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Identity work within attempts to transform healthcare: Invisible team processes

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Abstract

Studies have shown that workers' identities matter for a host of individual and organizational outcomes. However, the question of how identities work becomes more complex when considering settings where workers must negotiate multiple – and sometimes conflicting – identities. Interprofessional healthcare teams are one such setting. Within interprofessional teams, workers are expected to adopt both professional and team-based identities, sometimes leading to confusion and conflicts. Using longitudinal qualitative analyses of healthcare team members' reflective audio diaries, we document identity work of one team as they attempted to create and adopt a new approach to care. We analyze 176 recordings over 30 weeks and find that: team members experience multiple identification targets more or less conflicting, depending on the organizational context; team members from different professional backgrounds experience identity processes differently; and conflicts with others affect how team members see themselves and one another. These findings enrich our understanding of how multiple identities are reconciled in the workplace, and illustrate hidden aspects of forming and sustaining team-based work.

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Introduction

Identity is increasingly of interest to organizational scholars, especially as it intersects with individuals' work lives (Alvesson et al., 2008). Studies have found that work identities can bind people to the group (Ashforth and Mael, 1989; Eckel and Grossman, 2005), affirm individuals' own self-vision to guide action (Ashforth et al., 2008), foster motivation for the work (Ellemers et al., 2004), increase organizational commitment (Sass and Canary, 1991), create cooperation within the group (Milton and Westphal, 2005), improve worker well-being (Grant et al., 2014; Horton et al., 2014), and allow teams to integrate diverse experience and expertise (Mitchell et al., 2011). Although these findings are useful for thinking about how identity matters for organizational functioning, studies do not always appreciate the role of organizational context in the subjective experiences of identity, thus missing an opportunity to fully theorize how identity is created, used, sustained and changed in the workplace.

Subjective experiences of identity may be especially important for interprofessional team-based work as workers are expected to identify with their professional backgrounds as well as their team. In other words, workers must navigate multiple simultaneous – and sometimes conflicting – identification demands (Ashforth and Johnson, 2001; Scott, 1997). In this article, we use social identity theory (SIT) to analyze audio diary data from new team members over the course of 30 weeks to trace how team members talk about their sense of self, their roles on the team, and their professional identity as the organizational context changes. Team members in this study began with individual professional identities, but then went through training that explicitly asked them to foreground a team identity, and at one point even suggested that team members shed their previous professional identities. Team members actively resisted requests to shed professional identities, but also performed identity work to navigate the requirements of multiple identification targets.

This article contributes to scholarship on identity, teams and organizational change. Specifically, we illustrate how organizational contexts affect how workers manage multiple identification targets. In some contexts, team members were able to identify with their profession and their team with little conflict. In other situations, either the team or the professional identity was prioritized to effect change at the organizational level. We also show that identification processes varied based on workers' previous professional experiences, especially whether they were trained as 'clinicians' or not. Finally, we illustrate that organizational change contexts create ample opportunity for identification conflicts through changing targets of critique. Taken together, our findings illustrate how the study of the subjective experiences of team members' identities may help to understand the role of organizational context in supporting or challenging interprofessional teamwork.

Literature and theory

Identity and identification within teams

Stemming from scholarship within SIT, we conceptualize identities as emerging from membership in collectives, including work groups (Ashforth et al., 2008; Tajfel and Turner, 1979, 2004). Original theorizing of identity focused on the ways that collective identities permitted individuals to form a positive self-concept and ordered action and cognition, while also stereotyping those who do not belong to the group (Hornsey, 2008). Group members come to categorize themselves as part of the collective, accepting group norms and expectations for behavior (Hornsey, 2008; Richter et al., 2006). These self-concepts and group norms provide a sense of stability and meaning for individuals (Gioia et al., 2010), and increase individual self-esteem through promoting the group (Ashforth and Mael, 1989; Hennessy and West, 1999). SIT motivates our analysis by providing predictions regarding how small group dynamics are affected by (and affect) the identities of team members.

As research has expanded, the focus of identity research has moved away from a static sense of identity and onto a dynamic process of identification (Ashforth et al., 2008), acknowledging that context shapes how individuals identify and their relationship to the group (Fuller et al., 2006; Hornsey, 2008). Identities may change over time, especially as group interactions affirm or challenge existing visions of the self (van Knippenberg and Schippers, 2007). Simultaneously, identification processes of workers may also shape the organizational context. Scott et al. (1998) apply Giddens' theory of structuration to the study of identities, emphasizing the duality between structures and action. Specifically, the theory posits that actions create structures, but structures shape actions; identities are interconnected and geographically-situated; and context matters for understanding identification. Examining how actors talk about their shifting sense of self is one way to capture the structuration of identity (Kuhn and Nelson, 2002). This framework is especially useful for cases like ours, where team members and the organization are both shifting quickly, and identities iterate as understandings of the work change (Waring and Bishop, 2011).

Using insights from the structurational approach, we examine team members' experiences of multiple identification targets. Some identities – especially those at the most local level – provide guidance on everyday action; meanwhile, higher-level identities may provide a sense of stability and continuity (Ashforth and Johnson, 2001; Scott, 1997). Scott (1997) outlines various types of identities, including organizational, regional, work group and occupation. In this article, we are especially interested in two of these: work group and occupation. We use literature on the professions to understand how occupation informs identities.

Professional identities are a special type of occupational identity, owing to specialized knowledge and activities, reinforcement through governing bodies, and intense socialization processes (Lammers et al., 2013). Professionalization makes professional identities deeply felt (Ashforth et al., 2008; Dingwall and Lewis, 2014 [1983]; Mitchell and Boyle, 2015; Molleman and Rink, 2014), posing some problems for teamwork if teams challenge professional hierarchies (Hall, 2005; Rueschemeyer, 2014 [1983]), or new

roles are created (Currie et al., 2012). These simultaneous requirements of being a professional as well as a team member make identity especially salient as workers balance multiple identification targets.

When identification targets have competing demands, they can clash, producing conflict for the individual and the group (Scott, 1997). However, clashes are not inevitable. The multiple targets are sometimes compatible, or even enhance one another (Ramarajan, 2014). Strategies for balancing multiple identification demands include cognitively comparing options, selecting identification targets that fit with a larger logic of the work, and relying on the judgements of others to determine which identity should take priority (Larson and Pepper, 2003). Each of these strategies can be observed through actors' own reflections on the self. Research has focused on understanding varying levels of salience of multiple identities (Scott, 2007), or the strategies that actors use to balance competing identities (Larson and Pepper, 2003), but more attention is needed to understand how the organizational and work group contexts affect the management of multiple identification targets. In this article, we examine that context through actors' own reflections on the work of being a team. Three concepts common to literature on teams were central to our analysis: team cohesion, subgroup divisions and jurisdictional disputes. These are described in more detail below.

Cohesion, subgroups and jurisdictions

Cohesion within the team may be beneficial for workers and the organization. A review of effectiveness within healthcare teams concluded that cohesion was positively associated with work satisfaction and perceived efficacy (Lemieux-Charles and McGuire, 2006). On the other hand, too much cohesion to the group may make some members rigid (Ashforth et al., 2008). Leaders within the organization can support teamwork by creating a culture of inclusivity and appreciating contributions of all team members (Nembhard and Edmondson, 2006). Feeling respected and valued by other team members is critical for creating a team identity (Ellemers et al., 2013) and may reduce the free-rider problem where some team members do not participate, but receive benefits from the group (Eckel and Grossman, 2005).

SIT predicts that cohesion within small groups is a product of identification with the group (Hogg and Terry, 2000). However, because interprofessional teams often require workers to identify with both the small group (team) and workers' professions, cohesion can be challenging to achieve. Ideally, organizations can create conditions where the multiple identities can co-exist peacefully, sometimes even enhancing one another (Ramarajan, 2014). Theory on small group dynamics argues that these conditions are characterized by interdependencies in the work and a shared superordinate identity (Gaertner et al., 1994; Wageman, 1995). In fact, disparate roles can be united under a higher-level group identity, creating cohesion across professional divides (Gaertner et al., 1994). Importantly, the higher-level identity is not effective if it seeks to replace professional identities (Dovidio et al., 2007).

Even under conditions where cohesion is possible, teams with members from diverse professional backgrounds may find that subgroups form within the team. Research on diversity within teams examines how differences in status characteristics and

occupational position affect team functioning and individual members' experience of the team (Mitchell et al., 2010). Extant literature is divided on the effects of diversity. Some have argued that more diverse teams are more effective because they bring diverse information and experience for solving problems (Miller et al., 1998; Mitchell et al., 2010). Others have noted that teams with a great deal of diversity are more likely to have conflicts and misunderstandings, causing issues for individual team members and group harmony (Mohammed and Angell, 2004).

Recent scholarship has argued, however, that the role of diversity is not simple (Mitchell and Boyle, 2015; van Knippenberg and Schippers, 2007). Although SIT predicts that contact with those from differing professions makes one's own professional identity more salient (Ashforth and Mael, 1989), this salience does not necessarily create problems for working together or maximizing the benefits of diversity. The context of the team matters a great deal: diversity may be good under organizational contexts that nurture the whole group and promote open-mindedness, but problematic under organizational contexts that threaten the group or individuals within the group (Mitchell and Boyle, 2015). Team members in this study came from diverse professional backgrounds and explicitly discuss when and how these backgrounds affected the work.

Our third central concept comes from the sociology of professions and is related to disputes over jurisdictions of work. Workers negotiate work duties through their respective professional identities, which promote assumptions about work jurisdictions and boundaries (Abbott, 1988). These boundaries may cause conflict within interprofessional teams (Hall, 2005; Mitchell and Boyle, 2015), especially when the team lacks clarity around roles and responsibilities (Molleman and Rink, 2014) or new roles are created (Currie et al., 2012). One of the potential benefits of interprofessional teams is the ability to flexibly share work, but too much flexibility may make it difficult for team members to define their roles (Mitchell and Boyle, 2015). Whereas literature on the professions often treats professional identities as static, it is noteworthy that professional identities are relational, affected both by social dynamics in the setting and the larger organizational context (Currie et al., 2010).

When workers disagree about how to draw jurisdictional boundaries, distinctions between professional groups – and claims of ingroup and outgroup status – can be leveraged in that conflict. SIT makes it clear that defining one's self in terms of any group is a cognitive process that also de-individualizes those who are not part of the group, sometimes leading to stereotyping and ingroup bias (Hogg and Terry, 2000). While any other person or group can be labelled an outgroup, the organizational context shapes which identities are most salient and the implications of outgroup definition. These definitions of group membership may be used as tools for resolving or escalating disputes over jurisdictional boundaries (Hall, 2005).

Principles from SIT help to understand the complex interplay between professional and team identities, under differing organizational contexts. When team members are able to unite under a common vision of the team, professional identities are not a challenge to team identities and coherence. However, these unifying superordinate team identities are fragile (Dovidio et al., 2007) and, if no overarching identification exists, divisions between subgroups are magnified. If the subgroups worked independently from one another, these divisions would not be consequential. In the team context,

however, subgroups frequently come into contact and outgroup definitions may prompt stereotyping, biases and conflict. Given the complex role of identity in team functioning, scholarship must also look to the larger organizational context to understand when and how potential identity conflicts emerge and become problematic.

Organizational contexts of team identity

Cohesion, subgroups and jurisdictions are all social processes internal to the team. Factors external to the team also affect team members' subjective experiences of identity. Resistance to the work of the team creates a sense of threat, which can activate and challenge identification processes. Threats to professional authority (Mitchell et al., 2010; Molleman and Rink, 2014), workplace abuse and bullying (Lutgen-Sandvik, 2008), and invalidation of how particular others see their role and do the work (Fiol et al., 2009) produce contexts where workers use their identities to restore their own self-value. Simultaneously, however, the boundaries between professions are hardened by threats, making working together more difficult (Fiol et al., 2009). Social control within the workplace can also prompt identity work (Alvesson and Willmott, 2002; Grey, 1994), sometimes with unintended effects. Too much organizational control can have the contradictory effect of creating 'resistant' selves within workers (Collinson, 2003). Resistance and control are central aspects of any organizational context.

Organizational change represents another potential team threat. In some organizational change contexts, identities provide stability as organizations and social worlds shift (Ashforth et al., 2008; Hogg and Terry, 2000; Waring and Bishop, 2011). In other contexts, organizational missions, workers' identities and work processes adapt together. In this case, workers use their identities to change actions and shift how others view the organization (Clark et al., 2010; Dutton and Dukerich, 1991). In both cases, identities are used and may be supportive to organizational change, especially when workers feel empowered to contribute to change (Bordia et al., 2004; Cunningham et al., 2002). Workers may also use identities to resist organizational change. Identities may make some kinds of change seem incongruent with one's sense of self, making workers unwilling to support change (Ashforth et al., 2008). Studies of workers' subjective experiences of change show that one source of resistance is a strong sense of identity that is challenged by the changes organizations seek to make (Ford et al., 2008). Although change is frequent in organizations, the importance of workers' identities is underappreciated in studies of change.

Studying team identity in the changing healthcare environment

The literature above illustrates how small group dynamics – including cohesion, subgroups and jurisdictional disputes – shape workers' sense of self within organizational contexts that may include resistance and pressures for change. How these dynamics affect workers' subjective experiences within team-based work, especially within a team in formation, is not yet fully elaborated. This is especially true within healthcare teams, where strong professional hierarchies and licensing criteria may make it difficult for new teams to become established in the healthcare system (Mitchell and Boyle, 2015).

Healthcare organizations are quite hierarchical and roles are interdependent (Chreim et al., 2007; Currie et al., 2010), meaning that shifts to team-based models present challenges to professional identities. This article documents identity processes of a new healthcare team in the process of attempting to create and adopt transformative care practices.

Our approach uses longitudinal qualitative data to define two 'critical moments' in which individual team members were actively engaged in identity work. We conceptualize critical moments as periods of time in which workers' emotions were high and they attempted to use 'sensebreaking and sensegiving' to reconcile perceived tensions between multiple identification targets (Ashforth et al., 2008). Sensebreaking occurs when the social context challenges one's fit within the setting, prompting the individual to ask 'who am I?' in an attempt to align self-concept with actions (Pratt, 2000). Sensegiving provides meaning during these moments of exploration, and can come from organizational leadership, peers, or others (Ashforth et al., 2008; Pratt, 2000). We extract these critical moments from workers' weekly-recorded audio diaries. Our use of audio diaries is similar to biographical methods where respondents reflect on turning points in their life trajectory (Riessman, 2008; Thomson et al., 2002). Audio diaries include narratives of work experiences, infused with narratives of the self as workers engaged and negotiated the work (Sandelowski, 1991).

In this article, we ask: How do workers in a new healthcare team negotiate multiple identification targets, including their previous professional identities as well as their new team identities? What contextual events produce shifts in how workers identify? What do these shifts tell us about work identities, teams and organizational change?

Data and methods

To document identity work, we use individual audio diaries from healthcare workers as they formed a team. A total of 176 recordings spanning 30 weeks were transcribed and analyzed. We isolate our analysis to an early period in order to focus on a time when team members navigated multiple identification targets, including professional and team identities. Diary methods are especially helpful for documenting workers' experiences in real time and analyzing changes within the individual and group (Bolger et al., 2003). These data permit analysis of how workers' identity presentations shifted as they engaged in boundary work (Owens et al., 2010), framed their individual roles and responsibilities (Simpson and Carroll, 2008), and described their attempt to assemble a cohesive team and collective identity (Polletta and Jasper, 2001). Next, we will describe the team, and then detail our data collection and analysis techniques.

The Whole Person team

Healthcare increasingly relies on teams to administer care, especially for complex patients with medical and non-medical needs. The team studied here, called Whole Person (a pseudonym), was a new team, based in a large health system in the Midwestern United States. Because the team was new, team members grappled with how to work together, share their value with others in the healthcare system, and create team

processes. We thus had an opportunity to focus on team formation and growth, and discern the ways organizational context shaped identity processes.

The team was interdisciplinary: it included a nurse, pharmacist, social worker, marriage and family therapist, and chaplain, in conjunction with three to nine 'care guides.' In this study, care guides were lay healthcare workers who served as the team's primary contact to patients. The care guide linked patients, families and caregivers to resources within and beyond the team. Care guides also provided support to patients through learning their personal stories and understanding how life experiences shaped patients' preferences. The Whole Person team was premised on the clinically trained professionals and the lay care guides working together to serve patients and their family members. It is important to note that the clinicians and care guides did not come to the team with the same professional identities. Whereas the clinicians had completed education and credentialing that likely made their professional identities salient, care guides came in with a variety of identities, only some of which were relevant for the work. Because of these different starting places, the identity work of clinicians and care guides likely varied.

Care team members were hired and underwent four weeks of training together, prior to the start of our study. Once training ended, all care team members started seeing patients and recording audio diaries. In addition to working within their own team, participants in this study also worked with healthcare providers outside of their team. The task of supporting patients and their family members included partnering with existing providers to improve the care continuum. These other healthcare providers often did not have knowledge of the Whole Person approach, causing some challenges in creating working relationships. This research initiative offered a unique opportunity to understand workers' subjective experiences of work identities, as job descriptions were broadly defined, but left open to revision, as team members learned about the needs of patients and their family members. This open approach to defining and dividing the work offered ample opportunity for team members to struggle with and reflect upon their own work identities.

Data collection and analysis

Care team members were asked to submit their observations on being part of the Whole Person team, work with patients and caregivers, and interactions with other professionals. These observations were collected through weekly audio diary recordings in which team members shared brief stories or examples pertaining to the work. These qualitative data revealed discursive formations of identity through showing how workers aligned themselves with others and imagined selves (Kuhn and Nelson, 2002), as well as through the narration of experiences (Crozier and Cassell, 2016). These recordings were not the product of explicit prompting to talk about identity, offering a more organic view of how individuals thought about themselves as compared with interview methods that try to assess identity directly, but may be producing responses based on the interview context – not the work context (Sveningsson and Alvesson, 2003).

Recordings were transcribed and all three authors participated in coding the transcripts. Initial concepts came from literature on team dynamics, role conflict and clarity, professions, diversity, boundaries, and group cohesion. We developed a deductive

coding scheme from these literatures. All authors coded approximately 50 recordings as we continued to refine the coding scheme. We met weekly to discuss definitions, reconcile differences in codes and add inductive codes. After finalizing the codes and definitions, each transcript was then coded by two team members to ensure reliability. Any disagreements were discussed and decided in person. We used NVivo 10 for data analysis and management.

Our final set of codes for this analysis included team cohesion, subgroup divisions and jurisdictional disputes (see Table 1). Each of these themes signaled how the individual team members saw themselves in relation to the team as a whole. Cohesion indicated an alignment with the team, and participants often used 'we' instead of 'I' in the recordings. Subgroup divisions were an acknowledgement of diversity within the team, especially in terms of occupational diversity and the differences between clinically trained professionals and lay care guides. These acknowledgements of subgroups did not necessarily produce conflict, but were times that the individual noted that experiences, perceptions and behaviors were shaped by occupational groups. Jurisdictional disputes represented times that the individual discussed struggles to define roles and responsibilities. These struggles could be with other team members, managers or other healthcare providers.

Once we coded each recording, we tallied the number of care team members per week who spoke to each of the themes related to identity. This form of absence/presence coding served as our first lens for understanding how particular themes emerged and changed over time (Boyatzis, 1998), and aided in comparison across time periods (Ryan and Bernard, 2000). In total, we observed these trends over 30 weeks. We analyzed these temporal patterns, then used the textual data from the recordings to theorize times of active identity work, defined here as 'critical moments' in the context of team formation (Sandelowski, 1991; Thomson et al., 2002). Our approach combined the richness of qualitative data with the analytical power of comparison across time and within the group. Our use of counts of the main themes permitted a rough measure of heightened emotions on the team. These heightened emotions were our signal that team members were engaging in identity work and that this period of time represented a critical moment in the trajectory of the team. We then linked critical moments to data on the context of the team. Contextual data were gleaned from the audio recordings, research notes and project documents such as meeting minutes.

Research ethics

All components of the larger study were approved by the relevant institutional review board. The board determined that recordings from workers were part of normal process improvement activities and did not constitute research data. However, because we believed these recordings to be sensitive, we put in place several protections. First, given that the authors were employed by the same organization as the care team members, we were sensitive to how data were shared. Access to data was only allowed for a subset of research team members (authors), and authors' limited contact with care team members aside from data collection times. Second, all qualitative examples presented in the article were circulated to individual care team members to assess if they felt vulnerable and

Table 1. Themes, definitions and examples.

	Definition	Percentage recordings with theme	Example
Cohesion	Mentions feeling reliant on other team members; feeling like part of the group	61%	'I have never been so invested, I feel, in being part of a team. I have been on nominal teams and work groups before, but this is one … it seems it's really important to see it as a team, to have this really stellar team that everyone is going to look towards. So I [spend] a lot more time thinking about the team as a whole and how we can all work together.'
Subgroups	Discusses divisions within the team (care guides vs clinicians); not necessarily leading to conflict	56%	'I was trying to figure out how the clinical roles intersect with care guides and roles, how we work as a team. I had an interesting request from a care guide this week. I think there is a lot of information to learn in how we do this work together, clinician and care guide.'
Jurisdiction	Discusses claims to authority or ownership of work task or process; mentions conflict over work tasks	30%	'I feel there has been some miscommunication or misinterpretation on the team around my involvement, or so that I would gather information and sort of hand it off to them to pick up and take to the patient, rather than me jumping in and doing that. I feel that I have created some unnecessary tension between me and the clinical managers, as well as me and some team members.'

identifiable through the use of the quote. In no instances did team members find both of these conditions to be met. Finally, findings about team formation and evolution were only shared with the full Whole Person team once themes had been aggregated and analyzed. Managers and supervisors did not have access to raw data provided by care team members.

We were also reflexive about how our own affiliations with the organization shaped our interpretation of the data. The first author was a post-doctoral scholar brought in to help understand team dynamics. The second author was a research scientist within the organization, specializing in qualitative methods. The third author was a research assistant who helped to code qualitative data on team processes. The three of us frequently reflected on how to maintain data integrity and ethical commitments to participants. In addition to protecting research participants, the policies we put in place permitted greater distance from the operational activities that may have blurred our own roles as researchers.

Results

Our analysis focuses on three themes: cohesion among team members, acknowledgement of subgroup divisions within the team, and jurisdictional disputes. The prevalence of these themes varied widely during the data collection period (see Figure 1). For instance, in the earliest stages of the project, all three themes were common, and showed similar peak and valley patterns: during weeks 1–9, the three themes largely moved together. Then, from weeks 10–20, the different themes settled into a steady pattern with less variation, and moved more independently from one another. In the final third of the 30 weeks (weeks 21–30), the themes reverted back to a peak and valley pattern, mostly moving together, though not as closely as in the early period. This pattern indicates that identity work took place in different ways under different organizational and team contexts.

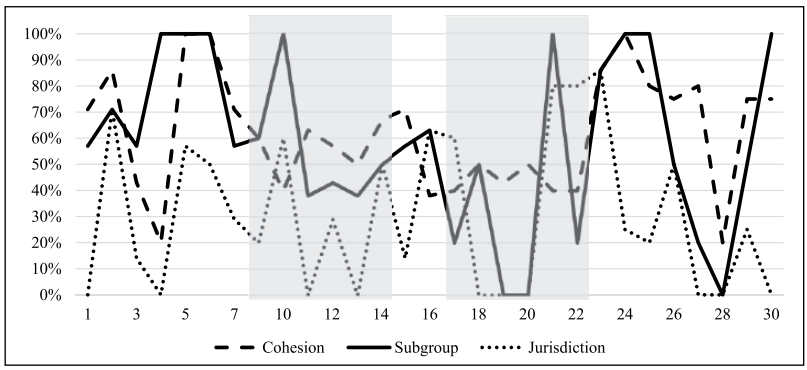

Figure 1. Percentage of team members using identity themes, over 30 weeks.
Note: Week 9 is excluded because it was a holiday week and only one team member turned in a recording. Shaded areas represent the critical moments we feature in this article.

Although Figure 1 is useful in a descriptive sense, our interest was in theorizing the context around some of the most critical moments in the team process. We selected two critical moments that capture transitions in how team members thought about themselves in reference to the team. The first critical moment took place as the peaks and valleys moved into the steady middle period (weeks 8–14). The second critical moment represents the movement out of the steady period and back into the peaks and valleys of the final 10 weeks (weeks 17–22). Table 2 summarizes the main findings discussed below.

Critical moment 1: Critique and stabilization

The first critical moment took place just as the team was gearing up for a holiday during week 8. Most staff members took off week 9 to celebrate, so only one weekly recording was submitted. We removed week 9 from Figure 2 to aid interpretation of the overall pattern. Weeks 10–14 represent the return to work after the holiday. At the beginning of the critical moment, subgroup and jurisdiction themes were both high (with cohesion slightly lower). As the team continued to work together, reports of jurisdictional issues decreased, subgroup themes decreased slightly, and cohesion themes remained steady.

Table 2. Summary of findings.

	Themes	Early context	Later context	Summary
Critique and stabilization	*Cohesion* is steady throughout. *Subgroup* divisions and *Jurisdictional* disputes start high, but then steady.	• Confusion and critique of 'transdisciplinary' model • Tension between innovation and using past experience • Team work on roles	• 'Transdisciplinary' term rejected • Individual work on roles	Team members banded together to reject management control during a time of organizational change. Team members engaged in group identity work when they defined managerial control as negatively affecting the team. Team members engaged in individual identity work once their critique had been heard.
Stability to conflict	*Cohesion* is steady throughout. *Subgroup* divisions and *Jurisdictional* disputes start moderate, go down, and then rise even higher.	• Individual work on roles • Frustration with lack of direction and model change • Mixed response from other providers in the system	• Overt conflict with other providers in the system • Tension over roles within the team	Team members were emotionally supportive of one another as tensions with other providers increased. Identity work took place individually. Tensions with other providers brought out jurisdictional questions within the team.

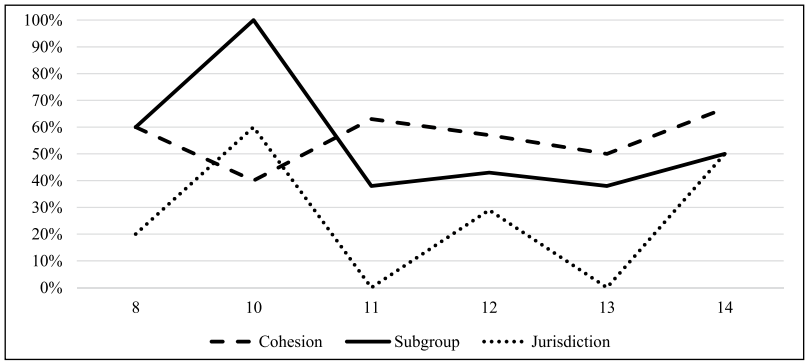

Figure 2. Critique and stabilization.
Note: Week 9 is excluded because it was a holiday week and only one team member turned in a recording.

This pattern illustrates re-stabilization after a spike in action. We use additional data on the team context to understand how this re-stabilization happened.

During weeks 8 and 10, when subgroup divisions and jurisdictional issues were high, team members expressed dissatisfaction with elements of the Whole Person model, especially the emphasis on 'transdisciplinary' team approaches and pressures to be innovative. In particular, clinicians (professionals holding practice licenses) expressed frustration and a lack of guidance on how they should be engaging with care guides (lay healthcare workers):

> I'm having more frustration with the model itself this week and the whole idea of clinical and non-clinical transdisciplinary, but yet, we are to be consultants to the non-clinical people. I think the term 'experts' has been used, 'Well, you are the experts, but then we don't want you to do your traditional role.' I'm feeling pulled, pulled in a lot of different directions and pulled without the clarity of what this all is supposed to be … Those mixed messages leave me feeling confused and leave me feeling a lot of dissonance in how it is that I should participate in meetings and how I should be talking to the care guides.

Acknowledgment of subgroups is illustrated in the example when this clinician, who had extensive professional training, was not sure how their training fitted within a model that was intended to be non-hierarchical. The clinician's professional identity was made salient by requests to be 'transdisciplinary.' As this team member pointed out, the assumption that some team members act as 'experts,' giving consultations to non-clinical team members, inherently implied unequal standing and did not transcend disciplinary differences.

The lack of clarity about the transdisciplinary team model also brought out some team members' concerns that valuing innovation meant not fully using team members' professional expertise. One team member summarized the problem as one of valuing innovation above drawing on lessons that had already been learned:

> I'm here because of some of my past experience and works that I've done and training, yet we don't want to do anything that works exactly like that here because we need to shake it up and

> it needs to look different. I get that for the most part, as far as the interactive pieces that we are trying to do and bring forth in Whole Person, but I really question that, in that why wouldn't we tap into those past experiences and trainings and who we are as professionals? Do we really have to do everything differently?

In this case, the team member aligned herself with the team, but also argued that she could use her professional identity to enrich the team and deliver the best care. Aligning with the team showed that it was possible for clinician team members to hold team and professional identities in balance, even enhancing both. This enhancement likely comes from a higher-level identification with the project and its goals.

Care guides also noted that, with careful attention, all team members could develop roles that incorporated both team and professional identities. One care guide argued for supporting clinicians in pushing for greater clarity on their roles. In describing a meeting meant to offer more clarity, she said:

> It was very difficult because the clinical team members of my team are finding that they are lost in what their roles can be. I think so much energy has gone into determining what the care guide role would be and getting that launched and supporting that. It makes total perfect sense to me that right now while we've got that figured out for the time being that we need to work on these other roles and hopefully work together as a team in defining how the other clinical roles on our team can be a part of Whole Person.

Others similarly stated that it had been an emotional week, but that they felt like the discussions over roles had been productive. In the common ingroup identity model (Gaertner et al., 1994), team members from different subgroups see their ultimate goals as aligned and understand how different professionals can come together in service of that higher-level goal. For the Whole Person team, this meant spending dedicated time to defining the roles of clinicians, as well as care guides.

Pressures related to the transdisciplinary approach reached a peak during week 10. Although tensions with the model were high, cohesion was evidenced as one care guide emphasized feeling thankful for her team after a difficult patient situation:

> My week was very, very difficult, but also, my team has been so amazing in supporting me through what this event caused for me. They just have been great. I've been able to be really open and they have put me in touch, and in addition to just being very supportive themselves as my coworkers and from within their own professions. They have been able to put me in touch with other resources and I feel very grateful.

Importantly, in recounting how other team members were helpful, this team member described her colleagues as drawing on their own professional experiences to offer support. Whereas discussions of the transdisciplinary model often focused on reducing difference and hierarchy, this team member identified others as beneficial *because* of their different professional training. Even across the clinician/care guide divide, team members were increasingly aware that the transdisciplinary model hindered their ability to use both team and professional identities and skills.

By week 11, these pressures had been partially relieved, in part through the quiet time that followed the holiday. One team member reported using this time to reflect on her individual role and identity. Time apart from the team permitted this reflection and was described as a complement to intensive group meeting times:

> When we are in the office, we tend to have meeting after meeting as a group all together and that kind of creative and research process tends to give way to the personal role that I have on this team, so it was very nice to have some space to follow up on some of the things that I needed to get done as well as start to think from a larger perspective about what this role should be and how maybe the model needs to be.

Although at some moments professional identities may make it difficult to come together as a team (Mitchell and Boyle, 2015; Molleman and Rink, 2014), this team member framed her professional identity work as good for the team and her personally.

Shortly after, project leaders responded to team members' concerns by dropping the emphasis on transdisciplinarity. Whereas the first several weeks included explicit messaging that all team members should commit to team identifications over professional identifications, dropping the transdisciplinary approach meant that team members could create a different way to navigate multiple identification targets coming from the work group and professional training. This was especially important for clinically trained team members, who likely experienced threats to their professional identity through attempts to work differently (Currie et al., 2012). Several team members expressed gratitude that the team's critique had been heard, and the term was changed to 'cross-understanding' instead:

> I've been so vocal and so constant with frustration that we aren't a transdisciplinary team and I'm so grateful … it really is a pretty remarkable experience to be a part of this Whole Person team and to recognize that when we have things that don't sit with us and that don't make sense and that just don't seem quite right, that we are truly heard.

Although several team members previously reported not feeling heard, once this decision had been made, most team members discussed appreciating being involved in these operational decisions, causing many team members to then align themselves with management and the larger project again.

Some team members explicitly linked the new approach of cross-understanding to improved team cohesion: 'I think the emerging awareness of who we are as a team or who we might be as a team is evolving, and I think we truly are moving toward greater cross understanding and a new level of cohesiveness as a team.' The team member then went on to describe new activities she had initiated to better understand the roles of others. As critiques of the transdisciplinary model fell away, most team members used their recordings to talk through specific, individual details related to their new roles.

The progression from weeks 8 to 14 shows how attempts at innovation were held in tension with attempts to use professional expertise. The use of the term 'transdisciplinary' epitomized this tension. Managerial direction to flatten the professional hierarchy was perceived as confusing and misaligned with how team members conceptualized both their professional selves and the purpose of the team. The guidance on how to carry out this collaboration seemed to be contradictory: clinicians should serve as

consultants, but all hierarchical differences should be erased. Team members across all positions aligned to push against directions to be transdisciplinary, coming together and reinforcing team identities in the process. After the tension was resolved, team members reported feeling positively about their team, but talked about themselves in more individualized terms. This example illustrates how identities work in times of organizational change where workers do not have adequate control. Team members agreed with the overarching mission of the project, but did not feel empowered to shape it. Once their critiques were heard, team members felt more at ease and more able to work with one another and managers.

Critical moment 2: Understanding the work and drawing boundaries

Whereas in the earlier critical moment the team moved from a period of tension to relative stability, the second critical moment represents a time that stability gave way to increased tensions. In particular, from weeks 17 to 20, cohesion remained steady and subgroup and jurisdictional issues were low. However, in weeks 21 to 22, cohesion was still steady, but subgroups and jurisdictional conflicts were heightened (Figure 3).

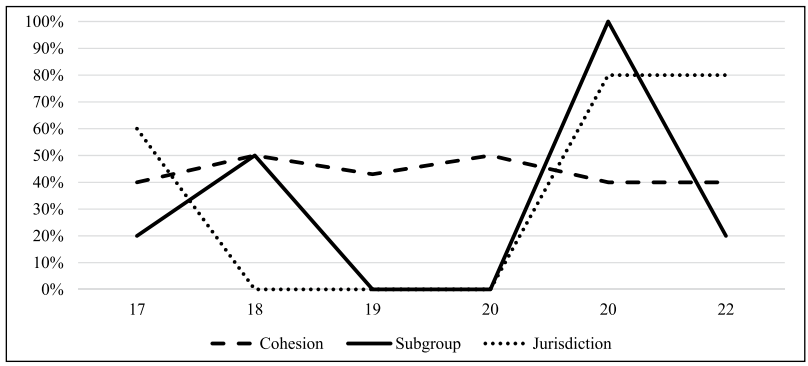

Figure 3. Stability to conflict.

During weeks 17–20, team members' reflections involved a great deal of individual engagement with their formal job descriptions and other materials related to model development. Several team members expressed that they were working through expectations, with recordings indicating that this was largely done individually, not as a group. For instance, one team member described work to develop the role, 'I've also been doing some reading on my own, some literature review, looking at building of community palliative care teams, which I think is closest to that, although certainly different.'

Many team members reported appreciating dedicated time for developing their individual roles, but some also expressed frustration with a lack of direction from managers:

> I think decisions and how we make decisions continue to be a challenge. We had conversations and the [managers] come in and talk with us about what that should look like … But again, I have this feeling like there is something they are trying to tell us, without actually telling us

> what we should be doing. I think what the team needs, what I need, is clear expectations. So if there is something that is wanted or expected or desired from us, [we want] that it just be told to us, so that we can then work within those guidelines or guardrails to produce or create a program that is also what the [managers] had in mind.

This team member uses both team and individual identities by saying, '… what *the team* needs, what *I* need is clear expectations.' Again in this instance, team members were able to align with the team – despite functional diversity and differences between clinicians and care guides – to push against management practices that seemed to make the work more difficult.

Despite their individualized work, frustration with management prompted the team to come together:

> In terms of team dynamics, I think we had a really intense day on Wednesday, but it was great. I think the whole team is feeling very cohesive and that we are taking some big steps forward, at least that is what I feel like, so that feels really good. I'm feeling that this is by far the best team of coworkers that I've ever had, and there's certainly a big reason why we can get through quite a bit of stress and uncertainty, and we are all sticking with it to make this project really great, so it's kind of fun.

During this stable time, team members worked individually on their roles, but were still able to come together as a team during group tasks, especially to ask for what was needed from management.

Lack of clarity from managers was especially challenging for establishing collaborative relationships with healthcare providers outside the team. As this moment progressed, some wondered if they were doing the right thing to nurture relationships with other providers:

> What I'm finding increasingly is questions about effective collaboration. One of my patients has a family with a lot of discord and disagreement, so I'm communicating a lot with hospice and with nursing home staff and with different factions of this family trying to make each member of the family who is involved really feel understood and heard … Several times now and definitely today I find myself in the position of wondering 'am I taking on dealing with problems that should be dealt with by other people; am I overstepping my bounds?' I don't want to be stepping on anybody's toes, from the hospice or the nursing home.

Nurturing these relationships required more attention to jurisdictions – what should be the work of this team, and what should be left to other care providers?

The focus of many team members' recordings moved from issues with management to issues in collaborating with other healthcare providers. These other providers frequently did not understand the Whole Person team, and team members performed identity work as they tried to demonstrate their value to others, who may not have had the time or willingness to be open to new approaches. Some team members were critical of other providers, foreshadowing conflict that arises explicitly in weeks 20–21:

> I'm finding that, when in these collaborative meetings with residents in the long-term care facilities, that there isn't a whole lot of knowledge, especially by the [professional workers].

> Even some of the [managers] don't have as much knowledge either, so it's like how do we get the right people at these meetings. I find it incredibly frustrating.

These examples show that as team members worked individually on refining how to fit within the team, they were also engaged with other providers. Balancing individual role work and collaborations with other providers reinforced both professional and team identities as they used each in their negotiation with outside providers.

By weeks 21 and 22, conflict and subgroup divisions became common in team members' reflections. Overt conflict had begun to break out between some of the team members and other providers in the healthcare system. Jurisdictional disputes were linked to some team members' perception that the quality of care had been reduced by other providers' involvement, thus reinforcing an 'us/them' dynamic between the Whole Person team and other providers:

> I'm feeling a little bit of dissonance just about how the Whole Person involvement jived with hospice, and the effect of hospice on my relationships with the patient and [family], I would say was not as good as I would have hoped, once hospice was involved … So, now the patient has died and I'm feeling like there may have been real lost opportunities to help this patient and family.

Cohesion and support from the team were used to work through difficult relationships with other providers. Team members reported sharing tips on how to see the situation from physicians' and other providers' perspectives. Some drew on expertise from clinically trained managers: 'I'm taking the good coaching advice that I'm getting from my managers and team members and am laying low and keeping very open communication.' Resistance from outside providers reinforced team members' alignment with the team as well as with management.

Even though the team came together to support one another through potential conflicts with other providers, some divisions within the team were renewed. In weeks 21 and 22, subgroups within the team re-emerged as conflicts with others in the system made the division between clinical and lay person workers salient. As other providers pushed back on the innovative potential of Whole Person, clinicians within the team began to worry that lay care guides did not have the skills necessary for remaining detached from the work. In particular, one outside provider raised specific concerns about appropriate relational boundaries of care guides, which then prompted several clinicians to comment explicitly on this issue:

> I really struggle at times when I think so many of these kinds of decisions are pretty therapeutically and clinically focused where we don't have similar ideas and those of us working in the mental health field / spiritual realm / social work field have a lot of experience and training in these areas. I guess I can't say I know that, but it hasn't been my experience or something I've noticed that [medically trained healthcare professionals] have the same kind of training and support around boundary issues. So it gets tricky when so much of our leadership is medically based and leadership is making decisions about these pieces and I feel like they don't have the information or the training themselves that's needed.

During this critical moment, the target of critique shifted from management to other providers in the healthcare system. The team was cohesive throughout this

period, but the ways that cohesion manifested changed in response to changing tensions. When managers were the target of critique, cohesion was used to reconcile professional and team identities and present a united front. Team members were able to align themselves to advocate for their needs from management. However, when other providers in the healthcare system were targets of critique, cohesion was used primarily as a form of emotional support. Clinicians used their dual identities as professionals and as team members to provide support and mentorship to care guides, who were most frequently challenged by resistance from other providers. At the same time, however, clinicians drew distinctions between their own expertise and that of the care guides. Their concerns focused on the edges of appropriate roles, performing boundary work, even as they were supportive. Ultimately, this boundary work reinforced professional divisions and the medical hierarchy that gave authority to credentialed providers over the lay care guides (Currie et al., 2012).

Discussion and conclusion

In this article, we have conceptualized identity as a hidden process within team-based work. For teams to be effective, team members must balance multiple identification targets: organizational, team and professional (Eckel and Grossman, 2005; Kuhn and Nelson, 2002; Scott et al., 1998). We focus on the subjective experiences of team members during two 'critical moments' where workers actively engaged in identity work. Critical moments are characterized as times when emotions were high in response to the work. Specifically, we analyzed times that team members grappled with resistance and organizational change. Workers came in with strong support for the vision of the team, but as the actual procedures for carrying out the vision were unclear and team members experienced resistance, they felt a meaning void (Gioia et al., 2010). Their identities provided stability and potential courses of action, especially during these times of turmoil and organizational change (Hornsey, 2008; Tajfel and Turner, 1979, 2004).

Our analysis enriches theory on work identities in three ways. First, whereas extant literature and SIT posit that strong professional identities may make teamwork difficult (Hall, 2005; Mitchell and Boyle, 2015; Molleman and Rink, 2014), we analyze how context affects how workers navigate multiple identification targets. At some times, professional and team identities conflict, such as when jurisdictional disputes emerge between clinicians and care guides. In these moments, team members are not always clear about when they are acting as a team member or as professionals. However, in other moments, team and professional identities are integrated in meaningful ways, even enhancing one another. Similar to Waring and Bishop's (2011) study of workers' identities through changes in organizational ownership, we find that higher-level uniting identifications provide some stability to workers and even permit potentially conflicting professional and team identities to be reconciled (Gaertner et al., 1994). However, these unifying identities can be difficult to sustain (Dovidio et al., 2007), making it essential to examine how organizational context provides opportunities and constraints for workers to come together (Chreim et al., 2007).

Critical moment 1 illustrates how the shifting context affected the balance of identification targets. Initially, project leaders thought that the team would function best if they erased professional differences and prompted team members to relate as people,

not as representatives from different professions. Although this may have encouraged interpersonal relationships, team members found this very difficult to do and were frustrated. Team members banded together, relying on their team identity to effect change. The change they created was an acknowledgement of the strengths of different professional backgrounds. Extant literature suggests that this is most likely to happen when threats are low and all forms of expertise are welcome (Bartel, 2001; Fiol et al., 2009; Nembhard and Edmondson, 2006). In this situation, management control was perceived as a threat, but the collective power of the group mitigated the effect of management control. Further refinement of our understanding of the conditions under which multiple (sometimes contradictory) identities can be reconciled may come from more nuanced analyses of power, managerial action and constraints within the organization.

Second, we show that group members vary in their experiences of identity work, based on the strength and relevance of their professional identities before coming to the team. This finding provides insight into how professionalization processes and diversity affect teamwork (Dingwall and Lewis, 2014 [1983]; Mitchell et al., 2010; Rueschemeyer, 2014 [1983]; van Knippenberg and Schippers, 2007). The most salient division within the Whole Person Team was between professionally trained clinicians and lay care guides. While we found that professionals were able to reconcile professional and team identities when they aligned with the larger goals of the project, we also found that the professional workers had difficulties with what they saw as violations of jurisdictional boundaries. This finding is consistent with previous research that shows how new roles and new ways of working can be perceived as threatening to professionals who rely on jurisdictional boundaries to reaffirm their status (Currie et al., 2010, 2012; Waring and Bishop, 2011). This is especially apparent in critical moment 2 where clinicians expressed some concern about how care guides were performing the work. Professional workers struggled more than care guides to establish firm identities and communicate what made some work professional work whereas other work could be completed by the care guides. The clinicians found it increasingly difficult to support a model that minimized their professional training (Fiol et al., 2009; Rueschemeyer, 2014 [1983]), creating a conflict of identity that could not be overcome by banding together as a group (Ashforth et al., 2008).

Our findings show that some types of professional identities may be more malleable than others, and that times of stress may exacerbate differences within the team. Specifically, professional identity may be especially hardened through socialization processes (Dingwall and Lewis, 2014 [1983]; Mitchell et al., 2010), whereas identities based on new roles (such as care guides) are more malleable. Additionally, those with the most professional status have the most to lose by the reconfiguration of roles (Currie, et al., 2012), supporting the idea that group members perceive changing identity processes differently, based upon their power within the group (Dovidio et al., 2007). Scholars measuring team diversity moving forward may also include measures of openness, identity malleability and power (Tse and Mitchell, 2010). These findings also enrich SIT by showing that identification processes in real-world settings are affected by a range of factors (Hennessey and West, 1999), including one's previous professionalization and one's current sense of resistance from peers.

Finally, we analyze examples of work situations in which the work of the team shifts in response to team members' changing targets of critique. By documenting context around conflicts with managers and other providers, we engage with theories of boundary work, boundary spanning and interdisciplinary teams (Bartel, 2001; Richter et al., 2006; Williams, 2011). For example, in critical moment 2, pressures from other providers renewed some team members' critique of processes within the team (especially boundaries around care guide work), while simultaneously reinforcing team cohesion. Cohesion was used differently according to the nature of the pressure. When critiques were lobbed at managers, cohesion was used to effect change within the project. When problems arose with providers from outside the team, cohesion was used to provide support and mentorship to other team members. Team members were most likely to talk about themselves as a team during times where pressures were high, even as these moments also included internal critique about who should conduct sensitive work. Findings suggest that we should conceptualize boundaries as multi-layered. As team members spanned multiple local contexts, their engagement with various outgroups shifted, which then prompted identity work and in-depth reflection on team processes.

Our approach is strengthened by the quality of our longitudinal qualitative data from reflective audio diary recordings of team members. Our data are especially well-suited for thinking about how identification processes change alongside organizational contexts because team members regularly reported on their work experiences, struggles and successes. Team members were not prompted to reflect on their identities, which gives a naturalistic account of how they thought about their selves during the development of this team. By tying team members' references to themselves as professionals, parts of the group, or in conflict with the group to actual contextual events, we are able to isolate critical moments in team development and understand the role of identity in resolving tensions in the work. Critical moments have been used in narrative approaches in the past and offer nuanced data on subjective experiences, contextualized in real time (Riessman, 2008; Thomson et al., 2002). In this analysis, we used this same framework to analyze times where emotions were high, prompting team members to describe their current situation, and revealing identity work in the process.

Management practice significance

To translate these findings into management practice, more research is needed on how workers navigate multiple identity targets, including profession and team. In particular, the dark side of identity is the process of defining who is not like you – an outgroup (Hogg and Terry, 2000). Having outgroups is not necessarily a problem, but managers must seek to understand why particular divisions take hold and their lasting effect. In fact, occasional outgroup distinctions likely help the team to cohere, through individual team members identifying with the group more than their professional positions. Managers must ensure that outgroups do not stigmatize workers or allow bullying within the group (Lutgen-Sandvik, 2008; Toyoki and Brown, 2014) as this is detrimental to the group and the individuals.

Our findings also highlight the importance of carefully considering how to manage teams. Managers might provide teams the freedom to self-define and control some

aspects of their process (Wageman, 1995, 2001), but should provide guidance as the team requests it. This kind of freedom may encourage team members to creatively determine how to best use and synthesize professional and team identities (Grant et al., 2014). Another critical role for managers is to provide support when team members experience resistance from other providers. Too much managerial-imposed change can make workers feel threatened (Callan et al., 2007), which then may trigger resistant selves and refusals to participate in innovation (Collinson, 2003).

Some have suggested that one way to deal with professional identities and teamwork is to create a culture where individuals align more with the organization than their professions (Molleman and Rink, 2014). While this may be especially important in times of organizational change where roles and responsibilities may shift, we caution against trying to eliminate professional identities. Our findings show that erasing professional identities was not successful and actually set the team back in terms of figuring out how to work together. Hall (2005) outlines the ways that professional culture inhibit teamwork by making it difficult to include all disciplines, infusing teamwork with hierarchy, role-blurring between some team members, and the use of different languages and value systems to solve problems. For teams to overcome these issues, team members need an identity beyond the profession – an identification with the team but not an erasure of professions. Following the common ingroup identity model, this approach my appreciate divisions within the team, but also includes a higher-level commitment to inclusion of all (Dovidio et al., 2007; Gaertner et al., 1994).

Limitations and future research

Although it is a strength of this study that the data reflect a naturally adaptive context in which the team worked, the question of additional identities that are imported into work situations warrants further research. The group studied in this article was racially and ethnically homogenous, but workplace identities intersect with other important identities: as gendered and racialized persons (Kenny and Briner, 2013) or as members of religious groups (Gebert et al., 2014). These intersections are especially theoretically fruitful when they contradict one another, or have differing levels of social prestige or stigma attached to them (Slay and Smith, 2011). Future research should examine how context matters for these complex intersections of professional and personal identities.

Additionally, our study includes a single team, and the findings should not be generalized to all teams. Given that our goal was to contribute to theory regarding the role of context in identity processes within teams, this lack of generalizability does not undermine our contribution. Our findings may transfer to similar teams: teams early in formation, using team members from varying professional backgrounds, asked to perform innovative work, which included boundary-spanning responsibilities. We would expect that similar teams would experience similar processes of identity negotiation, especially in response to outgroups and struggles with role definition. Because healthcare organizations increasingly rely on teams to carry out services, these findings will be useful for managers who seek to understand the social dynamics that affect the success of team-based work.

Additionally, healthcare organizations increasingly push for transformation, such as innovative team approaches, but organizational contexts often do little to support transformation. Workers' subjective experiences shape how (and if) they participate in transformation efforts. Understanding the range of experiences of workers in these roles provides opportunities to strengthen commitment to organizational objectives and improve work satisfaction.

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References

Abbott A (1988) *The System of Professions: An Essay on the Division of Expert Labor*. Chicago, IL: University of Chicago Press.

Alvesson M and Willmott H (2002) Identity regulation as organizational control: Producing the appropriate individual. *Journal of Management Studies* 39(5): 619–644.

Alvesson M, Ashcraft KL and Thomas R (2008) Identity matters: Reflections on the construction of identity scholarship in organization studies. *Organization* 15(1): 5–28.

Ashforth BE and Johnson SA (2001) Which hat to wear? The relative salience of multiple identities in organizational contexts. In: Hogg MA and Terry DJ (eds) *Social Identity Processes in Organizational Contexts*. Philadelphia, PA: Psychology Press, 31–48.

Ashforth BE and Mael F (1989) Social identity theory and the organization. *Academy of Management Review* 14(1): 20–39.

Ashforth BE, Harrison SH and Corley KG (2008) Identification in organizations: An examination of four fundamental questions. *Journal of Management* 34(3): 325–374.

Bartel CA (2001) Social comparisons in boundary-spanning work: Effects of community outreach on members' organizational identity and identification. *Administrative Science Quarterly* 46(3): 379–413.

Bolger N, Davis A and Rafaeli E (2003) Diary methods: Capturing life as it is lived. *Annual Review of Psychology* 54(1): 579–616.

Bordia P, Hunt E, Paulsen N, et al. (2004) Uncertainty during organizational change: Is it all about control? *European Journal of Work and Organizational Psychology* 13(3): 345–365.

Boyatzis RE (1998) *Transforming Qualitative Information: Thematic Analysis and Code Development*. Thousand Oaks, CA: SAGE.

Callan VJ, Gallois C, Mayhew MG, et al. (2007) Restructuring the multi-professional organization: Professional identity and adjustment to change in a public hospital. *Journal of Health and Human Services Administration* 29(4): 448–477.

Chreim S, Williams BE and Hinings CR (2007) Interlevel influences on the reconstruction of professional role identity. *Academy of Management Journal* 50(6): 1515–1539.

Clark SM, Gioia DA, Ketchen DJ and Thomas JB (2010) Transitional identity as a facilitator of organizational identity change during a merger. *Administrative Science Quarterly* 55(3): 397–438.

Collinson DL (2003) Identities and insecurities: Selves at work. *Organization* 10(3): 527–547.

Crozier SE and Cassell CM (2016) Methodological considerations in the use of audio diaries in work psychology: Adding to the qualitative toolkit. *Journal of Occupational and Organizational Psychology* 89(2): 396–419.

Cunningham CE, Woodward CA, Shannon HS, et al. (2002) Readiness for organizational change: A longitudinal study of workplace, psychological and behavioural correlates. *Journal of Occupational and Organizational Psychology* 75(4): 377–392.

Currie G, Finn R and Martin G (2010) Role transition and the interaction of relational and social identity: New nursing roles in the English NHS. *Organization Studies* 31(7): 941–961.

Currie G, Lockett A, Finn R, et al. (2012) Institutional work to maintain professional power: Recreating the model of medical professionalism. *Organization Studies* 33(7): 937–962.

Dingwall R and Lewis P (eds) (2014 [1983]) *The Sociology of the Professions: Lawyers, Doctors and Others*. New Orleans, LA: Quid Pro Books.

Dovidio JF, Gaertner SL and Saguy T (2007) Another view of "we": Majority and minority group perspectives on a common ingroup identity. *European Review of Social Psychology* 18(1): 296–330.

Dutton JE and Dukerich JM (1991) Keeping an eye on the mirror: Image and identity in organizational adaptation. *Academy of Management Journal* 34(3): 517–554.

Eckel CC and Grossman PJ (2005) Managing diversity by creating team identity. *Journal of Economic Behavior & Organization* 58(3): 371–392.

Ellemers N, de Gilder D and Haslam SA (2004) Motivating individuals and groups at work: A social identity perspective on leadership and group performance. *Academy of Management Review* 29(3): 459–478.

Ellemers N, Sleebos E, Stam D and de Gilder D (2013) Feeling included and valued: How perceived respect affects positive team identity and willingness to invest in the team. *British Journal of Management* 24(1): 21–37.

Fiol CM, Pratt MG and O'Connor EJ (2009) Managing intractable identity conflicts. *Academy of Management Review* 34(1): 32–55.

Ford JD, Ford LW and D'Amelio A (2008) Resistance to change: The rest of the story. *Academy of Management Review* 33(2): 362–377.

Fuller JB, Hester K, Barnett T, et al. (2006) Perceived external prestige and internal respect: New insights into the organizational identification process. *Human Relations* 59(6): 815–846.

Gaertner SL, Rust MC, Dovidio JF, et al. (1994) The contact hypothesis: The role of a common ingroup identity on reducing intergroup bias among majority and minority group members. *Small Group Research* 25(2): 224–249.

Gebert D, Boerner S, Kearney E, King Jr JE, Zhang K and Song LJ (2014) Expressing religious identities in the workplace: Analyzing a neglected diversity dimension. *Human Relations* 67(5): 543–563.

Gioia DA, Price KN, Hamilton AL and Thomas JB (2010) Forging an identity: An insider-outsider study of processes involved in the formation of organizational identity. *Administrative Science Quarterly* 55(1): 1–46.

Grant AM, Berg JM and Cable DM (2014) Job titles as identity badges: How self-reflective titles can reduce emotional exhaustion. *Academy of Management Journal* 57(4): 1201–1225.

Grey C (1994) Career as a project of the self and labour process discipline. *Sociology* 28(2): 479–497.

Hall P (2005) Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care* 19(suppl. 1): 188–196.

Hennessy J and West MA (1999) Intergroup behavior in organizations – A field test of social identity theory. *Small Group Research* 30(3): 361–382.

Hogg MA and Terry DJ (2000) Social identity and self-categorization processes in organizational contexts. *The Academy of Management Review* 25(1): 121–140.

Hornsey MJ (2008) Social identity theory and self-categorization theory: A historical review. *Social and Personality Psychology Compass* 2(1): 204–222.

Horton KE, McClelland CR and Griffin MA (2014) Defined by our hierarchy? How hierarchical positions shape our identifications and well-being at work. *Human Relations* 67(10): 1167–1188.

Kenny EJ and Briner RB (2013) Increases in salience of ethnic identity at work: The roles of ethnic assignation and ethnic identification. *Human Relations* 66(5): 725–748.

Kuhn T and Nelson N (2002) Reengineering identity: A case study of multiplicity and duality in organizational identification. *Management Communication Quarterly* 16(1): 5–38.

Lammers JC, Atouba YL and Carlson EJ (2013) Which identities matter? A mixed-method study of group, organizational, and professional identities and their relationship to burnout. *Management Communication Quarterly* 27(4): 503–536.

Larson GS and Pepper GL (2003) Strategies for managing multiple organizational identifications: A case of competing identities. *Management Communication Quarterly* 16(4): 528–557.

Lemieux-Charles L and McGuire WL (2006) What do we know about health care team effectiveness? A review of the literature. *Medical Care Research and Review* 63(3): 263–300.

Lutgen-Sandvik P (2008) Intensive remedial identity work: Responses to workplace bullying trauma and stigmatization. *Organization* 15(1): 97–119.

Miller CC, Burke LM and Glick WH (1998) Cognitive diversity among upper-echelon executives: Implications for strategic decision processes. *Strategic Management Journal* 19(1): 39–58.

Milton LP and Westphal JD (2005) Identity confirmation networks and cooperation in work groups. *Academy of Management Journal* 48(2): 191–212.

Mitchell R and Boyle B (2015) Professional diversity, identity salience and team innovation: The moderating role of openmindedness norms. *Journal of Organizational Behavior* 36(6): 873–894.

Mitchell R, Parker V, Giles M and White N (2010) Toward realizing the potential of diversity in composition of interprofessional health care teams. *Medical Care Research and Review* 67(1): 3–26.

Mitchell RJ, Parker V and Giles M (2011) When do interprofessional teams succeed? Investigating the moderating roles of team and professional identity in interprofesional effectiveness. *Human Relations* 64(10): 1321–1343.

Mohammed S and Angell LC (2004) Surface- and deep-level diversity in workgroups: Examining the moderating effects of team orientation and team process on relationship conflict. *Journal of Organizational Behavior* 25(8): 1015–1039.

Molleman E and Rink F (2014) The antecedents and consequences of a strong professional identity among medical specialists. *Social Theory & Health* 13(1): 46–61.

Nembhard IM and Edmondson AC (2006) Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior* 27(7): 941–966.

Owens TJ, Robinson DT and Smith-Lovin L (2010) Three faces of identity. *Annual Review of Sociology* 36(1): 477–499.

Polletta F and Jasper JM (2001) Collective identity and social movements. *Annual Review of Sociology* 27(1): 283–305.

Pratt MG (2000) The good, the bad, and the ambivalent: Managing identification among Amway distributors. *Administrative Science Quarterly* 45(3): 456–493.

Ramarajan L (2014) Past, present and future research on multiple identities: Toward an intrapersonal network approach. *The Academy of Management Annals* 8(1): 589–659.

Richter AW, West MA, van Dick R and Dawson JF (2006) Boundary spanners' identification, intergroup contact, and effective intergroup relations. *Academy of Management Journal* 49(6): 1252–1269.

Riessman CK (2008) *Narrative Methods for the Human Sciences*. Thousand Oaks, CA: SAGE.

Rueschemeyer D (2014 [1983]) Professional autonomy and the social control of expertise. In: Dingwall R and Lewis P (eds) *The Sociology of Professions: Lawyers, Doctors and Others*. New Orleans, LA: Quid Pro Books.

Ryan GW and Bernard HR (2000) Data management and analysis methods. In: Denzin NK and Lincoln YS (eds) *Handbook of Qualitative Research*. Thousand Oaks, CA: SAGE.

Sandelowski M (1991) Telling stories: Narrative approaches in qualitative research. *Image: The Journal of Nursing Scholarship* 23(3): 161–166.

Sass JS and Canary DJ (1991) Organizational commitment and identification: An examination of conceptual and operational convergence. *Western Journal of Speech Communication* 55(3): 275–293.

Scott CR (1997) Identification with multiple targets in a geographically dispersed organization. *Management Communication Quarterly* 10(4): 491–522.

Scott CR (2007) Communication and social identity theory: Existing and potential connections in organizational identification research. *Communication Studies* 58(2): 123–138.

Scott CR, Corman SR and Cheney G (1998) Development of a structurational model of identification in the organization. *Communication Theory* 8(3): 298–336.

Simpson B and Carroll B (2008) Re-viewing 'role' in processes of identity construction. *Organization* 15(1): 29–50.

Slay HS and Smith DA (2011) Professional identity construction: Using narrative to understand the negotiation of professional and stigmatized cultural identities. *Human Relations* 64(1): 85–107.

Sveningsson S and Alvesson M (2003) Managing managerial identities: Organizational fragmentation, discourse and identity struggle. *Human Relations* 56(10): 1163–1193.

Tajfel H and Turner JC (1979) An integrative theory of intergroup conflict. In: Austin WG and Worchel S (eds) *The Social Psychology of Intergroup Relations*. Monterey, CA: Brooks/Cole.

Tajfel H and Turner JC (2004) The social identity theory of intergroup behavior. In: Jost JT and Sidanius J (eds) *Political Psychology: Key Readings in Social Psychology*. New York, NY: Psychology Press.

Thomson R, Bell R, Holland J, et al. (2002) Critical moments: Choice, chance and opportunity in young people's narratives of transition. *Sociology* 36(2): 335–354.

Toyoki S and Brown AD (2014) Stigma, identity and power: Managing stigmatized identities through discourse. *Human Relations* 67(6): 715–737.

Tse H and Mitchell R (2010) A theoretical model of transformational leadership and knowledge creation: The role of open-mindedness norms and leader–member exchange. *Journal of Management & Organization* 16(1): 83–99.

van Knippenberg D and Schippers MC (2007) Work group diversity. *Annual Review of Psychology* 58(1): 515–541.

Wageman R (1995) Interdependence and group effectiveness. *Administrative Science Quarterly* 40(1): 145–180.

Wageman R (2001) How leaders foster self-managing team effectiveness: Design choices versus hands-on coaching. *Organization Science* 12(5): 559–577.

Waring J and Bishop S (2011) Healthcare identities at the crossroads of service modernisation: The transfer of NHS clinicians to the independent sector? *Sociology of Health & Illness* 33(5): 661–676.

Williams P (2011) The life and times of the boundary spanner. *Journal of Integrated Care* 19(3): 26–33.

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