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Source: *Organization Science*, Vol. 9, No. 1 (Jan. - Feb., 1998), pp. 103-118

Published by: INFORMS

Stable URL: <http://www.jstor.org/stable/2640424>

Accessed: 04/12/2009 16:34

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Feeling Stressed and Burned Out: A Feminist Reading and Re-Visioning of Stress-based Emotions Within Medicine and Organization Science

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This article provides a new lens through which to interpret research findings about stress and burnout in organizations. Adopting a feminist postmodern viewpoint, Meyerson shows how the questions asked and the knowledge produced about this emotional condition are culturally situated, and she provides a revised interpretation for theorizing about stress, burnout, and other emotions in organizations.

Richard L. Daft

Abstract

This article is written in the spirit of resistance, as a challenge and alternative to what are accepted as neutral, unbiased conceptualizations of stress and burnout within traditional and popular discourse. Findings reported in a previous study suggest that the ways we conceptualize and experience stress and burnout are not inherently neutral, but are shaped by culture and a particular set of dominant themes prevalent in organizational and professional discourse. This article exposes the processes by which some forms of organizational experience and knowledge related to stress and burnout have become dominant, whereas “other” forms have become marginal and suppressed. Through a postmodern feminist reading of stress and burnout as expressed within the medical and organizational discourses, the author reveals how gender acts as an axis of power and meaning that helps sustain dominant and seemingly neutral conceptualizations within the discourses. Building from the feminist reading, she develops a radical reconstruction of the ways organizational participants and theorists could interpret and experience stress related emotions, and discusses the cultural conditions that could produce and sustain such a revision. The reading and revision reveal ways in which experiences of stress and burnout have been shaped and constrained by the dominant discourse and suggest ways social scientists might rewrite those experiences toward more humane ends. Insofar as stress and burnout are among the most common and well-researched topics (and emotions) within the field of organizational behavior, this paper has far-reaching theoretical, epistemological, and

practical implications. More generally, the feminist reading and revision open new spaces for other ways of theorizing and argues against the limitations of knowledge and experience imposed by traditional organizational theory and medical discourse.

(Feminist Organization Theory; Feminist Reconstruction; Stress and Gender; Emotions and Gender; Medicine and Feminist Theory; Feminist Organization Theory; Feminist Epistemology)

Introduction

In the fast-paced, resource-constrained, “high-tech” environment of contemporary life, feelings of stress and burnout have achieved the prominence of social epidemic. The incidence of stress and burnout, as well as the claim of “stress,” is unequivocally on the rise (Barley and Knight 1991). That trend and the perceived consequences of the “epidemic” have not escaped the attention of managers, therapists, industrial psychologists, and self-help book publishers. With the attention has come a portfolio of strategies intended to help individuals avoid, control, and cope with stress and burnout.

Although rarely explicit, the language of organizational and popular discourse formulates stress and burnout as “problems” to control, manage, or avoid. With a few exceptions (e.g., Abbott 1990, Colligen et al. 1982), work on stress and burnout within the organizational behavior and industrial psychology literatures (e.g., Cartwright and Cooper 1996, Maslach 1982), as well as popular self-help books focus on methods of management and coping. They emphasize (1) emotional and (2) bodily control, (3) the individual as the locus of control (if not the source of the problem), and (4) the abnormal—not normal—nature of stress and/or burnout.

Those four themes are implicit in how stress and burnout are traditionally conceptualized. They are taken for granted as neutral and rarely questioned. In a previous article (Meyerson 1994), I challenged the neutrality of those themes by exposing the ways in which the dominant formulation of stress and burnout are products (and producers) of a broader set of cultural and institutional conditions. I contrasted the language of stress used by social workers practicing in a traditional medical culture with that used by social workers practicing in a culture shaped by psychosocial ideology. Whereas the language of stress among the medical social workers mirrored the institutionalized conceptualizations of stress and burnout within organizational and popular discourse, the social workers in the psychosocial culture talked qualitatively differently about such experiences. Those findings suggested the set of questions addressed here:

1. Why does the dominant conceptualization of stress and burnout within organizational and popular discourse mirror that expressed within the medical culture?
2. What cultural and institutional processes account for parallels across disciplines and the systematic privileging of some conceptualizations of stress and burnout and marginalization of “others”?
3. How is gender implicated in the privileging of certain forms of knowledge and meaning over “other” forms? How does gender figure into the way stress knowledge and experience have been socially constituted and sustained?
4. Can a gender-based critique suggest alternative ways to conceptualize and experience stress and burnout that would engage alternative sensitivities and allow for other forms of knowledge and experience?

I begin with a brief summary of the relevant findings from my ethnographic study of social workers in two distinct cultural contexts. Next, I consider questions about parallel patterns of knowledge and meaning across medical, organizational, and popular discourse and discuss briefly why postmodern analysis, and in particular feminist postmodernism, provides the theoretical and epistemological foundation for addressing those questions. I

then deconstruct the four themes central within medical and organizational discourses and show, for each theme, (1) how it shapes dominant conceptualizations of stress and burnout, (2) how the theme figures more generally in the disciplinary discourses, and (3) how it has been sustained and privileged by its gendered associations. Finally, I propose a revised way to conceptualize stress and burnout that is based on a reconstruction of the meaning and association of the prevailing themes.

Dominant and Marginalized Conceptualizations

Interpretations of Stress and Burnout in Medical and Social Work Cultures

A previous study revealed patterns of dominance and marginalization in interpretations of stress and burnout (Meyerson 1994). That work contrasted social workers’ interpretations in acute-care medically dominated cultures with social workers’ interpretations in a chronic-care psychosocially oriented culture. Social workers in the predominantly medical cultures tended to talk about stress and burnout in the language of coping and control. They spoke of burnout as emotional and physical lapses of control. They treated burnout as an individual failure and stress and burnout as diseases, undesirable aberrations from a universal definition of “normal.” In contrast, social workers in the psychosocially oriented organizational culture tended to talk about stress and burnout as “no big deal,” as an inevitable and “normal part of the ebb and flow of work life.” They described burnout as an occupational hazard. As a professional, a person was expected to burn out on occasion. Emotional control was seen as impossible and sometimes undesirable because social workers were supposed to use their emotions as a source of connection and insight. The capacity to feel for clients and develop empathy was viewed as a professional skill, which meant that social workers regularly lost “control” of their emotions and were therefore normally prone to burn out.

The contrast between social workers in the two distinct cultures has several implications.¹ First, social workers in the medicalized culture talked about stress and burnout in ways that reflected the values and beliefs of traditional medicine: the emphasis on finding objective “cures,” the professional mandate of “control,” the focus on individuals as the locus of disease and cure, and the universal definition of “normality” and, by contrast, abnormality (Friedson 1970, Starr 1982). Second, the “other” way of talking about stress and burnout reflected the ideology of social work: a marginalized and feminized profession.

Psychosocial ideology, with its foundation of self-determination, places control with “clients” and thereby devalues (in theory) professional control, emphasizes the social bases of conditions and therapies, and accepts ambiguity and multiple definitions of “normality” (Meyerson 1991). Third, identifying the “other” way of talking about stress and burnout challenges the apparent neutrality of the dominant medical conceptualizations and, by implication, the seeming neutrality of the dominant and parallel conceptualizations of stress and burnout within organizational and popular discourse.

Gendered Conceptualizations Within Medicine and Organizational Discourse

Observed patterns of dominance and marginalization in the way the social workers in the different organizational cultures interpreted stress suggest gendered patterns of relations and meanings. First, medicine and social work, the professional cultures that shaped interpretations of stress and burnout have traditionally been made up mainly of men and women respectively. Second, the readily apparent subordination of social work to medicine is a “feminized” position. Third, the traditional professional ideologies of medicine and social work have gendered associations. Medical values and beliefs, such as the value placed on control, have been socially constructed as “masculine,” whereas social work values and beliefs, such as the value placed on empathy and relationships, have been socially constituted as “feminine.” Medicine has long been associated as the prototypical patriarchy in practice, language, and structure (Larson 1977, Merantz-Sanchez 1985). Social work has established a reputation as a “feminized” occupation, in part through its language and values of “care” (versus “cure”) and its “mothering” image. Fourth, the contrasting images of the two occupations and their respective ideologies stand in opposition, partly sustained by their gendered meanings and relations.

From this perspective, gender acts as a power relation with associated meanings and social legitimacy. Gender relations help constitute what counts as legitimate versus marginalized knowledge. The ways in which gender was associated with the distinct interpretations of stress and burnout among social workers in the different cultural contexts help account for patterns of dominance and marginalization in those interpretations. Questions about the parallels between dominant conceptualizations of stress and burnout expressed within the medical culture and dominant conceptualizations within organizational and popular discourse represent concerns about the social and political constitution of dominant forms of knowledge. Those concerns, and specifically concerns about the gendered construction of knowledge and meaning, are the

domain of postmodern theorizing and postmodern feminist theorizing.

Postmodern theory focuses on the cultural and political forces that constitute knowledge and social activity. Some theorists reveal how taken-for-granted and seemingly neutral rules, practices, language, and myths of culture woven into the fabric of social institutions, such as scholarly disciplines, obscure questions about what counts as knowledge, criteria that establish the validity of knowledge claims, and the social distribution of knowledge (Bordo 1990, Cooper and Burrell 1988, Weedon 1987). Insofar as language, rules of culture, and dynamics of power—the discourse—define what knowledge and experience count as normal and abnormal, true and false, legitimate and disqualified, some people’s forms of knowledge and experience will be outside that which is privileged. Foucault (1988) refers to marginalized knowledge as “subjugated knowledge” to suggest the relationship between power and the relative status of different bodies of knowledge.

Although Foucault (1988) made central the ways in which power is reinforced in everyday micro actions and social relations, he virtually ignored gender as an important axis of relations and power. Postmodern feminism places gender as the central axis of power and social relations, and gendering as an ongoing process of distributing power, assigning meanings, and sustaining specific relations (e.g., Nicholson 1990). Gender, according to some postmodern feminists, “enters into and partially constitutes all other social relations and activities” (Flax 1990, p. 46). As Flax (1990, p. 45) explains:

Through gender relations two types of persons are created: man and woman. Man and woman are posited as exclusionary categories. . . . Nevertheless, gender relations, so far as we have been able to understand them, have been (more or less) relations of domination. That is, gender relations have been (more) defined and (imperfectly) controlled by one of their interrelated aspects—the man. . . . As a practical social relation, gender can be understood only by close examination of the meanings of “male” and “female” and the consequences being assigned to one or the other gender within concrete social practices.

From that perspective, concerns about gender relations are not about “man versus woman” and do not acknowledge male versus female realities. Questions about gender address how this culturally constructed relation, where man and all that is associated with man (e.g., masculinity) takes on meaning and value in relation to its opposite—woman (Diamond and Quinby 1988, Fraser and Nicholson 1990). Hence, the cultural category of gender and the process of gendering are based on the concept of “differance” (Derrida 1978).

“Differance” rests on the notion that Western thought

is organized into a series of hierarchical oppositions, such as reason-emotion, mind-body, fact-value, good-evil, and male-female, where each term in a pair implicitly contains its own opposite and becomes defined by what its opposite is not (Hare-Mustin and Marecek 1988). The construction of the first term as “male” and its implicit or explicit opposite as “female” helps sustain dichotomies and the relative valuing of either term. Postmodern feminist readings reveal how gender mediates specific oppositional relations that maintain the dominance and apparent neutrality of particular forms of organizational knowledge—typically associated with “male”—and the marginalization of other forms—associated with “female” (e.g., Calas and Smircich 1991, Martin 1990, Mumby and Putnam 1992).

In that way, a postmodern feminist analysis can help address questions about the different patterns of dominance and marginalization in the conceptualizations of stress and burnout across disciplinary boundaries and how gender accounts for those patterns in forms of meaning and experience.

A Feminist Reading of Stress

The following analysis illustrates ways in which gender relations constitute the language of stress through a set of themes prominent in both medical and organizational discourses. The themes are not arbitrary; they are apparent in the parallels between the ways in which social workers in medical institutions interpreted stress and burnout and the ways in which organizational theorists have written about stress and burnout. Within both discourses, stress and burnout have been conceptualized as (1) emotional and (2) bodily conditions to control, (3) problems located within the individual, and (4) abnormal (not normal) states.

The analysis shows how each of those themes shapes the language of stress and burnout, figures into the medical and organizational discourses more generally, and is given meaning, power, and legitimacy through gendered associations. It reveals ways in which particular forms of knowing and experiencing have been marginalized and suppressed, thereby providing a foundation for the feminist reconstruction of stress and burnout that follows.

Control over Emotions

Social workers in the predominantly medical cultures talked about stress and burnout as lapses of emotional control and as symptoms of professional weakness. They claimed that, as professionals, they were supposed to stay in control of their emotions; they were “not allowed to

burn out” or to show other signs of “weakness.” Similarly, within the traditional organizational and popular literature, stress is described as an undesirable “arousal” condition and burnout is defined, in part, by emotional exhaustion (Gaines and Jermier 1983, Maslach and Jackson 1982). Much of the research centers on finding moderators and mediators, coping mechanisms to help control symptoms and their causes (Cordes and Dougherty 1993).

Control over Emotions Within the Medical and Organizational Discourses. The theme of emotional control is historically and culturally situated and reproduced throughout the disciplinary discourses. The emphasis on emotional control within medicine can be traced to the discipline’s reliance on science and rationality as the basis of professional authority. The dominance of scientific thought within medicine developed toward the end of the nineteenth century when science and technology began to alter daily life dramatically; people came to expect similar results from healing technology (Starr 1982). As medicine’s authority became tied to scientific reason, the profession constructed elaborate structural and ideological mechanisms to support scientific thought and sustain the image of a scientific practice (Merantz-Sanchez 1985). Insofar as science is based on a premise of rationality and objectivity, its practice within traditional medicine has translated into the norm of emotional detachment and control.

The practice of traditional/scientific medicine produces norms that devalue and suppress the emotions of patients. Even the most humane efforts of medical professionals to help patients through traumatic conditions are practiced as helping people *get through* and *over* their feelings, *work out* their anger, and *minimize* their suffering (Frank 1992). Such practice resembles what Goffman (1952) describes as “cooling the mark out,” convincing people to accept their losses and silence their complaints. Suppressing feelings becomes part of the “sick role” in which “sick” persons are expected to comply with medical efforts to make them well (Parsons 1951).

Within the organizational and popular discourse, the theme of emotional control also figures prominently beyond its expression in relation to stress. Organizational behavior as a field of social science has relied on the “hard” sciences (originally biology) for its disciplinary authority. The reverence for scientific/rational thought within the discipline has resulted in a knowledge base and range of conceptualizations that devalue and rationalize emotions. The subordination of emotions to rationality surfaces in a variety of ways, perhaps most notably in the concept of “bounded rationality.” According to Mumby and Putnam (1992, p. 471):

researchers using the bounded rationality concept treat emotional experience (defined as the feelings, sensations, and affective responses to organizational situations) as either a weak and handicapped appendage to reason or as another means to serve organizational ends. . . . Emotions are ways to achieve such organizational ends as efficiency, profit, and productivity. As such, the emotional realm is coopted and alienated in a form known as *emotional labor*.

With few exceptions (e.g., Sandelands and Buckner 1989), studies of emotions in organizations have focused on emotional expression as a form of organizational work. They have shown how emotions have been rationalized and put to service toward instrumental ends of the organization (e.g., Hochschild 1979, Rafaeli and Sutton 1991).

Control over Emotions as a Gendered Theme. The conditions that sustain the preeminence of rationality and the subordination of emotionality throughout the medical and organizational discourses can be understood as a “gendered” power/knowledge relation (Mumby and Putnam 1992). That is, gender mediates the apparent dichotomy of rationality/emotionality, where each of the two terms acquires meaning in relation to the other. The cultural construction of rationality as male and emotionality as female and contemporary depictions of men as rational and stable and women as emotional and unstable (Jordonova 1989) reflect and reinforce gendered images and relations. Those images reinforce the (false) dichotomy of rationality versus emotionality, where emotions are culturally defined as that which is not rational, or *irrational*. That opposition and the resulting images thereby support the apparent neutrality of the “rational man” who retains unquestionable legitimacy when implicitly he stands in opposition to the emotional, irrational, or “hysterical woman” (Calas and Smircich 1993). Such gendered images appear throughout the dominant institutional discourses of Western culture and serve to devalue emotions and reproduce a cultural mandate of emotional control.

Control over Body

Social workers in medical settings talked about stress-related conditions as bodily disorders—*diseases*—to be controlled and possibly “cured.” Statements of medical social workers, such as “burnout is like ashes, when there is nothing left to give,” convey images of disembodied pieces of flesh “burning away.” Organizational researchers also use language that constructs stress and burnout as physical as well as emotional conditions. Assessments of strain—a manifestation of excessive stress—routinely rely on physiological indicators, such as elevated blood pressure, hypertension, insomnia, and indigestion, among others (Kahn and Byosiere 1992). Much research is done

to find ways to control causes and consequences of stress-related ailments.

Control over Body Within Medical and Organizational Discourses. The conceptualization of stress and burnout as bodily conditions to control can be viewed in light of a wider phenomenon in Western society—the medicalization of an expanding array of conditions, such as alcohol and drug abuse, domestic violence, and eating disorders. Reflecting the growing authority of medical discourse in our culture is the tendency to translate conditions into diseases: conditions of individuals’ bodies amenable to specialized treatment (Larson 1977, Starr 1982). In medicine, “specialized” treatment presumes a simple power relationship: expert physician (as mind) reigns over patient (as body).

The presumption of control over body and the related separation of mind and body are supported by the medical practice of translating whole people into abstract bodily specimens and conditions. Medical specialization reinforces that practice; for example, a person with cancer is depicted in the psycho-oncology literature as a “disturbed bodily image” (Frank 1992, p. 474). The scientific ideal of “objectivity,” which translates into the practice of measuring and treating isolated conditions (including burnout or stress), also helps to separate the person from his or her bodily condition. Consequently, control over patients’ bodies appears neutral and legitimate within the medical discourse.

Language that treats the body as a site of control is reinforced throughout the organizational literature. In addition to such expression in conceptualizations of stress, the “participative management” and “empowerment” literatures have grappled with questions about the distribution of control and how to give control and voice to workers. Throughout those discussions, management retains the image of “mastermind” and with it control of participation and how much “mind” to give to workers. A worker remains a body until given permission to participate as a mind. The bureaucratic premise of managerial control reinforces the theme of control over body.

The mind/body dualism also appears in the discourse of rationality and “bounded rationality.” According to Mumby and Putnam (1992, p. 470):

Simon’s (1976) reformulation of rationality employs the mind-body dualism by subordinating choice to organizational goals. In this case, mental choices are valorized, whereas physical and emotional experiences are marginalized. . . . This institutionalization of the organizational mind reifies its separation from the suppressed and negated body.

Hence, experiences such as arousal, stress, and burnout are relegated to conditions of the brainless and irrational

body and are conceptualized as conditions to be controlled implicitly, if not explicitly, by the (organizational) mind.

Control over Body as a Gendered Theme. The theme of control over body and the mind/body dualism that sustains it can be understood as products and producers of a gendered discourse. Following Foucault, feminists have focused on the body as the site of power and locus of domination (Diamond and Quinby 1988). Those theorists have shown how gendered images of the insatiable, uncontrollable female body, paired with Enlightenment images of male reason (Young-Bruehl 1987), discipline, and rationality create the power dynamics that sustain the mind/body opposition. As Bordo (1988, p. 91–92) states:

Whether as an impediment to reason or as the home of the “slimy desires of the flesh” (as Augustine calls them), the body is the locus of all that threatens our attempts at control. It overtakes, it overwhelms, it erupts and disrupts. This situation, for the dualist, becomes an incitement to battle the unruly forces of the body, to show it who is the boss; . . . Descartes provides instructions, rules, or models of how to gain control over the body, with the ultimate aim of learning to live without it.

The image conveyed is that of the body, a female self, out of control, requiring male discipline and rationality to save itself from itself.

Perhaps nowhere does the gendered relationship between mind and body appear more vividly than in the description of patients (almost exclusively young women) with eating disorders. Such patients talk of having a “dictator who dominates me; a little man who objects when I eat” (Bordo 1988). The dictator or “the other self” (as it is often described), associated with higher intellectuality and strength of will, is always male and is perceived in constant battle for control with the “flabby will” and uncontrollable body, which nearly always assumes the image of the female (Bordo 1988). Those images reinforce the cultural preeminence of the mind. The images also recall how gendered meaning sustain a mind/body dualism that is enacted in everyday practices and language, including the traditional language of stress and burnout.

Individualism

Medical social workers talked about burnout as an individual disease and excessive stress as an individual’s inability to cope. According to one medical social worker:

I think that the people that burn out will have the same problem wherever they go. They probably had the problem before they came. I see it as an internal (individual) problem. I don’t see it as job situated at all.

Likewise, the language of stress within social and organizational science has reinforced the image of the

“stressed individual.” Even when the rhetoric emphasizes the social or occupational nature of the “problem,” with few exceptions (e.g., Abbott 1990, Fineman 1993, Meyerson 1994), individuals are still “held accountable for their predicament” (Barley and Knight 1991). Popular management discourse reinforces the theme as it attempts to bolster individuals’ capacities to cope. Some discussions explicitly point to society as the source of stress, but it remains the individual who feels stress, copes with stress, and shapes his/her environments to moderate stress (e.g., Frankenhaeuser 1996, Kahn et al. 1964).

Individualism Within the Medical and Organizational Discourses. Besides its manifestation in the language of stress and burnout, an individualist orientation is reinforced throughout medical discourse. The individual remains the primary unit of analysis and causal agent. Even within specialties of medicine that attempt to treat whole systems rather than individuals, institutional structures and practices conspire against such efforts. Recourse to predefined diagnostic categories (DSM) within medicine and reliance on psychopharmacology reinforce the independence of the ill individual as the locus of treatment and disease (Frank 1992). In addition, standard clinical practice reifies the qualities it measures into fixed and stable properties of the individual by acting as though measurements were unaffected by the conditions of measurement or the measurer (Stone 1993). Individuals occupy the “sick role” (Parsons 1951).

The theme of individualism figures prominently in most central concepts of organizational theory and behavior, including, as we have seen, the conceptualization of stress and burnout. The organizational subject as “employee,” “manager,” “leader,” “worker,” “decision maker,” “negotiator,” and “mentor” suggests an independent, ahistoric individual (e.g., Jacques 1996). Concepts like absenteeism, turnover, leadership, motivation, even group dynamics rest on the notion of the individual (Staw 1984) as autonomous and acultural. Critiques of the discipline only rarely call into question the individualist orientation of our favorite constructs (e.g., Calas and Smircich 1992, Kolb and Putnam 1996). Similarly, within mainstream organizational research, the author/researcher is regarded as an individual independently (and objectively) constructing knowledge outside the cultural conditions of his or her “existence.”

Individualism as a Gendered Theme. Individualism is closely linked to the concept of independence, which has long been associated with men and masculinity. “Independence” derives meaning, in part, from its implicit opposite: dependence, an orientation historically and culturally linked to women and femininity. The construction of masculinity in Western culture turns on images of

strength, autonomy, achievement, and competition—images of the “provider” and “father” figure who takes action and makes decisions on behalf of lesser individuals or groups in his “care” or “protection” (Reed 1996, p. 106).

Sustaining that image of masculinity is the suggestion of the weak “other”: the dependent woman. Cultural images of femininity evoke images of dependence, including dependence on male approval for everything from the attractiveness of one’s body to the competence and credibility of one’s behavior. Judgments of female competence are generally based on the implicit, if not explicit, standard of masculine behavior and norms. As P. Martin (1996, p. 191) has pointed out:

I have heard men describe her by saying: “She kicks ass with the best of them,” or “She’s as hard as nails.” But such compliments cut two ways. While acknowledging a woman’s ability to “act like a man,” for example in mobilizing competitive masculinity, they acknowledge her violation of norms associated with “emphasized femininity” and her status as a woman.

Individualism surfaces throughout Western discourse and is perpetuated through cultural images of masculinity as independence and autonomy (Connell 1987), images sustained through the continual representation of femininity as dependence and that which is not masculine.

Images of the autonomous self as maker of decisions and causal agent figure prominently throughout modern discourse. Postmodern critiques decenter the self, and thus the individual, regardless of whether the individual is independent or dependent, and replaces it with a subject that is constantly being saturated (Gergen 1991), constructed, and reconstructed within the discourse: “. . . a subject as body in fluid motion continually constituting itself as well as the material and cultural conditions of its existence” (Flax 1992, p. 2).

Universal Definitions of “Normality” and “Abnormality”

Universal definitions of normality surfaced as social workers in the medical cultures talked about burnout as a disease and as a “syndrome” or “problem.” Some suggested that burnout represents a deviation from normal and appropriate experience, where definitions of “(ab)normal” and “appropriate” were taken for granted as stable and widely shared criteria. There seemed to be little ambiguity about what constitutes “normal,” and that which is not normal was defined as abnormal. Similarly, the dominant conceptualization of burnout in the organizational literature applies universal standards of classification. If a person tests outside the range of normal, as defined by a widely accepted standard scale, the Maslach Burnout Inventory (Maslach and Jackson 1981),

he or she is classified as burned out and therefore as *not normal* (Cordes and Dougherty 1993). (The scale differentiates between three subscales and identifies the magnitude of the “problem.”) Ambiguities about what constitutes normal and what scales of burnout measure and mean are ignored in favor of universal standards and classifications.

Universal Definitions Within Medical and Organizational Discourses. Foucault (1973, p. 34–35) noted the significance of universal standards of normality and health in medicine and showed how those standards play out in everyday medical practice and carry a variety of normative implications:

Medicine must no longer be confined to a body of techniques for curing ills . . . it will also embrace a knowledge of the *healthy man*, that is, a study of *non-sickman* and a definition of the *model man*. In the ordering of human existence it assumes a normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and the society in which he lives. . . . Nineteenth century medicine was regulated more in accordance with normality than with health.

Universal standards of normality are no less prevalent within modern medicine. Modern definitions of normal (healthy) and abnormal (sick) are based on statistical norms, such that every new technology or diagnostic procedure requires new norms to be calibrated. That which deviates from universally defined norms is constructed as abnormal—pathology—regardless of the source or significance of the deviation. For instance, women who have tested outside the statistical definition of normal in mammograms, but later found to be non-malignant, are routinely classified as benign rather than normal. On that basis, many women cannot secure life insurance (Stone 1993).

Universalizing constructions pervade organizational discourse. In addition to measures of burnout, assessments of personality disorders, intelligence, and other constructs central within organizational behavior, such as employee satisfaction, leadership, and “fit,” rely on this normative logic. Psychological and managerial tests, feedback sessions, and intervention strategies are based on clear and universal definitions of normal and abnormal. The reliance on universal standards and classifications reflects the reverence for scientific-like typologies and a general disdain for ambiguity, or as Levine (1985) has termed it, a “flight from ambiguity” within social science (Meyerson 1991).

Universalizing Definitions as a Gendered Theme. Universalizing definitions and standards of normality within the dominant discourses tend to reflect and reify the experiences of mostly white Western heterosexual

men and mask the multiplicity of perspectives, standards, and criteria that more closely reflect the experience of disempowered groups (Flax 1990, Millman and Kanter 1975). Recent efforts have been made within the social sciences and medicine to critique those standards and assert alternatives. The dominant theory of moral development, for example, celebrated the “morally developed” individual as an “atomistic” self who makes judgments based on a universalistic and abstract hierarchy of rights (Kohlberg 1969). Finding that women’s moral judgments were predicated less on the logic of abstract rights and more on the logic of relationships, Gilligan (1982) asserted a “different,” yet equally valid, standard of moral development based on interdependence rather than independence. Gilligan’s influential critique revealed that monolithic definitions of normal and “morally developed” were not, in fact, universally relevant, but were based on and biased toward the experience of (white) men.

Similarly, critiques have been leveled at traditional models of leadership and negotiation that assume a set of universal attributes but are based on qualities associated with men, such as aggressiveness, decisiveness, independence. The critiques routinely offer alternative standards of leadership based on female attributes and thus make salient the androcentric bias inherent in the universal “neutral” standard (e.g., Helgesen 1990, Rosener 1990). The form of critique that asserts a set of “essentially” male or female characteristics has been applied to a host of constructs, energized by Gilligan’s critique of the dominant standard of moral reasoning. Like Gilligan’s critique, the alternatives often attempt to invert the male universal definition or standard. They fail to challenge—and often reinforce—the gendered dichotomies. Research that asserts *the* female way of making moral judgments, leading, negotiating, reasoning, knowing, or even experiencing stress or burnout conspires with universalizing tendencies and reinforces gendered dichotomies. The theories reinforce definitions of female as that which is “other”: not dominant and not male. Such revision implicitly reifies the male and masculine standard by which female is constituted.

As a modest contrast to dichotomous and universal approaches, postmodern feminist critiques, including this one, create resistance to universalizing definitions by rendering suspect simple dichotomies and the gendered processes that sustain them (Ferguson 1991, Flax 1990). Such critiques call into question the processes by which some standards come to be seen as normal and neutral, while all others appear abnormal and different. They make salient the ambiguities in the social world and point to categories and social processes within discourse that

suppress and mask ambiguities (Martin and Meyerson 1988, Meyerson 1991).

A Dilemma of Postmodern Inquiry

The preceding analysis (see Table 1) illustrates how gender acts as an axis of power and signifier of meaning that sustains particular forms of knowledge and images of truth, while devaluing and suppressing “others.” I have suggested that the gendering of social categories and relations leaves little room for ambiguities, instabilities, or contingencies. In deconstructing those themes that figure prominently in the dominant conceptualization of stress, I exposed images and meanings that represent the devalued “other,” and showed the gendered processes that hold those images in their subordinated place.

Next, I tentatively offer a revision of stress and burnout that follows from the preceding feminist reading. My intent thus far has been to reveal how seemingly unimpeachable claims to Truth, neutrality, and normality suppress and silence alternatives. I had hoped that such an analysis would make room for alternatives predicated on the experiences and subjectivities of the marginalized “other.” I had presumed that a “real” alternative could be constructed from the perspective of the other and, by implication, that the other is somehow outside and defined by the dominant discourse. However, as one reviewer noted, “*the other* cannot be ever articulated as an alternative for it would do nothing but to continue to ratify the presence of that [for] which it is *the other*.”

Therein lies a seemingly intractable dilemma of postmodern inquiry. Postmodern readings lead to new understandings, but the alternative possibilities suggested by those understandings cannot stand as “real” or stable alternatives. In short, postmodernism leaves us on ground that is politically and epistemologically unstable. We are left with a dilemma: How can we create revised discourses if the revisions are necessarily undermined by the postmodern position? This is a position in which the subject/author does not exist beyond the discourse and all constructions of truth and knowledge are necessarily contingent and multiple and produced *within* a historicized/politicized discourse. We cannot revise a discourse if the revision—and our subjectivity—is itself a product of the dominant discourse.

Ferguson (1991, p. 335) provides a response to that dilemma:

Because the world turns us no legible face, because nothing stands under the layers of constituted meaning except other layers of constituted meaning, one returns to interpretations [a

Table 1 Gendered Themes Within Medicine and Organization Science

Theme	Exemplary Expression in Medicine	Exemplary Expression in Organization Science	Exemplary Expression in Stress and Burnout	Sustained Through Gender Relations
Control over emotions	Clinical reasoning presumes rationality	"Bounded rationality"	Professionals stay in control of emotions; do not burn out	Rationality as male vs. emotionality (irrationality) as female
Control over body	Help patients over emotions Physician (mind) over patient (body)	Emotional labor for instrumental ends Manager (mind) over worker (body); bureaucratic mandate of control	Burnout as bodily "disease"	Mind as male maintains control of body as female
Individualism	Individuals occupy "sick role"	Individual as "leader," "manager," "worker"	Individuals "catch" burnout, cope with stress	Independent, autonomous "masculine" constituted by opposition to dependent "feminine"
Universal definitions of "normality"	Statistical notions of "normality" define pathology and eschew ambiguities	Universal standards of "leadership," "fit" and "burnout" eschew ambiguities	Burnout and stress as "abnormal" conditions	Universal notions of "normal" reflect male standards, reify dichotomies

modernist position] with the fragile understanding that interpretation of various kinds is *all* that there is. The genealogist [post-modern critic] thus indirectly confesses her rootedness in interpretation, her “hermeneutic anchor.”

Further, as Calas and Smircich (1992, p. 227) note, “they [the postmodern and modernist feminist positions] need each other for creating the space which brings society, *constantly* toward a more just and moral state.”

With that as my aim, I offer a revision of stress experience and knowledge which turns back to interpretation with a heightened self consciousness of how subjectivity is constructed. The self consciousness includes an acknowledgment that I cannot possibly create an alternative to the dominant discourse or speak from outside the very conditions that produce my authority and subjectivity. My revision, which privileges the subjectivity of the marginalized/feminized other, relies somewhat on an interpretive position and is written in a style that reflects such a position. I therefore offer this revision of stress and burnout tentatively in the spirit of resistance, as one of many possible revisions.

A Feminist Revision

Revising Emotional Control

The theme of emotional control is rooted in and sustained by the dominant discourse of rationality, particularly the implicit dichotomy of rationality versus emotionality. The devaluing of emotions is so well entrenched in the dominant discourse that rarely do we find research on emotions, beyond research on emotional expression, that is not located within marginalized or critical discussions (e.g., Fineman 1993, Mumby and Putnam 1992). A discourse that values emotions would overturn the rational/emotional dichotomy and place emotions, not as that which is not rational, or *irrational* but as a distinct and legitimate realm of experience to understand and validate rather than control (Hochschild 1983). A discourse that values emotions would enable caregivers (e.g., physicians, social workers) to help people feel, rather than help them *control, get through, and contain their feelings*.

In his critique of traditional therapeutic practice, Frank (1992, p. 480) offers an alternative approach to emotions, specifically to emotions associated with suffering:

The relevant question is not what action do we take with regard to such a patient, but, rather, how can we communicate recognition of the experience such a person is going through? Only in the context of such recognition can there be true caring, and only in that context can an ethical decision be made.

The shift from a clinical to what he calls a “narrative” mode of practice entails a leap in epistemology from an

approach based on detachment and judgment to one based on empathy and engagement (Davis 1991, Frank 1992). One mode need not replace the other, but appreciation of feelings and the capacity to “join” and care for a client in addition to curing her affords the hope of creating a more humane practice.

For social scientists also, recognizing and understanding emotional experiences rather than reproducing the language of emotional control would require a shift in practice. Again, Frank (1992, p. 481) offers suggestions for how social science might encounter (versus suppress) suffering. First, he suggests social science “evaluate itself more as care; simply care” and less as “research yielding findings” or as clinical intervention yielding “outcomes.” Second, social science could adopt a new pedagogy that lends itself to teaching people about themselves and others (p. 483):

To witness ill persons’ experiences as embodied, angry, contingent, eccentric, interrelated and suffering, and to communicate what has been witnessed to a larger group, is a genuine pedagogy . . . to witness suffering in all its depth and commonality.

The shift for social scientists represents a shift from researcher as analyst, trained to detach and classify emotions from a distance, to researcher as person who can respond to feelings, honor them, and describe them.

If the impact of social science depends on the capacity of knowledge to legitimate language, meanings, and experiences, the consequences of excluding knowledge of complex human emotion must be profound. The practical implications of the language of emotional control illustrate the general point and return us to our focus on stress and burnout. The interpretation of burnout as an arousal experience and a pathology reinforces the notion that one should remain in control of emotions and not burn out (or at least not admit to it). The dominant discourse does not include a vocabulary for engaging emotions or for talking about “being out of control” as a legitimate human experience. As they write the theme of emotional control into stress and burnout research, organizational scientists become complicit in silencing emotions, “medicalizing” persons who admit to being stressed or burned out, and, more generally, reinforcing the mandate of emotional control. That phenomenon has far-reaching consequences.

A recent example illustrates the implications of this discourse for organizational practice. I read a colleague’s paper about the stress associated with balancing work and family demands. The paper, written in the language of coping and control (“how I managed”), described a person who strategically allocated her time across competing demands. I knew from talking candidly with my colleague, my friend, that the essence of her experience as

“supermom” was described more accurately by her emotional anguish, feelings of guilt, stress, and burnout than her clever allocation of time. She routinely felt “out of control” of her emotions and situation; yet when she attempted to write her experience into the traditional text, she naturally relied on the familiar and seemingly neutral vocabulary of coping—and thus of retaining emotional control.

The suppression of emotions in her written account produced standards and expectations among consumers of this knowledge. What are individuals (probably most working parents) who feel overwhelmed, stressed, and burned out—who do not feel as though they are “coping”—to think of themselves after reading about a supermom who has been able to cope so cleverly? Is that cool and in-control woman a reasonable model, or might the “hysterical woman” (Calas and Smircich 1993), who is torn in too many directions with too few resources and too little support be a more reflective—and more helpful—portrait? Had my colleague been able to write a narrative that reflected her feelings of being out of control, she might have helped to legitimate such experiences and comforted the countless others in similar situations. Perhaps most important, acknowledging, revealing, and appreciating human emotion may be a crucial step in developing human communities that care for their members. As people express their feelings—anger, joy, sorrow—others in the organization can appreciate those feelings and authentically respond to them. With real feelings comes the basis of community (Turner 1974), not as the suppression of self, but as the full expression of self and the care of others.

A similar alternative applies to the conceptualization of stress and burnout within the medical and organizational discourses. If people could legitimately encounter and admit to feelings of stress and burnout—or more generally feeling out of control—others could honor them, respond to them, and create the capacity to heal. Such a cycle was suggested in the one hospital that resisted the dominance of the medical ideology. Social workers readily admitted to being burned out and talked about that feeling as an inevitable experience in their work. When a social worker reported feeling burned out, others listened and responded as though that was a normal cycle rather than a failure or flaw of the individual. People cared for and filled in for the person who felt burned out; they permitted the person to rest and heal. Understood as normal experiences of work, stress and burnout were less disruptive for the community because the *community* permitted members to feel, care for, and fill in for one another.

For social workers, the capacity to experience and express feelings such as burnout, and to be cared for by others as though those feelings were a legitimate and respected part of being a social worker, may itself be an instance of resistance, a challenge to that which is deemed normal within the dominant discourse. Social workers are in the business of caring for human beings; to legitimate their capacity to feel and their ability to create communities to support real feeling is to give them the capacity to do their work as whole people. Yet as simple as that sounds, such capacity is currently suspended within the dominant discourse, which privileges rationality and “professionalism” and translates those concepts into a dualistic choice of rational over emotional, thus mandating emotional control.

Rewriting Feelings. If social science is to produce knowledge that enables communities to care for their members, it must become self-conscious of how its texts conspire to suppress feelings in organizations. Although the dominant discourse cannot be fully escaped, it can be resisted and perhaps overturned. Through alternative forms of writing (Gordon 1988, Van Maanen 1995), expressing, and engaging, social science could help to legitimate modes of understanding that recognize, capture, and honor feelings, including feelings of stress and burnout.

Revising the Body as a Site of Control: The Body as a Subjectivity

The right to control the body has been one of the most contested sites of political and domestic struggle (Diamond and Quinby 1988). Nowhere else does the feminist adage—the personal is political—assume such vivid meaning. The preceding deconstruction of the mind/body dualism indicates how the false separation of mind/body and the gender associations of those spheres have perpetuated the political contest about control over the body. Should the dichotomy be overturned and the separation dissolved, a person—as mind *and* body—must naturally be “in control of” his/her own body. With this power relation suspended, the body could legitimately become a distinct source of subjectivity.

Overturning the relation therefore entails a shift from a perspective that categorizes, disembodies, and attempts to control bodily experiences to one that appreciates the body as an important source of subjectivity. With the revised perspective, stress and burnout would not be viewed as dysfunctional bodily reactions to be controlled, but as important indicators of the situation of work. Taking the body seriously as a source of subjectivity also suggests a different relation between caregiver and patient. No longer viewed as bodily parts, patients’ self reports of

their experience would be taken as seriously as the “objective” measures of statistical deviations. This form of subjectivity resists dominant ideology and threatens a central basis of professional authority. Some observers have argued that social work’s belief in self determination, which supports giving the client control, has contributed to social work’s marginalized professional status (Toren 1969). A discourse that resists the gendered relation of mind over body would naturally embrace and reinforce the ideology and practice of self determination.

Similarly, organizational theorists and practitioners have advocated distributing power and control more broadly to workers. Within a discourse that sustains the dominance relation of mind over body, where management still represents the “mind,” the rhetoric of power redistribution is necessarily constrained. A discourse in which the mind/body dualism has been overturned would merge the “conception and execution of work” and would thereby avoid “fragmented and alienated labor.” From that perspective, “work refers to the process through which the individual maintains control over his or her own physical, mental, and emotional resources to perform task activities . . .” (Mumby and Putnam 1992, p. 476).

Revising Individualism and the Independence/Interdependence Dichotomy

The hegemony of individualism is sustained through gendered dichotomies associated with individualism. Some attempts to resist the dominance of individualism have involved efforts to invert relevant dichotomies, to favor dependence and interdependence over independence and autonomy. However, such efforts reproduce gendered dichotomies.

Rather than privileging interdependence or dependence as *the* valued side of an opposition as Gilligan and others have suggested, one could imagine a discourse in which interdependence, dependence, and independence are intertwined. In such a perspective, an individual’s independence would be viewed interdependent with that of others in the “global family,” where an individual’s ability to live a decent life, obtain decent food, breathe decent air, drink decent water, and live in safe cities would depend crucially on others with whom the community and world are shared (Calas and Smircich 1993).

The valuing of community does not preclude autonomous interests; strong communities can nurture autonomy and true autonomy can nurture communities. I described previously how free and spontaneous emotional expression—a sign of individual autonomy—can engender caring within a community, which can foster autonomous emotional expression. In the workplace, an individual’s

autonomy stems from “recognizing, legitimating, and being legitimated by the social, communitarian dimensions of work” (Habermas 1987, in Mumby and Putnam 1992).

Such revision of individualism has specific implications for the construction and experience of stress within the medical and organizational discourses. Rather than being experienced as “problems” of the individual, stress and burnout could be reconstructed as social experiences. Within a revised discourse, interpretations and reports of stress may pose questions about the nature of the work, the communities that support the individual, and the requirements of the job, in addition to questions about the suitability, “health,” and professionalism of the individual. In the one nonmedical hospital, social workers talked about burnout as endemic to the work and “no big deal.” One person even claimed that “if you did not occasionally burn out you were not working hard enough.” Taking that perspective, a community might ask itself how it could best support and care for its members. How might members work with each other and fill in for each other through the ebbs and flows of stressful work? How might the community help its members feel? Stress and burnout would become a community-level concern, which would engender a system of nurturance rather than blame, emotional support rather than suppression. Such revision depicts a community that celebrates its relational work of caregiving as an individual *and* structural practice (Fletcher 1994, Jacques 1996), where members nurture each other so that individuals can give of themselves in the difficult work.

Rewriting Stress and Individualism. The revision also suggests a different way to study and write about burnout and stress. In addition to conceptualizing those conditions as individual experiences to be isolated, measured, and controlled, social scientists would produce other forms of writing that legitimate complex feelings and express contextualized experiences with fluid meanings. In addition to writing as a way to further individual professional interests, organization scientists might reflect on the social and political consequences of the knowledge they produce and begin to write to serve communities (Jacques 1992, Zald 1993) rather than to reproduce their own sub-systems (e.g., Pfeffer 1993) and enhance their own reputation as professionals. At a minimum, an organizational science based on such principles must be more attentive to context and politics and view itself as a political and cultural product and producer (e.g., Szymanski 1972). In contrast to an organization science that purports to be personally and politically independent, it might address the cultural and political implications of conceptualizing stress as an individual pathology. Whose experiences does this silence? Where does this formulation focus

blame and responsibility? How does it help suppress other questions about the organizational and professional community?

From the revised perspective, the “author,” like the organizational subject, cannot be regarded as an individual independently constructing knowledge or meaning, but as *subject* produced by and reproducing the cultural conditions of its existence (Clifford and Marcus 1986).

Revising Universal Constructions of “Normal” and “Abnormal”

Generating resistance to universal and self-referencing principles within modernist discourse is a central project of postmodern critiques. Resistance is the questioning of that which is taken for granted and the refusal to accept dominant definitions of “self,” “truth,” and “normality” (hooks 1984). Postmodern (including postmodern feminist) critiques reveal the ambiguities and ambivalences that are suppressed within modernist discourse. They expose power processes and relations that privilege universal standards of normality and construct that which deviates from those standards as pathological or abnormal. A revised discourse, therefore, would explicitly make room for multiple views of normality, multiple forms of experience, and multiple forms of subjectivity, and necessarily treat as suspect experiences, standards, subjectivities, and norms considered universal.

Within the revised discourse, the experience of burnout would not indicate a pathological condition, but would be constructed as a fluid and multidimensional experience with multiple possible meanings. An individual who claims to feel burned out would not be treated as sick or deficient, but as a person who is experiencing for a time one of many possible feelings and who could use some support. Some social workers in the nonmedicalized hospital described burnout and stress as “part of the ebb and flow” of life, rather than an abnormal condition that deviates from some stable and universal notion of normality.

In addition, within a revised discourse, the experience of ambiguity would be normal, or one of many possible normal experiences, and one’s ability to tolerate it would be viewed as a virtue. Flax (1992, p. 14) describes an alternative model of therapy premised on similar assumptions:

Therapy can make more dimensions of subjectivity available to people, encourage the development of the aspects of subjectivity that evoke and enjoy multiplicity while maintaining an appropriate equilibrium and self protective behavior within and against the constraints of the inner and outer worlds and increase people’s tolerance of ambiguity and ambivalence.

Such a revised interpretation surfaced in the language of social workers in the nonmedicalized culture of the rehabilitation facility. They openly embraced ambiguity

and talked about ambiguity as a normal experience of caregiving (Meyerson 1991). To place control of care with patients who need it and control of work with workers who perform it is to require caregivers and managers to accept ambiguity in the place of control. Under a revised discourse, tolerance of ambiguity rather than ability to reduce or control it (Weick 1979) would be an essential quality of professional managers, leaders, and caregivers, as well as scholars.

Rewriting Normality. A feminist reconstruction of universalistic tendencies must attempt to tell explicitly of experiences, subjectivities, and conditions that have been suppressed in and by the modernist discourse. It would include the telling of women’s experiences that have been silenced or forgotten in mainstream social science and the use of alternative forms of discourse, such as feminist ethnography (Visweswaran 1988), as the means of telling. It also would include exposure of experiences that have been suppressed and ignored and experiences that have been lost within the textual techniques of modernism. Capturing the texture of organizational experience, honoring emotions as a major part of that experience (Frank 1992, Sandelands and Buckner 1989) and revealing ambiguities in that experience will require different ways of thinking, doing research, and writing that resist the dominant discourse.

The revision must itself be told, not as an inversion or retelling of a revised “truth,” but as one of many possible stories that could be told, and itself as a product of its own cultural and institutional conditions. Although feminist revisions, such as this one, enter the space opened by the postmodern feminist critiques of universal standards, assumptions, and practices, the revisions must themselves be rendered suspect, necessarily a product of the discourse in which they are produced and thus subject to deconstruction and revision.

Conclusion

In the spirit of resistance, I developed a feminist revision of dominant conceptualizations of stress and burnout by critiquing and then reconstructing a set of relevant cultural themes within the dominant discourse. The revision I present invites further deconstruction. It speaks of possibilities, not “Truths.” It implies valuing other forms of experience and practice, as well as other ways to think about, orient, and produce knowledge. The critique and revision represent statements about knowledge, experience, and power; yet those statements do not represent a “discovery” of stable truths outside the conditions that produced them. The statements are tentative and they themselves have been produced within—not outside of—

a dominant discourse. At best, I hope the critique and reconstruction of stress and burnout generate further revision and possibilities of resistance.

Acknowledgment

The author thanks numerous individuals for insightful and supportive comments on previous drafts of the manuscript: Howard Aldrich, Marta Calas, Jane Dutton, Robin Ely, Mary Jo Hatch, Deborah Kolb, Joanne Martin, Linda Putnam, Lance Sandelands, Janet Weiss, Karl Weick, participants at the Keystone Conference on the Use of Narratives in Organizational Studies, participants at University of Michigan's Seminar on Organizational Studies, participants at MIT's Seminar on Organizational Studies, and several anonymous reviewers.

Endnote

¹In my previous article (Meyerson 1994), I develop in detail empirical and theoretical support for the claim that social workers' distinct patterns of interpretations were shaped partially by the different institutional and cultural conditions in which the social workers were embedded. Other explanations for these differences, such as the comparability of the two types of task environments, the closeness of the supervision, and the general amount of ambiguity in the work were shown to have been sufficiently controlled to ground the inductive claims. The article provides a thorough elaboration of those alternative explanations and the justification for my claims.

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Accepted by Richard L. Daft.