husband (Lorber, 1984) and is fueled by her innate need to take care of others.

Married female physicians face the need to juggle multiple roles such as career woman, mother, and wife, to name a few. This balancing act, which has been termed role strain, can take a toll on the female physician as she make become symptomatic when she is unable to live up to the expectations of each role. This too can cause result in marital unhappiness. If her husband refuses to assist at home (which is not uncommon), she is likely to feel overburdened (Myers 1986b). This is not to negate the fact that the

husbands of such women also have their share of role strain as they also have demands from their occupations and want to be involved in parenting (Myers 1986a). This leaves both partners stressed and the marriage is usually the institution that will suffer (Lorber, 1984). As the multiple responsibilities of their roles mount the marriage continues to erode.

Though there have been studies on married female physicians, their husbands have been an understudied population. This population deserves more attention as Myers (1994) states that the majority of female doctors marry other professionals. This is not to say that marriages in which the female is physician are consumed with stress. Instead, research posits that when the female physician feels supported, respected, and receives aid at home from her husband she tends to report higher levels of marital satisfaction (Parker & Jones, 1981). For husbands of physicians who report lower levels of marital satisfaction are few things were noticed; they didn't feel that their wives considered their profession and contribution to the home as important, they felt that their nurturing the marriage was not a priority for their wives, they didn't feel nurtured, affirmed, and appreciated, and they were starved from companionship and friendship from their wives (Parker & Jones, 1981). Husbands of such female physicians frequently showed resentment for their wives.

Like married male physicians, married female physicians encounter issues regarding sexuality and intimacy. When looking at married male and female physicians, this is the only area that researchers note that both groups consider an issue. The difference is that female physicians, unlike their male counterparts, have a desire for more quality time, better communication, more romance, and more nonsexual affection

(Myers, 1994). Unlike the marriages of male physicians, there seems to be considerable amount of sex in the female physician marriage, however, it quite often feels more like a chore and lacks real intimacy. Despite the difference that male and female physicians experience in regard to sex and intimacy, there it is important to note that this is the only area that both have mentioned as areas that could be improved in their marriages.

The female physician generally gives the appearance of a strong willed, independent, and very capable woman who does not have many emotional needs or at least is able to disguise and handle these without being flustered. Unfortunately, this view of the physician wife can result in marital discord, as her husband may feel that she is emotionless and as such does not have emotional needs that need to be fulfilled (Parker & Jones, 1981). A double bind may then ensue, as the female physician may be perceived as emotionless when she attempts to take control. This is not uncommon if the husband of the physician has obtained less formal education, when his work is less demanding and holds less prestige, when he earns less, or when his job allows him more 'flexible time' (Parker & Jones, 1981). Situations such as those mentioned contribute to marital unhappiness from, especially if the husband hears more negative than positive comments about his marriage. He may feel belittled and emasculated by the observations of family members, friends, acquaintances, and society at large.

In spite of the fact that many female physicians seem a bit aloof and detached emotionally, a final issue that is a factor of marital unhappiness in female physicians is that she often does the 'worry work' of the marriage. Society is of the view that it is the woman's 'responsibility' to monitor and maintain a healthy relationship (Parker & Jones, 1981). When this is imposed on a professional woman who has other obligations to other

entities in her life, and when she does not receive the support that she needs from her partner, tension tends to mount. It is clear that there is a dilemma and a bit of a double standard when one compares the marriages of male with that of female physicians.

Current statistics suggest that American marriages are stressed and many will end in divorce (US Census Bureau, 2005). According to the US Census Bureau (2005) the divorce rate in 2005 (per 1,000 people) was 3.6. The medical marriage encounters its share of stresses as the prestige of the profession coupled with the expectations of society can create additional marital stress. There have been a number of studies that have looked at the medical marriage and there have been differing results regarding the level of satisfaction that partners experience (Uhlenberg & Cooney, 1990; Lewis, 1993; Warde, Moonesinghe, Allen & Gelberg, 1999).

A survey of male and female physicians by Uhlenberg and Cooney (1990) indicated that there are gender differences in marriage patterns among physicians. Although female physicians are considered to be among the most elite women in the American society in terms of education, occupational status, and income (Uhlenberg & Cooney, 1990), they earn less than their male counterparts and work fewer hours. In addition, they tend to have husbands who are equally educated, however, their husbands earn more and work more hours. This is likely to impact the marital relationship.

Lewis (1993) supports the findings of the afore mentioned study as he posits that there is a disconnect between the treatment of male and female physicians. He also mentioned in his study of 744 physicians and 490 of their spouses that physicians who reported higher levels of marital satisfaction also reported lower levels of work stress. The major difference between Lewis's study and the majority of the other studies on

physicians and their marriages is that the results do not support the widely held belief that physician's marriages are more apt to be dysfunctional than those of non-physicians.

There were consistently similar findings regarding marital satisfaction for physicians and their spouses with 86% indicating that they had an enjoyable or a very enjoyable sexual relationship. More physicians than spouses mentioned that they experienced satisfactory physical reactions during sexual intercourse and more spouses indicated that intercourse was always an expression of love. A large percentage (84%) reported that they rarely or never wished that they had not been married, and almost 9 out of 10 physicians and their spouses indicated that they would marry the same person again. Of important note is that the spouses of physicians indicated that for them, marital satisfaction was associated with the physicians work satisfaction.

Areas of Conflict that affect the Medical Marriage

According to Warde, Moonesinghe, Allen and Gelberg (1999) divorce among physicians occurs less than it does for non-physicians. In their study of 656 male and female physicians in Southern California, 82% of the male physician's spouse were responsible for and performed household responsibilities compared to 5% of the spouses of female physicians. In the same study, frustration from the competing demands of career, marriage, and family appeared to be experienced at high to moderate levels when compared to male physicians (87% versus 62%).

There have been reported a number of areas of conflict in the medical marriage. Roles inside the home, job and family status, and priority setting have been cited by Glick and Borus (1984) as the major sources of conflict in the medical marriage. Areas of

priority setting that were identified were work, money, power, sex, and familial responsibilities. According to Glick, Jonathan, and Boris (1984), roles are affected by the amount of time that the physician spends with family versus the time he or she spends engaged in the profession. They suggest that often the male physician is unable to envision the role of a female outside of the household. This smothers the cope of influence that the woman can have, limiting her to have possible influence on issues such as the family and sexual relations.

We see here that marriages in which one spouse is a physician experience conflicts that may not be present in non-physician marriages. Gabbard, Menninger, and Coyne (1987) conducted a study with 134 physicians and 125 spouses. The purpose of the study was to identify the courses of marital conflict and the impact on marital satisfaction. Contrary to conventional wisdom, the number of hours at work did not relate to the degree of marital satisfaction. The chief sources of conflict in the medical marriage appear to revolve around differences in the partners' needs for intimacy, perceptions of the problems in the marital relationship and in each other, and communication styles. Lack of time due to the demands of practice seems to be a complaint that serves the function of externalizing the conflicts in the marriage onto factors outside the marriage. Their study posits that the families of male physicians live in constant competition with his chosen profession. This they suggest can be a cause as well as a result of marital conflict.

In the sample studied, physicians and their spouses reported similar perceptions of the sources of conflict in their marriage. The difference was evident in what either spouse believed was the source of conflict. For the physician, time away from home was

considered to be the major source of conflict while the spouse of the physician considered lack of intimacy to be the major cause of conflict. They suggest that the physician's family is constantly competing with his work for his time. The disproportionate amount of time devoted to work serves a dual function in the marriage. It is seen as both the cause and the result of marital conflict.

The evidence indicates that both physicians and their spouse reported having moderate or high levels of marital satisfaction. A considerable percentage of these couples also reported having some sort of marital counseling. Since marital counseling suggests problems there appears to be a discrepancy. Gabbard, Menninger, and Coyne (1987) proffered that if the marital satisfaction was not associated to the counseling, then it might be that couples assessed their marriage on how well it matched their expectations.

The physicians and their spouses held similar perceptions of the sources of conflict in their marriage. One particular difference in how they perceive conflict is the fact that the physicians viewed time away from home as a greater source of conflict, while the spouse thought lack of intimacy was a greater means of conflict. Garvey and Tuason (1979) found that dissatisfaction in the marriage is not associated with long hours of work. They observe that the male physician's passion (and involvement) for work is akin to having a second marriage. The attachment or commitment to work appears to be consistent with the medicinal ethic, which prioritizes the needs of patients (Grant & Simpson, 1994).

The rigid demands of the medical profession leave no room for concession about integrating family demands. Glick and Borus (1984) mention that usually the physician

does not conceive a role for the wife outside the home. That conception limits the wife's prestige in disparity to what the husband enjoys. The impact of the roles and status gives one spouse leverage that the other spouse does not have. This control over resources within the family is cited by Glick and Boris (1984) as a major source of contention in physician marriages. If the husband is the physician, the wife's influence is limited to the issues of family and less often sexual relations in the marriage. A study conducted by Garvey and Tuason (1979) suggested that dissatisfaction in the medical marriage is not a function of the number of hours that a physician works per week. Instead, their study reports that the passion that the male physician has for his job often serves as a second marriage resulting in the spouse feeling that the profession has become a second marriage, which will ultimately receive more attention.

In summary, the challenges of being a part of a dual career family are evident throughout empirical literature. The prestige of being part of a medical marriage is also fraught with difficulties. Despite this, there is research that indicates that it is possible to have a successful and rewarding professional marriage. A majority of the research articles have employed quantitative methods to investigate medical marriages. This is helpful but fails to bring to life the nuances that allow medical marriages function or not function. There is, therefore, greater need for qualitative studies, such as this one, that provide a more detailed description of lived experiences.

CHAPTER FOUR

METHODOLOGY

Overview of Research Design

Qualitative methods are the best choice for this research because qualitative methods allow the researcher to listen to the views of the research participants, while focusing on the natural setting or context in which participants express their views. Qualitative methods permit the researcher to approach the fieldwork without being constrained by predetermined categories of analysis, and allows the researcher to study the selected issue in depth and detail, which contributes to the depth, openness, and detail of the qualitative inquiry (Patton, 1990).

The research design being proposed will involve qualitative methods and utilize nonprobability snowball and theoretical sampling techniques (Glaser & Strauss, 1967). The sample will be limited to dual career couples in which one partner is a medical doctor. The study will be conducted in a fast-growing Southern California city whose population consists of a large number of physicians. Individuals in this sample not only require an extended period of training with a considerable investment of time and money, but they also require a degree of commitment and dedication which may compete with the demands of other roles. This should be true for both partners, as both husband and wife experience role strain and have to cope with the competing role demands between careers and home life. Limiting the sample to professional couples in which one partner is a physician will also ensure a degree of homogeneity in the sample.

The data gathering process will be aimed at the development of a theoretical model of coping skills employed by physicians and their spouses. In addition, it will be

necessary to gather information that sheds light on the lived experiences of such couples as they navigate, negotiate, and renegotiate their various roles and demands. This will lead to the development of a grounded theory. The most effective method of hearing the voices of research participants is using qualitative methods (Denzin & Lincoln, 2003). Qualitative research design has been shown to be effective in creating data categories, which assist in explaining the research participant's experiences (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Grounded theory will be useful in explaining abstract concepts (Charmaz, 2006; Strauss & Corbin, 1998).

Qualitative analysis typically includes words hence some researchers turn to qualitative methods to uncover the lived experiences of research participants. The major purpose of qualitative research is to develop descriptions and themes from data. This involves many processes including coding data, defining themes, and connecting and interrelating themes (Lincoln & Guba, 2003; Strauss & Corbin, 1998). As such, family research benefits from the use of qualitative research in the sense that the voices of individuals are made audible (Charmaz, 2006). This is not to say that quantitative research is unable to do this, as quantitative methods have been widely accepted due to the reliability and validity of the empirical research processes (Denzin & Lincoln, 2003). The research processes involved in qualitative methods will give depth and breadth to the proposed study of physician couples. Data collected may provide insight that can be used to understand the specific coping methods that have been successful for couples in which one is a physician and the other is a professional. This may also reveal how such couples navigate their relationship and the varying responsibilities that they are faced with.

There is one question that this research study seeks to explore: How do physicians and their professional spouses navigate the varying demands of work and family? The purpose of using constructivist-grounded theory will allow for the development of theory from that data rather than the other way around. This theory is developed inductively and if done well will fit the dataset (Charmaz, 2006).

The constructivist approach to grounded theory, proposed by Charmaz (2000), blends the rigor of grounded theory approaches, which offer clear guidelines that can be used to build explanatory frameworks and move each step of the analytic process forward to the development, refinement, and interrelation of concepts, but assumes the relativism of multiple social realities and the co-creation of knowledge by the researcher and participants. Rich data is drawn from multiple sources such as conversations, formal interviews, public records, organization reports, respondents, and researcher's reflections. Coding begins with the collection of data as does the definition and categorization of data in what Glaser (1992) called the constant comparative method. Grounded theorists are interested in expanding upon an explanation of a phenomenon by identifying the key elements of that phenomenon, and then categorizing the relationships of those elements to the context and process of the experiment (Strauss & Corbin, 1998). In essence, the goal of grounded theory is to go from the general to the specific without losing sight of what makes the subject of a study unique (Strauss & Corbin, 1998). As such, grounded theorists use categories drawn from respondents themselves and tend to focus on making implicit belief systems explicit.

The basic idea of the grounded theory approach is to read (and re-read) a textual database (such as a corpus of field notes) and label concepts, categories or properties and

their interrelationships. The ability to perceive variables and relationships is termed theoretical sensitivity and is affected by a number of things including one's reading of the literature and one's use of techniques designed to enhance sensitivity (Strauss & Corbin, 1998). This study will employ in-depth interviews with couples. In the event that the couple is unable to coordinate their schedules, the key informant, the physician, will be interviewed alone. However, much effort will be put into having the couple interviewed. The research protocol will consist of eight categories that are general and specific, and will be a part of a larger research study on physician families sponsored by the Department of Counseling and Family Sciences at Loma Linda University. From the information collected I will be looking specifically at physicians who are married to other professionals.

Participants

Recruiting participants for this study may be solicited from various medical entities in and around Southern California. Methods for recruiting research participants will be varied. Firstly, flyers will be created and placed on bulleting boards in the lunch or break rooms of hospitals and health care facilities in the Southern California area. The created flyer will include a brief description of the purpose of the study, how the data from the study will be used, contact information for the faculty members who are the principal investigators (PIs) associated with the study, and additional contact information for those who are interested in participating or required additional information.

Another method of collecting a participants will involve the use of snowball sampling. Once a couple that fits the inclusion criteria is identified telephone or e-mail

contact will occur. Regardless of whether a couple agreed to participate or not, they will be asked if they knew any other couples who the researcher might contact. Couple interviews will be preferred as perspectives from both partners will be useful. Interviews will be scheduled throughout the day and evening at offices, homes, conference rooms, and possibly local restaurants and book stores.

A third method of collecting participants will be mailed fliers. This directly relates to the method described above. Fliers will be mailed to individuals on this list generated via snowball sampling procedures. It is necessary to employ snowballing, also known as chain referral sampling, which begins with a small number of potential respondents. The initial respondents identify other potential respondents, who identify other potential respondents, and so on. The premise behind this form of sampling is due to the reality that participants are likely to know or be associated with others who will fit the inclusion criteria or the study due to their social and professional networks (Flick, 2006).

Inclusion Criteria and Screening Procedures

In order to be considered for this study the physician must be currently married for a minimum of 2 years, must be out of residency for a minimum of 1 year, and the physician must be married to someone who are employed outside of the home, either part time or full time. There is no age limit for the physician. Physicians of varying ages, religions, races/ethnicities, and specialties are all eligible. However, the majority of the subjects for this study are likely to be located in the Southern California area.

There is no predetermined number of respondents for this study. Grounded theory

development indicates that theoretical saturation is the deciding factor of when data should no longer be collected (Strauss & Corbin, 1998). The researcher will know when saturation has been reached based on data from the interviews. When new data no longer bring additional insights to the research questions interviews will cease. Despite the fact that the sample size will not be predetermined I will attempt to conduct about 30 interviews with physicians and their spouses. Previous studies have explored this topic using as few as 13 couples (Glick & Borus 1984), while others have used as many as a few thousand collected over twenty-one years (Sotile, & Sotile, 2000). Data saturation is required in order for the data gathering process to cease. Data saturation occurs when no more new information or themes are observed in the data. In order to know when data saturation has been reached, systematic coding will occur during the process of data collection. The purpose of this is two fold: to identify when saturation has been achieved and to ensure that protocol is focused on asking questions that target areas that the researcher is interested in explaining (Flick, 2006).

Screening procedures will be necessary to ensure that potential participants meet the inclusion criteria. Those who respond to posted or mailed fliers will be screened via telephone to ensure their eligibility for the study. There may be instances on the database are contacted directly. In such cases, screening will still be required. During the screening process, the research process and procedures as well as the possible risks involved in being a part of the study will be explained to the physicians. This information will also be provided prior to the in-depth interview.

Interview Procedures

After the physician has given his or her verbal consent to be interviewed, I will schedule a day, time, and location this is convenient for the physician and his or her spouse. Contact information will be shared so and the researcher will contact the physician at least 24 hours before the scheduled interview to remind him or her of location and time. Before the participant arrives for the interview, the researcher will ensure that the environment is safe as this adds to the feeling to security and confidentiality. The priority of the researcher is to make certain that the interview environment is suitable the participant and the researcher.

IRB Approval Informed Consent and Confidentiality

Prior to data collection, I will apply to the institutional review board (IRB), which oversees, approves, monitors, and reviews behavioral research that involved humans. The aim of this committee is to ensure that the rights and welfare of research participants is protected. After receiving approval data collection will begin. Part of the IRB protocol will indicate that research participants provide informed consent by signing a document constructed by the research team. This consent form will contain information regarding the risks and benefits of their participation in the study (Creswell, 1998). In addition, participants will be provided with information that directly relates to counseling in the event that their participation in the study resulted in emotional distress. The entities where they may choose to go may or may not be affiliated with Loma Linda University.

Participants will also be informed and asked to consent to being taped during the interview. Both questions will then be audio recorded for quality assurance purposes. It

will be necessary to make participants aware that their participation is voluntary and as such they are free to stop the interview if they are uncomfortable (Creswell, 1998). No coercive methods will be used to trick participants into consenting. Participants will be informed that audio recordings and notes taken during the interview process will be kept safely and all identifying information will be destroyed.

Babbie (2007), Flick (2006), Berg (2000), and Strauss and Corbin (1998) stress the importance of maintaining confidentiality in research. As such, the researcher will ensure that the premises and limitations of confidentiality will be explained. It may be necessary to remind participants that confidentiality will be maintained during not only during the interview process along with the data management process (Flick, 2006). The identity of the participant will be protected throughout the process beginning with the recruitment process and continuing through to the publication of the research data (Flick, 2006).

In an attempt to make certain that there are no concerns about what the data will be used for and how the interview process will progress the researcher will inform participants about the details of the research study and what the process will involve. The researcher will inform the participants that the information gained from the research data may be kept in strictest confidence (Berg, 2000).

I will maintain confidence and anonymity by assigning codes to each audio and transcribed interview. These codes will use only letters and numbers that will identify the number of the interview, the first and last initials of the interviewer, and a 'P' if the physician was interviewed alone or an 'PS' if the physician and his or her spouse were interviewed together. This system will allow for easy retrieval of transcripts.

Interview Questions

The protocol for this study was developed by a research group and includes a demographic questionnaire along with detailed questions about how the couple met, the importance and stresses of work for each partner, childcare issues, and how the couple makes time for each other despite their busy schedules. The demographic form will contain questions regarding gender, age, nationality, country of origin, religious affiliation, medical specialty, number of years married, number of children, number of hours spent on child care each week, number of hours spent on housework each week, and time spent with their spouse as a way of getting a better view of the sample.

As indicated, a grounded theory approach was the one chosen to uncover the lived experiences of the participants. The format of the interview was such that the participants were able to say as much as they chose about any given area. Flick (2006) suggests that using a semi-structured yet in-depth interview is helpful will better assist in exploring the world of research participants. This format gives participants the opportunity to be share information because of the use of carefully thought through, open-ended questions (Charmaz, 2006).

Data Storage

Interviews will be audio recorded and then downloaded to a computer that is password protected and saved based on preciously decided on codes. These audio files will then be erased from the recorder and also transferred onto CD's for storage and transcription purposes. In order to ensure that files are backed up properly, audio files will also be save on an external hard drive and kept safe in a filing cabinet that only the

research team has access to. Completed informed consent and demographic forms will be stored in a filing cabinet as well. Predetermined codes will be used to identify each consent form and demographic form.

All audio recordings will be given to a transcriber on a data CD. The transcriber in turn will return the completed transcribed interview on a data flash drive. All interviews that are sent out for transcribing will be either mailed certified or hand delivered. They will be returned the same way. These transcribed interviews will be kept as hard and electronic copies that will be archived in a locked file cabinet. Any information that could potentially identify the participants will be eliminated in the transcripts.

Analysis and Coding Procedures

To analyze data the researcher will utilize Constructivist Grounded-Theory line-by-line coding procedures proposed by Charmaz (1995; 2000) as well as open coding, axial coding, and selective coding procedures that were proposed by Strauss and Corbin (1998) for developing grounded theory. Charmaz (2006), Glaser and Strauss (1967), and Strauss and Corbin (1998) all outline the processes involved in analyzing qualitative data. They note that there is software that can aid in the coding processes as one develops grounded theory. This researcher, however, did not use any software in data analysis. Grounded theory tends to employ three methods of coding: open coding, axial coding and selective coding.

The first procedure for analyzing data gathered will be open coding. The aim of open coding is to discover, name, and categorize phenomena according to general or

specific characteristics or attributes of a category and to construct the range along which general properties of a category or construct vary, as well as to define the dimensions of the category or construct. During open coding, data will be broken down line-by-line, closely examined and compared for similarities and differences. Sensitizing concepts, which are the background ideas that offer ways of seeing, organizing and understanding experiences will be utilized and action codes will be developed (Charmaz, 2000). Open coding is based on the concept of data being ‘cracked open’ as a means of identifying relevant categories. In developing grounded theory the first stage of coding is open coding. During this stage, the interviewer will begin by reading each interview and asking broad questions about each section of the interview (Charmaz, 2006). These questions will then lead to code word or phrases being assigned to describe the meaning of a segment of text.

Axial coding will follow open coding. This process is used when categories are in an advanced stage of development. During axial coding, categories or constructs will be related to subcategories of constructs for forming more precise and complete explanations of the phenomena of the research participants’ perceptions of work/family balance and how they create time for each other as a couple. Subcategories that emerge will be utilized to answer questions about the phenomenon of work/family balance. Additional questions that emerge will be developed and used in an effort to expand the power of explanation and thick-description. Finally, categories or constructs will be organized through relational statements, all the while searching for cues in the data that denote how major and sub categories or constructs relate to each other.

The last procedure of data analysis is selective coding, which is the process of integrating and refining categories. During selective coding, categories will be organized around central explanatory concepts that represent the main themes that emerge during the research. To integrate the coding process the researcher will utilize techniques such as writing and relating the participant's stories to central facets or elements, using diagrams, and reviewing field-journal notes and the reflexive journal written by the researcher, throughout the data gathering and analysis process. Once the key concepts are delineated, the researcher will refine the analysis, filling in poorly developed categories and integrating and combining categories to diverge from, validate, or extend the conceptual framework by comparing it to raw data collected during the research and also by presenting the individual summaries to participants for their reactions and input in the process of member-checking. The aim at this stage of analysis is to have a few themes that clearly capture the categories that have been identified. The themes with similar codes will be aggregated together to form a major idea in the database. Following this, the most frequently occurring themes will be the ones chosen to create a model.

Glaser and Stauss (1967) note the importance of constant comparative analysis in qualitative research. Constant comparative analysis is a process whereby the data gradually evolve into a core of emerging theory. In order for this to happen, the researcher must be continuously revising the questions to ensure that the content that he or she wants to address is being discussed. It is this core theory that will then guide the collection of data. As time progresses, major modifications to the interview questions will become less and less.

Flick (2006) suggests that in qualitative research it is best to providing detailed information about a few themes rather than general information about many themes. The names of these themes or categories can come from the researcher, the words of the participants or the literature. What is most common is the researcher developing terms, concepts, and categories that reflect what he or she sees in the data. The themes should reflect the purpose of the research, be exhaustive, be sensitive to what is in the data, and be conceptually congruent in that the same level of abstraction should characterize all categories at the same level (Flick, 2006) and result in a concept map.

Validating the Accuracy of Findings – Trustworthiness

At the end, the qualitative researcher validates the finding by determining the accuracy or credibility of the findings. This will not be determined in the same way that it is in quantitative research. The methods that are employed in assuring that a qualitative study has internal and external validity include prolonged engagement and persistent observation in the field, triangulation, peer review, clarifying researcher bias, member checking, rich, thick description and employing an external audit (Lincoln & Guba, 2003).

To ensure credibility of findings, and to minimize possible distortions that may result from my presence, I will sustain engagement with the research participants to the point of data saturation, all the while using the grounded-theory process of recursive examination of research data, and recording my observations in field notes. Lincoln and Guba (1985) utilized the term “prolonged engagement” (p. 301) to address this aspect of rigor. To address possible distortions that could arise from my involvement with the

research participants, I will utilize peer debriefing with a team of disinterested peers, my peer-debriefing team, and a reflexive journal where I will record thoughts, decisions, questions and insights related to the research. During this research, the peer-debriefing team will review data generation techniques, procedures, and data analysis, which includes confirming or disconfirming emergent themes, and provided editing suggestions for the final research report. To address distortions that could arise from employment of data-gathering techniques I will carefully record data, and continually scrutinized the data for internal and external consistency utilizing “structural corroboration” (Eisner, 1979, p. 215) and the technique of “triangulation” (Guba & Lincoln, 1985, p. 283) to address issues of trustworthiness in this research.

The two major methods that will be used in the proposed study are triangulation, and rich, thick description. Triangulation strengthens a study by combining methods (Patton, 2002). Triangulation can take several forms using multiple researchers in an investigation. This method of triangulation is the one that will be applied to the current study. It is necessary to give a rich, thick description of the data as this allows readers to determine if the situation described in the qualitative study applies to the reader’s situation. Lincoln and Guba later (1985) explained that structural corroboration or triangulation of data sources is a matter of crucial importance in qualitative studies. They stressed that the researcher needs to take steps to validate each new piece of information in a research study, against at least one other source. In this research, I will utilize structural collaboration by validating information in one interview with information in subsequent interviews.

Two other areas that are necessary in evaluating the trustworthiness of a study are

by looking at the credibility and transferability of the study. Credibility involves establishing that the results of the research are believable from the perspective of the participant in the research. Since from this perspective, the purpose of qualitative research is to describe or understand the phenomena of interest from the participant's eyes, the participants are the only ones who can legitimately judge the credibility of the results (Patton, 2002). Transferability refers to the degree to which the results of the study can be generalized or transferred to other contexts or settings. From a qualitative perspective transferability is primarily the responsibility of the one doing the generalizing (Patton 2002). Transferability can be obtained by doing a thorough job of describing the research context and the assumptions that were central to the research. The person who wishes to 'transfer' the results to a different context is then responsible for making the judgment of how sensible the transfer is.

Issues of Reliability or Dependability and Confirmability

From a quantitative perspective, reliability refers to the extent to which research findings can be replicated. Dependability in the current research study is not based on outsiders getting the same results, but that outsiders concur that, given the data collected, the results make sense. In other words, the results are dependable and consistent (Lincoln & Guba, 1985). The idea of dependability emphasizes the need for the researcher to account for the ever-changing context within which research occurs (Patton, 2002). The research is responsible for describing the changes that occur in the setting and how these changes affected the way the research approached the study.

Confirmability refers to the degree to which the results could be confirmed or

corroborated by others. There are a number of strategies for enhancing confirmability (Patton, 2002). The researcher can document the procedures for checking and rechecking the data throughout the study. Another researcher can take a 'devil's advocate' role with respect to the results, and this process can be documented. In this instance, the researcher can actively search for and describe instances that contradict prior observations.

For this proposed research, the researcher will check and recheck the data throughout the study and may play devil's advocate. The protocol employs open-ended questions that allow the interviewee to set the direction of the interview. The researcher then follows the leads that the participant provides. This researcher plans to return to the interview questions after the leads have been followed. In addition, and as stated before, there was be a constant evaluation of the questions in the protocol so that the questionnaire is asking the necessary questions and will be aware of when data saturation occurs. Data saturation occurs when the researcher is no longer hearing or seeing new information (Patton, 2002).

Presentation of Findings and Conclusion

In presenting the results of this study, the researcher will give a rich description of the situation, ensuring to locate herself in the narrative. She will report patterns found and use quotes and examples to illustrate points. Finally she will attempt to create a connection between existing accounts of other cultural groups and or other theories if applicable and provide a concept map.

Dual career couples live and work in a very complex world. I am proposing a qualitative research study that will delve more deeply into the stressors and coping

methods that have developed by couples in which one partner is a physician and the other works outside the home. This proposed study will focus on how such couples find meaning in their marriages that assist them in living professionally and personally fulfilled lives. Using a variety of IRB approved methods, I propose to seek out couples in which one partner is a physician and the other works outside of the home. An in-depth interview will be used to gather information from the dyad. If the couple is unable to meet, I will interview the physician, who will be referred to as the key informant. In such a study, the input of the spouse will be helpful in determining family dynamics and as such, every effort will be made to ensure that both partners can be interviewed together. The data gathered from this study may contribute to the current body of knowledge by showing how dual career couples create time for each other, how they view work-family roles, and their impression of their marital satisfaction, considering the number of roles each partner has. Based on the research, this author feels that there is a need for further research to include samples of men who were married to physicians.

The increasing participation of women in the paid labor force continues to bring about many changes in the modern American family, which tend to emphasize role strain in the family. This study helps to fill a void in the dual career couple literature, as it will look specifically at how the selected sample is able to navigate and negotiate work/family issues while nurturing and maintaining their relationship. Previous studies have for the most part identified ways that individuals in dual career couples use to cope with their own role strain. This study will collect and analyze couple data in order to discover and describe dual career couple styles of coping with role strain. The study will therefore

strive to show how couples work together to cope with the competing demands of home life and careers.

This study will attempt to provide useful information for dual career couples, for those who counsel dual career couples, and those interested in creating policies that will affect dual career couples. The couples in this study will likely share the strategies they have employed for balancing home and work, which have made them successful at living the dual career lifestyle. These strategies will be reported as they may be useful to others in similar marriage situations. It is hoped that this study will assist therapists, clergy, and others who counsel dual career couples in helping prospective dual career couples understand the role strain issues present in the lifestyle which they are contemplating.

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CHAPTER FIVE

HOW DUAL CAREER COUPLES NAVIGATE THEIR MULTIPLE ROLES

Abstract

There are significant challenges associated with navigating multiple roles for dual career couples. The time demands of a dual career marriage can be challenging for even the most dedicated individuals as they attempt to navigate the many roles in their families and their careers. This present qualitative study explores the experiences of a sample of medical doctors who are married to non-physician professionals. From these in-depth interviews of 15 couples, three major themes emerged: familial support, non-traditional parenting and domestic roles, and paid help. These themes were further mediated by the couples' ability to put one person's career first. This study offers important implications for theory, research, and practice with dual career couples.

Introduction

Family life is often complicated by the multiple roles and responsibilities that are associated with family interactions and dynamics. One area that has received increasing attention is that of navigating the demands of multiple roles of family life within the context of paid work (Carter, 1995). Careers are often characterized by high levels of commitment and investment of time and energy. In the past, the symbiotic relationship of men and women in the management of paid work and family work was more easily determined along gender lines (Carter, 1995). Today, however, there have been numerous changes associated with these roles and expectations. These issues are likely to be especially true for those who are involved in high-status careers. The past several decades

have witnessed dramatic changes in roles and relationships and the way we integrate career and family issues to obtain a satisfying and economically prosperous life (Carter, 1995). Before the 1950's, the typical family structure consisted of a full-time working father, who was the sole wage earner, and a stay-at-home mother. Since then, some evidence suggests that less than 3% of the population fits that description (Carter, 1995).

This present study seeks to explore how dual career couples navigate the multiple role demands associated with home and work life. This is especially salient in professional contexts, such as physician families, where the demands of home and work are clearly identified. Largely because physicians have notably demanding schedules and responsibilities, relationships with partners that are engaged in careers present a crucible of challenging issues require empirical investigation. For example, while physician life has been studied to some extent, it must be noted that the empirical studies over the last few decades have been relatively sparse (Linzer, Konrad, Douglas et al., 2000; Pathman, Konrad, Williams, Scheckler, Linzer, & Douglas, 2002). Further, scholarly investigation of physicians married to other professionals is relatively absent in the present literature, and is therefore an important and necessary quest. This study seeks to fill the gap in the literature on dual career couples in which one is a physician. The present study uses in-depth interviews to examine how the various aspects of paid work and family responsibilities are managed.

Conceptual Framework

This present paper uses structural functionalism as the guiding framework. Structural functionalism focuses on how society functions and how the family as a social

unit is able to function in the context of that society (White & Klein, 2002). In this current research there is an interest in the way couples interact to sustain their existence and how they are able to meet the needs of self, other, and the family as they navigate their roles and relationships. I would argue that the world of the dual career couple imbibes challenging roles and demands that come from both spheres; career and family. In order to manage these roles, it appears that the couple must adapt significantly to role structures that may be in conflict with society's norms and values that prescribe their interaction. The study seems to be undergirded by the basic assumptions of structural functionalism.

Review of Literature

The term dual career family was coined by Rapoport and Rapoport (1971) and has been used to describe a family in which both partners are engaged in work outside of the home and which involves personal commitment. It is necessary to make a distinction between a dual career family in which both partners pursue occupational careers, and dual-earner families, where both partners are formally employed but only one, usually the male, pursues a career. Based on research, dual-earner families were the norm, however, there has been an increase in dual career families (Bureau of Labor Statistics, 1993).

Between 1950 and 1980, the number of married women who were members of the labor force more than doubled from 21.6% to 50.2% (Bureau of Labor Statistics, 1993). In 1996, dual career couples comprised 60% of all marriages (US Census Bureau, 2009). There are benefits to this lifestyle as a significant portion of the United States labor force

reports economic independence and security with a family's second income (Bureau of Labor Statistics, 1993).

Women from lower socioeconomic status groups have been in the labor force for an extended period of time, however, with the increase in middle and upper-class women entering the paid labor force, researchers have begun to address challenges for dual career couples (Haddock, Zimmerman, Ziemba, & Current, 2001). One of the most important concerns of dual career couples is navigating multiple role demands and gender has an impact on how this occurs.

Research on the gendered division of household labor suggests that despite the increase of women in the paid labor force, women do substantially more housework than men. This is especially true for married men and women (Coltrane, 2000), largely due to the implicit element of the marriage contract, which states that women take primary responsibility for domestic work (Kluwer & Mikula, 2002). Cancian and Oliker (2000) found that married women's movement into paid employment has not been accompanied by an equivalent increase in the amount of housework done by husbands. In spite of the fact that fathers are becoming more involved in childcare, there is a discrepancy between the number of hours of involvement in childcare between working mothers and working fathers. Such findings were reported also by Bond, Thompson, Galinsky, and Prottas, (2003), of the Families and Work Institute. Thus, regardless of the occupation of the wife, her career is often viewed as secondary to his.

Not only do women do significantly more housework, but they also engage in different types of household tasks and chores that take place inside the home (Blair & Lichter, 1991). Such tasks are routine, absorbing, and closely associated with childcare

(Blair & Lichter, 1991). Traditional male tasks tend to have a well-defined beginning and end, are more likely to take place outside the home, which offers discretion regarding when the task is performed, and may even be experienced as leisure (Blair & Lichter, 1991).

Although most partners in dual career marriages agree on a highly egalitarian division of household chores and child-care activities, there seems to be a shift towards a more traditional division after the transition to parenthood within such unions (DeStefano & Colastano, 1990). The shift towards a more traditional division of family and provider responsibilities is evidenced by fathers increased effort for professional work after transition to parenthood, while mothers typically decrease their effort (Jacobs, DeMaeyer & Beck, 1999).

Gender remains the most important predictor of time spent on housework (Cunningham, 2001). Researchers have then been forced to investigate the ‘doing gender’ perspective. This framework argues that domestic labor is a symbolic enactment of gender relations, rather than a rational choice due to time availability, or the conversion of external resources into the exercise of power in the home (Coltrane, 2000). At the core of a dual career marriage is an attempt to redefine the relationship between work life and family life (Rapoport & Rapoport, 1971). In traditional marriages, the husband was the primary breadwinner while the wife’s chief responsibility was caring for the family (Hochschild & Machung, 1989). In dual career families, husband and wife must combine both work and family. This can be even more challenging if children are involved. Silberstine (1992) in her book *Dual career Marriage: A System in Transition*, notes that dual career couples are forced to sacrifice time with each other and with their children to

pursue their careers. Within dual career marriages, partners must negotiate a redefinition of traditional gender roles in an attempt to cope with the stress of joint careers and family obligations (Rosen, Jerdee, & Prestwich, 1975).

As formerly noted, it is not uncommon in present day dual career marriages for the wife to be the one responsible for domestic tasks. Small and Riley's (1990) research on the influence of work on the family, also termed work-family conflict, postulates that responsibilities from separate domains compete for limited amounts of time, physical energy, and psychological resources. This results in role strain and had negative consequences in both the workplace and the family (Frone, Russell, & Cooper, 1992).

Although significant research studies view the workplace as the primary source of strain (Crouter, 1984), evidence from varying research samples indicates consistently that work-to-family conflict and family-to-work conflict are distinct aspects of the work-family interface and are at best only moderately correlated (Frone, Russell, & Cooper, 1992). Therefore, work-family spillover appears to be, at a minimum, bi-dimensional.

In addition to work-family spillover, researchers have found that social roles and gender roles have an impact on the how dual career couples navigate the multiple demands placed on them. Research studies have employed social role theory as one conceptual basis from which dual career couples' work and from which family role strain has been investigated (Perrone & Worthington, 2001). Social role theory explains that individuals meet personal and relational needs by participating in different roles with varying role partners (Fein, 1990, 1992). Researchers have examined the salience of the worker and family roles and the competing time demands they pose on each other for dual career couples (Cinamon & Rich, 2002; Bonebright, Clay, & Ankenmann, 2000).

Role strain becomes apparent when there are too many competing demands on an individual based on available resources and time (Silverstein, Auerbach, & Levant, 2002; Perrone & Worthington, 2001). In addition to role strain theory, gender can impact how dual career couples negotiate their lifestyle.

Gender role strain develops when individuals internalize stereotyped societal norms around gender ideals that are often contradictory, inconsistent, and often unattainable (Pleck, 1995). This tension between gendered stereotypes and the reality of the dual career couple creates conflict (Silverstein, Auerbach, & Levant, 2002). There is a positive side to the current phenomenon, and that is the concept of shared roles and responsibilities. Individuals in dual career couples that share responsibilities and negotiate roles are able to experience the benefits of being in a dual career couple (Haddock et al., 2001; Perrone & Worthington, 2001). Haddock, Zimmerman, Ziemba, & Current (2001) reported that couples who experience more egalitarian roles and de-gendered role responsibilities are likely to stay married and maintain higher marital satisfaction. Individuals in dual career marriages who are able to experience de-gendered roles experience less role strain and experience higher overall wellbeing (Haddock, Zimmerman, Ziemba, & Current, 2001). We see then that there are many factors that are likely to have an impact on the marriages of persons who are in dual career marriages.

According to Marks and MacDermid (1996) many studies on multiple roles have lost sight of the theoretical underpinnings of role theory, which hold that one must examine a total role system rather than treat individual roles as distinct entities separable from the whole. Role theorists suggest that role systems are inherently hierarchical, hence

the problem of juggling roles requires favoring one role over another (Marks & MacDermid, 1996).

The Dilemma of the Medical Marriage

Recent statistics suggest that American marriages are stressed and many will end in divorce (US Census Bureau, 2009). According to the US Census Bureau (2009) the divorce rate in 2005 (per 1,000 people) was 3.6. Medical marriages encounter their share of stresses as the prestige of the profession coupled with the expectations of society can create additional marital stress. There have been a number of studies that have looked at medical marriages and reported varying level of relationship satisfaction that partner's experience (Uhlenberg & Cooney, 1990; Lewis, 1993; Warde, Moonesinghe, Allen & Gelberg, 1999).

A survey of male and female physicians by Uhlenberg and Cooney (1990) indicated gender differences in marriage patterns among physicians. Although female physicians are considered to be among the most elite women in the American society in terms of education, occupational status, and income (Uhlenberg & Cooney, 1990), they earn less than their male counterparts and work fewer hours. In addition, they tend to have husbands who are equally educated, however, their husbands earn more and work more hours. This is likely to impact the marital relationship.

Lewis (1993) supports the findings of the aforementioned study by Uhlenberg and Cooney (1990). Also, Lewis (1993) mentioned that there is a disconnect between the treatment of male and female physicians. In his study of 744 physicians and 490 of their spouses, physicians who reported higher levels of marital satisfaction also reported lower

levels of work stress. The major difference between Lewis's study and the majority of the other studies on physicians and their marriages is that the results do not support the widely held belief that physician's marriages are more apt to be dysfunctional than those of non-physicians.

Consistently there were similar findings regarding marital satisfaction for physicians and their spouses with 86% indicating that they had an enjoyable or a very enjoyable sexual relationship (Lewis, 1993). More physicians than spouses mentioned that they experienced satisfactory physical reactions during sexual intercourse and more spouses indicated that intercourse was always an expression of love. A large percentage (84%) reported that they rarely or never wished that they had not been married, and almost 9 out of 10 physicians and their spouses indicated that they would marry the same person again. Of important note is that the spouses of physicians indicated that for them, marital satisfaction was associated with the physicians work satisfaction.

According to Warde, Moonesinghe, Allen, and Gelberg (1999), divorce among physicians occurs less than it does for non-physicians. In their study of 656 male and female physicians in Southern California, 82% of the male physician's spouse were responsible for and performed household responsibilities compared to 5% of the spouses of female physicians. In the same study, frustration from the competing demands of career, marriage, and family appeared to be experienced more high to moderate levels than male physicians (87% versus 62%).

Glick, Jonathan, and Boris (1984), reported that issues of roles, status, and priority setting were the major sources of conflict in the medical marriage. Areas of priority setting that were identified were work, money, power, sex, and familial

responsibilities. According to Glick, Jonathan, and Boris (1984), roles are affected by the amount of time that the physician spends with family versus the time he or she spends engaged in the profession. They suggest that often the male physician is unable to envision the role of a female outside of the household. This smothers the cope of influence that the woman can have, limiting her to have possible influence on issues such as the family and sexual relations.

We see here that marriages in which one spouse is a physician experience conflicts that may not be present in non-physician marriages. Gabbard, Menninger, and Coyne (1987) conducted a study with 134 physicians and 125 spouses. The purpose of the study was to identify the courses of marital conflict and the impact on marital satisfaction. Time constraints, conflicts in the preferred modes of communication, and differences in need for intimacy were identified as the primary sources of conflict in the medical marriage. Their study posits that the families of male physicians live in constant competition with his chosen profession. This they suggest can be a cause as well as a result of marital conflict. In the sample studied, physicians and their spouses reported similar perceptions of the sources of conflict in their marriage. The difference was evident in what either spouse believed was the source of conflict. For the physician, time away from home was considered to be the major source of conflict while the spouse of the physician considered lack of intimacy to be the major cause of conflict.

A study conducted by Garvey and Tuason (1979) suggested that dissatisfaction in the medical marriage is not a function of the number of hours that a physician works per week. Instead, their study reports that the passion that the male physician has for his job

often serves as a second marriage resulting in the spouse feeling that the profession has become a second marriage, which will ultimately receive more attention.

There is a burgeoning literature on dual-physician families, and while these may be a significant exhibit of the nature and functioning of professional families, for many reasons they may not represent life typical of the physician married to another professional. For example, a physician married to a physician is likely to bring a number of common stocks to the table, and therefore is likely to induce a greater semblance of egalitarianism. However, this may not be the case with many of the other professionals with whom they are united in intimate relationships.

Empirical literature on doctors and their marriages has mainly focused on male physicians (Linzer, Konrad, Douglas et al., 2000; Pathman, Konrad, Williams, Scheckler, Linzer, & Douglas, 2002) or has made an attempt to compare the work of male physicians with the work of their female counterparts (Bobula, 1980; Powers, Parmelle, & Wiesenfelder, 1969). Due to the historical role of men as the ‘good provider’, professions and certainly that of the physician has been preserved primarily for men. Today, however, we see a significant change in this reality (Lanska, Lanska, & Rimm, 1984). Interestingly, though we see increase in the number of women entering medical school and practicing medicine, it is an interesting fact that many of these women negate the practice of medicine, and this could be a function of family demands.

Many of the studies involving female physicians have focused on issues related to parenting (Cohen, Woodward, & Ferrier, 1988) and job stress (Mitchell, 1984). However, they have not done a thorough job of investigating women as physician’s without incorporating the fact that she is often a wife and a mother. In this sense, female

physicians are portrayed as living in at least two worlds, while their male counter parts reside only in the job sphere.

Many of the studies on medical doctors have employed quantitative methodology (Uhlenberg & Cooney, 1990; Warde, Moonesinghe, Allen, & Gelberg, 1999). In many cases, studies had apparently significant sample sizes, which must be commended. In consideration of research methodology, quantitative research has an important place but does not always respond to rich descriptions of the experiences of people in the context of their life. This reality calls for the use of other methodologies that might provide such descriptions. This present study uses a qualitative grounded theory approach to derive descriptions on how dual career couples in this sample are able to manage their multiple roles.

In a through survey of the literature on physician life, a number of important articles were found. While many of them have been published in professional journals there is a preponderance of articles that are more anecdotal in nature. While these articles may provide a substantive basis for theorizing and information making, there is an abject need for testable ideas and theories generated under the rigors of science. Evidently, there is much room for empirical data that shed light on physician life in its varied dimensions.

Methodology

Overview of Research Design

Qualitative inquiry is aimed at exploring issues, understanding phenomena, and gaining a picture of the lived experiences of research participants. As such, qualitative research has special value for investigating complex and sensitive issues. Qualitative

studies overcome some of the limits of quantitative work because they can explicate deeper meaning and complexity associated with questions such as how dual career couples navigate their lifestyle, how such couples view themselves as part of a dual career marriage, and how they manage their varying responsibilities. The present study utilized a detailed protocol that was administered to participants at a time and venue convenient for them. Audio files were then transcribed and coded.

Sample and Data Collection

This study employed recruitment methods including print advertisements in hospitals, clinics, and private practice offices in an around the Southern California area, word of mouth, and snowball sampling. Snowball referrals from participants appeared to provide the largest number of participants. Since couples were the unit of analysis, it was necessary to interview couples together. The in-depth interviews that were conducted lasted between one hour and an hour and a half. Faculty members and graduate students that were members of a research team conducted interviews. Interviews were audio taped using digital audio recorders. These audio files were processed for transcription and were given to transcribers who then completed transcriptions and returned the document in soft and hard copy. The interview began by asking the couple to give the story of how they met and what inspired them to choose their particular career. The couple was then asked questions about how their chosen careers impact their marital life and how they are able to cope with their lifestyle. If the couples had children, they were asked how childcare was managed.

To enhance rigor during the early stages of the interview process, the research

group met for debriefing and critiquing of the protocol as well as the process of analysis. The analysis process also used many checks and balances to enhance the rigor and credibility of findings, including the use of multiple coders, audit trails, member checks, and critical case analyses (Strauss & Corbin, 1998).

Analysis

The study employed a multisystemic interpretive approach (Strauss & Corbin, 1998), beginning with inductive open coding of the first few interviews in a research team. This approach involved multiple reads of the transcripts, coding without the use of a start list of codes (Strauss & Corbin, 1998). A final coding scheme was developed using a reflexive process similar to constant comparison (Strauss & Corbin, 1998). This process included scrutinizing codes by searching for exceptions and disconfirming evidence and conducting member checks by the continuation of interviews even when it appeared that saturation had been reached. Codes were refined, changed, combined, or omitted accordingly. These multiple stages generated a final list of codes that the researcher considers to be descriptive as well as conceptual. This was done while constantly keeping the participant's words in context.

Using this analytic approach, questions were asked that would lead to the exposing of broader contextual or socio-historical factors (Sullivan, 2002). For example, the question of how narratives of work-family stress, living in dual career marriage, and creating time for the couple were uniquely present in the participant's lives and experience was discussed. Questions also sought to explore how the identification as professionals helped or hindered their marriage. These were necessary to explore, as the

study's overall aim was to identify how physicians and their professional spouses navigate the varying demands of work and family.

About the Participants

Participants in this study were predominantly of African American descent (n = 9) and consisted mostly of primary care physicians and obstetrician gynecologists (n = 10). Most of them (n = 11) still had children residing in the home. It is important to emphasize that participants conveyed both advantages and disadvantages to being in a dual career couple. They frequently used words such as *not enough time* or *managing time* to describe one disadvantage of being part of such a dyad. On the other hand, words such as *teamwork* were used to express the way that some couples functioned.

The couples in this study have been married for an average of seven and a half years, and suggest that their marriages are satisfying. The professions of spouses ranged from allied health, to nursing, to business, to information technology. Both partners were employed outside the home and each was engaged in their careers for an average of forty hours a week.

Findings

Sometimes the hours are long, sometimes he brings stuff home and I want him to go out and play with me and the kids. And I say, you know, I'm (generally) always with the kids, which I love, but we can't make memories together, I don't like having to tell (husband) that we did this and the kids had so much fun. I want you (husband) to be there so when we are in our old age we can recall. So again it's him constantly seeking balance and asking, 'Am I giving enough time for this?' And he has accountability to the people at work because they are calling him in; numbers are up, numbers are down. And he's coming home and I'm saying the kids really need to spend some time with you. Sometimes I see that when he comes home the children are so ecstatic and my husband wants to get

undressed and relax, and the kids are saying ‘dad come throw the ball with me, let’s go the park’...despite his tiredness, I always say he has to push past tired and play with the kids and do for them what I can’t.

These sentiments shared by a nurse married to a Preventive Medical Specialist are echoed in many of the interviews. The couples are all pressed for time due to their dual career obligations and the responsibilities involved in being parents. While there are obvious benefits to being a professional couple, there are challenges in regard to navigating both careers.

Data from the interviews reflect the lived experiences of physicians and their non-physician professional spouses and was aimed at exploring how couples in this sample navigate two careers. Structural functionalism was used as a lens through which to view the stories that these couples told. A model demonstrating how these couples are able to function in a dual career marriage was developed and this resulted in the formation of grounded theory.

The theme that emerged from the data as creating the foundation for how dual career couples navigate their multiple roles, was *putting one career first* (see Figure 1). The dynamics of having two professions in a marriage, coupled with the responsibility of parenting, can be taxing for the most organized and determined persons. Since both partners had careers, it became necessary for the couple to put their effort into supporting one career over the other.

Putting one Career First

When couples valued the other person’s career and what he or she was doing professionally, it became apparent that they were better able to navigate living in a

marriage that had two professionals. This could be because they viewed their spouse as one who was a life partner but also as someone who was making a positive contribution to society. Value was shown for the spouse as a person and as a professional. In order to make this work, couples learned to put one career first. The career that was chosen, by default, was that of the medical doctor. In the interviews, nowhere did any of the couples mention that this was something they set out to do. Based on the demands of the medical profession it was almost automatic what career would take priority.

It seems intuitive that the wives of male physicians would be the ones to show support for their husbands demanding career. While this is true, findings show that the husbands of female physicians are no different. The conscious or unconscious decision of placing one career over the other was fundamental in being able to be successful professional, parent, and partner. The couples spoke of this occurrence as a matter of career *support* and less as it being a matter of whose career was more *valued*. None of the couples mentioned that they actually sat down and spoke about whose career would be ‘put first’. Rather, this evolved based on the demands of both career. A father of two, with one on the way, who holds an MBA and is married to a pediatrician, put it this way:

I support my wife in her career is listening to her and allowing her to watch the TV program “House” so she can continue her education by guessing what the diagnosis is. But you know mainly listening to her and I have an interest in what she does.

To this, the wife responded:

I think we work well together as a team. Almost as if we had a dress rehearsal beforehand. Because we really work well together with each other and with the kids. There was never a problem with this is my role, this is your role. We just

stepped in and filled in when we thought there was a need. Nobody actually had to say anything. I think we communicate very well, have from the beginning. And that hasn't changed even though the amount of time that you get to communicate is a lot less because of kids...And I think we have grown to appreciate things about each other that we did not earlier on. My husband is a great support. He does not stress me out. He helps me out as much as any man can help put somebody. In the house and with the kids which is a big deal; because you get done with one stressful situation and come home to another stressful situation. As much as I love my kids it's stressful raising children. So when he is here he says I will take them to the park to let you relax. That's a big deal. If he plays hide and seek with them and I get a chance to sit down. It's helps a lot in giving me a chance to sit down. That's big for me in having a moment to get my adrenaline down so I can be a mom. So he helps me out a lot.

A female gastroenterology married to a software specialist noted support in a slightly different way:

He has always been supportive. His work hours are more definite than mine. And in the part of my career when I'm always training, I don't get to decide what my hours are, they were set by the department. He has a more definite schedule so he has been taking on the brunt of the work when it comes to taking care of the kid. Like picking her up. Taking a small course with her. He does a lot of it. If I don't have anything to do I take them no questions asked. That's because I know he does a lot of it.

A female emergency physician who has two children and is married to an accountant shared a similar sentiment:

He has a calendar and everything is mapped out. I (also) have a calendar, and actually his calendar is different than mine. His calendar has my work schedule and the kid's activities and class activities, when he has to be room dad, etc, etc, etc...Balance and teamwork.

The idea that the physician spouse's career takes priority over the other career is interesting and raises questions. One such question is the idea that the prestige of the medical profession seems to be more significant than the issues of gender. There is a

tendency to believe that with professional couples, the husband's career takes precedence. This, however, does not seem to be the case in marriages that involve female physicians. Despite the gender and profession of the non-physician spouse, the career that was held in highest esteem was that of the medical doctor. One can surmise that there is something inherent in the medical profession that gives greater deference over other professions. Certainly, the remuneration often associated with physician salary and handling life and death issues somehow lead to a high appraisal of value for the profession.

Other ways of Navigating Two Careers

Even though couples in this study made a subconscious decision to place one career over the other, they were faced with learning how to navigate two careers. Since both partners work outside the home and hold jobs that have personal and time demands, they have learned to develop ways to manage the challenges of two careers. Couples in this study did this in three distinct ways: familial support, non-traditional domestic and parenting roles, and paid help. Each of these strategies allowed them to successfully experience what it means to be a part of a dual career marriage (see Figure 1).

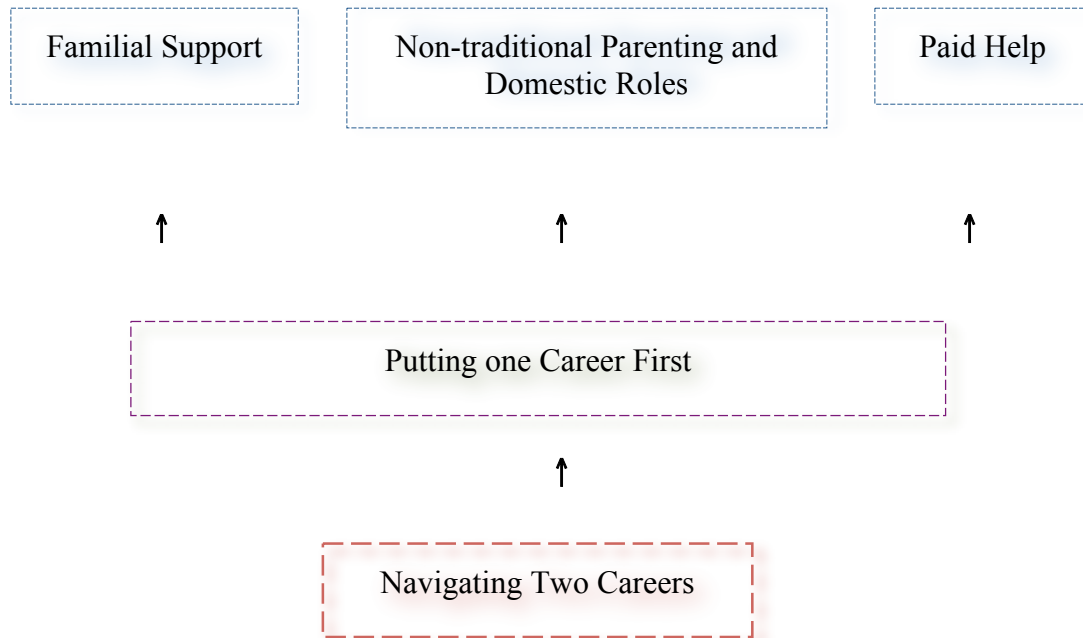


Figure 1: Model explaining how Dual career Couples Navigate their Multiple Roles

Familial Support

Dual career couples often tap resources inside and outside of their family system to reduce overall stress (Staines & O'Connor, 1980). Research on dual career couple's life cycle stage also suggests that parents with children less than 6 years of age had the highest work-family stress and it progressively decreased with older children (Staines & O'Connor, 1980). This suggests support for parents in different stages of family life will help reduce stress. An individual's church and biological family not only serves to assist with talking care of children, but for many couples, the presence of immediate and extended family assisted them with creating a balance. Such entities acted as sounding

boards that also gave encouragement and facilitated surviving their multiple role demands. A female microbiologist married to a urologist mentioned:

We have family and (close) friends; and friends include of course, church friends. The Sabbath School that we go to is fairly small and the people in there connect well...It really is nice to have a support group of people of like-minded values and beliefs.

Emotional support was not the only thing that family members and friends provided, some of them were available to assist with domestic tasks as well. A female gastroenterologist married to a software specialist recount:

...We have a lot more help from the families. My mother or his mother take on ninety nine percent of the cooking...Family is a big thing for us, so that helps.

The necessity of having this sort of support allowed both partners to effectively function in the role as career person. As a male Pediatrician married to Physical Therapist stated,

You have to keep the relationship with your family alive. It's a very dangerous lure.

This couple was referring to the pull that their careers have. There is a certain level of personal fulfillment that is attached to being a professional who assists persons will getting better and seeing positive changes in their lives. The presence of this social support was used to as a coping mechanism for professional families in this study.

Couples that work in high-status professions seek the assistance of family members to assist with childcare. The presence of an individual who shares similar values may be important due to the varying obligations that dual career couples hold. Not only can family members and alternative non-related caregivers provide low or no cost care, but

the comfort in knowing that someone familiar is assisting with the development and care of children can reduce stresses for dual career couples.

Non-traditional Domestic and Parenting Roles

Marital shared responsibility between partners seems pivotal in work-family harmony (Schwartz, 1994). Shared housework, mutual and active contribution to childcare, joint decision making both inside and outside the house, are important in reducing the couple's sense of balance with maintaining jobs and family life. Several households have a seemingly equal division of labor where the wife does the "inside work" and the husband takes care of "outside work", or the wife looks after children while the husband takes care of finances often seem like equal division of labor (Schwartz, 1994). The reality is that such marriages are not 'equal' and are still somewhat defined by gender-based expectations. An adjustment instead to mutually sharing responsibilities and the tendency to value each other's aspirations and work-life goals are important in achieving the work family balance.

The question of household tasks was another issue that the couples in this sample had to grapple with. The reality of having to work and still maintain a functional family life gave them the opportunity to evaluate how domestic duties would be handled. Couples were willing to adopt fluid domestic roles, and it became apparent that female physicians more than their male counterparts were the one who would be catered towards. Some couples viewed their non-traditional roles as working as a team, while others spoke of the experience in terms of whoever was available.

The reality of role sharing allowed the couples to be able to negotiate the multiple roles involved in being a dual career couple with a certain amount of ease. It must be understood that the non-traditional roles that these couples adopted was not the cure to their dilemma, but it certainly did assist in making the challenges more manageable. A female Obstetrician and Gynecologist married to a college Professor put it this way:

...he really had to pick up basically being you know the “wife” in the relationship. He did all the housework, he did the grocery shopping, he did the laundry, pretty much everything...It was tough to see him working so hard to make my life better and I wasn't able to do the same thing for him...

Her husband then added

I will clean up the kitchen, I tell her, okay, you cook and I will clean it up and it will be no problem.

A similar dynamic was also seen with a general practitioner and her husband who is a middle school teacher:

If anything he really is supportive of my work. I know there are times when he is frustrated when I tell him I will be home at one time and I'm not, I know that frustrates him. But he, I feel like I can do my job the way I need to because I know he is taking care of the kids. I know they are taken care of and I can finish up what I am doing, but I know it frustrates him sometimes.

Couples who worked as a team, valued discussion about how they would function as a family, and made sure to have such discussions on a regular basis. A businessman married to a pediatrician stated it this way:

I think we work well together as a team. Almost as if we had a dress rehearsal beforehand. Because we really work well together with each other and with the kids...I think we communicate very well, have from the beginning. And that hasn't changed even though the amount of time that you get to communicate is a lot less because of kids...There was never a problem 'with this is my role, this is

your role'. We just stepped in and filled in when we thought there was a need. Nobody actually had to say anything

To this, his wife added:

My husband helps out as much as any man can help out somebody; in the house and with the kids which is a big deal...As much as I love my kids it's stressful raising children. So when he is here he says I will take them to the park to let you relax. That's big deal. If he plays hide and seek with them and I get a chance to sit down. It helps a lot in giving me a chance to sit down. That's big for me in having a moment to get my adrenaline down so I can be a mom. So he helps a lot.

An emergency physician and her husband who is an accountant shared this experience:

...if something isn't coked I will pick up and cook if I can. We cross over roles...In general there is nothing really stated; we don't state "oh you're going to do XYZ". If I'm off and there is laundry to be done, like ironing for example then I will just start ironing. I don't say well it's his job and I'm going to leave it for him.

Gender roles are changing at work and at home. This requires fluidity in domestic roles.

Both partners are faced with the reality of meeting domestic needs while still functioning as professionals. This balancing act involves rearranging household responsibilities in such a way that things function smoothly and seemingly effortlessly. The adaptation of non-traditional domestic and parenting roles functioned to create equilibrium in the lives of these dual career couples.

Paid Help

The final way that couples in this study were able to navigate living in a dual career marriage was through hiring someone to assist with childcare and domestic work.

Most of the couples in this sample had small children who require more attention and

care than adolescents. Although immediate and extended family members often lent aid, there were couples who, because of their schedules, had to hire someone to assist with childcare as well as household responsibilities.

A male internal medicine specialist married to a physical therapist mentioned:

We do a little bit everyday. Some days nothing gets done, other days everything gets done... We do have a lady that comes when we need her.

A female obstetrician and gynecologist married to a college lecturer who also had paid help noted:

We found some lady to clean our apartment and uh, she's cleaned our apartment for like 2 years. And that's like the best thing it took a weight off my shoulders and then I could pay the bills and straighten up and do you know, the laundry and the dishes... I just could not do all of it and work a full-time job

A nurse and her husband who is a surgeon who were both in their second marriage mentioned that hired help was one way to ensure that their home remained cleaned.

Somebody comes in to do it; we pay somebody

Extra familial assistance with the care of children was a part of the reality of a female general practitioner and her husband who is a middle school teacher.

We have a babysitter till three and then he comes home from school

We see then that for dual career couples in this study it was difficult to find time to sit down and relax for a few minutes each day, and it was also hard to find time to

thoroughly clean their home and care for the children. This strain led many of the couples to hire someone to assist with the tasks of housekeeping and childcare.

Discussion

The goal of this study was to elaborate on the how physicians and their non-physician professional spouses navigate the challenges inherent in multiple roles. I found that there are at least three ways that this was achieved: through the aid of familial support, by utilizing non-traditional domestic and parenting roles; and by employing paid help. Moreover, the current findings suggest that these three ways of managing the dual career roles become considerably easier once the couple puts one career over the other. Whether this is done intentionally or not, it helps mediate the challenges that arise from living in a dual career marriage.

It is of importance to note that despite the gender of the non-physician spouse, the holder of the medical degree was the one who was shown more support, and, in a sense, that spouse was catered to. The household seemed to revolve around the physician spouse and his or her career. For me, the social organization of careers is based on earning power. When considering economic contribution, gender appears to matter less. The income of physicians can have a major impact on the standard of living for his or her family as such, the person who has greater earning power is given deference.

In reviewing the transcripts, it seemed obvious that in this dual career family context, the discussion regarding whether or not one member of the couple stay at home to engage primarily in the domestic sphere, was not existent. It appears that both of them were equally committed to career and derived gratification from such involvement. As

such, it seems as if this family arrangement was inconsistent with the gendered drama often seen in other family arrangements. Each had the capability to develop and survive as a relatively independent social and economic unit, yet one career had to take center stage. The choice to prioritize the career of the physician spouse may not have been as a result of the economic advantages of a physician's salary, but rather the prestige attached to profession.

Parsons talks about instrumental and expressive roles as a method used by adults in families work with various roles (Boss, et al, 1993). Parsons describes the role of husbands as was instrumental. His role was to be the dominant and required heavy involvement in work outside the home. On the other hand, the wife was confined to the expressive role that was person-oriented and emotionally laden. Her responsibilities included ensuring that the family maintained equilibrium and functioned as a well-oiled machine. Parson further stated that any deviation from this would create family dysfunction. In this current research, we see, however, a different picture. It appears that the structural functionalist perspective was more relevant during periods when family and paid work was divided among gender lines.

Another noteworthy area of the current research is the fact that dual career couples had to employ non-traditional gender and parenting roles in an attempt to create equilibrium in their family and work lives. According to a study conducted by the Families and Work Institute (Bond, Thompson, Galinsky, & Prottas, 2003), gender roles at home have changed. This study conducted the Families and Work Institute further suggests that the role of fathers in the home has expanded. Since 1977, fathers have increased the time they spend doing household chores on workdays by approximately 42

minutes. Interestingly, mothers have reduced their time involved in housework by the same amount, although they still do more than fathers. This suggests that the amount of time that couples with children spend on household work has not changed. What has changed is how that labor is divided. While fathers appear to be taking more responsibility than they used to, women are still much more likely to shoulder greater overall responsibility in other home activities such as cooking and childcare.

There appears to be a symbiotic balance that occurs when women work outside of the home, as her absence encourages men become more involved in housework (Haddock, Zimmerman, Ziembra, & Current, 2001; Perrone & Worthington, 2001). Through the lens of structural functionalism one sees that the nature of one part of the system (paid work) had an impact on an additional part of that system (family responsibilities). In order to function and maintain equilibrium in their family system, couples in this study had to be involved in teamwork that would give a certain level of balance to their lives. Balance was maintained by the three methods discussed as the couples saw it necessary to find the most effective way to be a professional, a parent, and a partner.

There was more discussion about being married to a physician, rather than being a part of a dual career couple. It would appear that the title of medical doctor is one that is held in high regard by spouses of physicians. The prestige of the medical profession therefore made it easier for the non-physician spouse to make himself or herself more available to take responsibility of domestic chores. This division of labor helped in balancing roles (Bond, Thompson, Galinsky, & Prottas, 2003). In light of the assumptions of structural functionalism, the most capable and available individual in the

couple was motivated to fill the role of caregiver in regard to the home and children. This is how equilibrium was maintained.

According to structural functionalism, systems tend toward self-maintenance involving control of boundaries and relationships of parts to the whole (White & Klein, 2002). As such, if one or more parts significantly conflicts with others, others must adapt. Couples in this study were able to do this by seeking the aid of other individuals to allow the structure to function well. Couples in dual career marriages face many work-family issues due to the multiple roles that are placed on them. It is hardly surprising, therefore, that individuals within such marriages find it difficult to juggle their multiple roles. This research discusses only three ways that such challenges can be confronted. Once partners are aware that both will, at some point in their marriage, be engaged in paid labor, the discussion about how that reality will be navigated should begin. In general, such findings are consistent with other studies involving dual career couples (Uma, 1983; Bunker, Zubek, Vanderslice & Rice, 1992).

There are two concepts that differ from this current research and previous in studies on similar populations. Firstly, the issue of putting one career has not been well articulated in the dual career literature. My thoughts are that there is something distinct about the dynamics of marriages in which one partner is a physician. This uniqueness allows their relationship to stand outside of the gender drama. The motives and reasons behind this decision have not been investigated thoroughly. A second issue that the current literature does not address has to do with the interaction between female physicians and their spouses. While former studies have noted that female physicians are more likely to be involved in domestic responsibilities (Uhlenberg & Cooney, 1990;

Lewis, 1993; Warde, Moonesinghe, Allen & Gelberg, 1999), few studies have discussed how her professional spouse supports her career.

As noted earlier, structural functionalism was adopted as the theoretical framework for this study, and tends to be a good fit as it addresses the contextual reality of patriarchy. Men have dominated the practice of medicine, but with the changes in this system all spheres of society are now required to adjust. In regard to the assignment of instrumental and expressive roles, gender appears to matter less for couples in this study. The holder of the medical degree is seen to be more instrumental, while his or her spouse is expressive. This change from Parsons theory requires additional attention. Studies must now consider medical doctors in relationship to the multiple systems in which they function. Based on the question being explored and the themes that emerged one can see that being aware this knowledge can be useful in helping dual career couples in which one partner is a physician. Information from this study can be useful in making such couples aware of how they can navigate the demands of being a part of a professional couple. The results of this study contribute to the existing literature on dual career families by highlighting the ways in which couples navigate the duties of being a professional while being a part of a family unit. Possibly the area that is most noteworthy is the notion that one career dominates the other.

While structural functionalism has been useful in its historical context, it must be noted that the lines are not as clearly demarcated and certainly not on the basis of gender, in this current study. Instrumental and expressive roles are played out differently in these couples and occur based on profession. Some of these other professions are equal in regard to remuneration, but there still seems to be a greater deference given to the

physician's career over the profession. As such, physicians appear to be the ones who are more instrumental while their professional spouses are more expressive. Parsons theory does a good job of describing more traditional family styles, however, with the changing climate of families this theory may need to be amended to address the roles within professional families.

Limitations and Strengths

As is the case with research in general, this study is not void of limitations. Time and budget limitations made it impractical to assess how narrative-based processing might have influenced participant's long-term thinking over multiple months or years. The majority of the participants are religious and this may influence their views of roles in the context of a marriage. In addition to the sample being religious, many of them are based in Southern California and were acquired via snowball sampling. While this method of sampling has many strengths, it is likely that the sample may be more homogenous than if another sampling method was employed.

The lack of employing multiple methods of triangulation is one other limitation. While the process of coding did involve processing information other researchers, a focus group could have clarified themes and given me the opportunity to access how couples interact around the issue being investigated. In addition, the information was gathered in a single interview. If interviews were conducted over time and with different methods needed clarifications may be obtained.

Due to the nature of the present study, the transferability of the research findings is limited. It must also be noted that the research design was not intended to produce

results that account for, or predict the behavior of a wide group of people. While qualitative inquiry does not focus on the generalizability of data, the premise of this research is to synthesize concepts on family relationships. This study, employing a qualitative analysis, cannot produce results that are generalizable, yet assumptions regarding other professional couples may be drawn.

Despite these limitations, it must be noted that the current study adds to qualitative literature on the dual career marriages involving physicians and their professional spouses. This research also looked at couple data versus individual data, adding to the research that is currently available on dyads. Methodological strategies that focus on the dyad as the unit of analysis will make it possible to understand how spouses shape each others' attitudes and behaviors over time, as well as the consequences of those interactions for the marriage and individual psychological functioning. A final strength of this research is the sample size. Certainly, saturation was obtained.

Suggestions for Future Research

Considering that the physician spouse was the one who was being catered to, a few questions have been raised; could it be that the medical career is considered more valued by society at large, or is the issue of showing more support to the physician spouse a function of economics? On the other hand, could this be a result of the personalities of the spouses of female physicians? The current research did not delve into these questions, and this is a limitation. Due to the changing reality of couples, research may consider investigating how the marital expectations in dual career couples influenced whose career takes precedence over the other. One area that would be worthy

for further research is looking at the process involved in selecting which career takes more precedence over the other.

Research involving multiple roles often views work and family roles as static, despite research that points to the fluid and dynamic nature of many roles. Future research on the management of multiple roles would benefit from a life-course perspective that guides researchers to examine differing work and family trajectories that take shape over time, with attention to the precursors and outcomes of these different paths.

It was observed that there has been a steady increase in the number of dual career couples in the United States, and one can expect that the challenges associated with managing the multiple roles of these families will be a present reality. From this present study, it was seen that many of the couples were able to make a relatively good adjustment to their dual career environment. While the challenges were often significant, they found ways to manage these realities. The major categories derived seem to bear this out. What seemed obvious was that many of these dual career families operated in a unique context, in which flexibility of attitudes toward work, career preferences, and involvement in domestic work were organized outside of traditional gender prescriptions. This appeared to be similar whether the physician spouse was male or female. This study suggests then that deference is given to the career of physician over the other career and this helps in the assignment of roles for the couple.

It is likely that work-family research will include more data on dual career couples and their attempts to exist in various social systems. Implications for this study fall into at least three categories: theory, research, and practice of family life education.

Using a qualitative approach, this present study was able to develop theory from the data. These theories offer insight into the structure and function of dual career couples. The exploration of these theories from the lived experiences of these couples, highlighted the need for better theories that can explain how these families are able to navigate their many roles. The development of theories that can assist in our understanding of the dynamics of dual career marriages, and increased awareness of the processes that are involved with navigating multiple roles is necessary.

This study was able to yield important insights using qualitative methods. Many of the previous studies used quantitative methodology, neglecting the voices of the population under investigation. The ability to derive rich description of these experiences, as attained in this study, suggest the need for more qualitative inquiry to better understand the phenomenon in question. Mixed method designs may offer more sophistication in compiling data on dual career couples. Also, this study has implications for intervention work with dual career couples. The increasing numbers of dual career families is likely to require better understanding of these families, as well as provide tools for working with them in an attempt to help them to adjust to the work and family roles. As such, psychotherapists and family life educators may find here some important tools for working with these unique family experiences.

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APPENDIX A
COVER SHEET

Respondent ID #:.....

Interviewer ID #:.....

Date of interview:.....

Interview start time:

Interview finish time:

Medical Doctors and Their Families:

A Qualitative Inquiry

Loma Linda University
Department of Counseling & Family Science

APPENDIX B
CONSENT FORM

Medical Doctors and Their Families: A Qualitative Inquiry
Loma Linda University Department of Counseling and Family Science

Consent Form

Thank you for choosing to participate in this study on physicians and their marriages and families. We would like to talk with you and your spouse about your relationship and familial experiences so that we may better understand physician families. The project is overseen by Doctoral level Faculty at Loma Linda University within the Department of Counseling and Family Science.

Purpose

The purpose of the interview is to gain insight and knowledge into the marriages and families of physicians.

Voluntary

Your participation in the interview is completely voluntary. You have the right to not participate in the interview and withdraw from the interview at any time.

Confidentiality

All information you share is confidential, which means all identifying information about you or your spouse will be removed from the interview transcripts. Only members of the research team will have access to the audio tapes and transcripts from which all identifying information will have been removed.

Referral

Due to the nature of the interview questions, you may experience emotional discomfort or new awareness of interpersonal issues. If you should chose, you may pursue counseling services at:

Loma Linda University
Marriage and Family Therapy Clinic
164 W. Hospitality Lane, Ste 15
San Bernardino, CA 92408
(909) 558-4934

Psychological Services Clinic
Loma Linda University
11130 Anderson Street
Loma Linda, CA 92354
(909) 558-8576

By signing below, I give my informed consent to participate in this research project:

Name of Participant

Date

Signature of Participant

Date

APPENDIX C

PHYSICIAN QUESTIONNAIRE

Medical Doctors and Their Families:
Physician Questionnaire

Please answer the following questions:

- 1. Gender: Male Female
2. Age
3. Country of Birth: 3A. If other than the USA, how long have you been in the US? years
4. Race/ethnicity you most closely identify with: Caucasian Black/African American Hispanic/Latino American Asian American Other
5. Religious organization/denomination that you most closely identify with?
6. Where did you attend medical school?
7. Year of graduation from medical school
8. Where did you do your internship/residency?
9. Medical specialty
10. Current place of work: Private Practice Community Hospital University Hospital
Other
11. Marital Status: First Marriage Second Marriage
Other
11a. Spouse Occupation
12. Years in current marriage
13. Years in current relationship
14. Number of children
15. Number of children living at home
16. Children's gender and age in the home:

Table with 3 columns: Birth Order, Gender (male/female), Age. Rows include First child, Second child, and Third child.

17. How many hours per week do you typically spend on:
- | | | |
|--|------------------------|-------------------------------|
| Paid work..... | Housework..... | Childcare..... |
| Leisure..... | Being with spouse..... | Being with child(ren)..... |
| Being with both spouse and child(ren)..... | | |
18. Do you have a housekeeper? Yes No If yes, for how many hours per week?.....

19. Please respond to the following items using the following scale:

- 1 - Extremely dissatisfied
- 2 - Very dissatisfied
- 3 - Somewhat dissatisfied
- 4 - Mixed
- 5 - Somewhat satisfied
- 6 - Very satisfied
- 7 - Extremely satisfied

Please write the appropriate response in the blank to the left of the item number.

- _____ 1. How satisfied are you with your marriage?
- _____ 2. How satisfied are you with your husband/wife as a spouse?
- _____ 3. How satisfied are you with your relationship with your husband/wife?

APPENDIX D

SPOUSE QUESTIONNAIRE

**Medical Doctors and Their Families:
Spouse Questionnaire**

Please answer the following questions:

1. Gender: Male Female
2. Age.....
3. Place of Birth: Other If other, how long have you been in the US?.....
4. Race/ethnicity you most closely identify with:
 Caucasian Black/African American Hispanic/Latino American
 Asian American Other
5. Religious organization/denomination that you most closely identify with:.....
6. What part has God played in your experience in the US?.....
7. Occupation
8. Highest level of education completed: Less than High School
 High School Degree Some College College Degree
 Masters Degree Doctorate Degree Other.....
9. Marital Status: First Marriage Second Marriage Other.....
10. Years in current marriage.....
11. Years in current relationship.....
12. Number of children.....
13. Number of children living at home.....
14. Children's gender and age:

| <i>Birth Order</i> | <i>Gender (male/female)</i> | <i>Age</i> |
|--------------------|-----------------------------|------------|
| First child | | |
| Second child | | |
| Third child | | |
| Fourth child | | |

15. How many hours per week do you typically spend on:

| | |
|---|----------------|
| Paid work..... | Housework..... |
| Childcare..... | Leisure..... |
| Being with spouse..... | Being with |
| child(ren).....= | |
| Being with both spouse and child(ren) | |

16. Do you have a housekeeper? Yes No
 If yes, for how many hours per week.....

17. Please respond to the following items using the following scale:

- 1 - Extremely dissatisfied
- 2 - Very dissatisfied
- 3 - Somewhat dissatisfied
- 4 - Mixed
- 5 - Somewhat satisfied
- 6 - Very satisfied
- 7 - Extremely satisfied

Please write the appropriate response in the blank to the left of the item number.

- _____ 1. How satisfied are you with your marriage?
- _____ 2. How satisfied are you with your husband/wife as a spouse?
- _____ 3. How satisfied are you with your relationship with your husband/wife?

APPENDIX E
PROTOCOL

*Interview Questions for
Medical Doctors and their Families: Qualitative Study*

- A. Physician as Individual** (background, family of origin, identity, career)
1. How did it come about in your life that you chose to become a physician?
 - a. Probe: How did your childhood and family experiences affect your desire to become a physician?
 - b. Probe: How did you choose your particular specialty?
 2. What is it like being a physician for you? (shape who you are/what you should be)
 - a. Probe: How rewarding or satisfying is your professional life?
 - b. Probe: What are some aspects of being a physician that are challenging to you?
 - c. Probe: What makes your work meaningful to you?
 - d. Probe: How does being a physician help shape your identity/sense of self?
 3. What core values or ethics guide you personally as a physician?
 - a. Probe: What motivates you and guides you in your profession?
 - b. Probe: How do you relate to the core-values/ethics of your profession?
- B. Relationship Formation** (how the couple met, what attracted them, etc.)
1. Please tell me about the story of your relationship.

- a. Probe: How did you two meet?
 - b. Probe: What attracted you to each other?
 - c. Probe: What stage of your medical training or career were you in when your relationship began? What was it like to begin a relationship during that time? (ASK ONLY IF APPLICABLE)
2. How has your relationship evolved or changed during each stage of your medical training and career?
 - a. Probes: During medical school, residency training, early practice, established practice, retirement? (ASK ONLY IF APPLICABLE)

C. Marital Relationship (satisfaction, challenges, conflict, intimacy, time, etc.)

ALL questions must be asked of MD AND professional spouse. Include ALL probes.

1. Tell me about your expectations for marriage.
2. How would you describe your current relationship?
 - a. Probe: What aspects of your relationship do you find most satisfying?
 - b. Probe: *Get a sense of how the following are experienced*
 - i. intimacy (physical, emotional, sexual)
 - ii. communication
 - iii. time together
 - iv. closeness
 - v. sense of partnership

- c. Probe: What aspects of your relationship do you perceive to be most challenging or how might you wish it to be different?

3. What aspects of being in a physician marriage most impact your marital life?

4. How does being married to your spouse affect your work life?

- a. Probe: How does your spouse support your career goals?
- b. Probe: How does your spouse support you with the demands of your profession?
- c. Probe: *(to the physician then to spouse)* What are some areas in which physicians have expressed a need for more spousal support?

5. Can you talk about how you both manage work and family?

- a. Probe: How are housework (and childcare) responsibilities divided?
Why is it that way?
- b. Probe: How do you manage the responsibilities or the conflict associated with paid work and family work?

6. As a medical doctor, how do you manage the professional demands of your job and that of your spouse?

- a. Probe: How do you manage when there is a conflict between your job and your spouse's job?
- b. Probe: What are your thoughts about how your spouse feels about how their needs are being met? Probe further for professional and personal needs
- c. Probe: Would you say that one person's professional responsibilities precedence over the others'? Why is that?

d. *Probe: How do you perceive support from your partner?

7. As a professional how do you manage the professional demands of your job and that of your spouse?

a. Probe: How do you manage when there is a conflict between your job and your spouse's job?

b. Probe: What are your thoughts about how your spouse feels about how their needs are being met? Probe further for professional and personal needs

c. Probe: Would you say that one person's professional responsibilities precedence over the others'? Why is that?

d. *Probe: How do you perceive support from your partner?

8. How do the two of you handle disagreements or conflicts between yourselves?

9. What do you do as a couple to nurture your relationship with each other?

10. What advice about marriage and staying connected to each other would you give to couples that have work schedules like you do?

D1.--Immigrant Couples (Immigrant Physicians only)

1. It is common for both spouses to work outside of the home. How does this fit with your cultural upbringing (being from the Caribbean)?

2. Has this issue of both spouses working outside the home been a source of conflict in your marriage?

a. If so how?

3. From time to time, conflicts between career and family arise for dual career couples.
 - a. Do you feel that your cultural heritage has helped or harmed the way you negotiate these conflicts? How so?

D2.--Minority Female Physicians

1. At times, professional who are members of a minority group face challenges because of their race or culture. As a minority female physician, have your experience any of these challenges and how did it impact your functioning at work?
2. As a minority female physician, could you tell me of some of the challenges you face in your profession in relation to your race and/or ethnicity?
3. (As a minority female physician), could you describe for me some of the challenges you face in your family life in relation to your race and ethnicity?
4. As a result of the demands of your profession and the demands of family life, if you had a choice to do your education over, would you chose the same profession, why or why not?

E.--Spirituality (in professional and personal lives)

1. Please describe your view of God.
 - a. Probe: If you don't believe in God, how do you make sense of life?
 - b. Probe: Do you have a particular worldview? What makes life meaningful to you?

2.What is your experience of God being aware or not aware of you and your thoughts and feelings?

- a. Probe: What lets you know he is aware or not aware of you?
- b. Probe: How do you experience His awareness of you?

3.Can you describe a difficult experience and what thoughts or emotions you were or were not able to share with God?

- a. Probe: Describe what it's like trying to articulate your feelings/thoughts to God?
- b. Probe: What might be holding you back from sharing certain things with God? (i.e. guilt, shame?)

4.How would you describe your impact on God?

- a. Probe: Describe your how your choices, thoughts, behavior affect God?

5.How do you know whether or not you are willing to be influenced by God?

- a. Probe: How do you feel when you are aware of God wanting you to do something you may not want to do?

6.What is your experience of being able or not able to influence God?

- a. Probe: What is it like feeling like you can or cannot alter God's actions?

7.What is your experience of being able or not able to influence God?

- a. Probe: What is it like feeling like you can or cannot alter God's actions?

8. Sometimes what one believes about God may not match one's experience of God.

Can you describe what that's like for you?

- a. Probe: What is it like for you when you don't experience what you believe to be true about God?
- b. Probe: For example, when something bad happens, I might not feel God cares. Or it may be hard to feel God loves me even when I believe God loves everyone. What's it like not experiencing what you believe?

Sections F, G, and H contain questions for the physicians only:

F.--Stress (*questions for the physician only*)

1. What are your thoughts about the demands of your professional life?
 - a. Probes: What are the demands? How stressful are the demands?
2. What other demands or expectations do you experience apart from your job?
 - a. Probes: What are those demands? How stressful are those demands?
3. How do you cope with stress?
 - a. Probes: What works best? What does not work as well?
4. What kinds of support are available to you in managing the stressors in your life?
 - a. What is most helpful about their support? Least helpful?
5. How does stress affect your relationships?
 - a. Probes: With your spouse? With your children? With colleagues? With patients? With friends or extended family?

F1. Stress (for spouse of MD). If spouse is not a professional then will ask about their daily stressors.

1. What are your thoughts regarding the demands of your spouse's profession?
2. What are the demands of your own profession?
3. As a couple, how have you been able to cope with the varying demands of each partner's profession?

Probe: What works best?

Probe: What does not work as well?

G.--Physicians and Gender

1. (*Male and Female physician*) Tell me about any differences you have observed between female vs. male physicians
 - a. Probe: What if any are the differences you have experienced?
 - b. Probe: In the workplace?
 - c. Probe: In marital life?
 - d. Probe: In experiences of parenting?
 - e. Probe: In regards to ethnicity (personally and to other professionals at work)
2. (*Female and Male physician*) How have you felt supported and empowered (as a woman) in your professional life?
 - a. Probe: In the workplace?
 - b. Probe: In marital life?

- c. Probe: In experiences of parenting?

******For those couples with children, only**

H.--Parenting

1. How did you make the decision (or how are you making the decision whether or not) to become parents? **(If have no children move to section H)**
2. How does having children impact your professional life?
 - a. Probe: When in your professional training or career did you begin your family?
 - b. Probes: Do you feel this was the ideal timing? What would the ideal timing be, if there is any?
3. What does quality time as a family look like?
4. How are you able to arrange for quality time as a family?
5. How do you balance work and family demands with your personal needs?
 - a. Probe: What values and priorities guide you in balancing these demands and needs?
 - b. Probe: What expectations do you place on yourself?
 - c. Probe: What expectations does your ethnicity place on you?
 - d. Probe: What does it mean to be a good parent? How do you achieve that?
 - e. Probe: What does it mean to be a good spouse? How do you achieve that?

- f. Probe: How positively do you feel about your ability to meet these expectations from yourself and from others?
6. What is your relationship like with your children?
 - a. Probes: Is it enjoyable? How do you spend time together? What do you do? How do you communicate with each other?
 7. How is parenting handled with your children?
 - a. Probe: How do you discipline?
 - b. Probe: Who does most of the discipline of the children?
 8. What aspects of being a physician parent affect your parenting or your relationship with your children?
 - a. Probe: What are some of the benefits to your family of your being (your spouse's being) a physician?
 9. How do you think your child(ren) view(s) your professional life as a physician?
 10. If you had a choice to do your life over again, would you choose the same profession, **why or why not**?
 - a. Probe: For family life

******For those couples in dual-physician marriages, only******

I.--Dual Physician Marriages

1. What are some benefits or advantages of being in a dual-physician marriage?
2. What are some challenges particular to being in a dual-physician marriage?
3. How have you handled these challenges?
4. What advice would you offer to others in dual-physician marriages?

APPENDIX F
INSTRUCTIONS ON CONDUCTING QUALITATIVE
INTERVIEWS

*Instructions on Conducting Qualitative Interviews – presented by Dr. Susan Montgomery
on September 16, 2009 at Doctor’s Project Meeting.*

- It is important to build rapport with the interviewee. Use the first few minutes of the interview to get to know the participant.
- Keep the interview objectives in mind as you conduct the interview, that way you are aware that the important issues are covered even if all the questions are not asked.
- Questions should not be read. Try to commit the flow of questions to memory, that way the interview is more conversational.
 - Questions should be open ended, clear, short, simple, conversational, and should not be double barrel.
- Questions should follow a ‘question journey’ with the least intrusive questions being asked first, followed by questions that are more intrusive, then ending with questions that give power back to the interviewee.
 - You may choose to ask about successes and things that have worked.
- The interview environment:
 - Avoid tables (can be seen as barriers)
 - Mimic non-verbal without making fun
 - Use appropriate eye contact
 - Venue: Private environment

- Give the interviewee the option of where to meet (their home may not be the best option)
- Transcription of interviews should occur shortly after interviews.
- Have two recording devices – just in case.
- Make observational notes following the interview.
- If consent is not given to record, make the interviewee aware that you may have to pause to take notes during the interview process.
- Meetings with the research team should be held after interviews are completed to ensure that everyone is on the same page and to evaluate level of saturation. This may show that some questions need to be changed.
- When interviewing couples:
 - Note the dominant speaker
 - Normalize
 - If difficult questions are avoided, try to ask again at some point during the interview (rephrase it). If the question is avoided again, don't continue to ask it.
- Focus groups can be used to validate the experiences of individuals.

Suggestions for current study:

- Interview key informant first then interview couple
- Use group validation process
- If saturation is achieved for one area, focus on other areas where saturation has not been achieved.

APPENXID G
CODING PROCESS: HOW COUPLES NAVIGATE TWO
CAREERS

Find support outside of marriage

→ Male MD (Urologist) married to Microbiologist

“Family. Friends. And friends includes of course, church friends. Wife adds: The Sabbath school that we go to is fairly small and the people in there connect well. And I think there’s if people will share whatever problems and it really is nice to have a support group of people of like-minded values and beliefs. Those are the best support groups I think. But really good support groups”

→ Female MD (Gastroenterology) married to Software Specialist

“...Since (child), we have a lot more help from the families. My mother or his mother takes on ninety nine percent of the cooking. But cleaning we do have a helper that comes every two or three weeks. The laundry and stuff like that we take care of that on the weekends.”

“Both of us are there for each other. And family is a big thing for us, so that helps.”

→ Male MD (internal Medicine and Pediatrics) married to Physical Therapist

(OUTLIER)

“I actually don’t talk too much at work at all. Once I get home I don’t want to talk about work. No, I don’t talk to anybody at work.”

“You have to keep the relationship with your family alive. It’s a very dangerous lure.”

Division of household labor that is more catered toward MD doing less ('catering' to MD)

→ Male MD (internal Medicine and Pediatrics) married to Physical Therapist

“We do a little bit everyday. Some days nothing gets done, other days everything gets done. And we do have a lady that comes when we need her.”

→ Female MD (OBGYN) married to Educator

“he really had to pick up basically being you know the “wife” in the relationship. He did all the housework, he did the grocery shopping, he did the laundry, pretty much everything”

“it was tough to see him working so hard to make my life better and I wasn't able to do the same thing for him...”

“I will clean up the kitchen, I tell her, okay, you cook and I will clean it up and it will be no problem. ”

→ Male MD (Anesthesiologist) married to Physical Therapist

“...I always try in that sense not make it a stress situation...”

→ Female MD (Family Medicine) married to Middle School Teacher

“If anything he really is supportive of my work. I know there are times when he is frustrated when I tell him I will be home at one time and I'm not, I know that frustrates him. But he, I feel like I can do my job the way I need to because I know he is taking care of the kids. I know they are taken care of and I can finish up what I am doing, but I know it frustrates him sometimes.”

Shared experience of parenting

→ Male MD (Urologist) married to Microbiologist

“Well, (wife) had to work occasional weekend. And that left m with the kids, changing diapers, doing it... Yes, you really get the sense that it’s a *shared experience*”

* “Schooling decisions were agreed upon. Since they’ve been going to college, it was their own personal college. For grade school and high school we pretty much agreed on school.”

→ Female MD (Pediatrician) married to MBA

“He helps with the kids, he helps with the housework. Like I said there have never been any defined rules, so if something is not done he steps in and does it. He supports me.”

Sharing with the other partner

→ Male MD (orthopedic surgeon) married to Physiotherapist (OUTLIER – due to busy lifestyle)

“I suppose we don’t talk about things that really matter. We don’t take the time to really get to the bottom of things like we used to.”

→ Female MD (Gastroenterology) married to Software Specialist

“Both of us are there for each other. And family is a big thing for us, so that helps.”

“Just the fact that we are able to see each other when we come home, and talk to each other. That makes it good... Just to be able to talk to know that he is there.”

→ Female MD (OBGYN) married to Educator

“We talked about it with each other”

Support shown for spouse

→Female MD (Pediatrician) married to MBA

“I think how I support my wife in her career is listening to her and allowing her to watch the TV program house so she can continue her education by guessing what the diagnosis is. But you know mainly listening to her and I have an interest in what she does.”

Relying on other partner/Working as a team

→ Female MD (Gastroenterology) married to Software Specialist

“He has always been supportive. His work hours are more definite than mine. And in the part of my career when I’m always training, I don’t get to decide what my hours are. They were set by the department. He has a more definite schedule so he has been taking on the brunt of the work when it comes to taking care of the kid. Like picking her up. Taking small course with her. He does a lot of it. If I don’t have anything to do I take them no questions asked. That’s because I know he does a lot of it. It’s basically whoever can. It’s whoever is available.”

→Female MD (Pediatrician) married to MBA

“I think we work well together as a team. Almost as if we had a dress rehearsal beforehand. Because we really work well together with each other and with the kids. There was never a problem with this is my role, this is your role. We just stepped in and filled in when we thought there was a need. Nobody actually had to say anything. I think we communicate very well, have from the beginning. And that hasn’t changed even though the amount of time that you get to communicate is a lot less because of kids...And I think we have grown to appreciate things about each other that we did not earlier on.”

“My husband is a great support. He does not stress me out. He helps me out as much as any man can help put somebody. In the house and with the kids which is a big deal. Because you get done with one stressful situation and come home to another stressful situation. As much as I love my kids it’s stressful raising children. So when he is here he says I will take them to the park to let you relax. That’s big deal. If he plays hide and seek with them and I get a chance to sit down. It’s helps a lot in giving me a chance to sit down. That’s big for me in having a moment to get my adrenaline down so I can be a mom. So he helps me out a lot.”

→Female MD (ER) married to Accountant

“Balance and teamwork. He has a calendar and everything is mapped out. And I have a calendar, and actually his calendar is different than mine. His calendar has my work schedule and the kid’s activities and class activities, when he has to be room dad, etc, etc, etc.”

Hire someone to help with domestic chores

→Female MD (OBGYN) married to Educator

“we found some lady to clean our apartment and uh, she’s cleaned our apartment for like 2 years. And that’s like the best thing it took a weight off my shoulders and then I could pay the bills and straighten up and do you know, the laundry and the dishes...I just could not do all of it and work a full-time job”

→Male MD (Surgeon) married to Nurse (*second marriage for both*)

“(Regarding housework) Somebody comes in to do it; we pay somebody”

→Female MD (Family Medicine) married to Middle School Teacher

“We have a babysitter till three and then he comes home from school”

Both

→ Male MD (Urologist) married to Microbiologist:

“Before we got married we went to a marriage seminar at the University church that gave insight... I talk to you the most.

Wife responds: Yeah he would talk to me more than he talks to anybody else. And I guess he trusts me not to tell anyone at work”

Other

Accepting influence of spouse

→ Male MD (Urologist) married to Microbiologist:

“Right, so I went along with (wife’s) decision. And it’s fine, I wouldn’t change a thing.”

Importance of being married to someone who is ambitious

→ Female MD (Gastroenterology) married to Software Specialist

“That makes a huge difference too, because the fact that he was looking for someone that was pursuing a career was important to me too. Because spent so much time that he was looking for someone that was going to stay busy was important for me... And that runs in the marriage, they both pursue their own careers.”

Care shown for non-MD spouse/Giving spouse the opportunity to work or not

→ Male MD (internal Medicine and Pediatrics) married to Physical Therapist

“My main focus at this point in our lives is to give her the space to be at home if she wants to be home and go to work if she wants to. My work is enough that she can stay at home and not work. Whatever we have to do to adjust our lifestyle so she could accomplish that. If she only wants to do it for a few years that’s fine. If she wants to do it fifteen years that’s fine.”

Concern shown for MD spouse

→Male MD (internal Medicine and Pediatrics) married to Physical Therapist

“I’m always grateful when he has a vacation or a break. I’m grateful for his days off; he needs to relax any chance he can get it.”

→Female MD (Pediatrician) married to MBA

“He allows me to still do what I like to do. He does tell me when ok that’s enough. So as not to impinge upon our family life because it is still my propensity to be obsessed about what I do. SO he still has to put the reigns on and say I will support you but that enough. He still does do that. Hoe I support him? I suppose I really just take care of him and the family and let the house run like a well oiled machine so he doesn’t have to worry about it. HE goes to work and comes home and he can eat and sleep and he can have a happy family. Because if he ever wanted to talk about work he knows I would listen but that’s not his thing.”

Physician guilt

→Female MD (OBGYN) married to Educator

“But um, it was hard, I felt frustrated a lot of the time that I couldn’t give him what I wanted to and what he needed and I didn’t feel like it was fair to him. And we talked about it multiple times, like I said, I don’t want to do this anymore you know, this is tearing apart our relationship and I don’t want to do this. ”

“I feel like I have time to be the ‘good wife’ to him now, so I try to cook for him, and we actually have a person who cleans for us, cause that works much better ”

→ Male MD (Cardiologist) married to Nurse

“At times I have felt inadequate. It was like I wasn’t giving my patients the attention they deserved and I was not living up to my promises to my family, I felt very inadequate, very divided and it was no win situation. I would always be losing. They were unhappy, I wasn’t keeping up with the work load, and work piles were growing”

Impact of Medical Marriage

→ Male MD (Preventive Medicine) married to Nurse (also has a degree in MFT)

“yes sometimes the hours are long, sometimes he brings stuff home and I want him to go out and play with us and the kids. And I say you know I’m (generally) always with the kids, which I love, but we can’t make memories together, I don’t like having to tell (husband) that we did this and the kids had so much fun. I want you to be there so we are in our old age we can recall. So again it’s him constantly balance am I giving enough time for this. And he has accountability to the people at work because they are calling him in, numbers are up, numbers are down. And he’s coming home and I’m saying the kids really need to spend some time with you. Sometimes I see that when he comes home the children are so ecstatic and my husband wants to get dressed and relaxed, and the

kids are4 dad come throw the ball with me, let's go the park...despite his tiredness, I always say he has to push past tired and play with the kids and do for them what I can't”

Genuine connection as a couple

→Female MD (Pediatrician) married to MBA

“Just what she said, I'll play that. That was good dear. That sounds good. No I've always thought my wife was a wonderful person and to marry someone like me, that just made me cry at our wedding because I think she is wonderful, calm, beautiful, loving person and I also saw how she treated her siblings and her parents and how she respected them. I knew she would respect me and I never had any fear that one day she would leave me, or cheat on me, and I saw her fall in love for God and just portrayed everything she did everyday. I knew she would be a god mother to our children. That's definitely shown everyday that she's patient and kind and loving. Patience is very important.”

“I pretty much trust his judgment calls if he wants to do something for the family. I support him that way. He's my balance, if I'm starting to do too much he will let me know so I can back off.”

Existed as separate entities almost

→Male MD (Surgeon) married to Nurse (*second marriage for both*)

“Her money's her, mine is mine. She pays her bills, I pay the house bills and my bills.”

“...I had to adjust. With my first husband he supported (me more). He'd pay (all) the bills and whatever was left over we would decide what we wanted to do with it...I'm still adjusting.”