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Getting that Certain Feeling: The Role of Emotions in the Meaning, Construction and Enactment of Doctor Managers' Identities

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Although identity research in organizations has increased in recent years, none of the current perspectives has examined the role of emotion for understanding how individuals construct and enact professional identity. In this paper we examine how emotions affect the development, conduct and meanings of professional identity among a sample of 20 doctor managers from two Spanish hospitals. While not excluding other approaches, we found that a social identity approach was especially useful. The contribution of this paper is threefold. First, our results provide new insights about how, in a work setting, emotions prioritize awareness of identity issues that need attention. Second, we discuss the role of emotions for understanding complex role identities by reference to the enactment of different sides of doctor managers' identities. Third, we show how our analysis of the findings may be used to embellish the social identity approach.

Introduction

It is now 30 years since the publication of Tajfel and Turner's (1979) seminal account of social identity's importance for understanding organizational and other forms of social life (Albert, Ashforth and Dutton, 2000; Hogg and Terry, 2001). Since then, Tajfel's (1978, p. 63) exposition of social identity has been acknowledged in a body of research that has not merely validated his original ideas and principles in a host of settings but also, with the development of social categorization theory (SCT), extended its reach to encompass the antecedents of identification. Over the last decade, however, other approaches to understanding identity have also developed in importance. According to Alvesson, Ashcraft and Thomas (2008, p. 5) not only has 'identity ... become a popular frame from which to investigate a wide array of phenomena', but also research into work identities has prompted new theoretical perspectives and analytical debates to emerge which have extended our understanding of how identity can be examined and understood. Here, interpretive and post-structuralist approaches have been seen as the main additional theoretical perspectives on identity.

The last two perspectives have been valuable in encouraging new questions about the nature of identity including whether it is something enduring and central to each of us or temporary,

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malleable and context-sensitive (Ashforth, 1998; McAdams, 1996); the extent to which identities are integrated or fragmented (Clarke, Brown and Hope Hailey, 2009; Worthington, 1996); and the different structural levels at which identity operates such as organizational, group or individual levels (Ashforth, Harrison and Corley, 2008; Watson, 2008). Yet, despite the broadening of focus on identity this has entailed, none of the approaches that has gained prominence has examined the possibility that emotions play a part in the construction and experience of professional identity at work. Instead, each perspective, in its own way, has retained a cognitive-focused examination of how individuals or groups construct and interpret identification. In one respect, this is surprising since Tajfel's original conception of social identity included an emotional emphasis. When describing social identity he referred to it as 'the individual's knowledge that s/he belongs to certain social groups together with some emotional and value significance to him/her of this group membership' (2010, p. 2). Thus, Tajfel envisaged a theory that could attend to both the cognitive and emotional bases of intergroup differentiation.

Using a study of doctor managers (DMs), this paper takes up this issue by exploring the role that emotions play in the construction, meaning and enactment of professional identities. Prior health sector research has studied the relationship between medical engagement and organizational performance as part of an agenda to increase organizational performance and patient services (Ham and Dickinson, 2008; Hamilton *et al.*, 2008). But while these assessments of the engagement in management of medical and clinical directors in different health systems and countries have linked the outputs of health reform to how much doctors are engaged in leadership, they have ignored the underlying processes that explain such outcomes.

To explore the processes by which DMs may be able to identify with their professional group, occupation or role (Watson, 2008), we draw in part on the social identity approach (SIA) incorporating social identity theory (SIT) and its conceptual companion SCT (Haslam, 2004). While not excluding other approaches that may help us to explain emotional identity experiences, the SIA is useful in examining the processes by which collectives and individuals perceive and act towards their own and other significant groups (Bornman and Mynhardt, 1992; Turner and Oakes, 1997). In this way, we conceive identification as an evolving process by which the individual uses some social categories as self-defining and self-involving (Pratt, 1998, pp. 172–174). In essence, then, we acknowledge that constructing and enacting identity involves a dynamic process of becoming (Alvesson, Ashcraft and Thomas, 2008) 'by which people come to define themselves, communicate that definition to others and use that definition to navigate their lives, work-wise or other' (Ashforth, Harrison and Corley, 2008, p. 334).

The paper is structured as follows. First, we trace the failure of the literature on work identity to address emotional issues. Drawing on emotion and identity theory and research, we then show how the SIA may be embellished from social constructionist and identity theory traditions on emotion. The value in adopting this approach lies in the opportunity to incorporate emotions into our understanding of how social identity is perceived and constructed in novel situations. Thereafter, we present the research procedure and method before examining our findings on how DMs defined themselves; the role that emotions played in these definitions; and how emotion affected identity enactment. In the conclusion, we discuss our findings and their implications for enhancing the SIA.

Emotions and identity – a well-matched couple in organizational behaviour research?

While several assessments of research into identity in work and organizations from different theoretical perspectives have emerged in the last five years (Alvesson, Ashcraft and Thomas, 2008; Ashforth, Harrison and Corley, 2008; Jaros, 2009; Marks and Thompson, 2010), none of these directly addresses emotions as a key element in how identity develops and is experienced. This is not to say that emotion is never mentioned, however. Meyer, Becker and Van Dick (2006), for example, argue that social identities have cognitive, emotional and evaluative aspects which according to Jaros (2009) might mean that in some settings emotion

becomes more crucial to identity construction or maintenance than cognition. Nevertheless, as Harquail (1998) notes, detailed conceptualization of emotion and its place in understanding identity in the workplace has never attracted serious research attention.

This neglect of the role of emotion in identity by organizational researchers seems surprising for several reasons. First, and perhaps most significantly, has been the fact that emotion has become a popular focus in a number of organizational research areas (Briner, 1999; Fineman, 2000) such as emotional labour (Ashforth and Tomiuk, 2000; Bolton and Boyd, 2003; Hochschild, 1983; Rafaeli and Sutton, 1990; Sutton and Rafaeli, 1988; Van Maanen and Kunda, 1989), where emotion research has become synonymous with examining the ways that managements attempt to shape worker displays of feelings for organizational purposes (Morris and Feldman, 1996, p. 987).

More recently, studies of the emotional features of the workplace have expanded beyond just workers' expressions of organizationally scripted emotions to include their felt emotions (Booth and Mann, 2005; Domagalski and Steelman, 2005) or feelings according to Fineman's (2000) distinction. This widening of scope reflects a logical shift away from just examining organizational antecedents and outcomes of expressed emotions (George and Brief, 1996; Rafaeli and Sutton, 1989; Weiss and Cropanzano, 1996) to an in-depth understanding from social constructionist perspectives (Coupland *et al*., 2008; Fineman and Sturdy, 1999; Grandey, Tam and Brauburger, 2002; Mumby and Putnam, 1992; Patient, Lawrence and Maitlis, 2003). These perspectives understand emotions as a product of the way that systems of meaning are created and negotiated (Ashforth and Humphrey, 1995; Harré and Parrott, 1996) and include an analysis of the social contexts in which emotions are felt or displayed. In related vein, Domagalski (1999) has called for research to shift beyond the current emphasis on organizational goals towards examining worker outcomes.

While scholars have answered this call by focusing on outcomes at an individual level such as job satisfaction (Glomb, 2002) and stress (Côté, 2005), this approach has not extended to a consideration of the direct influence and effects of emotions on worker identity. For example, Vince (2006) focused on the emotions generated by managers' attempts to rationalize and cope with takeover. He proposed a two-way connection between emotions and reason in which individuals' rationalizations of intense emotions then elicit broader emotional and political consequences for the organization. Similarly, Gabriel, Gray and Goregaokar (2010) examined emotions in managers' narratives of their experience of job loss, but like Vince (2006) they too did not examine the role that emotions might play in constructing identity. And while Ashforth and Humphrey (1993) do refer to the influence of identity on the negative effects of emotional labour, they do not explore the influence of 'felt and displayed emotions' on the construction of professional identity.

This neglect to directly examine the role of emotions in identity processes seems curious since considerable research linking identity and emotion theoretically has been undertaken outside the fields of management, work and organization (Stryker, 2004). Among the most important findings has been Simons's (1999) evidence that the salience of identities affects the level of emotional reaction. That is, in comparison with their effects on less valued identities, events threatening highly meaningful identities engender stronger negative emotions whereas events reinforcing such identities engender stronger positive emotions. Emotion is also found to signal threat or satisfaction not only to the person but also to who or what they are (Thoits, 2003).

Taken as a whole, the research reviewed by Stryker provides compelling evidence of the importance of emotions in the construction and experience of identity. Yet, in itself this evidence does not provide a way to apply what is known about emotion and identity in this general sense to existing perspectives on identity in the workplace. In thinking further about this issue, the next section considers the extent of the task to integrate emotion into a conventional approach to examining professional identity such as SCT and SIT.

Missing emotions in the SIA

The SIA should be a useful starting point for this study because we are examining professional identities as a social group category and explor-

ing doctors' and managers' occupations as targets of identification. The SIA comprises two theories. SCT focuses on those aspects of identity which derive from the groups we belong to and how we set about socially defining ourselves in important memberships. SIT examines the processes by which collections of individuals perceive and act towards their own and other relevant groups. Both theories have been found helpful for illuminating identity definitions and relations between organizational groups including those that can evolve between DMs, clinical groups and hospital managers (Hallier and Forbes, 2004, 2005). Moreover, Ashforth and Mael (1989) concluded that applying SCT to organizational problems can help with understanding the resolution of multiple role demands and the ordering of multiple identities. And so, because DMs perform separate roles as clinicians and as managers, this framework is not just applicable for understanding identification through group membership but also the situation where the target of identity is the DM role itself.

But while these theories contribute to our understanding of the cognitive processes involved in identity construction and group relations, neither considers the emotional issues that might arise. Yet, while both SIT and SCT have developed through an important cognitive agenda (Haslam, 2004), this is not to say that emotions could not become incorporated if they have a place in identity. And there is much reason to believe this is possible. Both theories already contain certain identity processes which we would expect to be understandable not merely in terms of cognitions but also in terms of emotions.

Tajfel's original scope for SIT, for example, included sources of identity salience: the individual's and group's responses to threats to group status and self-esteem from other groups and uncertainty, as well as the causes of stereotyping of outgroup and ingroup bias in members' quest for positive distinctiveness. These aspects of social identity experience implicitly emphasize motives and values that we would expect to contain emotional as well as cognitive content. And while recently Haslam and Ellemers (2005) have begun to consider the motivational bases for identification, emotional issues remain largely unattended by the SIA.

An example of this neglect can be seen in SCT's reading of how uncertainty in a new identity is reduced. Hogg and Terry (2001) suggest that uncertainty reduction about matters of value to the self provides groups with confidence in how to behave and what to expect from a particular situation. As elsewhere in the SIA, identity uncertainty and threat are dealt with as a wholly cognitive process. Any uncertainty caused by a novel environment such as a novice DM role is assumed to be managed solely by checking and amendment of image to ensure its compatibility with personal and social identity. Where content-related expectations are not met, the prepared identity will cease to be evoked to make sense of events or define the person's actions (Haslam, 2004). Yet, in response to identity uncertainty from contradictory experiences in the chosen group, we would expect the individual to feel at least some emotional stress, if only from facing role ambiguities or conflicts. Stryker (2004) confirmed this by finding that unmet identity expectations give rise to negative affect towards others (anger, disappointment) and self (embarrassment, guilt) that lower self-esteem. Generally, the more discrepancy from expectations, the more intense the negative affect, especially when the person's obligations are considerable. Failure of others to meet expectations that prevents persons from meeting their own role expectations also intensifies emotional displays towards others. Both Heise (1979) and Burke (1996, 2004) found that resolving these identity uncertainties was strongly dependent on the person's capacity to maintain a low emotional level. Such findings therefore suggest that the inclusion of emotion in the SIA might clarify its conventional explanations (Harquail, 1998).

Consequently, while some of the basic findings on emotion and identity helped to sketch out how they might articulate with the SIA, essentially this was an exploratory investigation which sought to develop explanations of doctors' emotional and socially constructed experiences from the data that emerged (Skinner, 1985; Starkey, 1990).

The research setting

Similar to many other western European countries, the 1990s saw a new public management logic adopted by the Spanish Health Service as part of a reform agenda to improve efficiency and effectiveness. Catalonia was one of the first

regions to implement these changes with its Parliament passing the Law for Healthcare Administration in Catalonia in 1990.[1] Besides separating provision and purchase of healthcare services, introducing contractual relationships between these parties and creating a competitive environment within healthcare provision (Gallego, 2000), Catalonia was unusual in introducing private sector management logic into public hospitals. Clinicians were incorporated more fully into management by devolving accountability for units' resources to DMs. Although it might be tempting to see this initiative as no different from others in northern Europe and particularly in the UK, there are notable variations. For example, unlike the UK where doctors are appointed to clinical director for a fixed term, Spanish DMs often remain in the role for the rest of their career. This provided the opportunity to examine the evolution of DMs' identity experiences over considerable lengths of service. Such differences make Catalan hospitals suitable as 'extreme case' contexts (Eisenhardt, 1989) for exploring identification within the managerial role in professions like medicine that have traditionally been regarded as vocational.

The fieldwork was conducted in two teaching hospitals in a health region of Catalonia. Both hospitals were sampled because they were experiencing organizational changes driven by a new public management logic that included increasing clinical directors' involvement in management. To maximize opportunities for comparison, we selected a privately managed public hospital (hospital A) and a public-owned and managed hospital (hospital B). Both teaching hospitals were similar in size and in their specialties. In hospital B, 'clinical director' was a permanent position and selection was by entrance examination, whereas in hospital A appointment was by senior management. In hospital A, senior management could demote clinical directors back to doctors, whereas in hospital B this was not possible. Another difference between these hospitals was hospital directors' clinical expertise: whereas the medical director of hospital A had a clinical specialty in preventive medicine and public health, in hospital B the medical director had no clinical specialty but a Masters degree in health management.

Although the job description for DMs in hospital A included more management emphasis than in hospital B, no differences were found when participants from each hospital were asked to describe their jobs and to allocate actual and ideal percentages to the time devoted to each of these duties: clinical work, administrative tasks, people management, financial management, teaching and research. Variations in these perceived percentages and comments by DMs confirmed that their roles were not clearly defined. That said, most of them grouped people management, administrative tasks and financial management into one broad category termed 'administrative work'.

Research procedure and data collection

Our study adopted a constructionist perspective using a grounded theory methodology (Glaser and Strauss, 1967), although we entered with some notions of the issues that might be of theoretical importance. Therefore, we adopted the Straussian mode of this methodology (Strauss and Corbin, 1998). This methodology was suitable to our research since we aimed to extend the theory (Locke, 2001) of professional identity construction by understanding how DMs assemble, understand and enact their identities. Following Craib (1997), we recognized our subjectivity as researchers and our results as social constructions of DMs' realities. Fieldwork was undertaken over 12 months by one of the authors, a Spanish 27-year-old female. She presented herself as a PhD researcher and an economist when negotiating access with senior management but once in the field she also presented herself as a psychologist. The latter category, combined with the white coat that senior management recommended she wear, helped participants to trust her almost as an insider. In fact, DMs referred to her as 'the hospital's psychologist'.[2] This label was indeed helpful in eliciting participants' candour. Using a

[1]Llei 15/1990, de 9 de Juliol, d'Ordenació Sanitària de Catalunya (D.O.G.C. no. 1324 de 30-7-1990).

[2]For instance, in hospital A while having a coffee alone in the bar she overheard a group of DMs say: 'Have you already talked to the psychologist? It's so therapeutic, you'll see.' I felt that at least I was giving them something back in return for their rich information.

reflexive approach to interviews (Alvesson, 2003) also helped us understand how interviewees constructed the interview situation and the interviewer's role.

To ensure an emic perspective, senior and middle management were asked to identify the middle management ranks within the hospitals. They identified clinical directors (doctors), ward managers (nurses) and middle managers from general services. Data were collected through several methods. A primary method was in-depth semi-structured interviews with 20 out of 34 clinical directors, ten at hospital A and ten at hospital B. Interviews lasted two to four hours over two rounds and were recorded and transcribed. Opportunities to build theory were sought by diversifying our sample of clinical directors by age, speciality, gender, tenure in their position, previous training in management, tenure in the hospital and number of staff. To ensure appropriate selection, informal conversations and participant observation were undertaken. The interviews were framed by a number of core question areas: how participants defined themselves as professionals; perceptions of difficulties and experiences of their managerial role; content of their managerial role; role transition; and relationships with senior management and with subordinates. However, participants were free to raise and explore anything they considered salient to their experiences. We also interviewed senior managers from both hospitals to compare their impressions with those of clinical directors.

Other data used included handwritten field notes taken from participant observation of doctors at work and from 'hanging around' observing the dynamics that occurred in relation to our research interests. In interactions with actors such as hospital managers and unit clinicians, gesture, tone of voice and choice of language were observed as manifestations of DMs' felt emotions. Interviews and observation were the main data collection methods as they have proved suitable elsewhere for understanding actors' subjective feelings, personal meanings and emotional interpersonal dynamics in specific contexts (Fineman, 2004; Sturdy, 2003). Nevertheless, hospital documentation and records covering the period studied were also examined to provide information about the setting and enrich our understanding of the data collected from interviews and participant observation. These included hospital pamphlets, websites, news articles, internal department files on job descriptions and performance assessment templates.

Data analysis

We entered the field with two broad research questions: how did our sample of DMs experience their roles as managers and what factors influenced their perceptions? To answer these questions, for analysis of the data we adopted what Glaser and Strauss (1967) call constant comparison analysis where data gathering and data analysis activities are intertwined. No preconceptions were imposed with theory emerging from 'constant comparison' of interview data, observational notes and documentary evidence.

The data were initially organized into first-order codes such as 'self-definitions' (i.e. doctor), 'meaning of management' (i.e. distance from reality), 'meaning of clinical work' (i.e. close to reality), 'difficulties perceived' (i.e. lack of autonomy), 'emotions' (i.e. loneliness). These were integrated into emerged key categories and then interrogated for fit while being alert to the possibility of contrasts and disconfirming data. As we proceeded from open coding into axial and selective coding (Strauss and Corbin, 1998), analysis explored differences within professional identity as the key category that emerged. Thereafter, we attempted to explain the source of any differences, identifying the relation between their identities, previous exposure to management, tenure in their positions and the emotions reported. At this point we returned to the literature and discovered a fit between our emergent model and SIA as a suitable theoretical framework. NVivo software was used to organize these data from interviews and participant observation.

Emotions and the construction, meaning and enactment of DM identities

Our findings are presented in two sections. The first considers the role that felt emotions played in the construction and meaning of our DMs' identities. In the second, we examine how felt emotions shaped the enactment of their identities in different interactive settings. In the first section

the results are drawn from our interviews, whereas in the second they derive from interviews and participant observations.

Becoming with feeling

In this section, we consider how our DMs defined themselves as professionals. All DMs defined themselves as clinicians no matter their age, medical specialty (clinical and non-clinical, and within the former, surgical and non-surgical[3]), gender, length of hospital employment, or their reasons for entering clinical management. While we had expected that DMs working in the privately managed hospital would define themselves primarily as managers because of the private sector's explicit commercial emphasis, this too had no differentiating effect:

> I'm a doctor. I mean, a doctor by definition is someone who feels that they are a doctor. Appearance is another thing, isn't it? How it is portrayed ... if you do any managing. But when you're with a patient, a doctor is a doctor. (Dr C)

> Above anything else I'm a doctor, but you have to get involved in management and you have to do it well. (Dr G)

These quotes exemplify Rousseau's (1998) distinction between situated and deep structure identification. That is, DMs' deep-seated identity was that of doctor since for them medicine was a vocation, whereas the notion of manager, although often perceived as an important role, was something they did for supplementary reasons. As deeply meaningful, the 'doctor' categorization lay embedded at the core of the self, whereas the manager role might or might not be integrated into their DM identity as a surface layer. For some this outer layer contributed to their self-definitions but for others it was insufficiently meaningful to become self-defining. In this way, both categories were constituted according to their relevance and importance to their definition of self.

Given that our entire sample defined themselves essentially as doctors the question arises why only some DMs identified with managing. Reference to SCT suggests that the employee's readiness to adopt a new identity emanates from assessments of what are referred to as comparative and normative fit. People seek comparative fit by defining themselves in terms of the group that they regard as most similar to their own characteristics compared with other available memberships (Haslam and Turner, 1998; Oakes, 1987). Yet we found that comparative fit was not merely a purely cognitive process of choosing between available role/group identities. Rather, it was emotions elicited by doing management alongside clinical work that first signalled to them the attractiveness and meaning of their role as an identity. For example, in some DMs, a lack of match between the characteristics of managing and their pre-existing doctor identity emanated from how management activity induced feelings of anxiety, sadness and insecurity:

> I feel awful when I get to my office, close the door and see all the papers and things I have to do all over my desk. ... all of a sudden I just want to get out from my office and go back again to the operating theatre where I really feel I'm in control. ... here [his office] it's all uncontrollable and that makes me feel stupid and anxious ... I was happier when I just attended to my clinical duties. (Dr F)

Following Stryker (2004), these unmet expectations directed their negative feelings not only towards themselves but also externally towards the hospital managers. Thus, emotions not only influenced their negative definitions of managing but also generated a need to disassociate their role as a DM from the identity of manager. To do this, they relied on the defence mechanism of projection in which a person ascribes a fear onto another person or group (Holmes, 1978). In this way, DMs projected their fears about managing onto hospital managers as the only people who 'managed'. As DMs they were doing something different referred to as 'organizing their unit'. Disgust and contempt for managing even spread to the vocabulary of management:

> **Could you tell how much of your daily work is providing care, how much is management ...?** (interrupting) I don't actually see many patients now. But I don't like the word management very much (grimaces in disgust). I prefer organization. (Dr V)

Negative emotions centring on the value of managing also emerged in DMs' efforts at

[3]Non-clinical specialities have a low degree of patient contact whereas clinical specialities have a high degree of patient contact. Surgical specialities help acute problems through direct and invasive intervention.

achieving normative fit. Like comparative fit, normative fit is seen as an important matching process in determining the person's readiness to adopt a social identity. Here, the person seeks consistency between his/her expectations and the presumed goals, values and behaviours associated with belonging to a particular group. However, SCT says little about whether this process is begun before or after accepting a role. In our study, those DMs who rejected a management identity had undertaken very little preparation and experienced the most negative emotions. Indeed, where negative affect about managing became salient, DMs had usually accepted a management post for instrumental reasons such as promotion, work change, salary improvement or work–life balance.

In order to feel self-worth while managing, these DMs felt it was crucial to emphasize their medical practice as doctors. Their lack of fit with the goals and values of managing was underscored in the positive emotions elicited by clinical work such as feelings of control, enthusiasm, security, self-confidence, self-efficacy and belongingness to a meaningful group. These emotions not only underpinned these DMs' self-esteem but also tied them to the practice of clinical work. As the following quote illustrates, once they became a DM the opportunity to practice their clinical skills became essential if they were to continue to see themselves as doctors:

> What I could not do, what I could never do, is stop providing medical care (said emphatically). That's to say, if I stop operating, if I stop operating . . . I might just as well give up. That is what I could never stop doing . . . but everything else you do because you have to . . . That's why I'm a doctor. (Dr B)

By contrast, those DMs who identified themselves with their management roles were mostly characterized by a passion to 'lead' and 'command' and to improve clinical working practices. This matching of self with other managers and management's goals mainly occurred because the idea of leading and the language of management and business were seen as natural to them. Usually, they had sought out some prior exposure to management work under the guidance of a former head of unit or been brought up in their family's business.

> For budgetary reasons, I'm buying prostheses cheaper than anyone else in Catalonia! Why? Well, because I know the market, because all my family has always been in business, because doing business is in my blood, because my father was a businessman and my brothers still are. So, yeah, I've lived in a business environment all my life. And, hell, I've got principles. Look, in this world, everybody's selling, you know. But when I tell other doctors that, they tell me I'm mad. (Dr G)

From this, we might assume that this enthusiasm merely reflected DMs feeling increasingly positive emotions of security, ability and power as they gain experience of managing. Yet, some novice DMs exhibited equally positive emotions and meanings towards managing. Like their more experienced colleagues, these novice DMs defined themselves as 'born leaders' and recounted instances where they had shown natural leadership at school. Two of them were so convinced of their 'born' leadership qualities that they believed they could see these 'leadership traits' in their children.

This is not to say that management identifiers always displayed positive emotions from managing. Unlike their colleagues, however, these negative emotions were not directed at their managerial identity. Instead, these emotions were accounted for by projecting their origin onto the inadequacies of the hospital health system. Typically, expressions of intense anger and frustration arose from what they saw as their lack of autonomy and resources to manage their units adequately.

> If you have technical expertise but . . . well . . . can't control the money, if you can't get hold of the money to buy material or personnel, if you can't take that decision, then you're in a straitjacket that . . . well, chokes you! (Dr R)

Equally, a sense of the isolation of their positions was felt by almost all DMs. But while commonly experienced in the role, these feelings of loneliness gave rise to different emotional responses between fledgling and experienced DMs. For inexperienced DMs this feeling of loneliness was felt as intense sadness and provoked attempts to escape into clinical work. However, with time, these feelings eventually became accommodated as a price of being a manager:

> I'm a born leader! (said passionately). But I'm finding it difficult because I was much happier when I was everybody's mate, one of the lads (sadly). It was much easier then. The leader is just so lonely!

> I'd like to go out for a few drinks and get drunk now and again with my workmates but I can't! And today I'd like to go out for lunch with them and have a paella . . . I'd love to . . . but I won't. Mmm . . . I also like the trade union world but I can't get involved because I'm a director. But I've got used to it now! (Dr G)

Thus, in contrast to those who merely endured their managing role, negative emotions among management identifiers, whatever their intensity, could be kept separate from the value they felt for managing. For them, their identities adapted sufficiently so that while their self-definition was still primarily that of doctor they could assimilate their managerial identification enough to see themselves positively as members of a distinct group that was different from management and from medics (Nicholson, 1984).

In considering these different responses to managing, these findings suggest several possibilities for how emotion might add to the usual process of identity construction under SCT. For instance, doctors' identification was found not just to be reliant on a process of cognitive 'matching' of characteristics that defines the self and the role. In addition, the emotions provoked by these early experiences of managing appeared to unconsciously signal the value of the managing role identity as positive or negative. That is, DMs' emotions conveyed the importance of incorporating the managing role into their identity with positive emotions motivating identification and negative emotions confirming its inconsequentiality. In also associating certain emotions with particular tasks or interactions, feelings also helped DMs to develop the meaning given to the role. In these two ways, emotions that emanated from particular experiences enabled doctors to develop their rationales of managing that in turn helped them explain the causes of negative experiences. Of particular note here was the way that both management identifiers and those who merely tolerated managing used projection to shift negative aspects of the role away from themselves and onto the members and goals of hospital management. In taking Vince's (2006) findings a step further, therefore, DMs' negative emotional experiences shaped identity rationales and meanings that the process of projection could then protect and refine. In the next section we explore further this relationship between emotions and identity rationales by considering the ways that emotions impacted on the enacting of these complex identities among our leader DMs.

Emotions and the enactment of multiple self-categories

Emotions were not only vital in the process of constructing and providing explanation of the DM identity but were also important in signalling which particular self-categories to use in particular interactions and settings. That is, once constructed, these identities and the explanations that derived from these emotions then went on to shape the emotions and behaviours that arose subsequently in interactions with other organizational figures such as medical directors or clinical colleagues. In this sense, DMs were not engaging in surface performances in the ways identified by Goffman (1959) and Hochschild (1983). Rather, the categories adopted were adaptive and arose from emotions elicited as identity-appropriate for particular encounters and relationships with adjacent outgroups such as senior managers or their unit's clinicians.

For example, some DMs came to feel that their personal autonomy and status were constantly undermined by the hospital management agenda. In a situation where disagreeable relationships with senior managers developed and the general status of DMs was perceived as low and threatened, SIT suggests they would resort to a social competition strategy of identity protection (Haslam, 2004). Thus, to protect their self-esteem, the clinical role would be used to directly challenge the legitimacy of management's authority, decisions and superiority. So it was that particular medical aspects of their DM identity were indeed employed as a social competition tactic predicted by SIT to expose senior managers' ignorance of what was happening on the ground or their lack of clinical knowledge:

> Dr A (clinical director) is talking with me as a manager, using some managerial terminology. We are in his office. Suddenly, the medical director burst into his office (without knocking at the door) saying that she needs to see him urgently in her office upstairs to talk about the paediatrics budget. He rapidly changes his tone of voice (making it stronger), his pose (he was relaxed sitting backwards in his armchair and he suddenly comes forward and tenses his posture), his facial expression

> (frowning) and says to her (in a very serious and defensive manner) that he can't go to her office because he has some paediatric clinics to do and proposes she come downstairs to his office again tomorrow at 4 p.m. if she wants to talk. (Note from participant observation.)

Yet, while this illustrates conventional social competition behaviour, it also illustrates how these DMs' 'emotions in interaction' were shaped by their earlier rationalizations of their own leadership identity and by the specific meanings they attached to 'others' in hospital management. In providing a version of self that complements with their views of managers and others, these rationalizations then went on to provoke feelings of anger and hostility in interactions with these others. In this way, existing identity rationalizations led to emotions which subconsciously indicated the appropriateness of the DM identity to be enacted. Thus, their emotional experiences served as signals that acted to steer DMs' cognitions about how to define and present their identity. The result of this process was that social competition behaviour did not emerge solely from a cognitive assessment of the interaction itself or from the emotions felt only in the dynamics of the encounter. Rather, the identity constructions and meanings developed in earlier emotion experiences provoked emotion responses that shaped the social competition and other behaviours that arose.

Other examples illustrate the same process but with different emotions and outcome identity behaviour. For instance, DMs projected unpalatable feelings shaped by their own rationalizations onto others in order to control the importance of their own negative affect (Vince, 2006). That is, negative emotions were projected onto some medical directors as the group that was most unhappy with the hospital system. Here, we found empathic emotions such as compassion and concern expressed towards particular senior figures. In hospital A, for example, DMs' commiseration for a medical director in his compromising role contrasts strikingly with their contempt for the CEO:

> Well, I think that the hospital directors are under a lot of economic pressure (long silence as if in reproach). Perhaps they have the same values as we do, but they can't ... they don't transmit them (sadly). **What about the management?** Ah (raises her voice, angrily), the management ... well, they certainly don't have values! They have absolutely no idea (contemptuously, angrily). They have no idea about the reality of hospital life. One day I told them to come and see it for themselves but ... well ... they hardly ever come. I don't think anyone has ever gone into the Intensive Care Unit. Except for the director, of course (shows her warmth for the director in her tone of voice). But managers and all that sort ... I really want them to come one day! (vengeful tone) I hope they have a heart attack and they come and see what a state we are in! I mean, the management hasn't got a bloody clue about what things are like and about the reality of the hospital! (indignant) (Dr V)

What this highlights is the way that prior rationalizations of intense emotions subsequently shaped emotional consequences for the relationships that developed between DMs and others, and set a social tone to their evolving relationships in their organizations. For example, DMs spoke with deep sadness about how their appointment immediately found them excluded from social gatherings arranged by their clinical staff. Drawing on SIT, these exclusions can be seen either as a betrayal of the loyalties of past membership or as a threat to the new relationship. Yet, given that the most meaningful self-category was still that of 'doctor', DMs mostly saw their past colleagues' behaviours as a saddening personal rejection. Instead of reacting with overt hostility towards clinicians and identifying themselves unequivocally as 'managers' as predicted by SIT, they continued to seek acceptance by their former membership as a way to manage their feelings of desertion. In this way, DMs saw the doctor category as a critical facet of the identity they should adopt with clinical staff. However, when dealing with a former DM a different component self-category was elicited:

> I'd prefer that they (unit clinicians) look at me as a colleague rather than a boss. **Why?** I don't know, I suppose that the relationship is easier (long silence). It's easier for me that they consider me as a colleague, a colleague that gives orders a bit more or organizes a bit more but ... I prefer that they consider me as their colleague ... But, I mean ... when I'm talking about colleagues, I referred to them, not to him (referring to the former head of unit). I'm his boss now. (Dr B)

If we consider these examples alongside the corresponding tactics used to cope with over-

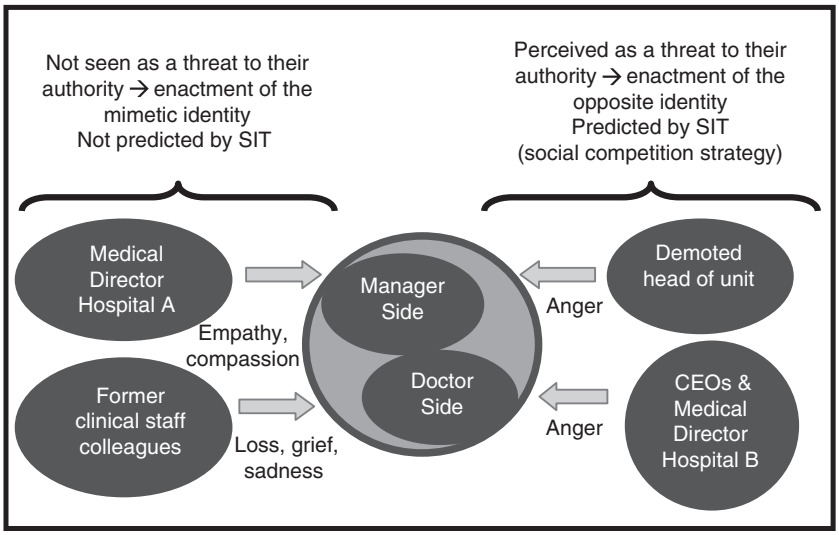

Figure 1. Emotions and the enactment of DMs' multifaceted identities

demanding senior managers, they show how emotions elicited by pre-rationalizations of identity threat from encounters with another person or group activates an appropriate slice of the DM identity to shape a defence (see Figure 1). In our sample, we identified three types of emotion that reflected how 'the other' had been constructed: these were empathy; loss and sadness; and anger and hostility. Empathic emotions arose from projections of sympathy and solidarity with less well off 'others', whereas feelings of loss emanated from abandonment by a valued clinical membership. In the third, anger surfaced from a perceived threat to authority, autonomy and status by an already stereotyped management group. Thus, DMs enacted a particular 'side' of their identity depending on the emotions that existing rationalizations of their identity and others prompted in them. So, to disarm a threat from a representative of another group (e.g. CEOs, medical director from hospital B and the former head of unit) they displayed the contrary 'side' to the manifest identity of the person or people with whom they were interacting. However, when perceiving an outgroup relationship as a threat of abandonment or as someone similar and worthy of compassion, DMs displayed the same identity as the one represented by the person with whom they were interacting.

In sum, existing identity constructions and meanings attached to others directed emotional responses in interaction so that identity enactment was kept appropriate. Appropriateness was found to be reflected in whichever facet of their identity DMs' emotions activated to protect their self-esteem.

Discussion and conclusion

Our findings have suggested a central role for emotions in the construction, meaning and enactment of DMs' professional identities. In particular, our investigation supports the notion that social identity cannot be understood just as a process of cognitive assessments of social comparison based on best fit, intergroup status, and identity expectation and threat in particular settings (Jagger, 1989). Within these processes, our findings showed that emotions did not act just as an outcome of DMs' experiences but also provided signals that helped them shape the eventual cognitive definitions, meaning and enactments of their identities. As such, the main contribution of this study is to provide some pointers as to how the incorporation of emotions into the SIA might proceed and enhance our understanding of social identity in work settings. These are illustrated in Figure 2.

In first considering how emotions contribute to identity construction in a new work role, several embellishments to SCT are suggested by our findings. First, while not suggesting that emotions always drive identification, the assumption

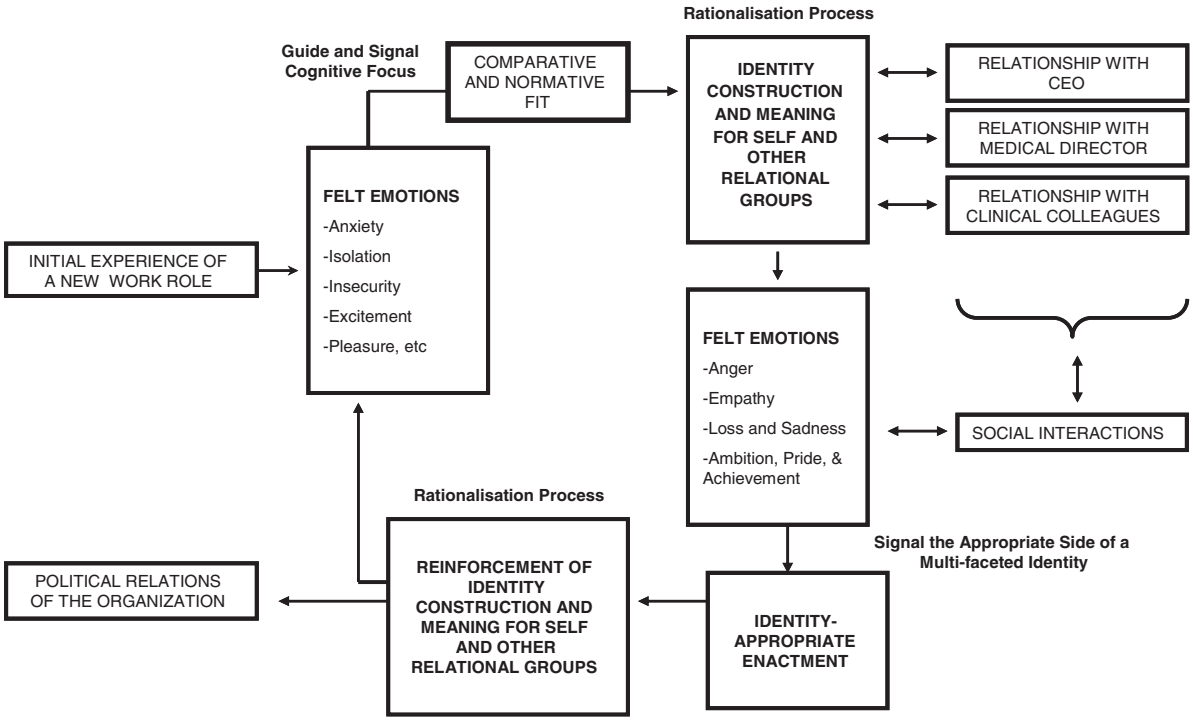

Figure 2. The role of emotions in the meaning, construction and enactment of DMs' identities

that cognition mainly underpins the key matching processes of comparative and normative fit seems mistaken. Our doctors' behaviours suggested that readiness to identify or incorporate a new role into existing self-definitions can also be initiated by emotional responses to experiences of tasks and interactions. Such emotions were of two kinds. First, emotions indicated to the person the value or importance s/he places on adopting or rejecting a particular identity. Here affect provided information about the emotional familiarity and satisfaction of a particular role that then contributed to the cognitive fit assessment by which DMs decided their motivation to identify with managing. Second, emotions operated in a similar fashion as indicators of how close DMs' values and goals were to those of the management role and group. In these two ways, affect was found to initiate and guide comparative and normative fit. In this sense, emotional experiences provided guidance to DMs about where their cognitive attention was needed.

Besides providing emotional data that determined the strength of motivation to identify, doctors' early emotion experiences were also found to shape the meaning that the identity was given. Whether identifying with managing or not, these emotions helped to direct our doctors' cognitive efforts to explain their identities to themselves and others. Here, DMs' initial emotional experiences of managing (e.g. experiences with role models and initial relationship with senior managers) became rationalized into the meanings they gave to management and by projecting complementary explanations onto other groups such as hospital managers and clinicians. This chimes with Vince's (2006) findings that initial emotional responses help to shape explanatory rationalizations. This role for emotion may thus be seen to precede existing SIA processes of meaning such as identity salience, positive distinctiveness and member prototypicality, which have all been largely seen to be shaped only by cognitive comparison of relevant groups (Oakes and Turner, 1990; Oakes, Haslam and Turner, 1994). Besides this, DMs' emotion-shaped explanations point us to several other ways in which this process is important and used. These include the use of emotions to shape adaptive explanations by projecting negative features of the role onto other managers; the claiming of special abilities of leadership; and the

need to use clinical expertise to disassociate from management.

While all of these embellishments can be seen as complementary to conventional SIT processes to enhance self-esteem, DMs' identity rationalizations were also used in a way quite different to the usual role of identity salience in the SIA. SIT suggests that the form of intergroup behaviours used are drawn separately from long-standing ingroup and outgroup stereotyping as well as in-the-moment cognitions of legitimacy and stability of status relations. Yet, in the course of carrying out their roles, DMs' emotion-influenced rationalizations provoked the emergence of identity-appropriate emotions that then shaped their behaviour towards other organizational actors. Our findings therefore suggest that, in addition to the importance of emotions in the processes of identity readiness and construction, they may also affect the type of relationships that emerge and further bolster the meanings given to their identity and those they give to outgroups.

Our last point examines the selected aspects of identity enactment used by our sample to offer additional insights about the nature of identity-congruent behaviour. The SIA assumes that some form of recognizable behavioural continuity in a salient identity is pursued. And while our findings do not refute this assumption, they do expand the notion of what constitutes and causes identity congruence. In particular, they reveal that identity-appropriate behaviour does not have to be displayed as an all-encompassing version of the identity, nor emanate purely from perceptions of similarity and difference. Instead, in a multi-faceted identity, as with DMs, appropriate parts of the whole can be drawn upon to meet the needs of different settings and interactions. And while DMs' side behaviour often emerged to meet the threats posed by particular situations where the identity's status was not fully acknowledged by others, it was provoked by emotions that reflected their earlier emotion-shaped explanations of their preferred professional identity. Given that this process links emotions, and identity construction and meaning to the emergence of a specific behavioural repertoire among professionals, it is not unrealistic to see this explanation as also informing our understanding of how particular emotional and political relational patterns originate and spread across organizations.

In contrast to the logic that separates the cognitive processes of identity readiness deployed in SCT from those of identity behaviour in SIT, it follows from all our findings that the role of emotion in identity construction, meaning and behaviour is best understood by a single explanatory framework. In this, we are not saying that emotion will always drive social identification. Nevertheless, what our study has indicated is that to fully understand the development and enactment of identity in complex roles requires an analysis of how the person's emotional readings contribute to early cognitive identity assessments and later identity-appropriate behaviours. While neglected so far in social identity theory and research, our analysis of the role of emotions in identity development and behaviour offers considerable promise as a starting point from which to enhance the SIA and other approaches to identity.

References

Albert, S., B. E. Ashforth and J. E. Dutton (2000). 'Organizational identity and identification: charting new waters and building new brides', *Academy of Management Review*, **25**, pp. 13–17.

Alvesson, M. (2003). 'Beyond neopositivists, romantics and localists: a reflexive approach to interviews in organizational research', *Academy of Management Review*, **28**, pp. 13–33.

Alvesson, M., K. L. Ashcraft and R. Thomas (2008). 'Identity matters: reflections on the construction of identity scholarship in organization studies', *Organization*, **15**, pp. 5–28.

Ashforth, B. E. (1998). 'Becoming: how does the process of identification unfold?'. In D. Whetten and P. Godfrey (eds), *Identity in Organizations: Developing Theory through Conversations*, pp. 213–222. Thousand Oakes, CA: Sage.

Ashforth, B. E. and R. H. Humphrey (1993). 'Emotional labor in service roles: the influence of identity', *Academy of Management Review*, **18**, pp. 88–115.

Ashforth, B. E. and R. H. Humphrey (1995). 'Emotion in the workplace: a reappraisal', *Human Relations*, **48**, pp. 97–125.

Ashforth, B. E. and F. Mael (1989). 'Social identity theory and the organization', *Academy of Management Review*, **14**, pp. 20–39.

Ashforth, B. E. and M. A. Tomiuk (2000). 'Emotional labour and authenticity: views from service agents'. In S. Fineman (ed.), *Emotions in Organizations*, pp. 194–201. London: Sage.

Ashforth, B. E., S. H. Harrison and K. G. Corley (2008). 'Identification in organizations: an examination of four fundamental questions', *Journal of Management*, **34**, pp. 325–374.

Bolton, S. C. and C. Boyd (2003). 'Trolley dolly or skilled emotion manager? Moving on from Hochschild's managed heart', *Work, Employment and Society*, **17**, pp. 289–308.

Booth, J. and S. Mann (2005). 'The experience of workplace anger', *Leadership and Organization Development Journal*, **26**, pp. 250–262.

Bornman, E. and J. Mynhardt (1992). 'Social identity and intergroup contact with specific reference to the work situation', *Genetic, Social and General Psychology Monographs*, **117**, pp. 439–462.

Briner, R. B. (1999). 'The neglect and importance of emotion at work', *European Journal of Work and Organizational Psychology*, **8**, pp. 323–346.

Burke, P. J. (1996). 'Social identities and psychosocial stress'. In H. B. Kaplan (ed.), *Psychosocial Stress: Perspectives on Structure, Theory, Life Course and Methods*, pp. 141–174. San Diego, CA: Academic Press.

Burke, P. J. (2004). 'Identities and social structure: the Cooley–Mead award address', *Social Psychology Quarterly*, **67**, pp. 5–15.

Clarke, C. A., A. D. Brown and V. Hope Hailey (2009). 'Working identities? Antagonistic discursive resources and managerial identity', *Human Relations*, **62**, pp. 323–352.

Côté, S. (2005). 'A social interaction model of the effects of emotion regulation on work strain', *Academy of Management Review*, **30**, pp. 509–530.

Coupland, C., A. D. Brown, K. Daniels and M. Humphreys (2008). 'Saying it with feeling: analysing speakable emotions', *Human Relations*, **61**, pp. 327–353.

Craib, I. (1997). *Classical Social Theory*. Oxford: Oxford University Press.

Domagalski, T. A. (1999). 'Emotion in organizations: main currents', *Human Relations*, **52**, pp. 833–852.

Domagalski, T. A. and L. A. Steelman (2005). 'The impact of work events and disposition on the experience and expression of employee anger', *Organizational Analysis*, **13**, pp. 31–52.

Eisenhardt, K. M. (1989). 'Building theories from case study research', *Academy of Management Review*, **14**, pp. 532–550.

Fineman, S. (2000). *Emotion in Organizations*, 2nd edn. London: Sage.

Fineman, S. (2004). 'Getting the measure of emotion and the cautionary tale of emotional intelligence', *Human Relations*, **57**, pp. 719–740.

Fineman, S. and A. Sturdy (1999). 'The emotions of control: a qualitative exploration of environmental regulation', *Human Relations*, **52**, pp. 631–663.

Gabriel, Y., D. E. Gray and H. Goregaokar (2010). 'Temporary derailment or the end of the line? Managers coping with unemployment at 50', *Organization Studies*, **31**, pp. 1687–1712.

Gallego, R. (2000). 'Introducing purchaser/provider separation in the Catalan health administration: a budget analysis', *Public Administration*, **78**, pp. 423–442.

George, J. M. and A. P. Brief (1996). 'Motivational agendas in the workplace: the effects of feelings on focus of attention and work motivation', *Research in Organizational Behavior*, **18**, pp. 75–109.

Glaser, B. G. and A. L. Strauss (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago, IL: Aldine.

Glomb, T. M. (2002). 'Workplace anger and aggression: informing conceptual models with data from specific encounters', *Journal of Occupational Health Psychology*, **7**, pp. 20–36.

Goffman, E. (1959). *The Presentation of Self in Everyday Life*. New York: Doubleday Anchor.

Grandey, A. A., A. P. Tam and A. L. Brauburger (2002). 'Affective states and traits in the workplace: diary and survey data from young workers', *Motivation and Emotion*, **26**, pp. 31–55.

Hallier, J. and T. Forbes (2004). 'In search of theory development in grounded investigations: doctors' experiences of managing as an example of fitted and prospective theorizing', *Journal of Management Studies*, **41**, pp. 1379–1410.

Hallier, J. and T. Forbes (2005). 'The role of social identity in doctors' experiences of clinical managing', *Employee Relations*, **27**, pp. 47–70.

Ham, C. and H. Dickinson (2008). *Engaging Doctors in Leadership: What we can Learn from International Experience and Research Evidence*. Warwick: NHS Institute for Innovation and Improvement.

Hamilton, P., P. Spurgeon, J. Clark, J. Dent and K. Armit (2008). *Engaging Doctors: Can Doctors Influence Organisational Performance? Enhancing Engagement in Medical Leadership*. Warwick: NHS Institute for Innovation and Improvement.

Harquail, C. V. (1998). 'Organizational identification and the ''whole person'': integrating affect, behavior and cognition'. In D. A. Whetten and P. C. Godfrey (eds), *Identity in Organizations: Building Theory through Conversations*, pp. 223–231. London: Sage.

Harré, R. and W. G. Parrott (1996). *The Emotions*. London: Sage.

Haslam, S. A. (2004). *Psychology in Organizations: The Social Identity Approach*. London: Sage.

Haslam, S. A. and N. Ellemers (2005). 'Social identity in industrial and organizational psychology: concepts, controversies and contributions', *International Review of Industrial and Organizational Psychology*, **20**, pp. 39–117.

Haslam, S. A. and J. C. Turner (1998). 'Extremism and deviance: beyond taxonomy and bias', *Social Research*, **65**, pp. 435–448.

Heise, D. R. (1979). *Understanding Events: Affect and the Construction of Social Action*. New York: Cambridge University Press.

Hochschild, A. R. (1983). *The Managed Heart*. Berkeley, CA: University of California Press.

Hogg, M. A. and D. J. Terry (2001). *Social Identity Processes in Organizations*. Philadelphia, PA: Psychology Press.

Holmes, D. S. (1978). 'Projection as a defense mechanism', *Psychological Bulletin*, **85**, pp. 677–688.

Jagger, A. (1989). 'Love and knowledge: emotion in feminist epistemology', *Inquiry*, **32**, pp. 151–176.

Jaros, S. (2009). 'Identity and the workplace: an assessment of contextualist and discursive approaches'. Paper presented at the International Labour Process Conference, Edinburgh, UK.

Locke, K. (2001). *Grounded Theory in Management Research*. London: Sage.

Marks, A. and P. Thompson (2010). 'Beyond the blank slate: identities and interests at work'. In P. Thompson and C. Smith (eds), *Working Life: Renewing Labour Process Analysis*. London: Palgrave.

McAdams, D. P. (1996). 'Personality, modernity and the storied self: a contemporary framework for studying persons', *Psychological Inquiry*, **7**, pp. 295–321.

Meyer, J., T. Becker and R. Van Dick (2006). 'Social identities and commitments at work: toward an integrative model', *Journal of Organizational Behavior*, **27**, pp. 665–683.

Morris, J. A. and D. C. Feldman (1996). 'The dimensions, antecedents and consequences of emotional labor', *Academy of Management Review*, **21**, pp. 986–1010.

Mumby, D. K. and L. L. Putnam (1992). 'The politics of emotion: a feminist reading of bounded rationality', *Academy of Management Review*, **17**, pp. 465–486.

Nicholson, N. (1984). 'A theory of work role transitions', *Administrative Science Quarterly*, **29**, pp. 172–191.

Oakes, P. J. (1987). 'The salience of social categories'. In J. C. Turner, M. A. Hogg, P. J. Oakes, S. D. Reicher and M. S. Wetherell (eds), *Rediscovering the Social Group: A Self-categorization Theory*, pp. 117–141. Oxford: Blackwell.

Oakes, P. J. and J. C. Turner (1990). 'Is limited information processing the cause of social stereotyping?', *European Review of Social Psychology*, **1**, pp. 111–135.

Oakes, P. J., S. A. Haslam and J. C. Turner (1994). *Stereotyping and Social Reality*. Oxford: Blackwell.

Patient, D., T. B. Lawrence and S. Maitlis (2003). 'Understanding workplace envy through narrative fiction', *Organization Studies*, **24**, pp. 1015–1044.

Pratt, M. G. (1998). 'To be or not to be: central questions in organizational identification'. In D. Whetten and P. Godfrey (eds), *Identity in Organizations: Developing Theory through Conversations*, pp. 171–207. Thousand Oakes, CA: Sage.

Rafaeli, A. and R. Sutton (1989). 'The expression of emotion in organizational life'. In L. L. Cummings and B. M. Staw (eds), *Research in Organizational Behavior*, Vol. 11, pp. 1–42. Greenwich, CT: JAI Press.

Rafaeli, A. and R. Sutton (1990). 'Busy stores and demanding customers: how do they affect the display of emotion?', *Academy of Management Journal*, **33**, pp. 623–627.

Rousseau, D. M. (1998). 'Why workers still identify with organizations', *Journal of Organizational Behavior*, **19**, pp. 217–233.

Simons, R. F. (1999). 'Emotion processing in three systems: the medium and the message', *Psychophysiology*, **36**, pp. 619–627.

Skinner, Q. (1985). *The Return of Grand Theory in the Human Sciences*. Cambridge: Cambridge University Press.

Starkey, K. (1990). 'Studies on transition: meanings and method', *Journal of Management Studies*, **27**, pp. 97–110.

Strauss, A. and J. Corbin (1998). *Basics of Qualitative Research*. London: Sage.

Stryker, S. (2004). 'Integrating emotion into identity theory', *Advances in Group Processes*, **21**, pp. 1–23.

Sturdy, A. (2003). 'Knowing the unknowable? Discussion of methodological and theoretical issues in emotion research and organization studies', *Organization*, **10**, pp. 81–105.

Sutton, R. and A. Rafaeli (1988). 'Untangling the relationship between displayed emotions and organizational sales: the case of convenience stores', *Academy of Management Journal*, **31**, pp. 461–487.

Tajfel, H. (1978). 'Social categorization, social identity and social comparison'. In H. Tajfel (ed.), *Differentiation between Social Groups: Studies in the Social Psychology of Intergroup Relations*, pp. 61–76. London: Academic Press.

Tajfel, H. (2010). 'Introduction'. In H. Tajfel (ed.), *Social Identity and Intergroup Relations*, pp. 1–11. Cambridge: Cambridge University Press.

Tajfel, H. and J. C. Turner (1979). 'An integrative theory of intergroup conflict'. In W. G. Austin and S. Worchel (eds), *The Social Psychology of Intergroup Relations*, pp. 33–47. Monterey, CA: Brooks-Cole.

Thoits, P. A. (2003). 'Emotions norm, emotion work and social order'. In A. S. R. Manstead, N. H. Frijda and A. H. Fischer (eds), *Feelings and Emotions: The Amsterdam Symposium*. New York: Cambridge University Press.

Turner, J. and P. Oakes (1997). 'The socially structured mind'. In C. McGarty and S. A. Haslam (eds), *The Message of Social Psychology: Perspectives on Mind in Society*, pp. 355–373. Oxford: Blackwell.

Van Maanen, J. and G. Kunda (1989). 'Real feelings: emotional expression and organizational culture'. In L. L. Cummings and B. M. Staw (eds), *Research in Organizational Behavior*, Vol. 11, pp. 43–103. Greenwich, CT: JAI Press.

Vince, R. (2006). 'Being taken over: managers' emotions and rationalizations during a company takeover', *Journal of Management Studies*, **43**, pp. 343–365.

Watson, T. J. (2008). 'Managing identity: identity work, personal predicaments and structural circumstances', *Organization*, **15**, pp. 121–143.

Weiss, H. M. and R. Cropanzano (1996). 'Affective events theory: a theoretical discussion of the structure, causes and consequences of affective experiences at work', *Research in Organizational Behavior*, **18**, pp. 1–74.

Worthington, K. L. (1996). *Self as Narrative*. Oxford: Clarendon Press.

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