Boundary Management Tactics and Logics of Action: The Case of Peer-Support Providers

Samuel B. Bacharach
Cornell University
Peter Bamberger
Technion: Israel Institute of Technology
Valerie McKinney
Cornell University

From a qualitative study of flight attendants volunteering as support providers in a peer-based employee assistance program, we derive a typology of the boundary management tactics used by peer-support providers to maintain a comfortable distance from help recipients and propose a grounded theory explaining providers' selection of tactics. After identifying two factors associated with tactic selection (personal experience and social structure), we demonstrate that support providers' cognitive orientations, or logics of action, mediate the relationship between these factors and tactic selection. We identify four types of support providers' logics of action and show how a provider's logic may predict his or her preference for a particular boundary management tactic.●

Support relationships are becoming increasingly central to organizational functioning. A recent Gallup survey of 400 companies found workers' ability to form supportive relationships at work to be among the most powerful of 12 indicators of a highly productive workplace (*Wall Street Journal*, 2000). Supportive relationships in the workplace have also been found to explain a high proportion of the variance in job satisfaction, particularly among workers in high-stress jobs (Ducharme and Martin, 2000). It thus comes as no surprise that such peer-support frameworks as mentoring, coaching (Murray, 1991; Stone, 1999), peer review feedback (Tornow and London, 1998), or peer counseling and crisis intervention are used by an expanding number of organizations to develop employees and increase their job performance, resolve organizational conflicts, and enhance or preserve the emotional well-being of employees. Yet little is known about the act of support in organizations, especially as it relates to the provider (House, Umberson, and Landis, 1988).

Even though providing support may have emotional and psychological costs for support providers, the existing literature on social support has traditionally focused on the recipient and, in particular, on how support may improve the recipient's psychological and physical well-being. Researchers have examined the link between social support and such recipient outcomes as burnout (Leiter, 1991; Lee and Ashforth, 1993), job performance and role strain (Schauebroeck and Fink, 1998), job-related stress (Cohen and Wills, 1985), or physical health (for reviews, see Turner, Frankel, and Levin, 1983; House, Umberson, and Landis, 1988). They have examined how various types of support may affect recipients differently, distinguishing, for instance, between emotional and instrumental support (Caplan et al., 1975; Blau, 1981; Ganster, Fusilier, and Mayes, 1986; Thoits, 1986; Fenlason and Beehr, 1994) or among different sources of support, such as coworkers, supervisors, friends and family (e.g., Caplan et al., 1975; Beehr, 1985; Kaufman and Beehr, 1986; Cooper and Payne, 1988), or shop stewards (Fried and Tiegs, 1993). Some researchers have focused on the nature of the effects of support on recipients (e.g., buffering versus direct effects; Cohen and Wills, 1985; Ganster, Fusilier, and Mayes, 1986) or how recipients' individual characteristics, such as relational competence or network location, may affect the mobilization of social support (e.g., Sarason et al., 1983; Sarason, Sarason, and Shearin, 1986; Anderson, 1991). Those organization-

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al studies that do focus on support providers tend to conceptualize them either as good organizational citizens engaging in brief, unplanned, spontaneous acts of kindness (e.g., prosocial behavior or organizational citizenship behavior; Brief and Motowidlo, 1986; Organ, 1988; Schnake, 1991; Moorman, 1991; George and Brief, 1992; Van Dyne and LePine, 1998) vis-à-vis their peers or their customers or as paid help givers, such as physicians, teachers, or clinical psychologists, assisting clients in service organizations. Very little research exists, however, on support providers dispensing ongoing assistance to their peers in organizations. Furthermore, although burnout has been widely studied, be it among professional helpers (e.g., Kahn, 1993; Huebner, 1993; Meyerson, 1994) or among people caring for relatives (Pruchno and Resch, 1989; Coyne and Smith, 1991; Thompson and Pitts, 1992), there is little outside of the clinical literature on how organizational peer-support providers avoid burnout in their relationship with recipients and, in particular, how they tactically conduct and manage this relationship. Our objective in this paper is to begin to fill this gap in the organizational literature by exploring the ways in which peer-support providers attempt to manage boundaries in their relationships with help recipients.

BOUNDARIES IN SUPPORT RELATIONSHIPS

The act of support is fundamentally a transaction in which Actor A (the support provider) tries to affect Actor B (the recipient) to bring about constructive change in recipients and, perhaps in the process, receive a sense of gratification from his or her impact on the recipient. The means support providers use is building a relationship with the recipients. In the course of this relationship, providers must evaluate and interpret the recipient's actions and act accordingly. To do so, they use facilitative or empathetic skills (e.g., attending to, listening, probing) and action-oriented skills (e.g., providing advice or information) (Carkhuff, 1969). Meyerson (1994) and other studies of professional helpers suggest that one important aspect of such support relationships is their ambiguity. Support relationships are structured around what Strauss (1993) called problematic interactions, which require deliberation and reflection, as opposed to routine interactions, which are entirely directed by rules and regulations. In problematic relationships, actors' behaviors are neither narrowly rule-directed nor reflexive; each participant must think, evaluate various alternative actions, and interpret the other's actions. Although support providers and recipients may have sets of expectations about one another, more often than not, these expectations will vary from actor to actor and from dyad to dyad. Consequently, support providers must always evaluate how much to invest emotionally and how much to refrain from investing. They must decide how much they want to be distanced from the recipient by the veil of objectivity and detachment versus how much they want to be emotionally invested through empathy, compassion, and caring. This means that support providers must work at finding a balance between the pitfalls of indifference (i.e., detached, bureaucratic helping) and enmeshment (i.e., biased, overly emotion-

al helping), which involves determining the boundaries of the relationship.

In the support relationship, the creation and maintenance of boundaries between support provider and recipient are tactical issues, as actors must constantly evaluate when, where, and how to connect with, or disengage from, the other participant in the interaction (Kahn, 1990; Gutheil and Gabbard, 1993). Boundary management thus implies choosing boundary management tactics, the set of tactical decisions actors make about their emotional investment in other actors. Embedded in the boundary metaphor is the notion that rational actors, to define themselves as distinct from others, must consider and make choices as to how they will outline the limits of their self. Boundary management tactics are the tactics actors use to maintain, guard, or expand their boundaries. They are the tactics actors use to open, close, or expand their self vis-à-vis the other, along a continuum going from differentiation to enmeshment or identification, in classical therapeutic terms. At one end of the continuum, actors use boundaries to differentiate their sense of self from the other and to cast the other as an object that is distinct and separate from them. At the other extreme, boundaries are so unclear that the self of one actor is enmeshed in the other, and the other becomes an alter ego. Such enmeshment has been variously described by thinkers on intimacy and close relationships as "communion" (Bakan, 1966), "intersubjectivity" (Ickes at al., 1988), "unit relation" (Heider, 1944) or "double being" (Merleau-Ponty, 1945).

Support providers must be adept at breaking down the boundaries between themselves and recipients to listen empathetically and build trust; they also need to enforce boundaries to protect themselves from enmeshment with the recipient's problems, provide objective advice, and, eventually, terminate the relationship. This balancing act between inclusion and separation, dependence and autonomy—that is, between boundary crossing and boundary building—is at the center of the support relationship. As providers attempt to get recipients to acknowledge a certain problem or accept the help being offered, recipients attempt to get the providers either to disengage ("Get off my back") or to change the nature of their support ("Don't tell me what I need, tell me what I want to hear"). Support providers therefore use boundary management to maximize their influence attempts on recipients and to limit the effects of recipients' influence attempts on them. For instance, a provider may attempt to influence a recipient by telling him or her, "Either you go with me to an AA meeting, or you can just stop calling me." Alternatively, a provider may use boundary management to resist a recipient who says, "Get the supervisor off my back just this one last time, and then maybe we can even talk about treatment." The balancing of inclusion and separation raises a number of issues for support providers: they have to decide when, with whom, and under what circumstances to emphasize connectedness or separation. For example, providers may emphasize connectedness at the beginning of the relationship with a recipient and autonomy at the end. Providers may emphasize connectedness with

some recipients while stressing autonomy with others, depending on the recipient's needs and preferences, their own needs and preferences, or organizational and cultural constraints. Providers may choose to impose their boundaries on recipients or may negotiate them, depending on such factors as the nature of the interaction, the personal characteristics of the participants, or the organizational context.

Boundaries that support providers create and maintain can hardly be seen as static structures. Rather, they must be viewed as tactical devices support providers use in managing support relationships (Bacharach, Bamberger, and Mundell, 1995). Boundaries are generally construed as the literal or metaphorical demarcating structures created whenever one entity (as micro as an individual or as macro as a nation-state) interacts with another entity from which it is, or would like to be, distinguished (Cohen, 1985), but such a perspective may be misleading. Defining boundaries as structures may lead one to believe that boundaries are always reified, sustained, and institutionalized forms, but in the organizational support context, boundaries as tactical devices are likely to be dynamic and emergent, as well as a function of the conscious and reflective choices support providers make. A key problem facing organizational support providers is managing boundaries and selecting the boundary management tactics that allow them to do that. As Goffman (1967) suggested about face-work, when one is forced to challenge another, the challenger must make sure that the act of challenging does not have a negative emotional impact on him- or herself. Organizational support providers are faced with the dilemma of selecting tactics that will elicit the compliance that they are seeking from the support recipient while not requiring them to invest more emotional resources in the support relationship than they intended. In a context of broad and ambiguous expectations, of flexible role definitions requiring interpretation by organizational members (Czarniawska-Joerges, 1992), employees may question where their responsibility ends and where that of other organizational members begins and wonder whether they should invest in the other or be more interested in protecting themselves. When self-protection in daily interactions is no longer ensured by routinization, rules, and formal structures, organizational life becomes fair game for continual negotiations, mindful attention, justifications, and rationalizing (Weick, 1995). Within this fluid organizational context, the challenge for organizational actors is to make intersubjective sense (Weick, 1995) of their activity vis-à-vis the activity of others. To a large extent, this intersubjective sensemaking involves what we refer to as interpersonal boundary management.

In this paper, we thus focus on boundary management in the context of the social support provided by peer volunteers in work organizations. We explore the types of boundary management actions adopted by volunteer peer-support providers and attempt to explain the tactical intent underlying the selection of such actions. Our primary objective is to better understand the nature of boundary management and its role in allowing support providers to resolve the dilemma of sup-

port described above. We first identify a grounded typology of boundary management tactics and then generate a grounded theory explaining peer support providers' selection of these tactics, on the basis of ethnographic data collected from airline flight attendants participating in a union-based peer-support program. Such an ethnographic approach is ideal, given the fact that the boundary management construct remains poorly developed and that few theoretical frameworks exist upon which to ground the generation and testing of hypotheses (Perlow, 1998).

METHOD

Sample

We examined the issues discussed above in the context of peer-based and union-sponsored, member-assistance programs in the airline industry. Although such support-based concepts as citizenship and prosocial behavior are relatively new to the field of management, unions have long recognized the importance of social-support processes in enhancing member solidarity and commitment to the union (Barling, Fullagar, and Kelloway, 1992; Bamberger, Kluger, and Suchard, 1999). Many labor historians view mutual aid and social-support-based programs as the foundation on which the American trade union movement was built (Montgomery, 1979; Ducker, 1983). Perhaps nowhere are systems of social support more pervasive than in the hundreds of enterprises whose employees have volunteered to serve as peer-support providers in the context of their union's member-assistance programs (MAPs).

Like employee-assistance programs (EAPs), MAPs are designed to help workers and their family members with emotional or other problems by providing such emotional and instrumental support as basic counseling, assessment, referral, and follow-up services. Unlike EAPs, which are a management-provided benefit and tend to rely on professional support providers, MAPs are sponsored by a union, either unilaterally or in cooperation with management. More importantly, MAPs tend to place primary reliance on a network of peer-support providers, typically unpaid volunteers, who are both coworkers and counselors. This network of peers is responsible for identifying and referring troubled employees before serious job impairment occurs and for supporting their recovery from substance abuse and other problems. In this sense, peer support is both affective and instrumental in nature. MAP volunteers attempt subtly (and sometimes not so subtly) to nudge those that they believe to be in need of help into a help-seeking mode. For those seeking help, MAP volunteers' support may range from simply lending an ear to providing basic counseling. For example, support may, in one case, be limited to sitting at the bedside of a hospitalized coworker but, in another, require conducting a formal preliminary assessment (typically for referral purposes only) of a troubled flight attendant's problem. Once an assessment is made, the provider may then make all the arrangements for the recipient to be admitted and go as far as personally bringing the recipient to the treatment center or facility. For those referred to professional care (e.g., a substance abuse treat-

ment program), support providers may provide the core of recipients' after-treatment care, either by organizing and leading group counseling sessions or by periodically meeting with the recipient to monitor the recovery process.

Although MAPs are prevalent in a wide variety of industries, their administrative structure and focus of activity vary. For example, while MAPs in the auto industry tend to be jointly sponsored by labor and management, MAPs in the airline industry tend to be sponsored unilaterally by the union. Furthermore, while MAPs in the railroads tend to concentrate their attention on employee substance abuse problems, MAPs in the construction, airline, and auto industries tend to adopt more of a broad-brush approach (Bacharach, Bamberger, and Sonnenstuhl, 1996). Nevertheless, as noted by Bacharach, Bamberger and Sonnenstuhl (1996), the support processes enacted by MAP peer-support providers are, for the most part, similar across programs.

We opted to examine boundary management among support providers in the context of the airline Flight Attendants' MAP for a number of reasons. First, as one of the oldest MAPs in existence, the Flight Attendants' MAP has been used as a model by unions representing workers in a variety of other industries. Second, the Flight Attendants' MAP is widely diffused throughout the airline industry, which allowed us to collect data on support providers and boundary management phenomena across multiple organizations. Finally, in contrast with other MAPs, flight attendant support providers tend to keep careful notes on the cases they handle. The existence of such written records and the ability of informants to refer to these records provided us with increased assurance that case narratives would be less subject to retrospective biases.

In the Flight Attendants' MAP, peer-support providers take advantage of the long working hours and extensive contact with coworkers that characterize the work environment of flight attendants and use peer pressure as the leverage to get troubled employees to seek assistance. Although the Flight Attendants' MAP is unilaterally sponsored by the union, in the majority of airlines, management supports the peer-assistance effort; in fact, in some cases, peer-support providers are given a limited amount of time off to handle their caseload. In supporting the MAP, management recognizes the need to ensure program autonomy by enforcing a strict hands-off policy: while managers may ask a peer-support provider to contact and assist a particular worker who they feel needs help, once the request is made, it is understood that they will receive no further information from the peer-support provider as to the status of this case.

The Flight Attendants' MAP does not actively recruit peer-support providers. Instead, flight attendants that have either sought assistance through the MAP in the past and/or are simply interested in helping their coworkers request to join the MAP network of peer volunteers. Current local MAP members select these potential volunteers according to three criteria: (1) whether they will be able to respect the program's confidentiality requirements; (2) whether they will provide access to segments of the local flight attendant popula-

tion currently not sufficiently well served; and (3) whether they are emotionally able to handle the pressures involved with peer support. Approximately half of those volunteering to serve as a peer-support provider are accepted into the MAP corps of volunteers.

Those selected are informed that three skills are required: the ability to listen, the ability to give, and the ability to maintain 100 percent confidentiality. Peer-support providers participate in a 96-hour national training program focusing on crisis intervention and the problems posed by the need to balance involvement with psychological detachment from those they are trying to help. Additional informal training may be offered at the local level, particularly in larger bases with a larger pool of MAP volunteers. This additional training may take the form of periodic (i.e., annual, semiannual) refresher seminars, or case-review sessions. Informal, phone-based mentoring of less experienced providers by more experienced MAP members can be viewed as an additional training/socialization mechanism. Prospective peer-support providers are explicitly told by their trainers, who are primarily veteran support providers, that they need to be careful not to go beyond their prescribed role and "play doctor" and that the role of peer-support provider can place excessive demands on their own personal resources. Training sessions often revolve around role-playing exercises, but volunteers are not given any clearly defined set of guidelines as to how far to go in helping a coworker; no set of program expectations, other than to preserve confidentiality, are ever presented; nor are volunteers ever presented with any prototypic or schematic helping model upon which to base their future helping behaviors. For these reasons, flight attendant peer-support providers provide an ideal empirical referent for the analysis of problematic social support relationships and their inherent boundary problems.

We conducted extensive semistructured, in-person interviews with a theoretical sample (Glaser and Strauss, 1967) of 60 informants. All 60 came from the seven airlines whose flight attendants were represented by the Association of Flight Attendants (AFA) at the time of the study. For each airline, we interviewed at least one MAP activist and one rank and file member who had used the MAP within the last five years. Given our attempt to generate a theoretical sample, our selection of MAP activists was driven by a desire to maximize the diversity of our informants along demographic and job-related characteristics. Thus, for example, when possible (such as in larger bases), we sought to interview at least one male and one female peer volunteer. Working with the union, we succeeded in interviewing all of those volunteers we wanted to include in our sample. For the two larger carriers, we also interviewed at least two individuals from the following categories: (1) in-flight supervisors and/or base managers and (2) local union officials. Finally, we interviewed veteran activists and administrators to gain a better understanding of the program's history. Additional informants were added in specific categories for individual carriers until we began to hear the same information repeated again and again, sug-

gesting that we had reached what Glaser and Strauss (1967: 61–62) referred to as "theoretical saturation."

The semistructured interviews were based on a framework developed prior to data collection, focusing on the impact of personal and contextual characteristics on support providers' actions. Over time, we adjusted the interview protocol both to eliminate the collection of overly repetitive data and to allow us to refine the theoretical perspective being generated. Among the 60 individuals interviewed were ten in-flight supervisors and base managers (5 male, 5 female), 28 MAP members or peer-support providers (of whom 6 were men), and 22 AFA members (of whom 5 were men) who turned to the union-based peer-support network for assistance, i.e., "troubled flight attendants" (TFAs), or recipients. In this study, the focus of our analysis was on the 86 case descriptions provided by the 28 MAP help givers, 13 of whom had been support recipients at some point in the past. Given that both the occupation and the MAP are female-dominated, it is not surprising that well over two-thirds of these 86 cases involved women helping women.

Interview Structure

Our interviews were structured around two primary foci: (1) providers' background, experience, and work context, and (2) descriptions of individual case histories. With our focus on the impact of personal and contextual characteristics on providers' actions, we felt it necessary to control for case type. Consequently, we asked interviewees to focus on cases related to a highly prevalent MAP issue, namely, substance abuse. Thus, we began our interviews by asking providers how they became involved in peer-support activities and whether any particular experience of their own had led them to want to become a peer counselor. These initial questions were framed in such a way as to elicit information about how a provider's background might have influenced his or her overall orientation toward the support-provider role. For example, after we asked providers about their personal history and, in particular, their personal experience as a support recipient at any time in the past, we asked them to discuss their general concerns about becoming and remaining a support provider. We then asked them to discuss to what extent these concerns influenced their approach to the role of support provider. This discussion usually provided a natural transition into a discussion of particular cases handled. Consequently, we then asked peer counselors to describe three (and, when time permitted, four) substance abuse (i.e., alcohol or drug-related) cases that they were responsible for in the last two or three years. We asked them to describe each case from the moment it came to their attention until either the point at which they considered the case closed or, for those cases still active, until the present day, focusing on the way they attempted to manage each case. In the majority of cases, peer counselors spontaneously pulled out and referred to written case files as the basis for their descriptions. When this did not happen spontaneously, in an effort to minimize any retrospective bias, we asked them to do so, reminding them to protect recipients' anonymity and confidentiality. By having informants refer to their case notes, we were able to

reduce the risk of bias stemming for the tendency of informants to craft their responses in such a way as to be amenable to the researcher or to protect their self-interest. We further attempted to reduce the risk of informants imposing some sort of reconstructive rationality on their actions by adopting several of the suggestions proposed by Miles and Huberman (1984: 233), such as (1) spending several days with each informant, to enhance the level of trust and openness (over the course of these days, we would alternately interview the informant and have the informant accompany us when we went to interview support recipients); (2) being careful not to lead the informant in his or her responses (i.e., by sticking to a preformulated list of primary and secondary or probing questions); and (3) attempting to share as little of our knowledge or as few of our hunches with informants as possible, so as to avoid giving any implicit request for confirmation. For example, when informants asked, as they often did, if other interviewees handled similar cases in similar ways, our general response was that "every case is different and at this point in our study it's still too early to comment about the approaches taken by different support providers."

Not surprisingly, we found that in nearly every case, peer counselors focused their discussion and analysis of their own case management around the issue of boundaries and tactics. In fact, it appeared that the management of boundaries provided an almost natural framework for providers to describe their support actions. Recognizing this pattern within the first three or four interviews, we decided to encourage those peer counselors failing to initiate a discussion of boundary management to address the issue by asking them what actions they took to prevent their own burnout. This was necessary in only under 5 percent of the cases. All interviews, averaging about three hours in length, were taped, transcribed, and coded. In addition, we conducted a two-day, focus-group interview with 12 peer counselors who had been instrumental in developing the AFA's MAP. We also observed two five-day basic training sessions for new peer counselors, one advanced training program for more senior counselors, and two interim (one-day) training sessions for new peer counselors requiring immediate training. Finally, we attended a number of national and local MAP committee meetings. Transcripts of these sessions and field notes we took during them were also coded for analysis.

Data Analysis

We analyzed the data using the constant comparative method (Glaser and Strauss, 1967; Strauss, 1987; Strauss and Corbin, 1990), which is designed to develop rich descriptions of social phenomena, allowing the researcher to make discoveries and generate hypotheses and theory about them. Using this method, we began to identify theoretical categories and make comparisons across categories well before the formal process of data analysis began. These comparisons allowed us to develop construct definitions and associated coding criteria. These criteria played a critical role in allowing us to identify and categorize characteristics of both cases and providers. In generating our coding scheme, we were careful to ensure that the particular categories and con-

structs identified were not based on instances related by a non-representative informant or on non-representative events described by representative informants (Miles and Huberman, 1984: 231). We were also careful to avoid the "holistic bias," the tendency of researchers to see more meaningful patterns than exist in reality by looking purposively for counter-evidence (i.e., that the categories identified were, for example, not as comprehensive or as orthogonal as we inferred) (Miles and Huberman, 1984: 231). Furthermore, in an effort to triangulate or corroborate our hunches about particular constructs and patterns, we paid particular attention to case descriptions provided by support recipients, flight attendants who had used the MAP services within the last five years. We view these narratives as providing an independent measure of construct validity. When such counter-evidence was found, we revised the coding scheme and, where relevant, recoded interview transcripts. The coding criteria presented in the text below reflect the final coding scheme that emerged from several iterations of coding, category redefinition, and recoding. On the basis on these final coding criteria, one of the authors and a graduate assistant coded data independently. In addition, where applicable, these individuals assigned cases and providers to the particular categories identified in the analysis. For both data coding and category assignments, we evaluated intercoder reliability one interview at a time until it reached a consistent level of 95 percent agreement (after 15 interviews). All of the coded data (interview, observation, and archival) were analyzed using AQUAD, a commercially available software package that, like Ethnograph, was specifically designed for generating grounded theory from qualitative data. AQUAD allows for on-screen coding and case-category assignment, as well as for preliminary hypothesis testing (on the basis of Boolean logic) and cross-category comparisons (i.e., a kind of qualitative t-test). The analysis allowed us not only to refine the model generated during data collection but also to assess the degree to which our emerging model—its component constructs and propositions—was in fact empirically grounded.

The analysis of our qualitative data was structured around two main questions. First, if an important component of support action is the management of boundaries, what types of boundary management tactics do support providers adopt in the course of their support relationships? Second, what are some of the factors associated with, and potentially influencing, the adoption of specific types or patterns of boundary management tactics?

BOUNDARY MANAGEMENT AMONG PEER-SUPPORT PROVIDERS

A Typology of Boundary Management Tactics

One of the first things that struck us as observers of a training program for new MAP members was that veteran members constantly reinforced the need for support providers to "watch their 'B's & L's'" (i.e., boundaries and limits). As one of the veterans put it, "failure to do so means rapid burnout for you and poor assistance for those counting on you." Underlying this veteran's statement appears to be the implicit

understanding that setting and enforcing boundaries are the primary tactics available to providers seeking to elicit the recipient's compliance while not investing more emotional resources in the relationship than desired. The descriptions of the case histories revealed that support providers constantly thought of their relationships with recipients in tactical terms and that boundary management was a key component in their tactical thinking. In fact, from an analysis of these case histories, it became apparent that support providers see themselves as having available a repertoire of four types of boundary management tactics, ranging from relatively passive or mild tactics to relatively active or strong tactics on a continuum that parallels the one offered by Rafaeli (1989) in her analysis of the interaction between cashiers and customers.

Mild tactics: Tacit condition setting. The first type of boundary management tactics described by peer-support providers included highly passive and reflective tactics, which we called tacit condition-setting tactics. For example, several providers cited cases in which they attempted to provide support by placing an offer of help in a coworker's mailbox. Providers managed their boundaries in such cases by acknowledging to themselves that they had "planted a seed" and had no obligation to do anything else unless, as one support provider put it, the recipient "reciprocated." From this example it is clear that, as with all boundary management tactics, providers adopting these tacit condition-setting boundary management tactics did so with the intent of ensuring some degree of emotional distance between themselves and recipients. What set these tactics apart from the others, however, was the fact that they involved, at most, only the tacit voicing of actual boundaries and little or no enforcement activity. Support recipients were never explicitly informed that unless they responded to the initial offer for help, no further offer would be forthcoming and that the nascent support relationship would be terminated. Providers adopting such tactics only tacitly set boundaries and rationalized them to themselves; they did not have to legitimize the boundary to others or enforce it. As one peer counselor put it:

> You have to remember that you are responsible to them, not for them. You have to learn not to get so involved. And my big thing is trying to help people that know that they have a drug and alcohol problem. And I really want to help them, and I want them to see how *my* life has been turned around since I stopped. But I have to let it go. Like I say, it's like the fish: I let the line out and I dangle the bait, if they want to take, they can.

These tacit condition-setting tactics place few emotional demands on the provider and do not require the provider to invest personal resources such as time, effort, and emotion in either setting and enforcing the boundaries or in the support relationship itself. While, on the one hand, these boundary management tactics are often the least demanding for providers, on the other hand, they may also be the least likely to elicit the desired response from the recipient.

Strong tactics: Sanctioning. At the other end of the continuum from mild to strong tactics are what we called sanctioning boundary management tactics, tactics that are highly explicit and active. Our data suggest that these tactics as a group are distinct from the others support providers use in that they require an element of direct confrontation by the provider, a willingness to call a recipient's bluff and to take a stand (and stick with it) until the recipient complies. Examples of such sanctioning tactics include "hard love" (i.e., refusing to compromise with recipients until they make an effort to help themselves) and "in-your-face bluff calling," in which the provider quietly collects evidence about a recipient and then uses it strategically to let the recipient know that dishonesty has its costs, such as embarrassment or the end of the support relationship. Peer counselors described such tactics as the most emotionally demanding for them but also the most likely to elicit a response. Peer counselors adopting this form of boundary action not only stopped initiating contact with the recipient but also frequently refused to respond when contact was reinitiated by a "less than serious" recipient. For example, providers attempting to get alcoholic colleagues into treatment explained how they refused to talk to recipients with whom they had been working over a long period when the latter called in drunk. Such recipients were seen as "not serious," manipulative, and dangerous to the provider's own mental health, and therefore to be dealt with using stronger tactics. One provider, recalling such a case, noted:

> At the same time, if I don't feel like they're telling me the truth, I'll say, "I think you're bullshitting me." And it stops them dead in their tracks. They either tell me I'm wrong, and I can say, "OK, you're right." Or I tell them they're wrong. Like in the most recent case with a young man, I told him, "I'm sorry, but I won't work with you, because you can't give me a legitimate reason for needing my assistance."

Frequently, sanctioning tactics were used until the support provider believed that the recipient had altered his or her behavior, that is, until the recipient had acknowledged his or her problem and agreed to work with the provider to seek assistance. The low levels of support provided while such sanctions were in effect were believed, in many cases, to elicit the desired change in a recipient's behavior. Peer counselors noted that when they felt that the recipient had altered his or her behavior, they tended to relax their boundaries. Providers believed that by adopting such tactics they were able to successfully "close" their cases faster than those providers who were more hesitant to adopt such strong boundary management tactics, potentially shortening the necessary life cycle (i.e., the period between initiation of support and the recipient taking the action desired by the provider) of many support relationships.

Moderate/hybrid tactics: Warning and avoiding. Interviewees also described hybrid boundary management tactics that combined elements of the mild and strong tactics described above. We refer to these hybrid tactics as moderate in that, while not as strong as the sanctioning tactics, they also were not as mild as the tacit condition-setting tactics. They tended

to be more emotionally demanding for the support provider and were more likely, according to support providers, to elicit a response from the recipient. Peer counselors' comments suggested the use of two types of moderate/hybrid tactics. We labeled "warning" those tactics used by support providers to clarify for the recipients the limits of the support relationship and the consequences of not respecting these limits. We labeled "avoiding" those tactics aimed at enforcing the limits of the support relationship, such as walking away from a ringing phone for fear that it might be a recalcitrant troubled flight attendant.

Warning boundary tactics were apparent when providers verbally confronted the recipients and notified them that there were limits as to how far they could go. Typically, these tactics included some indication that it was preferable to take action immediately rather than to let the situation deteriorate further. For example, a typical warning tactic providers used involved statements like the following: "Word has it that there are a number of people building a case against you"; "Several of your peers have voiced concern about you and indicated that while they're willing to wait for you to do something about it, they're not willing to wait forever"; or "Management is letting me take a shot with you before they will be forced to take action." Such statements were typically followed by others suggesting that, for example, "Forces beyond my control will end our relationship unless you respond and respond fast." Providers admitted that they used such warning tactics even when there was no direct and impending threat to the recipient. Occasionally, they would exaggerate even a minimal threat if they felt that the recipient could not be "moved" without resorting to some sort of warning tactic. Overall, warning tactics were used when the provider realized that, despite all of his or her efforts, the recipient was not willing to take action. At this point, providers initiated some form of direct confrontation, including some indication that, at the very least, the support relationship would be terminated if the recipient continued to refuse to take any responsibility. One provider justified such confrontational boundary-setting tactics on the basis of her own frustrations:

> I was just tired of it. I was just tired of the bullshit, the whining. She had done the same thing over and over and over. She knew the program, she just didn't want to do it. I would say, well, when you decide when you want to help yourself, call me. But I can't do this for you. I can't move you out. I would say things like, "What is this doing to your child, he's two, he's three, he's four and what's going on, what's he seeing? What's going to happen to him when he grows up?" But if she didn't want to hear any more of that logic, what more can I do?

Examples of avoiding include refusing to meet the TFA in person, deciding not to offer the TFA the opportunity to spend the night at the provider's home, refusing to discuss MAP issues while on the job, or refusing to bid for trips so as to be able to fly with and, hence, observe or help a TFA. Overall, avoidance tactics therefore involved some action designed to reduce the intensity of the support relationship in order to enact some preset boundary. Discussing the dilem-

mas involved in adopting such tactics, one MAP member noted:

> There are situations, too, where I don't know if I would go over to somebody's house or have them come over to my house. There's been situations where I've really wanted to do that, just say to them, "All right, just come over here and stay here." That happens to me also certainly in dealing with people in AA [Alcoholics Anonymous] too. But there's only so far where you can go where you're responsible for somebody else.

Although some of the more experienced flight attendants warned or avoided recipients from the beginning of their support relationships, most adopted moderate/hybrid forms of tactics on a case-by-case basis only after mild tactics failed to influence the recipient in the way desired or when the recipient's condition was deemed to demand stronger forms of boundary tactics.

Boundary management tactics: Dimensions and implications. Embedded in the four types of boundary management tactics described above are two typological dimensions. The first dimension concerns the degree to which the tactics selected by the support provider are confrontational. We categorized boundary management tactics as confrontational when they were explicit, when the provider intended them to be clearly heard, seen, or felt by the recipient. We categorized boundary management tactics as non-confrontational when they were tacit, when the provider sought to elicit a response in a subtler way. Tacit condition setting and avoidance tactics are both inherently non-confrontational. In contrast, warning and sanctioning tactics place a strong emphasis on confronting the recipient. Similar distinctions have been drawn about the types of behaviors enacted by organizational members when serving customers (Hochschild, 1983; Rafaeli and Sutton, 1987). The second dimension concerns the degree to which boundary management was geared toward the setting versus the enforcing of boundaries. We categorized tactics as boundary setting when they involved providers' attempts to identify and clarify the limits of the relationship for themselves and/or the recipient. We labeled those tactics involving providers' attempts to exact compliance with implicit or explicit limits in the relationship as enforcing tactics. Tacit condition setting and warning are both primarily boundary-setting tactics, while avoiding and sanctioning are both primarily boundary-enforcing tactics.

Figure 1 summarizes our typology of boundary management tactics. We define mild tactics (i.e., tacit condition setting) as both non-confrontational and oriented toward setting boundaries, whereas we define strong tactics (i.e., sanctioning) as both confrontational and oriented toward enforcing set boundaries. The two cases falling on the diagonal of figure 1 (i.e., avoiding and warning) are moderate/hybrid forms of boundary management tactics. Avoidance tactics can be defined as non-confrontational and enforcement-oriented, whereas warning tactics can be defined as confrontational and oriented toward setting boundaries. Tactics were slotted into one of these four mutually exclusive categories on the

Figure 1. Types of boundary management tactics.

	Setting Boundaries (Identifying and clarifying boundaries)	*Enforcing Boundaries* (Exacting compliance with set boundaries)
Non-Confrontational (Tacit)	TACIT CONDITION SETTING Setting conditions for the continuation of the relationship, without explicitly informing recipient (e.g., not doing anything if recipient does not respond to first offer of help).	AVOIDING Limited initiation of interaction; when initiation by recipient, limits are placed on location and extent (e.g., not picking up the phone; no home visits; not driving across town to meet recipient).
Confrontational (Intended by provider to be clearly heard, seen, or felt by recipient)	WARNING Confrontative, verbal distancing; warning that break in relationship is imminent unless recipient changes behavior.	SANCTIONING Complete and direct refusal to interact in any way with recipient deemed "not serious," even when recipient requests support.

basis of the coding criteria generated from the data and presented in figure 1.

As Hochschild (1983) suggested, strong forms of boundary tactics may give fast results but may also require more emotional work than milder forms of boundary tactics. Strong tactics may deplete the support provider's emotional resources at a faster rate than they can be replenished (Hobfoll, 1988). Support providers tended to view mild boundary management tactics (i.e., tacit condition setting) as those types of actions that place limited, if any, pressure on the support recipient to comply but also place few emotional demands on the support provider. In contrast, strong boundary actions involve pressure tactics aimed at moving the recipient toward compliance—tactics that require support providers to exert substantial emotional energy.

Providers' Experience and Social Context

On the basis of this typology of providers' boundary management actions, we next sought to identify the factors associated with, and potentially influencing, the adoption of specific types of tactics related to the management of boundaries. This involved an exploratory search for the dispositional and social-context characteristics that might explain the variance in the types of boundary management tactics counselors used when providing support to substance-abusing peers. We investigated a number of potential factors, such as providers' sex, age, or previous experiences with the same recipient in earlier cases. We found only two factors related to providers' disposition and social-network characteristics with any clear and consistent pattern of association with types of providers' boundary management tactics: the provider's own experiences with recovery (i.e., whether the provider was recovering from some substance abuse or mental health problem) and the size of the provider's social network (i.e., the number of flight attendants assigned to the provider's base).

Provider's own experience with recovery. Our qualitative data suggest that providers who reported being in recovery

tended to describe cases in which they used stronger boundary management tactics than did non-recovering providers. Typically, recovering peer counselors claimed that they had to watch themselves to be sure that their own recovery was not being neglected and that recipients were not manipulating them directly or indirectly (i.e., by demanding too much personal time or emotional energy) and threatening their own recovery. At least one provider partly blamed her own relapse on her failure to keep a limit on her MAP activity and case involvement. She described what happened to her in the years following her decision to become involved in the MAP:

> I became very busy with MAP work and I mean I was extremely busy at this time doing a lot of referring and, doing a few interventions, putting them together. I think a lot of times when you get into this kind of helping people role that you tend to let yourself go. I was not going to meetings like I should be. It had probably been three months since I had been to a meeting. And I know that once you start doing that you are going to get in trouble. I saw the director of the halfway house, who was a recovering alcoholic, take care of all of us for so long. Once a month he would go to a meeting. He ended up relapsing and he also ended up dying on the street. I think when you don't take care of yourself, and when you let yourself get so involved in other people, you tend not to look at yourself. So, I don't do it anymore.

As shown in table 1, a greater proportion of the cases described by recovering providers tended to involve sanctioning tactics (22 percent as opposed to only 2 percent for non-recovering providers). The two cases in which no mention of boundary management was made at all were cases described by non-recovering peer counselors. For the 45 support relationships in which boundary management was discussed, non-recovering providers either disclosed that they failed to implement any type of boundary management tactic when they clearly should have (4 percent of the cases) or that the strongest form of action taken was either of the mild (62 percent of the cases) or moderate/hybrid type (31 percent of the cases).

Size of the provider's social network. Flight attendant (FA) bases or domiciles in the United States range in size from those with fewer than 50 FAs to those employing over 3,000. FAs at the smaller domiciles (especially those employing under 500 FAs) tend to fly with one another on a fairly common basis, are less likely to commute (and therefore more likely to live in the same communities), and tend to be overall

Table 1

Differences in Boundary Management Actions by Recovering and Non-recovering Providers in Cases in Which Boundary Management Was Discussed

Action taken	Recovering providers (N = 41 cases described by 13 providers)	Non-recovering providers (N = 45 cases described by 15 providers)
No boundary set	0 cases (0%)	2 cases (4%)
Tacit condition setting (mild)	17 cases (41%)	28 cases (62%)
Avoiding (hybrid)	5 cases (12%)	9 cases (20%)
Warning (hybrid)	10 cases (24%)	5 cases (11%)
Sanctioning (strong)	9 cases (22%)	1 case (2%)

better acquainted and more intimately involved with one another. FAs at the larger domiciles, especially those employing over 1,000 FAs, may at best fly with one another only once or twice in a career. Many of the FAs at these larger bases are just beginning their careers, and an equally large number commute from cities as much as half a continent away. Often, their only acquaintances at the base are those FAs with whom they completed training and who were assigned to the same domicile. Peer-support providers at small domiciles (i.e., with smaller social networks) typically know their recipients personally and quite often consider them to be close friends. Providers at large domiciles rarely have any personal relationship with the recipient prior to the establishment of the support relationship. Their relationship with the recipient is often grounded in their role as a MAP member rather than as a close friend or even a one-time flying partner.

In our conversations with support providers and recipients, it became clear that the more intimate relationships in smaller domiciles made it more difficult for providers to draw the boundaries that many, post hoc, felt should have been drawn. In the larger domiciles, the greater sense of anonymity and distance from the recipient appeared to make it easier for the provider to adopt stronger boundary management tactics. Furthermore, providers at large bases noted that if they failed to adopt stronger boundary management tactics they would not be acting fairly toward other coworkers who potentially needed assistance. While domicile sizes vary tremendously, MAP committee sizes do not: the number of MAP support providers is often the same in domiciles of under 500 FAs as it is in domiciles of over 2,000. The result is that providers in the larger domiciles feel pulled in many more directions and are always wondering how to find the time to take care of that next pressing case. They are thus typically less able and less willing to "put up with the recipient's nonsense" for as long as providers in smaller domiciles. Boundary management thus becomes a more salient issue when the ratio of support providers (i.e., MAP size) to potential support recipients (i.e., potential client base in terms of the overall size of the domicile) falls.

Although providers in small domiciles were as likely to express concerns when approaching a new support relationship as were their colleagues in larger domiciles, we found evidence that providers in smaller domiciles were less likely to translate these concerns into strong boundary management. As table 2 shows, providers in small domiciles described adopting milder boundary management tactics as often as did providers in large domiciles (53 percent and 52 percent, respectively). Large-domicile providers, however, described a substantially higher proportion of cases in which they adopted strong boundary management tactics (21 percent) than did providers in smaller domiciles (7 percent). This evidence suggests that stronger boundary management tactics, such as sanctioning, may be more prevalent as the size of the providers' social network increases.

We wondered why these factors might have such effects on the boundary management tactics of support providers

Table 2

Differences in Boundary Management Actions by Providers in Small and Large Domiciles in Cases in which Boundary Management Was Discussed

Boundary management action taken	Providers in small domiciles (N = 57 cases described by 18 providers)	Providers in large domiciles (N = 29 cases described by 10 providers)
No boundary set	1 case (2%)	1 case (3%)
Tacit condition setting (mild)	30 cases (53%)	15 cases (52%)
Avoiding (hybrid)	11 cases (19%)	3 cases (10%)
Warning (hybrid)	11 cases (19%)	4 cases (14%)
Sanctioning (strong)	4 cases (7%)	6 cases (21%)

and whether there was an underlying link between providers' experiences and work-based social networks, on the one hand, and providers' boundary management tactics, on the other. Our data suggest that underlying specific tactical choices is a cognitive orientation or logic of action that support providers bring to each support relationship. Volunteers often bring to the program a set of basic helping heuristics typically shaped by their own background experience and disposition. Through training, informal peer socialization, and initial trial-and-error experiences in helping troubled flight attendants, these heuristics are crystallized and transformed into a coherent and relatively stable logic of action. Providers' logics of action tend to emerge early on as they learn how to balance inherent, helping heuristics with the structural constraints and opportunities presented by the field. Logics mature and become almost institutionalized, in the sense that they become increasingly less open to revision from case to case, as providers attempt to make sense of their initial, often "seat-of-the-pants" experiences in the context of their own background and structural constraints and opportunities. Furthermore, our data suggest that it is this underlying logic or cognitive frame that mediates the relationship between, on one hand, such dispositional variables as providers' recovery status and such structural variables as network size, and, on the other hand, boundary management tactics.

A Grounded Typology of Providers' Logics of Action

In describing the tactics used to handle particular cases, social-support providers typically framed their accounts in terms of the ends they were trying to achieve and the general sorts of means used to achieve these ends. Distinct from tactics (e.g., threatening the cessation of support unless the recipient got "serious"), which they discussed in terms of specific actions taken in a case, they discussed means in terms of general support strategies and the personal resource investments they required (e.g., "I try never to hound or go after them. I just let them know that I'm there for them and that I'll do anything to help as long as I see that they want to help themselves first."). Providers' means-ends orientation was particularly evident when they described their fears, concerns, and apprehensions with respect to particular cases. Providers typically rationalized switches in tactics made in response to these concerns in terms of some previously stated means-ends linkage, which seemed to offer

them basic "rules of the game" to bring from one case to another.

We inferred from this pattern in our data that providers tend to approach each case with a relatively stable cognitive orientation, or logic of action. This is not surprising, since social support, like any meaningful social action (Weber, 1947), is based on the calculation of means and ends by the support provider, and support providers must calculate how much of an emotional investment they are willing to make in pursuit of varying degrees of recipient compliance. Support providers must calculate the cost of the means to be used (i.e., investment of resources) versus the scope of the ends they are pursuing. Thus, our data suggest that the selection of tactics is largely constrained by this means-ends logic. This logic allows support providers to frame (Goffman, 1974; Collins, 1988; DiMaggio, 1994) the specific means and ends that they bring to the support relationship. To the degree that they are abstract, general, and form a cognitive map, such logics of action may be seen as similar to schemas (Weick, 1979). In contrast to schemas, however, these logics of action appear to be specific to the means-ends relationship that individuals and parties bring to an exchange. In social support, a logic of action may be seen as the implicit relationship between means and ends underlying the specific tactics and actions of support providers. While the provider's logic of action is for the most part taken for granted, it becomes manifest when parties try to explain to themselves or justify to others the selection of specific means, ends, and, most importantly, the linkage between the two. It provides what Giddens (1993: 90) called the "rationalization of action" when such an explanation or justification is needed.

We attempted to identify types of peer-support providers' logics of action by systematically analyzing providers' expressions of helping concerns, both general and case-specific. By helping concerns, we are referring to statements made by providers in which they expressed fears and apprehensions about help giving, either in general or in reference to a particular support relationship. When support providers discussed their concerns about help giving, they tended to turn their attention to their means and ends, thus revealing their logic of action. Interestingly, the support providers we interviewed discussed ends strictly in terms of the scope of their support objectives and means strictly in terms of the depth of their personal investment, suggesting that scope and depth may serve as exhaustive dimensions by which to categorize providers' logics of action. Thus, in contrast to tactics, providers' expressions of support concerns were grounded more in philosophical guidelines than in practical lines of action. We identified four mutually exclusive types of providers' logics of action, which we termed minimalist, efficient investor, generous egalitarian, and maximalist. Figure 2 shows the typology of these logics and lists the criteria used to code them by type.

Minimalist. Providers linking narrow, tactical ends with low cost, quick-fix (i.e., temporary or stop-gap) means adopted what we refer to as minimalist logics of action. Regardless of their helping goals, their primary focus was on the ability

Figure 2. The four types of providers' logics of action.

MEANS	ENDS: Narrow Tactical	ENDS: Broad Strategic
Low Cost	*Minimalist* Concerns focus on provider's ability to meet helping goals at the lowest personal cost; little concern for possible failure of helping relationship.	*Efficient Investor* Concerns focus on the prevention of provider exploitation. Personal investment in recipient matches incremental efforts by recipient.
High Cost	*Generous Egalitarian* Concerns focus on balancing the needs of one recipient with those of other recipients. Little concern for personal resource expenditures.	*Maximalist* Concerns focus on providing maximum degree of help, regardless of consequences for personal welfare.

to meet these goals at the lowest possible cost to their own material or emotional welfare. Thus, on one hand, they expressed concerns about the choice of people with whom to establish support relationships and how much to "invest" in these support relationships. On the other hand, they expressed little concern over the failure of support relationship to evolve, typically noting satisfaction with the fact that they "tried." In this sense, the concerns expressed by those providers holding minimalist logics of action appear to be provider-focused. Minimalist providers expressed concern about how the exertion of too much supportive energy might have posed a personal risk to them. As one such peer counselor told us, "You can actually wear yourself out with flight attendants. I mean, wear yourself out, because especially in the beginning you become obsessed and you tend to get into their lives when you don't need to be there." We found that providers expressing such concerns did not push support. Rather, they tended to rely on simply letting the recipient know that information and instrumental assistance (typically from others, to whom the provider referred the recipient) was available if and when the recipient wanted it. One peer counselor whom we categorized as having a minimalist logic of action described the following phone-based encounter with a flight attendant known to be a heavy drinker:

> I said, "But, you know, your friends are concerned, and even some people who aren't your friends are concerned. People have called me and voiced concern and it's only because they care about you and I care about you too." She said, "Well, I'm okay." She said, "I've been under a lot of stress, but I'm okay." I said, "Well, if things change in the future, you know I'm always available." She said, "I know, thank you for calling." And that was it. [Interviewer: And then, did she ever call you again?] No. No, she never called me and she still drinks.

This provider, like others holding a minimalist logic of action, appeared to be completely satisfied with her own limited attempt at helping and felt that she had done the most possible at the time.

Efficient investor. Providers linking broad, strategic ends with low-cost means adopt what we refer to as efficient-

investor logics of action. Unlike the minimalists, providers adopting this logic of action focused on balancing their own needs with those of a particular recipient. In this sense, these providers were cost-conscious help givers seeking to justify marginal increases in the amount of help invested on the basis of a recipient's response. They made incremental investments in the recipient on the basis of his or her response to earlier investments. In our data, this logic of action was manifested by providers' concerns about how the use of supportive resources needs to be met by a reciprocal response to justify continued personal investment in a particular recipient. Typically, providers with an efficient-investor logic of action expressed skepticism about the motivation of the recipient to enter into a support relationship and thus assumed that their efforts would not be matched by the recipient. Their concerns focused around the fear of being exploited and taken advantage of or, in the words of one peer counselor, being "a naive sucker." In this sense, their concerns also focused on the need either to minimize their own expenditure of energy or at least match incremental increases in their own support efforts with reciprocal increases in help seeking on the part of the recipient. One peer counselor expressing such concerns noted:

> They are being disciplined for having 19,000 late reports. The only reason they're on the phone with me is because they're about to lose their job for one reason or another. So unless I know the person and I know they're being honest with me, I go into every situation leery. I definitely am not co-dependent with them. I don't buy into their problems.

We found that, like minimalist providers, providers expressing the types of concerns described above (i.e., having an efficient-investor logic of action) did not push support. Unlike minimalist providers, however, efficient investors went beyond simply letting the recipient know that information and instrumental assistance were available if the recipient acknowledged an interest and expressed a willingness to "meet [the provider] halfway." Once they saw the recipient's compliance, their concerns were reduced, and they were willing to make further investments of their time and energy. This notion of compliance-based incrementalism was best illustrated in the comments of one peer counselor: "There have been people that I have gone to far more effort and trouble for than either one of these cases I've mentioned. People that I would continue to do anything for because they are helping themselves. They are doing what they know they need to do."

Generous egalitarian. Providers linking narrow tactical ends with high-cost means, requiring a substantial expenditure of personal resources, adopt what we refer to as a generous-egalitarian logic of action. Unlike efficient investors, providers adopting this logic of action voiced little concern about their own personal resource expenditures. Instead, their concerns focused on balancing the needs of one particular recipient with those of other potential or actual recipients. In this sense, while these providers were less apprehensive about the personal consequences of possible resource depletion (hence, the label generous), they did express concern about

expending a disproportionate amount of resources on any one recipient. In our data, this logic of action was illustrated by providers' concerns about how to provide just enough assistance to the maximum number of potential or actual recipients and how to avoid becoming so embedded in any one particular support relationship that they would be unable to provide assistance to others. For example, one MAP committee chairperson told us that because of her concern with the availability of adequate service to all those in need at her base, she always tried to stay aware of those who, by "abusing the system," might endanger the system for others. These concerns were particularly clear in her comments on the case of one particular recipient:

> He is just, he has a way of manipulating when he asks for help. This is a matter of a couple of years now of dealing with this guy. He asks for the help and then he really doesn't do much. He starts therapy and then he stops. It's almost like he, he's the kind of a person that I have to be careful with because he could really abuse the system. He could abuse the program and my time and my energy. So, I have to be careful.

We found that providers expressing concerns indicative of a generous-egalitarian logic of action, unlike minimalists, expressed a willingness to "push support," but only to the point at which any further resource expenditure might endanger the personal resources available for others in need. Like efficient-investor providers, generous egalitarians tended to describe patterns of helping in which support was provided only on the basis of the recipient's compliance. Unlike efficient investors, however, this incrementalism was often based on the need to reserve resources for those "who were serious." Generous egalitarians rarely provided support to a recipient above a threshold based on the needs of all recipients, regardless of a recipient's compliance. This notion of providing assistance on the basis of an implied balance between the needs of one recipient and those of other actual or potential recipients was best illustrated by one peer counselor who recalled telling one of her more recalcitrant clients,

> There is a large number of people that need help, that want help. I think you really do, but you've shown me no indication of that. I only have so much time. I'll work with you, but if you're not going to follow my suggestions, then you better look for help elsewhere. I don't have the time to make suggestions unless you follow through. When you're ready to do that, you call me.

Maximalist. Providers linking broad strategic ends with high-cost means adopt what we refer to as maximalist logics of action. These providers were concerned with providing the maximum degree of assistance to each needy recipient, often without regard to the consequences for their own welfare. To the extent that they had any concerns about the depletion of their personal resources in assisting needy recipients, these concerns were almost entirely recipient-based. Thus, a maximalist logic concerns reflected fears about "enabling," making the recipient "too dependent," or creating recipients that could never be psychologically prepared to handle the eventual termination of the support relationship. As one such peer counselor told us, "I remember

this one girl talking about how she took this TFA home. When you do something like that, all of a sudden they are your problem. And they are there for ten days, fifteen days, twenty days. Sometimes months. And then you're taking care of them, and that's not good for either you or them." Providers expressing concerns indicative of a maximalist logic of action expressed a willingness to "push support," even to the point at which it could endanger their own personal well-being or employment status. Unlike efficient investors and generous egalitarians, they rarely mentioned the notion of compliance, instead suggesting that they preferred to "give as much as it takes at the point at which it is necessary" to provide the maximum degree of assistance possible. Thus, one peer counselor expressing maximalist concerns described a situation in which she attempted to physically remove an impaired flight attendant from the company's premises, despite the fact that this was in direct violation of company regulations and may have jeopardized her own job:

> I said, this is your job. You've got to be honest with me. I want to help you but you have to tell me the truth. And I'm just looking at her. And then she says, yeah, I've been drinking. So I says, when did you drink? She says, like twenty minutes ago. And she just checked in for a flight? Now, I can't let her go on a flight. I can't do that, right? I mean, in every way she couldn't go. So, I came out and says, okay, I'm going to try and get you out of here. So, let me just see what I can do. I've got to try to get you out of here.

Antecedents of Providers' Logics of Action

Having identified four types of providers' logics of action, we examined how network size and providers' recovery experience might shape their logics. To examine the possible link between network size and providers' recovery experience, on one hand, and providers' logic of action, on the other, we first categorized support providers according to the logics of action implied by their support concerns by counting the number of times each of the four types of concerns (i.e., implied logic of action) was mentioned during the course of the interview. When 50 percent or more of the expressed concerns consistently implied a particular logic of action, we assigned this logic of action category to the provider. In the case of four providers, no single type of concern accounted for 50 percent or more of the expressions of concern identified, and we excluded the cases handled by these four providers from further analysis. Next, for each logic of action category, we counted the number of providers who were based in small versus large domiciles (network size) and who were in recovery versus those who were not (personal recovery experience).

Table 3 shows that 86 percent, or seven out of the eight peer providers based in small domiciles (i.e., having smaller social networks) and lacking any personal recovery experience tended to express concerns consistent with a maximalist or generous egalitarian logic of action. Table 3 also shows that 75 percent, or three out of the four providers based in large domiciles (i.e., having larger social networks) and having a

Table 3

Link between Logics of Action and Social Structure and Experience

	Recovery Status	
Domicile size	**Not in recovery (N = 14 providers)**	**In recovery (N = 10 providers)**
Small (N = 14 providers)	Minimalist = 0 Efficient investor = 1 Generous egalitarian = 1 Maximalist = 6	Minimalist = 0 Efficient investor = 2 Generous egalitarian = 2 Maximalist = 2
Large (N = 10 providers)	Minimalist = 2 Efficient investor = 1 Generous egalitarian = 3 Maximalist = 0	Minimalist = 1 Efficient investor = 2 Generous egalitarian = 0 Maximalist = 1

personal recovery experience tended to express concerns consistent with a minimalist or efficient-investor logic of action. Furthermore, although a clear pattern is less apparent for recovering providers in small domiciles and non-recovering providers in large domiciles, none of the recovering providers in small domiciles expressed concerns consistent with a minimalist logic of action. In addition, none of the non-recovering providers in large domiciles expressed concerns consistent with a maximalist logic of action.

These findings suggest that to the degree that support providers operate within social structures, their logics of action will, at least in part, be associated with their position in the relevant social structure. This may be because an actor's position in the relevant social structure constrains his or her choice of means and ends and, consequently, the cognitive linkage between the two. Providers' ends may be largely defined by the nature of their role, while their means may be constrained by the opportunities associated with that role. For example, providers can neither seek to achieve an end that is not sanctioned by their role (e.g., a work-based peer may be unable to reverse the disciplinary action taken against a colleague or violate a work rule to get a colleague out of trouble) nor select from a set of means that exceeds the resources at their disposal (e.g., provide the monthly mortgage payment to an addicted colleague). In short, structural characteristics such as the size of the provider's domicile limit the peer-support providers' choice of means and ends. The question then becomes what underlies actors' selections from among the limited number of means and ends they do have at their disposal?

One possibility is that actors' choices from among available ends will be influenced by their own predisposition. For example, providers in recovery, because of their own experience-based norms and values, are likely to emphasize a recipient's sobriety as their primary end over merely getting through an alcohol-related crisis. For them, crisis resolution may be only the first step in the achievement of long-term sobriety. In this sense, we may speak of the scope of social-support ends ranging from narrow, tactically oriented ends (e.g., crisis resolution) to broad, strategically oriented ends (e.g., achievement of sobriety). Similarly, actors' choices from among available means may be influenced by their personal resources (Hobfoll, 1988), such as knowledge, skills, and abil-

ities. Thus, providers in recovery may also be more likely to emphasize confrontation over education and referral as their primary means, on the basis of knowledge and skills gained from personal experience. In this sense, we may speak of the depth of support with means ranging from those demanding the investment of few personal resources (e.g., low-cost means such as telephone-based referral) to those demanding the more costly expenditure of valuable personal resources (e.g., face-to-face, emotional, confrontation-based interventions). Our data thus suggest four types of logics of action underlying the choice of boundary management tactics by support providers, as well as two possible determinants of such logics.

Link between Logics of Action and Boundary Management Tactics

Our data provide empirical grounding for the application of the two dimensions of providers' logics of action discussed above, namely, the short-term tactical to long-term strategic nature of providers' ends and the low- to high-cost nature of providers' means. To determine whether such a typology of providers' logics of action may be useful in explaining the variance in providers' boundary management tactics, we conducted one last, provisional analysis. Glaser and Strauss (1967) noted that such provisional analyses are often a critical intermediary step between theory generation and formal theory testing. We began by calculating for each support provider the number of cases discussed for which the strongest type of boundary management action mentioned was mild (i.e., tacit condition setting), moderate/hybrid (i.e., warning or avoiding), or strong (i.e., sanctioning).[1] Then, for each provider, depending on his or her implied logic of action, as determined in our earlier analyses, we calculated the percentage of cases discussed for which the strongest type of boundary management mentioned was mild, moderate/hybrid, or strong. The results of this analysis are presented in table 4, which depicts a breakdown of tactic types by logic of action.

Several interesting insights can be drawn from this table. First, of the 24 providers categorized on the basis of their expressed support concerns, maximalists emerged as the largest group and minimalists the smallest group. This may be, to a large extent, a function of self-selection. All of the support providers examined in this study had volunteered to serve as peer counselors and were well informed prior to the

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Because our interview data provided us with no basis for identifying avoidance tactics or warning tactics as being stronger or weaker than the other, the analysis that follows compares tactics along a continuum ranging from mild to strong, with avoidance and warning tactics clustered together as moderate/hybrid tactics between these two poles.

Table 4

Patterns of Boundary Management as Reported by Types of Providers (N = 24)

Providers' logic of action as indicated by dominant concern	Number of Cases and Strongest Action Used				
	Tacit condition setting	Warning	Avoiding	Sanctioning	Total no. of cases
Minimalists (N = 3 providers)	4 (44%)	1 (11%)	4 (45%)	–	9
Efficient investors (N = 6 providers)	6 (31.5%)	4 (21%)	2 (10.5%)	7 (37%)	19
Generous egalitarians	15 (68%)	3 (14%)	1 (4%)	3 (14%)	22
Maximalists	19 (86%)	1 (4%)	2 (9%)	–	22
Total cases	44 (61%)	9 (12.5%)	9 (12.5%)	10 (14%)	72

initiation of their work that participation in the MAP would place substantial demands on their time, emotions, and energy. Second, out of the 72 cases discussed by the 24 providers, in 44 of them (61 percent), the strongest boundary management tactic reported was mild (i.e., tacit condition setting). In only 10 cases (14 percent of the total number of cases) did providers report having applied strong tactics (i.e., sanctioning). This tendency to make do with mild or, at most, moderate/hybrid boundary management tactics (i.e., warning or avoiding) may be explained by the fact that even those peer counselors stating that they were prepared to implement stronger boundary management tactics noted that they actually adopted these tactics only after having first tried milder ones. Finally, table 4 shows how patterns of boundary management action varied depending on the provider's logics of action. Providers expressing concerns indicating a minimalist logic of action reported almost equal numbers of mild (i.e., tacit condition setting) and moderate/hybrid (i.e., warning and avoiding) boundary management tactics. Although we expected these providers to report the occasional application of strong boundary management tactics, they did not. It may be that as a consequence of their implied logic of action, these providers simply avoid taking on cases that might demand stronger types of boundary management tactics and, thus, rarely have the opportunity to use sanctioning or to confront recipients about the enforcement of boundaries. Another possible explanation is that by adopting milder boundary management tactics early on, providers with a minimalist logic of action rarely allow themselves to get involved in the types of support relationships in which the provider's control over the recipient is contingent on the use of strong (i.e., confrontational or enforcing) tactics only.

Similarly, providers expressing concerns indicative of a maximalist logic of action also appeared to eschew strong boundary management tactics. Yet, rather than reporting near equal numbers of mild and moderate/hybrid tactics, as did minimalists, maximalists reported an overwhelming use of mild boundary management: mild boundary management cases outnumbered hybrid boundary management cases by over six to one. Thus, as could be expected, given the nature of this logic of action, maximalists, to the degree that they do set boundaries at all, tend to take primarily non-confrontational, condition-setting actions.

Our results indicate that only those providers expressing concerns indicative of off-quadrant or hybrid logics of action (i.e., efficient investors and generous egalitarians) used strong boundary management tactics. One reason may be that, unlike minimalists, who may be less likely to enter into support relationships requiring stronger boundary management tactics in the first place, and maximalists, who have problems with boundary management altogether, efficient investors and generous egalitarians have a much greater need to exert control over support recipients. Such control is needed either to retain the balance between their own personal needs and those of their recipients (in the case of efficient investors) or to retain the balance between the needs of individual recipients and those of other potential or current recipients (in the

case of generous egalitarians). Even among these providers, however, the pattern of boundary management differs between those categorized as efficient investors and those categorized as generous egalitarians. While among the former, mild (tacit condition setting), strong (sanctioning), and hybrid (warning and avoiding) boundary management tactics appear with more or less equal frequency, among the latter, mild boundary management tactics (15 cases) were reported over twice as often as hybrid (three cases of warning and one avoiding case) and strong (three cases) tactics combined. One explanation for this finding rests on the assumption implied earlier: when providers set boundaries early on in a support relationship, limits are placed on the ability of the support relationship to develop, and, as a consequence, there are simply fewer opportunities for providers to adopt stronger boundary management tactics. If this is the case, then it makes sense that generous egalitarians, seeking to spread support resources across a wide population of recipients, rely on mild tactics to set boundaries earlier on in the support relationship and hence rarely need to adopt stronger tactics. Similarly, it explains why efficient investors, reluctant to enforce boundaries as long as recipients respond appropriately to their support efforts, report applying hybrid and stronger boundary management tactics as frequently as mild tactics. Their support relationships are more likely to develop to the point at which mild tactics are no longer sufficient to balance their own needs with those of the recipient, thus making stronger boundary management tactics necessary. Most importantly, the results reported in table 4 show that providers' logics of action are likely to be differentially associated with different patterns of boundary management tactics. These results suggest that providers' logics of action may offer predictive utility and may even serve as a latent mediator between social structure and providers' experience, on the one hand, and providers' action, on the other.

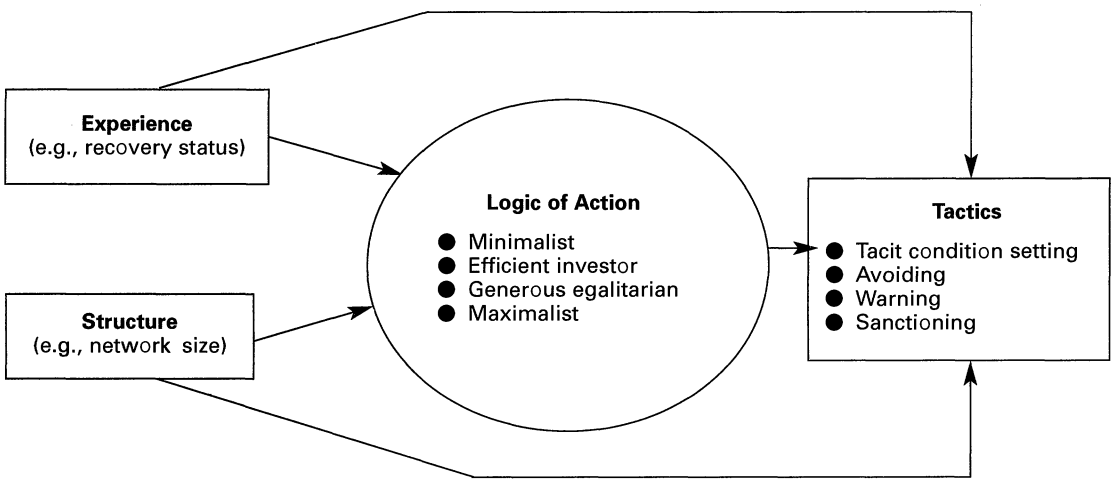
DISCUSSION AND CONCLUSION

We began this paper by arguing that the support provider in organizational support relationships has, for the most part, been neglected in organizational social-support research. Building on the assumption that support providers are tactical and reflective actors, we suggested that actors in such roles are faced with a difficult dilemma that revolves around the desire to elicit a recipient's compliance while not investing more emotional or temporal resources in the support relationship than intended. Implicitly, this dilemma reflects the kind of balancing act that support providers are constantly required to perform, balancing between inclusion and separation, dependence and autonomy, and, perhaps most importantly of all, between boundary breaking and boundary construction (or reconstruction). In our analysis, we examined three questions that emerge from such a framework. First, we examined the types of boundary management tactics social-support providers use in the course of their support relationships and identified four types: tacit condition setting, avoiding, warning, and sanctioning. Second, we examined some of the factors associated with, and potentially influencing, the adoption of specific types of boundary management

tactics and identified two primary sources of influence: social structure and providers' experience. Our analysis suggested that social structure determines the choices of means and ends available to support providers, that providers' experience serves as a primary determinant of providers' dispositions, and that the disposition of a support provider is itself the key factor influencing this provider's selection from among those choices of means and ends. Third, we explored why these factors might have such effects on providers' boundary management. We inferred from our data that the effects of social structure and providers' experience on providers' boundary management shape, and operate through, providers' logics of action, the cognitive systems of explanation underlying providers' actions. Using qualitative data, we showed how providers' logics of action (implied by the support concerns they expressed) may explain the link between social structure and providers' experience, on the one hand, and boundary management tactics, on the other.

Taken as a whole, our data thus suggest a process theory (Mohr, 1982) of boundary management tactics in peer-support relationships. Unlike a variance theory, a process theory focuses on discrete events and states and seeks to show how a phenomenon unfolds. A process model thus contains a chain of events, a set of steps or stages, with each stage serving as a necessary precursor to the next one. According to this process theory, which is represented in figure 3, support providers in organizations will select tactics for managing the boundaries between themselves and the recipient using a cognitive frame or logic of action. While program training sessions and early helping experiences may play an important role in providing a foundation upon which such logics are based, our data suggest that such logics are also strongly influenced by the provider's own experience and the social structure in which the provider operates. Providers' experiences are important because they are the basis of the basic helping heuristics that are then carried to the MAP. The social structure is important because structural constraints and limitations play a key role in providers' post-hoc sensemaking of individual cases. As noted above, it is through such sense-

Figure 3. A process model of boundary management tactics in peer-support relationships.



making processes that providers transform these basic helping heuristics into a more stable logic or epistemology about the nature of the organizational helping process. Subsequently, these logics themselves serve as frames through which providers are able to make sense of the situations and cases they confront. Given the centrality of both providers' experience and social structure in the emergence of helping logics, we may posit that two support providers operating in a similar organizational context and sharing similar experiences will be likely to adopt a similar logic of action when faced with the same type of case. Furthermore, we may posit that the adoption of a similar logic of action will result in providers adopting similar tactics for managing the boundaries between themselves and the help recipient.

Beyond providing insight into the nature of support providers' boundary management, our analysis also helps shed some light on micro-macro linkages in general and the relationship between structure and action in particular (Alexander et al., 1987). Our data suggest that organizational actors (in this context, peer-support providers) are constrained by the cognitive frame (logic of action) that they use to make sense (Weick, 1995) of their potential action, as well as by the structural context in which they operate (size of social network and experience). Thus, while our paper specifically concerns boundary management in peer-support relationships, it also addresses one of the most basic theoretical issues in any organizational analysis: the notion that structure constrains tactical actions through the mediating factor of cognition.

There are a number of limitations to the current study, however. First, nearly all of the data analyzed were retrospective: rather than observe actual support interactions, we asked providers to provide accounts of past support interactions. To the degree that such retrospective accounts may reflect systematic biases, many of the patterns we observed and, for example, attributed to the variance in providers' logics of action, may be spurious. In the future, researchers may wish to observe or inconspicuously record these interactions to eliminate such potential biases. Given the intimate and highly personal nature of many organizational support interactions, however, any ethical design based on real-time observation is likely to introduce its own biases. A second limitation of the study concerns the generalizability of our conclusions, given that we focused on flight attendants volunteering as support providers in a formalized peer-support program and that we discussed one particular type of cases, those having to do with substance abuse. On the one hand, by focusing on providers assisting peers with substance abuse issues in a formal peer-support program, we used a somewhat extreme case to bring differences in styles and strategies into bold relief (Miles and Huberman, 1984: 238). On the other hand, more mainstream cases of peer-based support abound, such as those in which peers assist one another with other less life-threatening issues (e.g., job stress, child care, elder care), or in which peer support is provided outside of the framework of a formal peer-support program. We believe, however, that the particular relevance of boundaries as socially con-

structed structures extends beyond the specific empirical case presented in this analysis. For instance, the perspective offered in this paper could be applied as easily to other support frameworks (such as mentoring, coaching, peer reviews, peer counseling, or crisis intervention) or any power-dependence relationship that involves strong affect. Just how generalizable the above results are with respect to more mainstream work contexts is an empirical question that goes beyond the realm of this paper and that demands further exploration.

Despite these limitations, the analysis discussed above and the theoretical framework it generated suggest that greater attention needs to be paid to the role of the peer-support provider and, in particular, to the antecedents and consequences of the tactics adopted by individuals as reflective actors in their day-to-day organizational support interactions. For organizations placing increased reliance on the role of peer support as a key element of their organizational culture, there is an inevitable dilemma. On the one hand, these organizations need to ensure the coordination and quality of peer-support activities. On the other hand, these organizations need to offer support providers enough flexibility so that they can both provide recipients with quality support and not overinvest in the relationship. In terms of boundary management, this means that organizations may have to require strong boundary tactics from their members under certain circumstances and emphasize the need for milder boundary tactics in others. Knowing when, with whom, and how to do so requires a far better understanding of the dynamics of boundary management and organizational peer-support relations than we currently have.

Finally, social structures are sustained by the institutionalized social interactions that occur among organizational members (Berger and Luckmann, 1968). By focusing on boundary tactics, we are suggesting the importance of examining the micro-sociological underpinnings (Scheff, 1990; Goffman, 1967) of social structure in organizations. Our findings about the enactment and maintenance of boundaries by support providers in organizations lends further credence to the notion that it may be more accurate to view structures not simply as reified entities (Silverman, 1970) but as composites of actions and cognitions that become stabilized and destabilized through interaction (Barley, 1986; Weick, 1995). In a world in which loose coupling in organizations is becoming more and more prevalent, it is often difficult to constrain the behavior of individual actors through highly prescribed role relations with precise rules and procedures. Consequently, the tactical management of boundaries among actors becomes an integral part of organizational life, deserving further exploration and analysis.

REFERENCES

Alexander, J., B. Giesen, R. Munch, and N. Smelser (eds.)
1987 The Micro-Macro Link. Berkeley, CA: University of California Press.

Anderson, J.
1991 "Stress and burnout among nurses: A social network approach." Journal of Social Behavior and Personality, 6: 251–272.

Bacharach, S., P. Bamberger, and B. Mundell
1995 "Strategic and tactical logics of justification: Power and decision criteria in organizations." Human Relations, 48: 1–22.

Bacharach, S., P. Bamberger, and W. Sonnenstuhl
1996 "The organizational transformation process: The micropolitics of dissonance reduction and the alignment of logics of action." Administrative Science Quarterly, 41: 477–506.

Bakan, D.
1966 The Duality of Human Existence: Isolation and Commitment in Western Man. Boston: Beacon Press.

Bamberger, P., A. Kluger, and R. Suchard
1999 "Antecedents and consequences of union commitment: A meta-analysis." Academy of Management Journal, 42: 304–325.

Barley, S.
1986 "Technology as an occasion for structuring: Evidence from observation of CT scanners and the social order of radiology departments." Administrative Science Quarterly, 31: 78–108.

Barling, J., C. Fullagar, and K. Kelloway
1992 The Union and Its Members: A Psychological Approach. New York: Oxford University Press.

Beehr, T.
1985 "The role of social support in coping with organizational stress." In T. Beehr and R. Bhagat (eds.), Human Stress and Cognition in Organizations: An Integrated Perspective: 375–398. New York: Wiley.

Berger, P., and T. Luckmann
1968 The Social Construction of Reality. Garden City, NY: Anchor Press.

Blau, G.
1981 "An empirical investigation of job stress, service length and job strain." Organizational Behavior and Human Performance, 27: 279–302.

Brief, A., and S. Motowidlo
1986 "Prosocial organizational behavior." Academy of Management Review, 11: 710–725.

Caplan, R., S. Cobb, J. French, R. Harrison, and S. Pinneau
1975 Job Demands and Worker Health. U.S. Department of Health, Education, and Welfare Publication No.75–160, Institute for Social Research. Washington, DC: U.S. Government Printing Office.

Carkhuff, R.
1969 Helping and Human Relations, vol. 2. New York: Holt, Rinehart and Winston.

Cohen, A.
1985 The Symbolic Construction of Community. London: Tavistock.

Cohen, S., and T. Wills
1985 "Stress, social support and the buffering hypothesis." Psychological Bulletin, 92: 257–310.

Collins, R.
1988 Theoretical Sociology. New York: Harcourt Brace Jovanovich.

Cooper, C., and R. Payne
1988 Causes, Coping, and Consequences of Stress at Work. Chichester, U.K.: Wiley.

Coyne, J., and D. Smith
1991 "Couples coping with a myocardial infarction: A contextual perspective on wives' distress." Journal of Personality and Social Psychology, 61: 404–412.

Czarniawska-Joerges, B.
1992 Exploring Complex Organizations: A Cultural Perspective. Newbury Park, CA: Sage.

DiMaggio, P. J.
1994 "Culture and economy." In N. J. Smelser and R. Swedberg (eds.), The Handbook of Economic Sociology: 27–57. Princeton, NJ: Princeton University Press.

Ducharme, L .J., and J. K. Martin
2000 "Unrewarding work, coworker support, and job satisfaction." Work and Occupations, 27: 223–243.

Ducker, J.
1983 Men of the Steel Rails: Workers on the Atchison, Topeka and Santa Fe Railroad, 1869–1900. Lincoln, NE: University of Nebraska Press.

Fenlason, K., and T. Beehr
1994 "Social support and occupational stress: Effects of talking to others." Journal of Organizational Behavior, 15: 157–175.

Fried, Y., and R. Tiegs
1993 "The main effect model versus buffering model of shop steward social support: A study of rank-and-file auto workers in the U.S.A." Journal of Organizational Behavior, 14: 481–493.

Ganster, D., M. Fusilier, and B. Mayes
1986 "Role of social support in the experience of stress at work." Journal of Applied Psychology, 71: 102–110.

George, J., and A. Brief
1992 "Feeling good—doing good: A conceptual analysis of the mood at work-organizational spontaneity relationship." Psychological Bulletin, 112: 310–329.

Giddens, A.
1993 New Rules of Sociological Method, 2d ed. Stanford, CA: Stanford University Press.

Glaser, B., and A. Strauss
1967 The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldine.

Goffman, E.
1967 Interaction Ritual: Essays on Face-to-Face Behavior. New York: Doubleday: Anchor Books.
1974 Frame Analysis: An Essay on the Organization of Experience. New York: Harper and Row.

Gutheil, T., and G. Gabbard
1993 "The concept of boundaries in clinical practice: Theoretical and risk-management dimensions." American Journal of Psychiatry, 150: 188–196.

Heider, F.
1944 "Social perception and phenomenological causality." Psychological Review, 51: 358–374.

Hobfoll, S. E.
1988 The Ecology of Stress. New York: Hemisphere.

Hochschild, A.
1983 The Managed Heart: Commercialization of Human Feeling. Berkeley, CA: University of California Press.

House, J. S., D. Umberson, and K. R. Landis
1988 "Structures and processes of social support." In Annual Review of Sociology, 14: 293–318. Palo Alto, CA: Annual Reviews.

Huebner, E.
1993 "Professionals under stress: A review of burnout among the helping professions with implications for school psychologists." Psychology in the Schools, 30: 40–49.

Ickes, W., W. Tooke, L. Stinson, V. Baker, and V. Bissonnette
1988 "Naturalistic social cognition: Intersubjectivity in same-sex dyads." Journal of Nonverbal Behavior, 12: 58–84.

Kahn, W.
1990 "Psychological conditions of personal engagement and disengagement at work." Academy of Management Journal, 33: 692–724.
1993 "Caring for the caregivers: Patterns of organizational caregiving." Administrative Science Quarterly, 38: 539–563.

Kaufman, G., and T. Beehr
1986 "Interactions between job stressors and social support: Some counterintuitive results." Journal of Applied Psychology, 71: 522–526.

Lee, R., and B. Ashforth
1993 "A further examination of managerial burnout: Toward an integrated model." Journal of Organizational Behavior, 14: 3–20.

Leiter, M.
1991 "Coping patterns and predictors of burnout: The function of control and escapist coping patterns." Journal of Organizational Behavior, 12: 123–144.

Merleau-Ponty, M.
1945 Phénoménologie de la perception. Paris: Gallimard.

Meyerson, D.
1994 "Interpretations of stress in institutions: The cultural production of ambiguity and burnout." Administrative Science Quarterly, 39: 628–653.

Miles, M., and A. Huberman
1984 Qualitative Data Analysis. Beverly Hills, CA: Sage.

Mohr, L.
1982 Explaining Organizational Behavior. San Francisco: Jossey-Bass.

Montgomery, D.
1979 Workers' Control in America: Studies in the History of Work, Technology, and Labor Struggles. Cambridge: Cambridge University Press.

Moorman, R.
1991 "Relationship between organizational justice and organizational citizenship behaviors: Do fairness perceptions influence employee citizenship?" Journal of Applied Psychology, 76: 845–855.

Murray, M.
1991 Beyond the Myths and Magic of Mentoring: How to Facilitate an Effective Mentoring Program. San Francisco: Jossey-Bass.

Organ, D.
1988 Organizational Citizenship Behavior: The Good Soldier Syndrome. Lexington, KY: Lexington Books.

Perlow, L.
1998 "Boundary control: The social ordering of work and family time in a high-tech corporation." Administrative Science Quarterly, 43: 328–357.

Pruchno, R., and N. Resch
1989 "Mental health of caregiving spouses: Coping as mediator, moderator, or main effect?" Psychology and Aging, 4: 454–463.

Rafaeli, A.
1989 "When cashiers meet customers: An analysis of the role of supermarket cashiers." Academy of Management Journal, 32: 245–273.

Rafaeli, A., and R. I. Sutton
1987 "Expression of emotion as part of the work role." Academy of Management Review, 12: 23–37.

Sarason, I., H. Levine, R. Basham, and B. Sarason
1983 "Assessing social support: The social support questionnaire." Journal of Personality and Social Psychology, 44: 127–139.

Sarason, I., B. Sarason, and E. Shearin
1986 "Social support as an individual difference variable: Its stability, origins, and relational aspects." Journal of Personality and Social Psychology, 50: 845–855.

Schauebroeck, J., and L. Fink
1998 "Facilitating and inhibiting effects of job control and social support on stress outcomes and role behavior: A contingency model." Journal of Organizational Behavior, 19: 167–195.

Scheff, T.
1990 Microsociology: Discourse, Emotion, and Social Structure. Chicago: University of Chicago Press.

Schnake, M.
1991 "Organizational citizenship: A review, proposed model, and research agenda." Human Relations, 44: 735–759.

Silverman, D.
1970 The Theory of Organisations: A Sociological Framework. London: Heinemann.

Stone, F.
1999 Coaching, Counseling and Mentoring: How to Choose and Use the Right Technique to Boost Employee Performance. New York: AMACOM.

Strauss, A.
1987 Qualitative Analysis for Social Scientists. New York: Cambridge University Press.
1993 Continual Permutations of Action. New York: de Gruyter.

Strauss, A., and J. Corbin
1990 Basics of Qualitative Research: Grounded Theory, Procedures and Techniques. Newbury Park, CA: Sage.

Thoits, P.
1986 "Social support as coping assistance." Journal of Consulting and Clinical Psychology, 54: 416–423.

Thompson, S., and J. Pitts
1992 "In sickness and in health: Chronic illness, marriage, and spousal caregiving." In S. Spacapan and S. Oskamp (eds.), Helping and Being Helped: Naturalistic Studies: 115–151. Newbury Park, CA: Sage.

Tornow, W., and M. London
1998 Maximizing the Value of 360-Degree Feedback: A Process for Successful Individual and Organizational Development. San Francisco: Jossey-Bass.

Turner, R. J., B. G. Frankel, and D. M. Levin
1983 "Social support: Conceptualization, measurement, and implications for mental health." Research in Community and Mental Health, 3: 67–111.

Van Dyne, L., and J. LePine
1998 "Helping and voice extra-role behaviors: Evidence of construct and predictive validity." Academy of Management Journal, 41: 108–119.

Wall Street Journal
2000 "An overlooked toll of job upheavals: Valuable friendships." Jan. 12: B1.

Weber, M.
1947 The Theory of Social and Economic Organization. Trans. A. M. Henderson and T. Parsons. New York: Oxford University Press. (Reprinted New York: Free Press, 1964.)

Weick, K.
1979 "Cognitive processes in organizations." In B. M. Staw and L. L. Cummings (eds.), Research in Organizational Behavior, 1: 41–79. Greenwich, CT: JAI Press.
1995 Sensemaking in Organizations. Thousand Oaks, CA: Sage.