

RACISM AT WORK: INTER-SPOUSE STRESS AND STRAIN TRANSFER

Abstract

The aim of this paper is to discuss pathways that interlink spouses' well-being in a study of male Indian origin doctors and their wives where husbands experienced racism at work.

This first study of its type was underpinned by Collins' Afro-centric feminist epistemology and Lazarus' cognitive mediational stress theory.

Sampling: A sample of eight couples was recruited through advertising and snowballing.

Data collection: Each spouse was interviewed separately through a semi-structured depth interview followed by a telephone interview.

Data analysis: Generic pathways that inter-linked spouses' well-being were delineated through cross-case analysis.

Findings: Pathways were found to be grounded in three areas: a) supportive behaviour of the wives, b) the nature of inter-spouse communication, and c) the husband's behaviour with the couple's children. These pathways were accentuated by the couples' values and beliefs related to Hinduism and middle-class, and doctors' personality characteristics.

Keywords: cross-over, Hindu, Indian, medicine, middle class, racism, spouse, stress, work, work-family-conflict

INTRODUCTION

This paper presents part of the findings of the study, '*Racism at work: Indian origin doctors' and their wives' well-being*', which explored Indian origin¹ doctors' experience of racism at work, their own and their wives' well-being, and how spouses' well-being was interlinked (Author 2007). To specify, it is only the findings related to the spouses' well-being interlinks, or how male hospital doctors' racism-induced stress and strain travelled between husbands and wives, are presented in this paper.

To set the scene, I will briefly discuss the premise of the study, and Asian, including Indian-origin doctors', experience of racism in the National Health Service (NHS). After this, I will focus on the literature on the experience of racism in any setting, e.g. at work and in shops, and its impact on the family as this will shed some light on the likely transfer processes, since there is no study of racism at work-induced stress and strain transfer processes between spouses. In this situation, it is desirable to build an

understanding of the basic transfer processes identified by normative work stress and strain transfer studies. Here, I will also highlight the factors that may govern the transfer process for the participants in this study. After this, I will discuss the study's theoretical foundations, methods, and findings about the 'spouses' well-being interlinks'. I will conclude by discussing factors that governed the transfer process, limitations of the study, and directions for future research.

Premise of the study

This study was conducted with a premise that racism is a type of stress since its targets, as a minimum, experience negative psychological consequences (Clark et al. 1999; Harrell 2000; Williams et al. 2003), but may also experience adverse physiological, e.g. raised blood pressure (Din-Dzietham et al. 2004; Krieger and Sidney 1996); and behavioural responses, e.g. excessive smoking (Landrine and Klonoff 2000) and drinking (Taylor and Jackson 1990).

The stressfulness of a stress depends on an individual's appraisal of how threatening it is for his/her well-being, and whether he/she can manage it or not (Lazarus and Folkman 1984, pp. 22-54; Lazarus and Launier 1978). Therefore, it is the subjective appraisal of individuals which is central to their health outcomes, especially mental health outcomes (Clark et al. 1999). In other words, if one has perceived stress, one has also experienced it because one's health depends on it. Based on this understanding, perception of racism was seen as the experience of racism since individuals' well-being was the outcome of interest in this study.

The next step is to understand the nature of racism experienced by Asian doctors and what type of stress it is for them.

Asian doctors' experience of racism

Racism in medicine is a heavily researched area in the UK (Coker 2001), and has been described as a cradle to grave experience for Asian doctors (Everington 2004). To elaborate, they experience racial discrimination in various employment situations, e.g. recruitment (Anwar and Ali 1987; BMA 2004a; Cooke et al. 2003; Esmail and Everington 1993), disciplinary procedures (Allen 2000), reward systems (Esmail et al. 2003), and through the Government's visa regulation changes which cut short their training and limit career progression and employment chances (Fox 2006; Unwin 2001).

It is important to note that Asian doctors' experience of bullying is generally taken as their experience of racial harassment (HPERU 2006; Quine 2003), so I will also highlight the findings of these 'bullying studies'. Many studies have found that Asian doctors experience bullying from patients, seniors, colleagues and nurses; and middle-grade² doctors are a particular target of bullying (HPERU 2004; HPERU 2006). Most doctors do not complain about bullying because of: the medical culture of silence that is perpetuated by the juniors' need for references for the next job and anticipated damage to career progression (BMA 2004a; BMA 2004b; Paice et al. 2004); lack of awareness about who to complain to; and a widespread view that if you do complain outcomes are likely to be negative (Hoosen and Callaghan 2004).

Doctors' experience of racism should be seen as a chronic experience that is interspersed with acute experience/s of racism. For example, an Asian doctor might be experiencing chronic harassment, e.g. in the form of the allocation of too much work on a daily basis, and during it he/she might be rejected for a job due to a biased interview forming his/her acute experience of racism. Therefore, doctors are likely to experience both chronic, e.g. long-term impacts on their psychological well-being, and acute strain, e.g. a short-term rise in blood pressure. So, what is the impact of an individual experience of racism on his/her family?

Experience of racism and its impact on the family

For this discussion, I will draw on two types of studies: individuals' experiences of racism and its impact on their family; and racism at work and work-family conflict, which I will discuss in turn.

As far as racism's impact on the family is concerned, I was only able to find one theoretical framework (Root 1992) and two empirical studies (Jean and Feagin 1998; Steele et al. 1982). Root's theoretical framework suggests that membership of a dominated group can lead to indirect trauma resulting from witnessing and/or listening about events that occur to family member/s and friend/s. These mechanisms have also been supported by the empirical studies.

According to Steele et al, witnessing racism results in family members feeling bitterness, anger, injustice and frustration (Steele et al. 1982). Jean and Feagin found that families of the targets of racism function as a sounding board, or a safe environment in which racial encounters are shared and reassessed (Jean and Feagin 1998). In this way, each family member pays the price of the experience of their kinfolk. They also highlighted that in some cases, male workers' feelings of indignation and humiliation resulting from their experiences of racism at work turn into spouse abuse due to a displaced rage. This involves husbands venting their anger on their wives at home instead of reacting angrily to racist encounters with their White colleagues and bosses at work. This displaced rage was found to ruin marital relations between the spouses through increased conflict and separation. In short, wives were affected through listening to their husbands' pain, and by being the target of their husbands' anger and its related negative marital consequences (Jean and Feagin 1998). However, this study was neither exclusively about racism at work nor about the inter-spouse stress and strain transfer process; and did not have access to data from both spouses³, as it is a secondary data analysis of Feagin and Sikes study about African-American middle-class professionals' experience of racism (Feagin and Sikes 1994), so its findings can be argued to be less than comprehensive.

In this context, Enchautegui de-Jesus' study about racism at work and work-family conflict becomes important (Enchautegui de Jesús 2001). Her study with African-American and Latino workers did not find any effects on the workers' marital well-being, but did report work-family interference. This involved workers being irritable and too tired at home and their problems at work distracted them at home. From this, one can deduce the inter-spouse stress and strain transfer processes involved, and conclude that workers' family life was negatively affected.

In the absence of specific racism at work research, it is desirable to build some understanding of the basic processes involved and the factors that may govern them, as identified by normative work-stress and strain transfer studies.

Basic processes of inter-spouse stress and strain transfer and relevant factors

Several studies have shown that stresses and behaviours of the workplace are taken home (Crouter et al. 1989; Friedman and Greenhaus 2000; Morrison and Clements 1997; Piotrkowski 1979) and vice versa (Jones and Fletcher 1996; Karlins et al. 1989; Pavett 1986).

There are two main processes through which work and home are supposed to be interlinked: spill-over and crossover; and these processes underlie spouses' well-being interlinks. Spill-over is a simple process in which the 'workers carry the emotions, attitudes, skills and behaviours that they establish at work into their family life' (Lambert 1990, p. 242). It is seen as an intra-individual process where one domain of life affects the other (Westman 2001).

Piortkowski has identified three types of spill-overs: positive carry-over, negative carry-over, and energy deficit (Piotrkowski 1979, pp. 31-63). Positive carry-over is a situation in which the employed worker returns home with satisfaction, and is therefore emotionally and interpersonally available. Negative carry-over is a state in which the worker is stressed at work, and comes home emotionally bruised. This situation requires family members to provide emotional support and problem solve to assist the worker to manage strain. Energy deficit means that the worker becomes so tired, emotionally and/or physically, that he/she withdraws from family interactions. This negative carry-over is found to result in anger, anxiety, tension, and conflict at home with an obvious impact on spouses' lives in terms of their marital satisfaction and social well-being (Jackson and Maslach 1982). Instances where wives take over more roles at home to give their husbands space to recover from work related stress (Jones and Fletcher 1993), or facilitate actions that relieve husbands' stress (Repetti 1989), both result in negative effects on the wives' well-being. This is not only because wives have to cope with an overall increased workload, but they also have to do it in a psychologically negative home environment, e.g. argument between spouses (Noor 1995).

The amount of help wives give to their husbands has been found to be linked to the religiosity and ethnic origin of the couples (Grossbard-Shechtman and Izraeli 1994). In traditional marriages, particularly Indian Hindu ones, there is a belief in traditional gender roles, where wives' unconditional support⁴ for their husbands is culturally binding, and marriages are considered to be a bond for ever with little acceptability of separation and divorce (Kakar 1996, pp. 52-112; Ramu 1987). In other words, wives fulfil most of the domestic and children's responsibilities whilst the husbands' role is to provide for the family, and wives must support their husbands' efforts at work. However, each spouse's emotional support for the other is implicit in fulfilling these roles (Ramu 1989). In these marriages, if husbands experience work stress, wives usually support their husbands by taking over all the household chores, and by providing encouragement and moral support (Ramu 1989).

Wives' support is also an institutional characteristic of medical marriages. To elaborate, the occupational success of most married male doctors is built on their wives freeing them from household responsibilities, physical and many times emotional ones too, to let them concentrate on a long period of training and frequent exams (Gerber 1983). Moreover, Jones and Fletcher have highlighted that professional men, in the situation of no or little support at work, rely heavily on their wives' emotional support, encompassing talking and listening, encouragement, regard, affection and so on. This results in their wives' poor psychological well-being (Jones and Fletcher 1993). Therefore, one can argue that wives in this study, by virtue of their own and their husbands' Indian Hindu origin related cultural values, and their husbands' profession and likely lack of support at work because of racism there, are very vulnerable to domestic work overload and poor psychological well-being related to negative home environment.

The other process through which work and home have been interlinked, especially workers and their spouses, is called crossover (Westman 2001). This process has been defined as 'dyadic, inter-individual transmission of stress and strain' (Westman 2001, p. 718). It happens because stress creates strain in the worker, e.g. mood changes, illness, depression, and dissatisfaction, which is then sent to the receiver spouse where it creates stress and strain (Westman 2002). It has been found to occur in three ways: through empathy; due to common stresses in the couple's home environment; and indirectly through factors like coping styles and personalities of the spouses (Westman 2001).

Studies that support empathy, i.e. 'we feel their pain as our own' (Riley and Eckenrode 1986, p. 771), as a cross-over mechanism for stress tend to call this inter-dyadic process 'transmission' instead of crossover (Jones and Fletcher 1996; Rook et al. 1991). There is some evidence that couples who have a good relationship experience greater transmission (Rook et al. 1991).

Additionally, there is evidence that indirect processes and factors, such as conflict between the couple (Westman and Vinokur 1998); workers' personality factors, e.g. workaholism, work salience, or type-A behaviour (Burke et al. 1979; Campbell Clark 2002; Pavett 1986); and the presence of children in the family (Friedman and Greenhaus 2000; Jones and Fletcher 1993), influence the crossover process.

To summarise, one can say that whatever the processes, e.g. spill-over and/or cross-over, and mechanisms, e.g. empathy, common stresses, and/or conflicts, stresses at work experienced by the workers affect their spouses' well-being and in return their own. These processes are influenced by workers' work salience, couples' gender role ideology, and the presence of children etc.

After this discussion, one needs to discuss the theoretical foundations, methods and 'well-being interlinks' related findings of this study.

THEORETICAL FOUNDATIONS

The conduct of this study was informed by Lazarus' cognitive mediational stress theory (Lazarus and Folkman 1984) and Collins' Afro-centric feminist epistemology (Collins 1990).

Lazarus' theory provided the basic guidance on how stress research should be conducted. According to Lazarus and Folkman, there is no other way of studying such a subjective phenomenon as stress and its effects, apart from listening to the target individuals (Lazarus and Folkman 1984, pp. 261-333). Lazarus even suggested that depth interviews are best for stress-related studies, because they are more accurate in revealing what is happening in individual lives and its personal significance to them (Lazarus 2000; Lazarus 1990). Since the stress dynamic is individualistic, Lazarus suggested that in studying work stress, as a more general view is needed to improve conditions at work, one should study a monocultural sample (Lazarus 1991). The latter is important because monocultural workers have similar goals, values, beliefs and coping strategies which reduce differences in their stress dynamics, thus rendering their data suitable for aggregational analysis (Lazarus 1991).

More specific guidance on data collection and analysis concerning racism was provided by the Afro-centric feminist epistemology (Collins 1990), which I consider to be a generic dominated groups epistemology and thus suitable for the Indian-origin participants of this study (Author 2007, pp. 106-7). Collins suggested that data should be collected with an ethic of caring based in racial consciousness together with inter-participant oral data validation; and analysed through aggregation and re-articulation of the participants' experiences (Collins 1990, pp. 201-20). The findings so produced are a preferred partial perspective on their situation of domination and its consequences, because 'Black feminist thought is less likely than the specialized knowledge produced by dominant groups to deny the connection between ideas and vested interests of their creators' (Collins 1990, p. 234).

Based on the above, the methods were as follows:

METHODS

Sampling: A sample of eight⁵ couples was achieved through advertising in the electronic newsletter of BAPIO (British Association of Physicians of Indian Origin) and snowballing.

Sample details: The sample was made up of mainly middle-grade surgeons and their wives who were all Hindus. All the doctors had qualified in India. There were equal numbers of employed women and homemakers but all were graduates. All the couples had children at the time of data collection.

Data collection: The first interviews were semi-structured and in-depth, and these were conducted with each participant separately in his/her home. Participants provided accounts of either their own or their husbands' experience of racism at work; its impact on their own and their spouses' well-being; support they received from their spouses; and their views on how racism-induced stresses and strains travelled

between the spouses. In order to clarify issues raised during the first interview, a shorter telephone interview was conducted with each participant. The combined average length of two interviews was 3 hours for the doctors and 2 hours for their wives. Three first interviews were hand noted; the rest were audio-recorded and transcribed. During transcription, the data was anonymised so as to protect the participants' identity. For example, participants' names were replaced by their self-chosen pseudonyms, and the names of cities and Health Trusts etc. were fictionalised. Furthermore, I have used the title 'Dr' for doctors who chose alphabet names as their pseudonyms to avoid any confusion.

Data analysis: The aim was to find generic pathways that interlinked spouses' well-being as described by the participants, therefore transcripts were read to identify the relevant text and coded. These were then displayed in a conceptual meta-matrix using Miles and Huberman's case stacking ideas (Miles and Huberman 1994, pp. 172-206). This meta-matrix consisted of three matrices, where row headings were pseudonyms for the couples, column headings were codes, and cell entries were the quotes and my interpretations of them. The purpose of building this conceptually ordered meta-matrix was to reveal similarities and differences in sub-themes on a cross-case/couple basis. Obviously, similarities were the sub-pathways, i.e. within a pathway, that interlinked couples' well-being across the cases. However, reasons for lack of agreement, i.e. a sub-pathway either not functioning or functioning in an opposite way for a couple/s, were also identified. This 'negative case confirmation' analysis is essential for generating generic pathways and is a hallmark of quality in qualitative research (Mason 2002, pp. 194-8; Mays and Pope 2000).

FINDINGS: INTER-SPOUSE STRESS AND STRAIN TRANSFER PATHWAYS

The pathways were grounded in three areas and were named accordingly: supportive behaviour of the wives, the nature of inter-spouse communication, and husbands' behaviour with the couples' children.

Supportive behaviour pathway

Couples in this study had a traditional gender role ideology driven by Hinduism (Author 2007, pp. 295-7). In this context, wives provided extensive emotional and instrumental support to their husbands and related to this there were two sub-pathways.

Unreasonable support expectations, provision and stress transmission

By unreasonable support expectations, I mean where the husbands' support expectations from their wives were either excessive or were for a type of support which their wives found difficult to provide. There were both excessive instrumental and emotional support expectations and provision.

By instrumental support provision, I mean the situation where wives took up all the responsibilities of the household and children. A good example of this was provided by Dr R's wife, about which Dr R said,

‘I’m taking over more and more now, getting back into being a Dad, but *there was a time when I wasn’t there and she was being both parents.*’
(Dr R, my emphasis)

It is clear that Dr R felt guilty about his wife needing to fulfil the role of both parents while he withdrew from all childcare responsibilities. Together with instrumental support, wives also provided excessive emotional support, and one poignant illustration of this was provided by Tina, who said,

‘Umm honestly sometimes, [...] I say, *‘I can’t take it anymore, just had enough.* I don’t want to talk about it [i.e. racism at work] anymore; [...] *jus[t] just leave the subject completely, drop it.*’ He stops.’
(Tina, my emphasis)

It is clear that Tina was exasperated from listening and talking about her husband’s experience of racism at work or his need for emotional support. Thus, this emotional support expectation can be argued to be excessive since she was fed up with the frequency of it. This increased frequency of talk can be understood in Campbell Clark’s terms, who in her work-home-communication research suggested that people for whom work identity is salient are likely to talk more about work at home (Campbell Clark 2002). As these doctor husbands were highly committed to their work, which was obvious from their desire to train and progress at work (Author 2007, pp. 238-41), their frequent talk about experiences of racism at work is understandable.

Furthermore, this finding is in line with Crossfield et al’s finding that the higher the frequency of ‘negative talk’ about work, i.e. about unpleasant experiences, between the spouses, the greater the crossover of strain from one spouse to the other (Crossfield et al. 2005). However, Jones and Fletcher in their study with professional couples did not find a relationship between the frequency of talk and crossover (Jones and Fletcher 1993).

Furthermore, this situation was not unique to Tina, as another wife, Jane, said,

‘I felt frustrated, but sometimes I thought that it would be the *same old story* so there is no point in asking. *I used to avoid asking because it was too much after coming back from work and then I had to look after children too.* It was *too much to cope with because it used to upset me too.*’
(Jane, my emphasis)

Jane was also overwhelmed by listening and talking about her husband’s experiences of racism at work, or from providing emotional support for it. Unlike Tina, Jane did not ask her husband to stop talking, but she sometimes avoided talking to him, or occasionally withdrew her emotional support from him. This was because of the lack of energy after coming back from work and commitment to children, and to avoid getting upset. According to House, this is quite common among dual income couples, where they have little time and energy to hear about each other’s work stresses because of their multiple responsibilities (House 1981, pp. 106-7).

Furthermore, it is clear that wives found listening to their husbands' negative experiences distressing. This can be argued to be the direct transmission of stress and strain from husbands to wives through empathy, as indicated in Westman's theoretical model of crossover (Westman 2001) and confirmed by previous cross-over research (Rook et al. 1991; Westman and Vinokur 1998).

Furthermore, in some cases, the support expectation was unreasonable because wives found it difficult to provide the type of support that their husband wanted. However, they still provided it due to cultural reasons. For example, Minnie said,

'He used to ask me to come to the [employment] tribunals.

Researcher: Did you go?

Minnie: I did go to the Metrocity one. Once *we had an argument because he had one in Layaga, he wanted me to come but I didn't want to go*, so I said, 'I cannot come because of the children.' *I know he wasn't very happy about that, saying he needed the help and I wouldn't go.'*

(Minnie, my emphasis)

Minnie later explained to me why she did not like to go the tribunal hearings but still attended some of them, because

'[...] when [I thought] about courts [...], the first thing which came to my mind was criminals, [...], so that's why I didn't like going there. [...].

Researcher: Okay, but what is it about a wife that she should go and support her husband?

Minnie: As a couple *you are supposed to support your husband unless you are uncaring.*

Researcher: Ah, so that's what makes you go?

Minnie: Well, it is *cultural as well. I have always seen my parents, brothers and sisters supporting each other [i.e. their spouses] so it would not occur to me to not go.'*

(Minnie, my emphasis)

It is clear that Minnie experienced distress and wanted to avoid attending the tribunal hearings with her husband, due to the mismatch between what was expected from her and what she could do, but she still provided that type of support for cultural reasons. However, one must note that her husband was unhappy because of her withdrawal of support on some occasions, and they had argued about it.

The above are examples of incongruity between support expectations and provision leading to: support providers experiencing support overload, particularly emotional support overload and withdrawing to self-protect; support receivers experiencing dissatisfaction (Shumaker and Brownell 1984); and conflicts between the support providers and receivers (Pearlin and Turner 1995).

In this climate of unreasonable support expectations and provision for work-based stresses and strains, wives felt inadequate in providing the 'right kind' of support to their husbands.

Inadequacy in supporting

The feelings of personal inadequacies or lack of skills to support their husbands arose for three reasons: First, wives felt that since racism was experienced at work they could not personally take any action/s which would change their husbands' situation. Moreover, they did not know how to solve such a problem. This anguish was expressed by Angie as,

‘When [...] a person at your workplace is constantly targeting you, I don't know how to deal with that problem, to be honest with you, [...]. The only way is to get mentally strong [...]. That sort of advice he knows very well [...], so I don't know how much I can do.’

(Angie)

Second, the non-doctor wives, i.e. 6 out of 8 wives, felt that since they were not doctors, they could neither adequately understand their husbands' difficulties nor could they empathise enough with them; and Tina described this feeling as follows:

‘Researcher: You raised the point that you are not a medico, does it matter at all?’

Tina: It doesn't matter really but [it helps to] understand the level of frustration he is going through. Unless [I am a doctor, how would I know] how much [he is] not getting in his professional career; [whether] he is not getting what he need[s] and when he is doing some rubbish job which he doesn't want to do. That job satisfaction, I wouldn't [understand]; I think a doctor would understand more.’

(Tina)

Third, wives felt that they didn't know how to console and/or deal with their husbands' career related disappointments, and Jessie simply said,

‘I don't think whatever I said would matter to him so I don't think I said much actually. [I] just tried to encourage him now and then, other than that I don't know.’

(Jessie)

Riley and Eckenrode in their research with women also reported that women feel distressed when they are unable to help their loved ones due to lack of skills and/or resources (Riley and Eckenrode 1986).

As far as the directionality of the ‘supportive behaviour pathway’ is concerned, I will build understanding through discussing the directionality of each of its sub-pathways and their components (see figure 1). As a part of the ‘unreasonable support expectations [...]’ sub-pathway, wives experienced emotional support overload because of which they took withdrawal action, however reluctantly, to self-protect and that resulted in husbands experiencing dissatisfaction. There was also a question of excessive instrumental support provision by wives, which caused domestic overload. This not only created feelings of guilt among husbands that they were not

adequately fulfilling their role as fathers but also changed wives' career plans and resulted in their reduced well-being (Author 2007, pp. 275-8). Hence, instrumental support overload is bidirectional in terms of strain transfer between the spouses. Overall, 'unreasonable support expectation and provision' is a bidirectional part of this sub-pathway. Within this sub-pathway, there was also empathetic transmission of husbands' stress and strain to their wives, which is a unidirectional element of it.

The inadequacy in supporting is a circular sub-pathway because this stress originated within the wives due to their own perceived inadequacies in supporting their husbands without reaching their husbands. To clarify, by a circular pathway I mean that this stress circulated within wives without reaching their husbands.

The second pathway was related to the nature of communication between spouses. This has two sub-pathways: 'avoiding oral communication', and 'negative interaction'.

Inter-spouse communication pathway

Avoiding oral communication

This had two elements: husbands not sharing their stress at work with their wives, and wives avoiding discussion with their husbands in case they aggravated the situation and it led to arguments. The former seems a contradictory statement in the light of the earlier discussion about the wives' emotional support overload because of their husbands' need to talk, but within this general scenario 'avoiding oral communication' was a regular but intermittent feature of these husbands' behaviour. Avoiding oral communication by both husbands and wives was equally important, but I will first discuss the husbands' efforts in this area. An example was provided by Priety, who said,

'Harry keeps a lot of things to himself and I am also perhaps too selfish, I just didn't ask him. *I have seen him upset.* [...] I was just too busy – first with small children and later with my own exams – to have paid much attention. [...] *Harry didn't want to trouble me either.*'
(Priety, original emphasis)

From the above, it is clear that Harry did not want to share his stress at work with Priety, because he did not want to add to her stresses. Despite this, Priety knew that Harry was distressed. Pearlin and Turner in their work stress research with couples also found that spouses did not want to disclose their work stress to each other, and one of the reasons was to avoid adding to their spouses' existing stresses. However, any such attempts were rarely successful because their spouses could tell when they were distressed as their moods and activities changed (Pearlin and Turner 1995). Contrary to Priety, some wives found this 'not sharing' by their husbands distressing, and Angie in this situation said,

'I don't think he discuss[es] any of his problems with anyone and to be honest that [is] a bit of [a] let down. I hope he shares all [his problems].'
(Angie)

Westman in her review of couples' communication characteristics concluded that wives feel better if husbands share their problems with them and negative when they do not (Westman 2002). In other words, husbands' avoidance of oral communication leads to the increased stress in their wives. There was also the case of wives avoiding communication with their husbands, and Jane explained the reason as,

'I sometimes ask him, 'What's the matter? He says, 'Oh, nothing. I've got a headache or something,' but I know that [...] something has upset him. Now I just go, leave him to it, because [...] he's not going to say and then you get into an argument.'

(Jane)

It is clear that Jane avoided enquiring about the nature of her husband's stresses so as to avoid arguments with him, and it was a learnt action for her. According to Pearlin and Turner, this type of behaviour if repeated frequently can lead to a pronounced undermining of marriage (Pearlin and Turner 1995).

Overall, husbands' avoidance of oral communication led to wives' distress, while wives' avoidance of oral communication to steer clear of arguments with their husbands became a source of distress for the wives themselves. Therefore, this sub-pathway was unidirectional in nature (see figure 1).

Since the issue of arguments between the spouses has already been raised in the above quotes, I will discuss it now. However, first, it is important to clarify that words such as argument, conflict, and negative interaction were used synonymously in this study. This is because the negative interaction behaviours, e.g. criticism, threat, anger, withdrawal during interaction, and lack of warmth (Donnellan et al. 2004), were displayed during and/or after the arguments by these couples.

Negative interactions

Husbands' expressions of anger at home invariably resulted in arguments between the spouses. One example was provided by Dr A, who was unable to get an SHO (Senior House Officer) surgical rotation post due to racism at work and thus became an A&E (Accident & Emergency) doctor. He talked about the recurring arguments with his wife and said,

'I used to say I am just an A&E doctor and she used to ask me, '*Are you frustrated about this, because this is what you are. This is what your job is. This is what you're going to do, so why do you have to be frustrated?*' I used to say that I still love my surgical job; I know [I] can't go back to it now but somehow this comes [again and again]. It goes in sort of a vicious circle. Once you start to talk about these things it ends up in this [...] *frustration that I couldn't, sort of, pursue a surgical career.* When it comes to that point, [...], I show my anger and other things like *I just walk away from her, not talk to her for next twelve hours or something like that. So, I think she is quite upset about that.*'

(Dr A, my emphasis)

In this extract, Dr A found his wife's acceptance of reality upsetting because he saw it as her invalidation of his dreams. This resulted in an expression of anger and withdrawal by him, a 'not talking' episode extending for 12 hours or so, and his wife getting upset. Moreover, this was a frequent occurrence. According to Stanley et al, withdrawal by either spouse during arguments results in frustration for the non-withdrawing spouse, and a less positive view of the relationship by the couple (Stanley et al. 2002).

Furthermore, there were instances of criticism during the arguments, and Jane described the nature of her disagreement with her husband as follows:

'It's just [that] he'd say, 'So and so did this,' [and] I [would] say, 'Why don't you answer them back or say something because I would.' To that he would say, 'It's not like what you think [that] I can't.' And, I would say, 'No *[if] you keep quiet, they will think [that] they can walk over you. You've got to say something or do something.*' And, that's when, [...], we started arguing. [...] It used to make me angry because he was getting upset.'
(Jane, original emphasis)

In the above quote, Jane's disagreement with her husband's way of dealing with racial harassment at work is obvious, which not only led to arguments between them but also increased their frustration. Vinokur and van Ryn in their longitudinal research with recently unemployed couples in America found that criticism of one spouse by the other creates further strain for the couple (Vinokur and van Ryn 1993). Moreover, it is well accepted that negative interaction depresses the mood and negatively affects the psychological health of both spouses (Dallos and Boswell 1993). This point was made by Minnie, who talked about her husband's (i.e. Dr R's) repeated 'shouting and apologising behaviour' in the following way,

'Apologising wasn't acceptable when he used to shout, you know; just doing it then apologising.
Researcher: So he apologised [...], were you back to normal very soon after that?
Minnie: *No, I don't think it'd be normal for a few days. I'd only ask what he wanted for dinner, just a little conversation.*'
(Minnie, my emphasis)

It is clear that shouting transferred Dr R's strain to Minnie which in turn resulted in him feeling guilty, and the whole thing culminated in a few days of strained relations between them, which are presented by Minnie as a few days of lack of normality and 'little conversation'. At this stage, it is important to note that

'among men and women alike, not only do conflicts have the largest effects on mood, but these effects are, in almost all cases, more than twice as large as those of [...] other stress[es]' (Bolger et al. 1989, p. 811).

Furthermore, in the case of marital arguments if an episode extends over days, it has significantly greater emotional impact on the spouses than if it was resolved quickly

(Bolger et al. 1989). This negative emotional impact basically means increased anxiety and depression for both spouses (Abbey et al. 1985).

In this scenario, repeated negative interaction was seen as a threat to the stability of marriage by the couples. One vivid example of it was provided by Dr K, who said,

‘Life was very tense at that time. I felt that my wife would leave me. I wasn’t doing the things which husbands and fathers do. We had *arguments on a daily basis*. They were bad; they weren’t physical, *but led to a lot of mental tension*. That is why I thought that *she would leave me*.’

(Dr K, my emphasis)

Karney and Bradbury in their meta-analysis of 14 longitudinal studies of marriage concluded that negative interactions are without doubt a threat to the stability of marriage (Karney and Bradbury 1995). Furthermore, Stanley et al in their large cross-sectional study of US couples found that negative interaction explained most of the divorce potential for the couples (Stanley et al. 2002).

In this environment of threat to marital stability, couples gave cultural reasons for the survival of their marriages, and Dr R explained,

‘The way I see it is that my marriage is not fragile so it has survived. Number one because there are parents on both sides who we’ve always known.’

(Dr R)

In the above quote, Dr R highlighted the relationships between their birth families as a reason for his marriage’s survival. It is a cultural aspect of a Hindu marriage because marriages are seen as the joining of two families not just the joining of bride and groom, therefore both families exert a lot of pressure on the couple to keep their marriage intact (Vatuk 1972, pp. 73-111). From this and my earlier discussion, it is clear that there is a strong cultural resistance and poor acceptability of divorce among Indian origin couples. Therefore, one can see how the perceived threats to marital stability further intensified the strain on both spouses in this study.

Based on the above, it is clear that negative interaction is a strong bidirectional pathway of strain transfer between the spouses whose potency is increased by the perceived threat to marital stability by the spouses (see figure 1).

Finally, husbands’ behaviour with the couples’ children was found to link spouses’ well-being.

Husbands’ behaviour with the couples’ children pathway

This analysis is based on data from 6 couples, since the situation of two couples was different. One couple had no children during the first period when the husband experienced racism at work; and during the second period the wife moved to India to resume her career and had the couple’s first child there. Therefore, there was no data available from this couple in this area. In the case of the second couple, children were a solace to the father after his experiences of racism at work, therefore data from this

couple is inconsistent with the thematic emphasis here or what happened in the case of other couples. The father in this case talked about his good relationship with the children and neither spouse mentioned inter-spouse arguments due to the father's behaviour with the children. In this way, it confirmed 'husbands' withdrawal and/or punishing behaviour' as a pathway that interlinked other couples' well-being.

Husbands' withdrawal and/or punishing behaviours as fathers

These husbands either withdrew or were irritated and angry with their children, and these behaviours led to stress and strain transfer between the spouses. One example of this was provided by Tanuja, who said,

'He was there but he couldn't give quality time to them. He was just so *busy or tired*. Sometimes I got angry because he didn't give time to children. *I wouldn't say that I didn't get angry.*'
(Tanuja, my emphasis)

In the above extract, Tanuja has raised two points: one, about her husband's tiredness and lack of time which made him withdraw from the children; and second, how this behaviour angered her because she saw 'not giving time to children' as an inappropriate parenting behaviour.

This withdrawal behaviour of fathers is in line with the work-family conflict literature where researchers have found that when fathers spend excessive time at work or are pre-occupied with work issues, they withdraw from their children. In other words, there is little or no interaction between father and children (MacEwen and Barling 1991; Repetti 1994). However, when fathers experience low job satisfaction, due to poor relationships at work and lack of promotion prospects etc., they not only reject but also punish their children (MacEwen and Barling 1991; Repetti 1994). This punishing behaviour was displayed by fathers in this study either as snapping at their children, or as excessive teaching of children and scholastic expectations from them. An example of the former was provided by Tina, who said,

'He was withdrawn from [Tim]. He would get snappy at him.'
(Tina)

And, this snapping at her son, Tim, was very distressing for Tina.

'I [was] mainly [affected by] how his relationship [was] with my son than me. [This] was worrying me more. That was getting really really bad.'
(Tina)

As mentioned before, some fathers' punishing behaviour manifested itself as excessive teaching and scholastic expectations from their children, and Jessie explained her anguish about it.

'You have to learn this' [her husband's command to her daughter].
Sometimes they will sit up to half-eight at night. I feel that [it] is sometimes too much.
Researcher: So, [...] when does he start?

Jessie: He starts at six and it goes on until half-eight, but that will still be the same sum. I don't know what it is whether it is daddy's fault or daughter's fault. [...] *They will both argue and she will cry and I feel like going somewhere actually. [...] She will be so tired, obviously, so she will be in tears and it goes on [for] quite some time. [...] I really feel that whatever he has missed out [...] he is making her do it.*'
(Jessie, my emphasis)

It is clear that Jessie found her husband's excessive teaching of their daughter as a case of not only transferring his expectations on her but also distressing. This was because each teaching session was too long and at the end of them her daughter invariably ending up crying that led to arguments at home. As mentioned before, arguments depress the mood and negatively affect the psychological health of both spouses.

This 'excessive teaching' can be argued to be a manifestation of Indian Hindu middle class belief in the value of formal education for success (Varma 1998; Varma 2005), which was perhaps intensified for fathers as they struggled to achieve success in an adverse psychosocial environment created by racism at work (Author 2007, pp. 166-70).

Overall, husbands' rejecting and punishing behaviours with the couples' children, transferred stress and strain between the spouses through: mothers' feeling distressed by seeing their children in distress; and through mothers' criticism of fathers' rejecting and punishing behaviours towards the children leading to additional negative interactions between the spouses. Hence, this pathway is bidirectional in nature (see figure 1).

To conclude, I would like to concentrate on the factors that accentuated the pathways since a good summary of the pathways is already provided by figure 1, discuss limitations of the study, and consider directions for future research.

CONCLUSION

The participating couples' gender role ideology was governed by the two main tenets of Hinduism: wives must support their husbands; and marriage is forever, meaning separation and divorce are unacceptable solutions to an unstable marriage. The influence of these was particularly obvious in the 'unreasonable support expectations and provision [...]' and 'negative interaction' sub-pathways. To elaborate on the first, wives not only provided excessive levels of support to their husbands but also gave the type of support, they found difficult to provide, e.g. a wife attending employment tribunal hearings with her husband. For these behaviours they gave cultural reasons, e.g. Hindu wives' unconditional support for their husbands, and this is what they have 'always seen'. If we look at the nature of communication pathway, the negative interaction-related threat to marital stability was seen as the exacerbator of both spouses' poor well-being. In the climate of increased negative interaction between the spouses, couples gave cultural reasons for their marriages' survival. For example, marriage is about joining two families and strong cultural resistance to separation and

divorce, which was presented as ‘parents on both sides [...] have always known’. From this one can see how the increased negative interaction-related threat to marital stability increased both spouses’ strain in this study.

Apart from Hinduism, doctors’ personality characteristics; and Indian middle-class values and beliefs also accentuated some pathways. For example, as doctors are very work and success oriented, they found their racism-related negative work experiences very stressful. Hence, they frequently talked about racism at work with their wives, or needed their emotional support. Wives found this emotionally draining and sometimes withdrew to self-protect and husbands found this distressing. In this way, characteristics of doctors, such as high work and success orientation, also accentuated the stress and strain transfer through the supportive behaviour pathway.

As far as the effect of Hindu middle-class values and beliefs is concerned, it was obvious in the functioning of ‘husbands’ behaviour with the couples’ children’ pathway. Belief in formal education for success is a central value of Indian middle class, although some will argue that it is a universal middle class characteristic (Brown 1995). This became an important aspect of the fathers’ punishing behaviour with children where they taught them for long periods, which made both their children and wives distressed, and led to negative interaction between the spouses.

To summarise, couples’ Hindu values and beliefs related to marriage were the main intensifiers of inter-spouse stress and strain transfer pathways. However, the role of doctor husbands’ work and success orientation and middle-class belief in the importance of formal education for success should also be acknowledged in the intensification of some pathways.

However, these findings should be seen in the context of the study’s limitations. As the pathways were derived from retrospective experiential data provided by the participants, some stress researchers would argue that they are their post-hoc rationalisations or perceptions, not the pathways operating at the time of their experiences (Kelloway et al. 1999). However, together with Mays and Pope, I will argue that since the inter-spouse stress and strain transfer pathways found in this study are largely supported by the existing studies of normative work stress and strain transfer studies, they are credible (Mays and Pope 2000).

As far as future research is concerned, larger replication studies are needed to confirm and refine these pathways. The research field will also benefit from studies of different professional and ethnic groups, as inter-spouse dynamics are governed by couples’ cultural and social class related values and beliefs and personality characteristics.

NOTES

1 This study only explored migrant Indian doctors' experiences of racism at work. Such monocultural studies are non-existent. The UK studies of racism in medicine group Indian origin doctors, i.e. both UK and non-UK qualified, with other minority ethnic and Black doctors. The latter group is then called: non-White, overseas, non-EU (non-European Union), or Asian doctors. The majority of non-EU doctors are of Indian origin (DoH 2004). To explain, according to the 2003 medical workforce census for England, 29% of the medical workforce is made up of non-EU doctors (DoH 2004). Out of these non-EU doctors, 67.6% are Asian doctors (DoH 2004). Since the DoH does not provide further breakdown by ethnicity, I will use Decker's estimate based on 1991 medical workforce census that approximately 75% of Asian or Asian-British doctors are of Indian origin (Decker 2001). Therefore, terms such as non-White, minority ethnic and Black, non-EU, overseas and Asian doctors were treated synonymously in this study.

2 Non-trainee hospital doctors, e.g. Associate Specialists, Clinical Assistants, Staff Grades and Hospital Practitioners, are collectively called middle-grade doctors.

3 Inter-spouse stress and strain transfer studies which collect data from both spouses provide a better picture of the family stress dynamics, and thus of inter-spouse stress and strain transfer processes. Therefore, they are more desirable than the studies which collect data from the workers only (Westman and Piotrkowski 1999).

4 There are two types of support that the individuals in one's social network, e.g. friends and family, can provide, and these are: emotional and instrumental support. Provision of emotional support includes expression of concern, listening, empathy, respecting, and caring to enhance the well-being of the support receiver (House 1981, pp. 13-40). Provision of instrumental support involves giving money, labour, or time to modify the environment of the support receiver to enhance his/her well-being (Hose 1981, pp. 13-40; Shumaker and Brownell 1984).

5 This includes seven couples recruited during the main study and one couple from the pilot study.

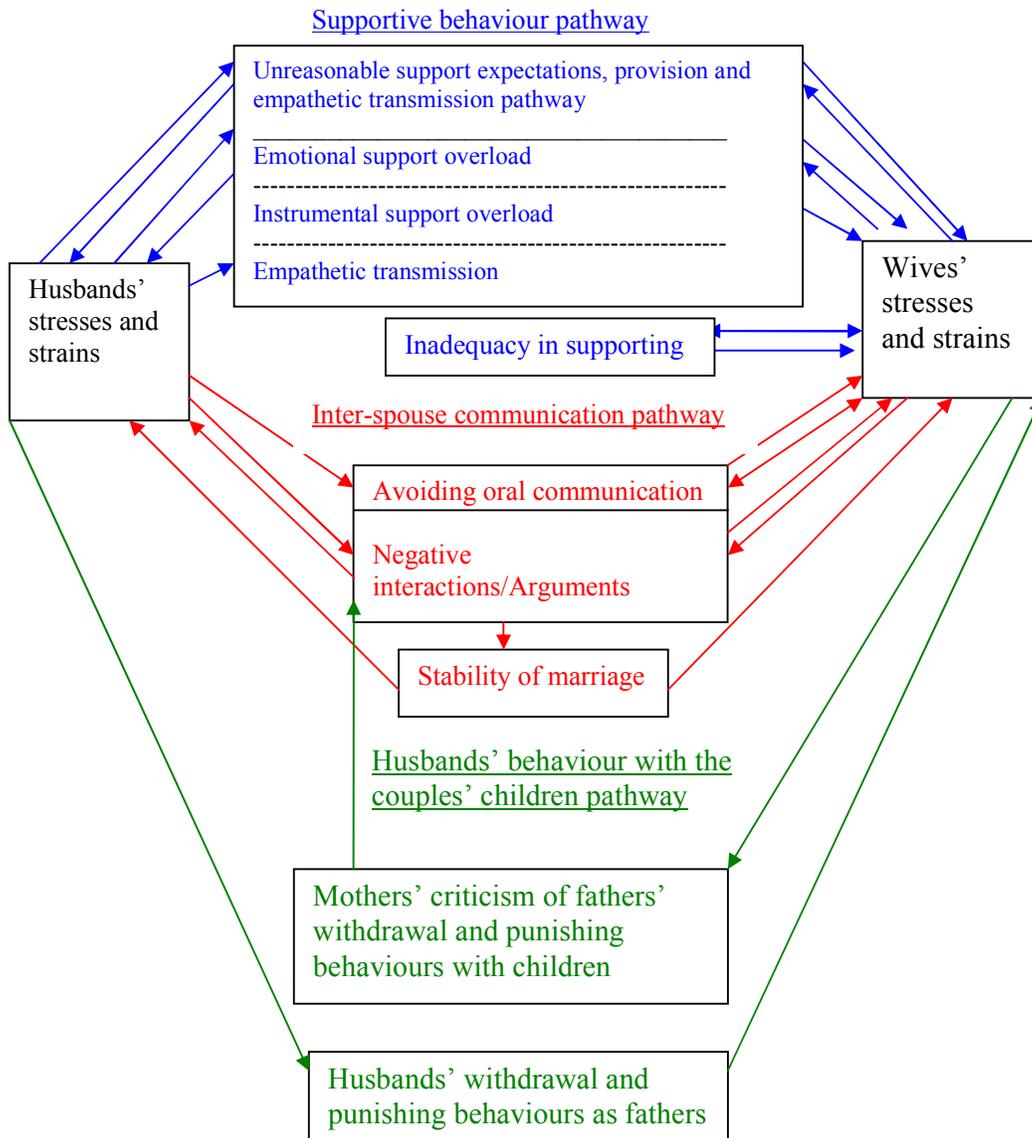


Figure 1, Racism at work: Spouses' well-being interlink pathways

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