© *Academy of Management Journal*
2017, Vol. 60, No. 2, 642–670.
https://doi.org/10.5465/amj.2014.0101

"DANCING ON HOT COALS": HOW EMOTION WORK FACILITATES COLLECTIVE SENSEMAKING

EMILY D. HEAPHY
University of Rhode Island

While organizations and researchers have traditionally conceptualized customers as consumers of their services and products, there is a growing recognition that organizations need to develop more collaborative relationships with clients. In this research, I explore one implication of this shift—how employees respond to client conflicts. In a multi-method qualitative study, I studied patient advocates, hospital employees who mediate conflicts between patients, families, and staff. I develop a process model that shows how mediators construct a web of discrete social interactions that, over time, enables them to develop an empathetic account of the conflict. They then selectively deploy the account to engage in sensegiving. The process model integrates research on emotions and sensemaking in novel ways. I identify how emotion work triggers emotion dynamics in interactions that facilitate or disrupt sensemaking and sensegiving. I show how plausible accounts are developed over the course of social interactions and that mediators pivoted from sensemaking to sensegiving when the account was characterized by empathy. Overall, this research shows how mediators actively generate, interpret, and influence their own and others' emotions, and that mediators' emotion work contributes to the success of collective sensemaking.

> It's important to understand the technicalities of the work because it's like we have a credibility gap. It's like a dance . . . Once they understand that we are here to help, usually they come around. But we don't want to escalate the patients, and we don't want to alienate the staff. It's like a dance—sometimes we're dancing on hot coals. And some days the patient will hang up on you, and the so-called health care professional does the same thing, and then we're really the monkey in the middle. *Patient Advocate*

There is growing recognition that the nature of the relationship between organizations and their clients is changing (Barrett, Davidson, Prabhu, & Vargo, 2015; Bowen, 2016:36). While clients traditionally have been viewed as recipients or consumers of organizations' services and products, organizations and scholars alike are recognizing that organizations need to develop more collaborative relationships with their clients (Adler, Kwon, & Heckscher, 2008; Gittell & Douglass, 2012). One implication of this shift is a need to be responsive to the problems and conflicts clients experience with organizations, taking seriously that long-acknowledged but seldom-reached potential that problems may signal opportunities for learning and improvement (Edmondson, 1996; Tucker, Edmondson, & Spear, 2002).

Yet, most of what we know about how organizations respond to problems and conflicts with clients is based on assumptions associated with the clients-as-consumers perspective, in which organizations try to control client problems and minimize any disruptions to the organization via routinization (Cunha, Clegg, & Kamoche, 2006). In this line of research, routinization involves "creating sets of tasks that can go forward without significant decision-making on the part of

I appreciate the generous feedback I received on this manuscript from Jane Dutton, Michel Anteby, Marlys Christianson, Elana Feldman, Stine Grodal, Jacoba Lilius, Erin Reid, Bess Rouse, Špela Trefalt, Tim Vogus, Editor Elaine Hollensbe, and three anonymous reviewers. Elana Feldman, Brandy Booth, Moira Killoran, and Steven Shafer provided critical research assistance. This manuscript has benefited from the constructive feedback of audiences at Cornell's OB/ILR Colloquia Series, McGill University, University of Rhode Island, the Academy of Management Meetings, May Meaning Meeting, UC Davis Conference for Qualitative Research, PROS Conference, and the Wharton OB Conference. The author is also grateful to Lloyd Sandelands, Karen Staller, Rick Bagozzi, and Julia Adams for input on my dissertation, on which this project is based. This research was supported by a grant from Blue Cross Blue Shield of Michigan and the University of Michigan's Public and Nonprofit Center. I am grateful for the time and consideration extended by my informants in the patient advocate community.

either workers or higher authorities" (Stinchcombe, 1990; Leidner, 1993: 28). Scholars have identified a number of processes through which organizations routinize the handling of client problems, such as scripting interactions between service workers and clients (Leidner, 1993), designing procedures to minimize anticipated controversies (Elsbach, Sutton, & Principe, 1998), and selecting and training service workers to control clients through emotional labor (Hochschild, 1983; Sutton, 1991).

If clients and organization members alike expect and are moving toward relationships that are more collaborative and responsive, how might organizations respond to the conflicts clients experience in organizations? There are indications in empirical research that frontline service employees escalate problems to managers for more careful attention when emotions run high (Goffman, 1952; Mintzberg, 1973; Pentland, 1992), but how these managers then *respond* is not typically the focus of these studies (for an exception, see Karambayya & Brett, 1989). Recent theorizing has suggested specialized roles may be appropriate for this work. Gittell and Douglass (2012) suggested that cross-role conflict resolution structures could assist by "providing a systematic way to articulate and accommodate multiple points of view." Lilius, Kanov, Dutton, Worline, and Maitlis (2012) suggested that organizations could institutionalize responses to client suffering via designated compassion-providing roles. And indeed, there is evidence that some organizations, recognizing the complexity and potential value of providing greater attention to clients experiencing problems—as well as the time, effort, and skill required—enlist people to engage in mediating work in response to client conflicts in the organization as a central part of their work role (Morrill & Rudes, 2010).

Mediating work involves providing assistance to interacting parties while not being directly involved, and lacking formal power to compel outcomes (Kolb, 1985; Wall & Dunne, 2012). Employees engaged in mediating work help clients who are experiencing conflicts with the organization, where *conflict* is defined as a real or perceived difference that arises in specific organizational circumstances and that engenders emotion as a consequence (Kolb & Bartunek, 1992). Ombuds, mediators, consultants, and public editors are examples of specialized roles that provide a formal organizational outlet for clients experiencing conflict with, or in, the organization (Morrill & Rudes, 2010).

Our existing accounts of how organizations handle client conflicts focus on routinization, which emphasize *removing* decision-making from employees (Leidner, 1993), and are not well-suited to theorizing about how conflict is handled by mediators attempting to be *responsive* to client conflicts. Mediators, as third parties to conflicts, face at least some degree of ambiguity or equivocality about a clients' conflict. As a result, while there may be important ways we can build on past research—namely the importance of emotion management given the emotion inherent in conflict—we need to account for the more active discernment and participation required to mediate client conflicts.

One perspective that can elucidate how mediators intervene in client conflicts is sensemaking. Sensemaking occurs when people confront ambiguity, equivocality, or surprise, and ask, "What's the story here? Now what do I do?" (Weick, Sutcliffe, & Obstfeld, 2005). It sheds light on the processes through which people construct meaning and produce joint action—or fail to do so—when faced with situations or ambiguity, equivocality, or surprise. As such, sensemaking is well suited to help us understand how mediators intervene in client conflicts. Yet the sensemaking perspective is only beginning to address emotions (Maitlis & Christianson, 2014; Sandberg & Tsoukas, 2014), a central consideration of the phenomenon of interest here.

In this paper, I investigate patient advocates, hospital employees whose specialized role involves intervening in conflicts between patients, their families, and hospital staff. My findings show how emotion work and the cognitive work of sensemaking and sensegiving influence one another both within interactions and across the multiple interactions required to respond to client conflicts. I develop a process model that shows how mediators engage in sensemaking interactions that enable them to develop an empathetic account of the conflict; they then selectively draw from the empathetic account to engage in sensegiving. More broadly, I identify how emotion work triggers emotion dynamics in interactions that facilitate, or disrupt, sensemaking and sensegiving. I show how plausible accounts are developed over the course of social interactions, and that mediators pivoted from sensemaking to sensegiving when the account was characterized by empathy. Overall, this research shows the critical ways in which emotion work and emotion dynamics contribute to the success or failure of collective sensemaking.

EMOTION WORK AND THE ROUTINIZATION OF CLIENT PROBLEMS

Given the centrality of clients to organizations, an important yet challenging task for organizations is to

respond to customers and clients when they experience problems with the organization and the services it provides. Research on interactive service work has shown that organizations go to great lengths to try to routinize the handling of customer problems (Hochschild, 1983; Leidner, 1993; Sutton, 1991). A foundational element of this work is a focus on interpersonal encounters between frontline employees and the clients experiencing problems, with a particular emphasis on strategies of emotion regulation (see Wharton, 2009 for a review).

Emotion regulation involves efforts to control one's own emotions, including "which emotions one has, when one has them, and how one experiences or expresses these emotions" (Gross, 2014: 6). Emotion regulation is important to the handling of customer conflicts because it can influence how other people feel, think, and engage with others (Wharton & Erickson, 1993). When customers experience distress, emotion regulation can help to make the others' emotions more manageable and enable social interactions to unfold in predictable ways (Ashforth & Humphrey, 1993; Dougherty & Drumheller, 2006). For example, pediatricians express and generate feelings of fun when working with patients and their families, shifting clients' emotions from anxious and fearful to reassured or even joyful (Locke, 1996).

Display rules govern emotion regulation and can vary depending on the social situation, reflecting organizational, professional, or social norms (Bolton & Boyd, 2003). Display rules vary in how prescriptive they are (Lopez, 2006; Martin, Knopoff, & Beckman, 1998). Most research on how employees respond to client problems involves *emotional labor*, which occurs when there are specific and narrow display rules regarding emotion regulation (Hochschild, 1983). When display rules are narrowly prescribed, variations from these norms can be punished (Yagil & Medler-Liraz, 2013). When employees have autonomy in how they engage with their emotions, this is referred to as *emotion work* (Bolton, 2000; Zapf, 2002). Evidence of emotion work is often found in caregiving work, such as nursing and midwifery (Benner, Tanner, & Chesla, 1996; Hunter, 2001). For example, Lopez (2006) showed, in his study of nursing homes, that some organizations provided support for their workers' emotional authenticity in relationships, in that they set broad limits on acceptable relationships (e.g., abuse and neglect were unacceptable), but did not dictate the emotional content of the relationships.

Despite the voluminous research on the interactive service work and emotion regulation, notably absent from this literature is attention to the employees' sensemaking processes about the underlying problem or conflict. This is consistent with Hochschild's (1983: 113) original focus, where "managing feeling was taken as the problem. The causes of anger were not acknowledged as part of the problem." Even in studies of detectives and physicians (Locke, 1996; Smith & Kleinman, 1989; Stenross & Kleinman, 1989), for whom some degree of sensemaking would appear to be central, the relation between sensemaking and emotion regulation has not yet been addressed.

SENSEMAKING AND SENSEGIVING

Sensemaking is a dynamic, reciprocal process through which individuals and groups work to understand ambiguous, equivocal, or novel situations (Weick et al., 2005). Scholars have identified three "sensemaking moves": noticing or perceiving cues, creating interpretations of those cues, and acting on those interpretations to attempt to create or restore order (Maitlis & Christianson, 2014; Sandberg & Tsoukas, 2014). Through sensemaking, people try to develop accounts, or discursive constructions of reality that interpret or explain (Antaki, 1994; Maitlis, 2005). They then draw on these accounts—the sense they have constructed—to engage in sensegiving. *Sensegiving* is a process in which individuals attempt to influence the sensemaking of others (Gioia & Chittipeddi, 1991; Maitlis & Lawrence, 2007; Sonenshein, 2010).

Sensemaking that occurs in organizations is referred to as *collective sensemaking*, as it unfolds among multiple stakeholders who exchange provisional understandings and try to construct an interpretation and course of action (Stigliani & Ravasi, 2012; Weick et al., 2005). Thus, collective sensemaking is a social process in which stakeholders engage in sensemaking and sensegiving (Maitlis, 2005). For example, Gioia and Chittipeddi (1991) found that leaders moved between phases of sensemaking and sensegiving as they initiated a strategic change. Members of a collective need not share the same meaning; indeed, they may have equivalent or overlapping meanings (Kendra & Wachtendorf, 2006; Weick et al., 2005). Studies of middle managers (Balogun, Bartunek, & Do, 2015; Balogun & Johnson, 2004, 2005; Rouleau & Balogun, 2011), change agents (Bartunek, Balogun, & Do, 2009; Huy, 2002, 2011), and most trusted advisors in family firms (Strike & Rerup, 2016) have found that such roles, that move between stakeholder groups, can be influential in constructing and deploying meaning. Collective sensemaking is considered successful if it enables coordinated action (Weick, 1995).

Organizational scholars who study sensemaking have historically emphasized how language and discursive practices—that is, written and spoken communication—shape the creation of joint understandings (Maitlis & Christianson, 2014; Sandberg & Tsoukas, 2014). Scholars have also emphasized the importance of social interactions in which sensemaking occurs. Who participates in sensemaking and the dynamics that characterize their interactions critically influence the accounts that develop and the action that is enabled (Balogun et al., 2015; Balogun & Johnson, 2004, 2005; Maitlis, 2005). We know less about the role of emotions—so central to our understanding of how organizations respond to client problems through interactive service work—in sensemaking and sensegiving.

What we do know about sensemaking and emotion has primarily focused on the effect of intense, negative emotions that accompany crisis situations, a phenomenon commonly studied in sensemaking research. This research has shown that when emotions are intense and negative (e.g., panic, fear, anxiety), they consume cognitive capacity, detract from the ability to attend to cues in the environment and update interpretations, thereby derailing people from engaging in the effortful work of sensemaking (Maitlis & Sonenshein, 2010). Intense, negative emotions also spread through groups through processes of emotional contagion (Barsade, 2002; Hatfield, Cacioppo, & Rapson, 1992), disrupting social relations (Weick, 1993), and triggering escalation of commitment to—sometimes tragically faulty—frames (Cornelissen, Mantere, & Vaara, 2014). In short, like the classic study illustrating these dynamics (i.e., Weick, 1993), intense, negative emotions spread like wildfire, destroying the possibility of sensemaking in their wake.

Scholars are beginning to theorize about and empirically examine the role of emotions in a broader array of sensemaking contexts. For example, felt emotions can serve as cues for individuals to interpret. Maitlis, Vogus, and Lawrence (2013) theorized that when felt emotions are consistent with one's interpretation and action orientation, this congruence can signal that an account is plausible. Felt emotions can also influence whether individuals are open to noticing and perceiving cues. While we know that individuals experiencing intense, negative felt emotions have difficulty engaging in sensemaking, Vogus, Rothman, Sutcliffe, and Weick (2014) theorized that when individuals experience emotional ambivalence (e.g., hope and doubt) they are more open to alternative perspectives.

Expressed emotions, which include words, facial expressions, body languages and movement (Ekman, 1992; Keltner & Haidt, 1999), can also serve as important cues about *others'* experiences and interpretations (Dougherty & Drumheller, 2006). Managers and change consultants who attend to change recipients' expressed emotions, for example, can use others' expressed emotions as cues to interpret how change is being experienced (Huy, 2002, 2011). Expressed emotions can also be strategically deployed in sensegiving (Maitlis & Sonenshein, 2010). Rouleau (2005) found that middle managers masked their negative emotions and expressed positive emotions to convince clients to be enthusiastic about a firm's new direction and attempted to intentionally spread positive emotions through processes of contagion.

While these studies have laid an important foundation for understanding the role of sensemaking and emotions, there are several limitations to how emotions might influence the sensemaking and sensegiving of employees intervening in client problems. *First,* previous research suggests that the amplification of intense negative emotions is disruptive to individual and collective sensemaking, but if employees confront or experience intense, negative emotions—as they might when facing a client problem—it is not clear how they might intervene to not just control others, but create opportunities for sensemaking and sensegiving. *Second*, while we know that expressed emotions and felt emotions can be valuable cues for sensemaking, it is unclear how an employee might access those cues. Recent research suggests that when employees have long-standing personal relationships with clients, they can use their knowledge to influence others' sensemaking (Strike & Rerup, 2016). However, when deep emotional and relational knowledge of clients does not exist, it is less clear how employees would be able to insert themselves into sensemaking or sensegiving interactions, make use of the potential cues that emotions can provide, and more generally intervene in a process of collective sensemaking. *Third,* studies of interactive service work have featured emotional labor, emphasizing the influence it has on client's emotional expressions and the employees' well-being and burn-out (Grandey & Gabriel, 2015). While undoubtedly important outcomes, this research does not tell us what kind of emotion work might facilitate employees' sensemaking and sensegiving. By studying how employees engage in mediating work about client conflicts with the organization, this study presents an opportunity to advance theory about the role of emotions in sensemaking.

METHODS

Research Context

To gain insight into how employees engage in mediating work about client conflicts in organizations, I studied patient advocates, or those hospital employees who handle emergent problems related to patient care and service in hospitals. They engage in mediation (American Hospital Association, 2002; Charters, 1993), in that they provide assistance to two or more interacting parties but lack formal power to prescribe agreements or enforce outcomes (Kolb, 1985; Lewicki, Weiss, & Lewin, 1992; Wall & Dunne, 2012). Patient advocates are known by a number of different job titles, including patient representative, ombudsman, and patient coordinator. They respond to patient, family member, and staff problems that cannot, or for some reason are not, handled through routine organizational processes. These problems are disruptive to one or more persons involved, causing some kind of conflict requiring mediation. Some are relatively straightforward, while others require extensive work to gain understanding and to resolve. (Table 1 shows conflicts as they were initially presented to patient advocates.)

First developed in the United States in the 1960s, the role was designed to provide a broad range of patients the opportunity to voice problems and achieve recourse for the problems they experienced while in the hospital's care (Mailick & Rehr, 1981). Over time, as formal mechanisms to monitor patient rights developed (e.g., Health Insurance Portability and Accountability Act of 1996, Joint Commission on Accreditation of Healthcare Organizations), patient advocate roles have become part of hospitals' institutionalized grievance mechanisms (Charters, 1993). Patient advocates keep records of a patient's or family member's problem and of how it was handled. These records can be used in formal legal actions or investigations that might be brought against the hospital.

Patient advocates intervene in emergent and unfolding conflicts among patients, families, and staff, but are not a party to the problem itself. Patients, families, or staff can call, write emails or letters, or walk in to patient advocates' offices, requesting assistance. As required by the hospitals' regulatory bodies, patient advocates have specific time frames to communicate a resolution or an update to patients and families who brought a problem to the office. Patient advocates in my sample represented and reported to the CEO or Medical Director.

Consistent with the logic of purposeful sampling, patient advocates provide transparency, that is, a relatively uncluttered view into the phenomenon of theoretical interest (Yin, 2009)–in this case, sensemaking and emotions. First, patient advocates engage in sensemaking as a central part of their work. For organizations in which the products and processes are subjective, the construction, and management of meaning is a central component (Maitlis, 2005). Patient advocates work in an industry–healthcare–in which the quality of care and service has a strong subjective component (Sullivan, 2003), making sensemaking a critical aspect of advocates' work. Second, while patient advocates do encounter some routine problems (e.g., a patient walking in to ask how to change doctors), patient advocates regularly confront ambiguous or equivocal conflicts in which they are asked to answer the core sensemaking questions: "What's the story here? Now what should I do?" (Weick et al., 2005). They cannot rely on first-hand experience of the situation and must work to understand the problem—and decide how it should be handled—by interacting with people with whom they have had little prior interaction.

Patient advocates' work also provides a rich context for viewing the role of emotions in collective sensemaking. First, the conflicts in which they intervene are inherently emotional (Kolb & Bartunek, 1992). In addition, patient advocates must interact with a number of different stakeholders (patients, families, staff) over whom they lack authority. It is precisely in these situations that emotion work occurs (Wharton & Erickson, 1993). Moreover, the processes of receiving care for one's health and providing care for those who need it are inherently emotional, as they involve the health and well-being of the self or of others. Finally, the emotions patients, families, and staff experience can be confusing, complex, or overwhelming, making them difficult to express and interpret (Fineman, 2003; Kahn, 2001), and thereby necessitating sensemaking.

Data Collection

Data collection proceeded in two phases over an eighteen-month period.[1] In the first phase, I developed an understanding of the patient advocate role itself in

[1] The data used here are part of a larger data collection effort. In addition to the current article, I have published two other pieces from these data (Heaphy, 2013; Heaphy, Locke, & Booth, 2016). Each addresses distinct research questions, draws on different theories, uses different constructs, and has different theoretical implications (Kirkman & Chen, 2011). In addition, this article draws on 18 additional interviews that were not used in my previous publications.

TABLE 1
Brief Examples of How Conflicts were Initially Presented to Patient Advocates

VA hospitals	Teaching hospitals
Patient wants to stay longer to recover from operation; believes doctor is pressuring physical therapist, who he likes, to say he can be discharged now.	Patient stops by office for help, because he has tried and failed to understand his hospital bills and can't get an answer to his questions.
Family members of patient with Alzheimer's-like illness had to wait a long time for a discharge, after unusually unpleasant night in the hospital.	Homecare nurse calls PAs office because concerned that disabled teenage patient and his family do not have the resources for taking care of their son in their home (a small trailer).
Elderly woman arrives at hospital, saying she had an appointment, but has no idea where to go. Very angry.	European woman had come to ER and had been terrified by witnessing a patient seemingly held against his will, as well as by what she viewed as the unnecessary treatment she had been given for her stomach pains; after receiving the bill, she felt that she should pay some but not all of the bill because the treatments seemed unnecessary. Billing department did not know how to handle case.
Patient says that he needs to be on "clear liquid diet" in preparation for colonoscopy and the hospital staff are not following his diet.	Patient and his wife upset because the patient had signed up for sleep study, but then couldn't be woken up in the middle of the night so was sent to ER, where he was disoriented, had to be restrained, and they forced a catheter into him; they called his wife but didn't tell her which ER he was at—patient and wife very upset!
Patient calls to complain that the ER nurses did not treat her respectfully when she came to be treated to for severe stomach pain due to *Salmonella* poisoning that she got from "bad" peanut butter.	Husband of patient upset because he had observed a nurse about to give his wife a medication she was allergic to, even though they had filled out medication allergy forms multiple times.
Wife of veteran calls because was supposed to receive husband's medication in the mail, and they have not yet received it.	Patient wasn't served enough food at dinner. Patient was so upset that it was impacting his blood pressure.
Man left message screaming into phone; difficult to understand what he was saying.	Discharged patient claims that she got scabies during hospital stay.
Nurses call for help with a patient who refused to sign form that would enable him to get surgery at another hospital; they say he is difficult and won't take any medications.	Son of a patient who had died in the hospital came in to complain. His father had died the night before and although he had left directions about what to do with the body, the body was sent to the wrong funeral home and embalmed instead of cremated.
Patient was supposed to be called by office to schedule surgery but can't get any response from the office.	Patient upset about treatment by staff, including one racist physician and another who said to the patient, "You getting on my nerves."
Podiatry clinic calls for help with veteran who had a clearly necrotic foot but refusing treatment.	Patient upset about how doctors and staff treated him when he said he needed more time off from work following two back surgeries.
Patient and his family feel that the VA should pay for him to come home for the weekend; angry that they can't get anyone to help them.	Wife of hospitalized patient upset because staff had divulged information that the patient did not want shared to other family members.

order to understand the social and organizational context in which the patient advocate works. I sought divergent sources and perspectives so I could develop a broad but relatively complete understanding of the hospital-employed patient advocate and the environment. I used three data sources to develop this understanding: over 1,000 pages of publicly available documents about the patient advocate role, 18 key informant interviews, and seven days of observation at patient advocate professional conferences (see Table 2 for details of data collection).

In the second phase of data collection, I refined my methods and sites to focus on patient advocates in teaching and U.S. Department of Veterans Affairs (VA) hospitals: these are hospitals where the role of advocates was full-time and they reported to a member of the top management team, making it more likely that the advocates acted as a grievance mechanism and mediated between patients and families and hospital staff (Charters, 1993). I used two data collection methods to generate complementary sources of data on patient advocates' handling of conflicts: interviews and shadowing. First, I conducted 31 one-on-one semi-structured qualitative interviews with patient advocates at 17 hospitals. To gain insight into patient advocates' handling of problems, these interviews emphasized "grand tour" questions about a typical day and "example questions" (Spradley, 1979), in which I asked advocates to tell me stories about specific cases (Appendix A lists the interview

TABLE 2
Data Collection and Analysis

Phase type of data	Amount of data and site	Use in analysis and theory development
Phase 1	*Understanding the patient advocate role*	
Interviews with key informants	18 key informants, including officers of the patient advocate professional association, hospital administrators, patient advocate educators, and one vendor	Provided foundational understanding of patient advocates' work and their role in healthcare context.
Participant observation at patient advocate conferences	3-day national patient advocacy professional association conference 1-day state patient advocacy professional association conference 2-day national VA patient advocate conference	Generated basis for theoretical sampling and site selection (focus on hospital types where role was full-time and reported to hospital leadership) for Phase 2 data collection.
Documents	Collected 1,000 pages of documents from key informants, conferences, and patient-advocacy websites	Extracted 39 mediating episodes from key informant interviews for analysis of mediating episodes.
Phase 2	*How patient advocates mediated client conflicts*	
Interviews with informants	20 patient advocates at 10 teaching hospitals; 11 patient advocates at 7 VA hospitals. On-site visits, hospital tours and informal conversations with managers and coworkers	Transcribed interviews and shadowing field notes. Extracted mediating episodes from interviews and shadowing field notes (163 and 92, respectively). Engaged in multiple rounds of coding of mediating cases.
Shadowing	5 patient advocates at a teaching hospital; 3 patient advocates at a VA hospital (15 hours/patient advocate)	

protocol, including those questions relevant to this study). After each interview, I made field notes (Lofland, Snow, Anderson, & Lofland, 2006; Spradley, 1979); all interviews were professionally transcribed. Second, I shadowed (McDonald, 2005) eight patient advocates from two hospitals with well-regarded advocate offices. I spent 15 hours with each advocate, focusing on how patient problems were handled. I took detailed notes of patient advocates' activities throughout the day, asked them to explain their activities as they went along, and wrote extensive field notes after leaving the field each day.

Data Analysis

Because I was interested in understanding the processes through which mediators accomplished their work, an inductive approach was warranted (Edmondson & McManus, 2007). Process theories concern how things evolve over time and why they evolve in a particular way, as opposed to variance theories, which try to explain how changes in antecedents affect consequences (Van de Ven & Poole, 1995; Langley, 1999). My initial research question was: *How do designated problem-handlers respond to non-routine problems between customers and organizations?* This question oriented me to mediators' everyday work activities of handling problems. Consistent with a grounded theory approach, analysis cycled between close analysis of the data, development of theoretical categories, and relating these emerging insights with the existing literature. As is often the case with inductive research, the initial research question became refined throughout the data collection and writing and review processes (Charmaz, 2006). Mediators' efforts to intervene in a collective sensemaking process in a complex social and emotional context became increasingly apparent to me. Their emotion work was more complex than existing theories would adequately explain; thus, I sought to understand better those processes as I observed them in my data. Hence, my refined research question became: *How do mediators engage in emotion work to intervene in collective sensemaking?* The interviews provided rich descriptions of mediators' experiences and meaning-making related to their work. Shadowing field notes provided me with data about mediating episodes as they unfolded in real-time, including my own reactions to situations, which I could then compare with those of the mediators. I moved back and forth between these two forms of

data, and then turned to the archival data and conference observation data to deepen my understanding about particular aspects of the process.

Phase 1: Extracting mediating episodes. I began by extracting mediation episodes from my shadowing field notes and interviews (Locke, 2001). Mediation episodes began when a mediator first learned about a conflict, and concluded when they felt the conflict had been resolved. I identified 92 mediating episodes from the shadowing data, and 202 accounts of mediating episodes from the interview data. Accounts are discursive descriptions of reality that interpret and explain (Maitlis, 2005). Mediating episodes became the focus of my data analysis.

Phase 2: Initial coding. I initially conducted open coding on the mediating episodes (Strauss & Corbin, 1997), paying close attention to mediators' and others' activities, how they constructed and conveyed meaning, and the challenges they faced in doing so. After looking closely at this detailed level, I stepped back to try to understand their theoretical import. It became clear that in handling conflicts, patient advocates were engaging in a process of sensemaking and sensegiving. For example, ambiguity and equivocality were a regular part of their work; an early informant said that there was "a great deal of ambiguity in the job." In addition, similar to a sensemaking perspective where the focus is on plausibility, it became clear that patient advocates were not in pursuit of the "truth" but rather a plausible understanding of a problem that would allow them to act. For example, one patient advocate described that people who want things to be exact have a hard time in the job, "because there are so many different ways of looking at things." Finally, mediators' sense of the problem shifted over time, such as when a mediator declared that her conception of a problem "totally changed." Mediators' work also entailed sensegiving, in that they conveyed understandings to others. Recognizing these characteristics led me to focused coding of mediator's sensemaking and sensegiving activities.

Phase 3: Coding sensemaking and sensegiving activities. First, following Maitlis and Lawrence (2007), I reviewed the relevant literature to identify and sensitize myself to typical sensemaking and sensegiving activities. Then, a research assistant and I coded all of the mediating episodes for their sensemaking and sensegiving activities. Common examples of activities related to sensemaking in these data included asking questions, listening, and discussing differing accounts with peers. Common examples of activities related to sensegiving included recounting abbreviated versions of a story and representing one person's perspective to another. As I worked on the sensemaking and sensegiving coding, it was clear that mediators' work with their own and others' emotions was critical. For example, mediators' carefully controlled their own emotional expressions, yet this is not typically included as part of sensemaking activities. This led me to code the mediating episodes for emotions.

Phase 4: Emotion coding. Following similar studies that are based on observational data, interviews or both (e.g., Maitlis & Ozcelik, 2004; Walsh & Bartunek, 2011), I familiarized myself with existing models of emotion (e.g., Russell, 2003; Smith & Ellsworth, 1985), to insure that I would be able to identify specific emotions (e.g., anger) in ways that were consistent with accepted definitions. I identified emotions in my field notes in individuals' verbal expressions of emotions, as well as my observations of their facial expressions and vocal tone (Cornelissen et al., 2014; Huy, 2002; Walsh & Bartunek, 2011). Each emotion code identified a discrete emotion (e.g., anger, sadness) or group of emotions (e.g., anger/upset/frustrated) and identified the person expressing the emotions (the mediator or someone else). As a result, there were three categories of emotion codes: (1) mediators' *expressed emotions* to others (e.g., expressing sympathy to someone else); (2) mediators' *felt emotions*, in which they discussed their own felt emotions with me or a peer (e.g., feelings of disgust or sadness); or (3) *others' emotional expressions* (e.g., expressions of grief, anger, or relief).

Phase 5: Comparing and contrasting interactions. Mediators' work was primarily social, involving a series of interactions. To identify patterns in these interactions, I grouped together the sensemaking and sensegiving activities (Phase 3) and emotion codes (Phase 4) within the interactions in which they occurred and then compared and contrasted these interactions (Charmaz, 2006; Locke, 2001). In making these comparisons, I asked generative questions, such as who was involved? what were actors doing and why? and with what effect (Strauss & Corbin, 1997)? Specifically, this helped me to identify that mediators interacted with patients, families, and staff in similar ways, resulting in me adopting the term "client" as a term encompassing all three groups. Furthermore, this helped me group together some sensemaking, sensegiving, and emotion codes. For example, sensemaking activities of listening and asking questions were accompanied by expressions of emotional neutrality (encouraging emotion-rich accounts). By asking "what effect," I also identified distinct

emotion dynamics, or the sequence of emotions that occurred during the interaction (Liu & Maitlis, 2014). For example, clients' emotions decreased in their intensity and even became positive when they heard mediators' concise directions in sensegiving interactions (mitigating others' emotions).

Noting that not all interactions enabled mediators' intervention in the collective sensemaking process, I tagged each sensemaking or sensegiving interaction as either successful or unsuccessful. I defined successful sensemaking as making progress in interpreting or constructing meaning, whereas in unsuccessful sensemaking, such progress was not achieved (e.g., the patient abruptly left the interaction). While I did not have direct access to others' sensemaking, I identified successful sensegiving as occurring when there was some evidence that the meaning the mediator had been trying to convey had been accepted (e.g., a patient acting on the mediator's suggestion), whereas unsuccessful sensegiving occurred when the mediator's meaning was not accepted (e.g., a doctor does the opposite of what the mediator wanted him/her to do). The comparisons of successful and unsuccessful episodes helped to illuminate that while unsuccessful interactions were triggered by a variety of circumstances, they shared a common emotion dynamic: the amplification of client's negative emotions.[2]

Phase 6: Pivoting from sensemaking to sensegiving. While these interaction patterns captured the social process through which mediators intervened in collective sensemaking, they did not help explain when mediators shifted from sensemaking to sensegiving interactions. In the sensemaking literature, research suggests this occurs when accounts are "plausible" (Weick et al., 2005). While the notion of plausibility is generally understood to reduce equivocality and facilitate action, it is also acknowledged that the criteria are also "locally determined" (Weick et al., 2005). To understand what constituted plausibility for mediators, I examined data that addressed when they shifted from sensemaking to sensegiving. Data that addressed this transition included data from interviews in which they described how they viewed cases, as well as data from shadowing in which I could observe when they shifted from sensemaking to sensegiving. For example, I noticed that after mediators had interacted with clients, they explained the accounts in terms of "understanding where [the client] was coming from," until they could do that for all of the clients involved, resulting in "making multiple perspectives understandable."

[2] I also explored comparisons between a number of other dimensions, including comparing the impact of the type of hospital; the mode of communication (letter, email, in-person, phone); whether the mediator had a previous relationship with the patient, families, or staff; the type of emotion expressed by others. Across these comparisons, I found no meaningful differences in the processes mediators used.

FINDINGS

When clients experienced conflicts in the organization, mediators intervened in the collective sensemaking process that emerged. First, they engaged with clients—patients, families, and staff—in *tabula rasa interactions*, encouraging clients to express emotion-rich accounts so that they could understand and clarify the clients' accounts. *Tabula rasa interactions* generated provisional accounts. Accounts are considered provisional in that they are emergent fragments of meaning, but may not be 'coherent, linear and ordered' narratives (Boje, 2001: 11). When mediators' *own* emotions were provoked, they engaged in *exclaiming interactions* with peers, engaging in unguarded sensemaking about their developing understanding of the conflict. Exclaiming interactions helped to elaborate mediators' developing account and mitigate their own emotions. Mediators cycled through these sensemaking interactions until they developed *empathetic accounts*, or accounts that made sense of events, relationships, and actions in such a way that reflected both cognitive and emotional understanding of others' actions.

Once mediators developed an empathetic account, mediators selectively drew on it to influence clients and employees through two types of sensegiving interactions. In *directing interactions*, they attempted to influence clients' sensemaking by telling abridged accounts and simultaneously mitigating their emotions. When mediators encountered resistance, they engaged in *re-narrating interactions*, telling empathetic accounts of the conflict from another client's perspective. Although relatively infrequent, *inflaming interactions*—in which clients' negative emotions amplified—derailed mediators' intervention into the collective sensemaking process during either sensemaking or sensegiving interactions. As detailed below, emotion work was a critical component of mediators' sensemaking and sensegiving interactions because of the emotion dynamics they evoked. Representative

quotes supporting these findings are displayed in Tables 3–8.

Tabula Rasa Interactions

Tabula rasa interactions are sensemaking interactions that occurred when *mediators encouraged clients to express emotion-rich accounts so that they could understand and clarify the client's account.* Specifically, mediators entered into a conflict, strategically engaging with clients for the purpose of developing plausible accounts. Clients' expression of emotion-rich accounts enabled mediators to make inferences about their own and others' emotions, thereby deepening their understanding of the client's perspective. Mediators also carefully concluded interactions to prevent the amplification of client's negative emotions. (See Table 3.)

Encouraging emotion-rich accounts. Mediators encouraged clients to express emotion-rich accounts. Mediators accomplished this by expressing emotional neutrality in their facial expressions, body movements and vocal tone. They also demonstrated they were listening (e.g., took notes) and asked questions to prompt clients. As one mediator described:

> Some of the things you hear [from patients and/or their families] are amazing. Just to be honest with you, they are incredulous. You look there and you just want to let your jaw drop and your eyes bug out. But you can't do that. [You have] to be neutral in facial expressions and not respond with arm or hand gestures or any movement that indicates one thing or another. I usually sit and speak to them face to face and make eye contact and hear what they have to say. If I need to, I'll ask them to slow down so I can write everything that they say. That's my standard for interacting with them.

Whether clients were expressing negative emotions, such as anger and annoyance, neutral, or even positive emotions, such as empathic concern for others or warmth, mediators were consistently emotionally neutral in tabula rasa interactions.

In encouraging emotion-rich accounts, the mediators did not provide an open-ended invitation to clients to share such accounts, but instead were alert to the moment at which clients began to repeat themselves. Because clients were often agitated and emotional, allowing them to repeat their accounts more than once could provide an opportunity for any negative emotions to amplify, which the mediator wanted to prevent. As one of my informants told me,

> [You have to have] the interviewing skills to cut to the chase and at the same time convey the compassion and the willingness to listen, but to frame the interview … Sometimes you have to say to a patient, 'Thank you for coming in, I will work on this, excuse me now, I need to go to the lady's room, let me walk you out'." [laughs] Or "Let me walk you to the front door." You know, finding a polite way to kind of excuse them from your office.

Being alert to these cues to end interactions helped to insure that they had full accounts but at the same time did not allow for rumination, which would leave the client more agitated than when they began (Afifi, Afifi, Merrill, Denes, & Davis, 2013; Hadley, 2014).

Making inferences about emotions. By encouraging clients to express emotion-rich accounts, mediators were able to recognize and interpret both clients' *expressed* emotions as well as their own *felt* emotions that emerged in response to hearing the accounts. Making inferences about others' and one's own emotions was critical to mediators' sensemaking.

By recognizing and interpreting *others'* emotional expressions, mediators were better able to understand the cares and concerns of the patients, families, or staff, and refine, update, or change their understanding of the problems. As one mediator described: "I am really good at reading people's body language. I am really good at paying attention to what they really care about or want." Mediators' encouragement of others' emotional expression stands in contrast to traditional theory about emotional labor, in which understanding the underlying meaning of emotion is less important than eliminating a disruptive emotional expression through emotion regulation (Hochschild, 1983: 113). Cicely, who described hearing a complaint from family members of a patient who had just died, exemplified the mediator's desire to not influence the emotions clients expressed:

> [When I got there] I let them vent their anger. I can't say that I know how [patient's families] feel, because I don't; they may be feeling guilt, or like they haven't resolved something; they may be angry. But I let them vent, and that's where they were—I didn't try to get them to do something else.

Cicely let the family members express their feelings and did not try to control or make those feelings fit

into how grieving families were supposed to react. She acknowledged that she did not know how the family felt. In fact, she suggested three *different* emotions the family members may be feeling: guilt, unresolved feelings, and anger.

Mediators attended not only to *others'* emotions, but also to their *own* felt emotions, particularly about when to challenge complainants about their account. Feelings of confusion, doubt, and "gut feelings," for example, prompted mediators to ask questions to clarify issues and sometimes to directly challenge an element of a client's story. In turn, a client's responses revealed more information about their underlying complaints and priorities. In the following example, Viola, the mediator receiving the call, had initially been quite concerned because the patient had left a message saying her "face was on fire" after undergoing a procedure at the hospital. But Viola began to doubt the patient's account when the patient claimed that Viola had been difficult to reach, prompting her further questioning of the patient.

> I was basically just telling her it was kind of insulting for her to say 'I tried to get in touch with you but I couldn't,' because I have—from day one—always made myself available. She ended up saying she didn't know whom she was supposed to contact and that she just wait[ed] until after the holiday. Okay, so, I appreciated her being honest and what I took from that was, I will e-mail the nurse manager and then the nurse manager would get back with me. In the meantime, there's really not much that I can do about it right now.

Viola's own feelings of doubt and defensiveness prompted her to ask a question that led to a revised understanding of the problem.

Mediators cycled through tabula rasa interactions with multiple clients, each of whom could provide an account of the conflict from their own perspective. Yet the mediator approached each interaction in the same way. In contrast to glossing, in which a person retells a narrative to shift its meaning, to either make it more coherent or explanatory, or to reflect own interests (Abolafia, 2010; Boje, 1991), mediators avoid either repeating client's perspective on the problem, or revealing their own developing perspective on it. Instead, by approaching each tabula rasa interaction as a "blank slate," mediators could elicit additional cues that helped flesh out their own developing account. For example, the girlfriend of a patient who was no longer able to make his own medical decisions was frustrated about several issues, including how long it took for the nurses to bring the patient's medicine so the couple could go home. When the mediator, Lily, approached the nurses' station about the medication issue, she stated simply, "I wanted to check about Mr. Thompson's discharge papers." The nurse responded, looking annoyed: "We have the discharge papers, but one thing bothers me. The girlfriend says she is the power of attorney, but I have seen nothing to document that. And [his situation] is really sad; he is in terrible shape. He has a terrible disease." The nurse's emotion-laden response gave Lily a new understanding of what some of the issues were—the girlfriend was not properly documented as a power of attorney, and therefore the nurses were not comfortable dealing with her, while further underlining the serious, sad, and empathy-inducing condition of the patient. This helped the mediator expand her *own* understanding of the problem, from being about missing medicine to include the nursing staff's discomfort in treating the girlfriend as the primary medical decision-maker.

Exclaiming Interactions

Tabula rasa interactions generated material—accounts, clients' expressed emotions, mediators' own felt emotions—from which mediators could construct sense. While mediators *expressed* emotional neutrality in the tabula rasa interactions, these interactions sometimes left mediators feeling emotions that were unpleasant or highly activated. When this occurred, they turned to their peers to express their own emotion-rich accounts. I label these exclaiming interactions, in that *mediators engaged in unguarded sensemaking with their peers about their developing understanding of the conflict.* (See Table 4.)

Discussing emotion-rich accounts. When mediators felt anger, frustration, or distress about a situation (unpleasant emotions of varying degrees of activation), or surprise and curiosity (emotions of high activation), they turned to their colleagues to express their own accounts. Peers responded with expressions of interest and curiosity, often sharing their own perspectives and reactions. Discussing their own emotion-fused accounts with peers regarding tough, unusual, or ridiculous cases was a way for them to elaborate and revise their understanding of the problem, helping them to see their developing account from different perspectives. For example, Shirli swung open the door to her office one afternoon to tell her

TABLE 3
Tabula Rasa Interactions

Second-order themes	First-order concepts	Evidence
Encouraging emotion-rich accounts	Listen, ask questions, take notes	Mother of patient was upset and crying about her altercation with a security guard and an administrative employee. The mediator was very still during this interaction. She wrote when a pertinent fact came up. She nodded a little bit. *(Shadowing)*
		Shirli introduced herself and then introduced me. Shirli asked how things were going . . . she was planted firmly on two feet, standing at an angle, looking at the patient with her head slightly tilted. She took notes occasionally. She was very quiet and still. Shirli said things like, "So you're concerned about that?" "Have you had a chance to talk to your new doctor about your concerns?" *(Shadowing)*
	Expressions of emotional neutrality with clients	As we listened to the mother of a sick infant tell us why she was so upset with the nurse manager, Karen's face was neutral, placid, and serious looking. *(Shadowing)*
		A patient walked into Sherry's office, saying, "I'm an angry vet!" During this conversation, Sherry's face was impassive. *(Shadowing)*
	Ending interactions after client had told complete account	"Then after he vented his spleen, and I found out a lot of good information from him . . . it got to a certain point, and I says, 'Okay, well, I got what I need. Now I got to go out and get things done. And I'll be in touch.'" *(Interview)*
		A mediator was meeting with the mother and sister of an adult patient. Mediator later explained how he carefully interrupted them. "I was listening to them and then I got my break. I said, 'You need to be there [with your brother/son] so I can do something here.'" *(Shadowing)*
Making inferences about emotions	Recognizing and interpreting *others'* emotions	After helping a couple in her office, I asked Christina what she was thinking during the interaction. She said that she had first noticed their appearance—the woman's pained face. And she wasn't talking, even though she was the patient; her husband was talking for her. Christina commented, "Usually if you're mad about something you're the one who is doing something about it." *(Shadowing)*
		"You have to be able to look at the cues that the patient is bringing to you both verbally and non-verbally because that is just a key part of what you're doing when you are interviewing them is being able to find out what the real issue is." *(Interview)*
	Recognizing and interpreting *own* emotions	"You have to know what your emotions are, you know, being able to act on them in a way that is not disruptive to what you are trying to do but rather in a way that is helpful to what you are trying to do." *(Interview)*
		Lili explained to me, pointing toward her stomach, "God gave me really good guts. I can just tell when there's something that's not quite right." *(Shadowing)*
	Using emotions as prompts to ask questions	After mediator had been surprised that a patient hadn't been invited to a meeting, the mediator asked the hospital staff if the patient could attend the meeting. *(Shadowing)*
		[When you have an instinct that something isn't quite right], you just ask them sometimes, "Is there something wrong?" Or, "Did something happen?" I never ask for details. And, generally, you can tell by their face, or the way they react . . . lots of times, they'll say, "I just need somebody to talk to that I can trust." *(Interview)*

fellow mediators and administrative assistant, incredulously, that a father had been "kicking up a fuss" that his pre-teen son could not get an appointment with neurosurgery to check his concussion before his team's championship football game. The administrative assistant responded that if it were her son, she would do everything to let him play, because it would mean so much to him. A fellow mediator chimed in that the boy could ruin his whole football career if he was badly injured in the game. An incredulous "Can you believe he did this?" generated a discussion of what a particular person might be feeling and thinking, providing the mediator with alternative perspectives on an account. These

alternative perspectives could then be integrated or discarded, but enriched the mediators' sensemaking, providing them with an elaborated account. Following Stigliani and Ravasi (2012), an elaborated account means integrating emergent understandings into more complex mental structures linking various perspectives on the account. Similar to previous work on community of practice (Orr, 1996), these interactions were an important way in which mediators could share provisional accounts and get alternative perspectives on an account (Garud, Dunbar, & Bartel, 2011). Yet they did not happen as a matter of routine (e.g., daily breakfast ritual [Orr, 1996]), but when mediators turned toward one another in moments of high emotional activation.

Mitigating own emotions. Expressing mediators' own emotions about a case was also a way to mitigate their own negative emotions (Fineman, 1993; Hadley, 2014). The negative emotions included the highly unpleasant activated emotions described above (anger, frustration, distress) and reported in previous work (Korczynski, 2003), but also unpleasant emotions of lower activation, such as sadness and grief, which occurred when a patient died, or disappointment or dejection, such as when they were struggling or had failed to engage someone in a tabula rasa interaction. Being able to talk about particularly intense, emotional cases provided a way for mediators to express and then mitigate their own negative emotions, and then move on from the experience. Tess, for example, said:

> Sometimes I'll go in [to my colleagues office] and unload at four o'clock and go, "You won't believe the day I've had," and I'll tell her, and it's just so nice to do that, to tell somebody the shitty day that you had today. To get it off your chest. Or else, you seem to bottle it up and take it home.

These peer interactions provided an emotional outlet for mediators, a safe space for them to express and release their emotions, which allowed them to continue in their work.

Empathetic Accounts

Canonical treatments of sensemaking emphasize that people engage in sensemaking until they develop plausible accounts, generally defined as those that enable practical action (Sonenshein, 2007; Weick, 1995). My analyses show that in this context, patient advocates continued to cycle through tabula rasa and exclaimed interactions until they developed empathetic accounts, or *accounts that made sense of events, relationships, and actions in such a way that reflected both cognitive and emotional understanding of others' actions*. (See Table 5.)

Mindfulness. The creation of such accounts was supported by the mediators' stance of being nonjudgmental toward each client (Hulsheger, Alberts, Feinholt, & Lang, 2013; Sutcliffe, Vogus, & Dane, 2016), even in the face of serious accusations from others. For example, after learning that a patient had allegedly threatened a doctor with a gun resulting in the patient's disenrollment from a clinic, the patient advocate calmly took this in stride as a piece of information, but it did not determine how she made sense of the patient. (Later, she characterized the patient as someone who was easily overwhelmed.) As mediators who had not been present when the problematic situation occurred, they had learned that "I can never say what has happened or can happen or didn't happen if I wasn't there." This stance was hard earned, as they had learned over time that the "truth" about a situation was often complex.

Multiple perspectives understandable. Empathetic accounts were able to make multiple, and often conflicting, perspectives on a conflict seem reasonable and understandable (Whittle & Mueller, 2012). After every interaction, mediators considered what the interaction meant for understanding each client's perspective. Over time, this meant that they constructed an account that reflected empathy for each of the clients involved in the conflict. In the following example, the mediator shared an account that reflects the perspectives of both the mother and doctor:

> The mom came in with her son, who was about 10 years old [and had a serious problem with his arm]. They were talking to the doctor, the doctor said that there was no option but surgery, and the mom stopped listening and asking questions, because she felt that the doctor wasn't listening to her. I don't think the doctor even realized it ... Now, my perception is that the husband wouldn't have allowed it to happen—he wouldn't have left without understanding why the doctor was saying that there was only one option, he wouldn't have been derailed by her bedside manner ... I think [the doctor] didn't think that she had done anything wrong ... What I think is going on is that she is stretched really thin. She's all over the place.

By creating an empathetic account that reflected both the mother's and doctor's perspectives—the

TABLE 4
Exclaiming Interactions

Second-order themes	First-order concepts	Evidence
Discussing emotion-rich account	Mediators and peers talk and question each other about cases	Lili explained that the family was trying to blame the nursing staff for not having the Advanced Directive and Karen said, "No, no, no, that's not right." It was very clear to them that this was not the hospital's fault; the patient would have been asked every time he came in about the Advanced Directive. They then talked about the role of the divorce in the conflict, coming to the view that it very well may be that the husband and wife were getting a divorce and the son was upset. But it's not the [patient advocates'] responsibility to get in the middle of that, they just have to do what's right legally in terms of medical decision making. And if they wanted it to work that out, they had to do it elsewhere. *(Shadowing)*
		Karen was telling a story, and Ian and I both listened; Ian asked a couple of questions—"Maybe this happened; did this happen? It could have been because . . ." and Karen answered all those questions, elaborating the story. *(Shadowing)*
	Peers express interest and curiosity	Then Sherry came in. It was 4:25, and said, "How did it go?" So Matt recounted the whole story. *(Shadowing)*
		"They come into my office, 'Oh my gosh, Amy, I just had this case. I have to tell you about it,' and I can say, 'I have had a similar thing.'" *(Interview)*
Mitigating own emotions	Mediators express anger, frustration	Karen has been working all day to try to get some shots for patients, with lots of false starts and no success. She says to me, "I'm going to go bitch at Dan for a minute." I hear her say to Dan, "Did you hear Erin [yelling at me] all the way from here? She pushed me over the edge." *(Shadowing)*
	Mediators express sadness, grief, disappointment	"We had an incident where one person . . . she has a hard time with a family. She has just started and she said, "You know, I always thought I'd know what to say to families but sometimes I feel like I trip over my own tongue . . . We have to be sensitive to each other as a team." *(Interview)*
		Ian to peer: "I feel like the discharge planner let me down. She said that she would get back to them in the morning, because she had an urgent discharge. What's an urgent discharge? The only urgent discharge you might have is if it's to get someone out of a bed so you can get someone else in a bed." *(Shadowing)*

mother's experience of the doctor as rude and unreceptive, and the doctor's presumed lack of realization about the mother's experience—the mediator portrayed both of these actors as worthy of understanding. By being able to approach parties with the sense that she understood both their perspectives and felt some empathy for them, she was then able to create a foundation for enlisting their help in resolving the conflict.

Once mediators had developed an empathetic account, they no longer wanted additional insights or accounts about what the problem was or how it should be resolved (i.e., sensemaking); rather, they wanted to influence others to understand the situation in particular ways (i.e., sensegiving), so that the problem would be handled according to the mediator's understanding of the situation. Mediators had developed an empathetic account rich in detail, yet when they engaged in sensegiving interactions, they did not recount the full empathetic account, but instead selectively drew on it. Which form of sensegiving interactions they engaged in depended on whether or not they viewed the client as exhibiting resistance to sensegiving.

Directing Interactions

Directing interactions occurred when mediators told abridged accounts to influence the sensemaking

TABLE 5
Empathetic Account

Second-order themes	First-order concepts	Evidence
Mindfulness	Stay open and non-judgmental	Sometimes you get this pre-conceived notion of how this patient is going to be [from the staff] and then sometimes it's . . . the very opposite of what I was expecting. *(Interview)*
		You have to keep an open mind. *(Interview)*
	Truth may be unknowable	"There's a whole spectrum of degrees of . . . truthfulness of issues." *(Interview)*
		"Sometimes its like people are talking about two different cities; somewhere in the middle is the truth." *(Interview)*
Multiple perspectives understandable	Mediator "understands where the client is coming from"	Even if I say it to myself, "Yeah, I understand where she's coming from." Sometimes I don't even say it . . . It's more that it's helping me to relate. *(Interview)*
		"I understand where they are coming from; they have been in and out of the hospital for four months; they've gone beyond their limit, it's gonna wear you down." *(Shadowing)*
	Mediator tells story that makes all clients seem sympathetic	The patient, I like to call them curmudgeons, you know, just an old friendly, kind of rascally guy. The doctors themselves just didn't know how to address the issue properly. It wasn't a medical issue, per se, it was a system issue . . . So they didn't know how to operate that . . . well, they did once, and it came back denied, and their opinion is, "Hey, look, we tried it, and we failed. Now, go away, and don't bother us." Because for the doctor, it's like, this isn't what they taught me at medical school. You know, I'm here to heal you. I'm not here to jump through seven bureaucratic rings for you. And they have a dollop of truth on their side. This isn't what doctors are trained to do. You know, this isn't why we educate them, and it's not what we pay them for. You know, and the nurses are . . . they're just like the doctors. They're there to render care, and to set things up, and to smooth the way, and to deliver care. Nurses really do so much of this in the normal course of the day. The thing of it is, is that under our primary care system, we load our doctors and nurses up so much that they don't have time allotted to stop the machine . . . to stop the process they're in .... and then just deal with a special patient and really take the time. *(Interview)*

of others while simultaneously mitigating their emotions. (See Table 6.)

Telling abridged accounts. In directing interactions, mediators told abridged accounts, which are those accounts that are abbreviated and simplified, with only those parts of the accounts told that are necessary to direct others' action. This is similar to what Boje (1991) calls "terse storytelling," in that it is an abbreviated and succinct simplification of the story. Mediators carefully controlled their emotions in directing interactions with clients. When mediators re-engaged with clients who had experienced pain and suffering, mediators acknowledged their experiences. Mediators expressed *sympathy*, acknowledging the client's emotional hardships, or *empathy*, conveying that they had been emotionally moved by the difficulties the client had experienced. These acknowledgments were not necessarily in depth, in that they did not encourage rumination (Hadley, 2014), but they did convey compassion (Dutton, Workman, & Hardin, 2014) in that the patients' and families' emotions had been witnessed and recognized, and the mediator was responding to that pain and suffering. For example, Ian began a letter responding to a patient who had had a very difficult experience in the Emergency Department with a sympathetic acknowledgment and affirmation that the patient had in fact suffered: "Thank you for taking the time to speak with me about your most difficult experience in the ER."

Directing interactions could also involve expressing emotional neutrality. For example, when interacting with staff, mediators removed aspects of the

account that might trigger emotions, and framed their requests for action in terms of the familiar categories of the hospital or of a specific job. By editing accounts in this way, they decreased the chances of provoking clients' emotions. For example, after working with a family about a cancelled surgery, a mediator wrote an email to the surgeon: "Overall the patient is satisfied with you. The patient is concerned about the bill; I will take care of that piece. The most important piece is a guarantee that she is the first patient on the 9th. Is that possible?" In this abridged account, the mediator conveyed that the problem she wanted the doctor to attend to was the scheduling of the surgery; she chose not to repeat or convey any of the emotionality present in the tearful and distraught interactions with the patient and her family. By focusing on a task, the mediator had effectively translated the sensegiving into an account that would be easily understandable and actionable, without simultaneously provoking their emotions.

Mitigating others' emotions. During directing interactions, clients' emotions decreased in their intensity and sometimes even became positive. Patients, families, and staff expressed positive emotions such as gratitude, contentment, or relief. For example, they said things like, "You have a Christmas present coming!" or "Thank you so much!" Mitigation of others' emotions was also evident in clients' willingness to do as they were asked, or when they acted in a way consistent with the abridged account the mediator told. For example, when Shirli told a nurse manager an abridged account, the staff member replied that the resource scheduler should handle this problem and that she (the staff member) would call the patient herself. Shirli gave her the phone number, hung up, and said to me, "There you go!" signaling the case was closed.

Re-narrating Interactions

Clients sometimes resisted mediator's sensegiving by expressing negative emotions, such as anger and frustration. In response, mediators engaged in re-narrating interactions, in which *they told empathetic accounts of the conflict from another client's perspective.* (See Table 7.)

Telling empathetic accounts. Mediators drew on empathetic aspects of their account to help one client see the situation from another's perspective. For example, Sandra described how she told an empathetic account to a staff member who was frustrated because the mother of a disabled child was consistently late to appointments.

> The physician's office was very angry, very upset. The staff person I spoke to was very unforgiving. I said, "Have you ever tried to dress a child in the morning let alone a disabled child and be dependent on public transportation to arrive someplace on time?" "Well, no I haven't," she replied. "Well until you do," I said, "perhaps the best thing to do is to schedule this [appointment] for an end of the day when, if there is a delay, she hasn't backed up the whole schedule for the whole office. Secondly, if she doesn't show, that time can be used as administrative time for the doctor."

In re-narrating the account to the staff member, Sandra did not hesitate to express her empathetic anger (Hoffman, 2008) on behalf of the patient and her mother. At the same time, the mediator could draw on her empathetic account to recognize the staff's needs for a predictable schedule and made suggestions that addressed those needs as well.

Updating. Re-narrating the problem from and expressing empathy for a different perspective compelled others to reconsider the situation and update their understanding based on new information (Maitlis & Sonenshein, 2010). For example, Luke was interacting with a patient who was angry that his treatment team had suggested he get a mental health evaluation. In response, Luke said, "Let me tell you what happened after you left," explaining that all the medical staff in the room had been concerned that the patient looked "sad and defeated." Surprised, the patient then reconsidered his perspective on the treatment team and acted on the mediator's suggestion that he focus on repairing a strained relationship with his physical therapist, who had previously been his biggest ally among his caregivers.

Inflaming Interactions

Mediators were not always successful in their interventions in collective sensemaking. As one mediator told me, "we have our share of failures." While these interactions were a small part of my data, what inflaming interactions have in common is the *clients' negative emotions disrupt the mediators' ability to influence the collective sensemaking process.* (See Table 8.)

Emotion triggers. I identified several different triggers for inflaming interactions, which could occur

TABLE 6
Directing Interactions

Second-order themes	First-order concepts	Evidence
Telling abridged account	Mediators expressing sympathy or empathy	Mediator was writing a letter responding to a mother's many complaints about her son's care. She wrote that she was sorry that receiving the recommendation for palliative care for her son was upsetting for her, but that it seemed reasonable, given his level of sickness. The mediator told me she was trying to address this woman's fear and sadness about her son's death. *(Shadowing)*
		Mediator called patient and apologized to her ("I am very, very sorry. Are you feeling any better?") for how she was treated in the emergency department and on the phone. *(Shadowing)*
	Mediators expressing emotional neutrality	Mediator was helping staff with a sensitive patient; when he came in, he seemed to want to talk, but she flatly repeated the instructions of what he was supposed to do but didn't encourage him to stay and chat. *(Shadowing)*
		Shirli talked to a physician about a patient's complaint, saying that there had been a problem with the physician's assistant and that the patient's main concern was about the blood pressure medication. The doctor asked, "Why had the patient told you about that and not me?" Shirli: "I asked her that and she said that she was planning to talk to you today. Is it possible for you to change the physician's assistant?" Doctor: "Yes." *(Shadowing)*
	Telling only information client needs to act on	Mediator says to me that she is not going to mention to the patient that he is not at the top of the list for cancelled appointments because "we know not to throw fuel on the fire." *(Shadowing)*
		"I don't want to give him too much information, it's too much instruction." So she called him back and talked to the son, and said when you get here, go to Health Benefits Office and bring this information. *(Shadowing)*
Mitigating others' emotions	Client's expression of gratitude, contentment, relief	The doctor was very appreciative when he learned what [the mediator had done], saying "thank you!" *(Shadowing)*
		She came back and handed it to the patient, and pointed out what information the insurance company would need—the codes. The man was so grateful for the information. *(Shadowing)*
	Client follows mediator's directions	The surgeons who were treating a very sick patient initially resisted because it's so hard to get them all together, but they eventually got all of them to agree to meet with the patient together. *(Shadowing)*
		Mediator carefully suggests that while the decision about which clinic to go to is up to the patient, the clinic at the dental school would entail less of a wait. The patient decides to do that, and the mediator gives them a map to help them find their way. *(Shadowing)*

in either sensemaking or sensegiving interactions. First, when mediators failed to display emotional neutrality in sensemaking interactions, and instead were emotionally expressive (Gross & John, 1995), clients' negative emotions amplified. Sometimes mediators failed to control their own negative emotions, such as when a mediator displayed frustration or anger. Other times, visibly displaying empathy could trigger client's negative emotions. Second, mediators identified that some clients were persistent and pushy; mediators made attributions about these clients' psychological well-being (i.e., a mental health diagnosis) or their privilege (i.e., discomfort with not being in control). Mediators referred to these clients as ones who "push and push and push." Third, in the process of sensegiving, some clients simply were dissatisfied with the mediator's sensegiving and the resolution mediators were offering.

Amplification of client's negative emotions. The result of these emotion triggers was that the client's negative emotions amplified. In this example, the mediator's display of empathy prompted the client's negative emotions to escalate, resulting in the mediator leaving the interaction:

> A patient's wife was at the pharmacy and just having an absolute meltdown situation about her dissatisfaction with the pharmacy. . . . I went down to the pharmacy, and I just said, [putting her hand across her chest in an

TABLE 7
Re-narrating Interactions

Second-order themes	First-order concepts	Evidence
Telling empathetic accounts	Re-narrating account from a different party's perspective	Surgeons refused to consider a burn victim for cosmetic surgery on his scar tissue because they thought there was a high likelihood that he would not recover from it, due to his own history of drug abuse. After meeting with patient to hear his story, mediator met with surgeons and explained the patient's goals and aspirations—to go to college after spending years as a drug addict—and suggested testing him for illegal drugs for three months; if he passed those, then they would do the surgery; they agreed. *(Interview)*
		Mediator talking to a staff person about a long wait time for a cancer patient: "This patient comes in every other Thursday [for treatment]. I understand there are safety reasons for the 3 hour wait time, but the patient is still dissatisfied . . . From the patient's perspective, the patient is dying of cancer and she doesn't want to waste three hours waiting at the hospital . . . I was just trying to see if there were any other options." *(Shadowing)*
	Mediators' expressions of empathy, empathic anger	"I understand that you love your daughter totally and completely and there is no greater love than that, but at the same time she's not at home with you so there are certain things that you have to be mindful of." *(Interview)*
		So I said, ok, let's all go in there together and we will all explain together, and I will interject. So the doctor explained the diagnosis, and I said, "You will NOT back the nurses into the corner. If you have a medical question, go talk to the physician, but do NOT back them into a corner. Now, repeat to me what we told you." . . . I'm very firm with him. *(Interview)*
Updating	Client's expression of surprise	A doctor called me up and said, "This patient is just not understanding anything. She doesn't want to go home." And so I went in to talk to her. And then I went back to the doctor, and I said, "Did you ask her why she didn't want to go home?" "No." "Well, she's homeless, so she can't go home, she is right." And he was sort of speechless. And I said, "Patients can get intimidated by doctors, so they won't just tell doctors things." *(Interview)*
		It was like I guess I could send him there, like the light went on. *(Interview)*
	Acceptance of new understanding	After hearing physician's perspective from patient advocate, the father said, "Well, I guess that is my responsibility." *(Shadowing)*
		Sometimes when they hear about the doctor's perspective from someone else, they will go, "Oh, all right." *(Interview)*

> empathetic gesture], "You know, Mrs. Matthew, I'm really sorry that this situation has happened." And she said, "Don't put your hand on your chest! Don't make me feel sorry for you!" Just like, screamed at me. And so, yeah . . . even subtle, like body language . . . And I was not effective in that situation at all. I mean, literally, I had to just like excuse myself, because I wasn't being any help.

In this case, the mediator's verbal and bodily expression of empathy infuriated the patient's wife and brought the mediator's sensemaking to an abrupt halt, as she had become the target of the family member's now amplifying anger. As a result, the mediator had to remove herself from the situation in order to prevent further emotional escalation, and her sensemaking of the situation halted.

Inflaming interactions also occurred in sensegiving interactions. For example, when clients did not feel that their pain and suffering had been understood and acknowledged, they did not accept mediators' sensegiving and instead persisted in trying to have their experiences and accompanying feelings recognized. As noted above, mediators attributed this to clients themselves (i.e., clients who "just push and push and push") but this also occurred when clients were dissatisfied with how their case had been handled. For example,

a patient called Shirli to complain that Shirli had not taken her experience of waiting three months for lab results seriously. The patient's agitation had increased and she wanted more to be done to address her concerns. Shirli's sensegiving had been ineffective, and she was left having to re-engage in sensegiving.

Theoretical Model: Intervening in Collective Sensemaking to Mediate Client Conflicts

My investigation of how patient advocates mediate client conflicts led me to develop a theoretical model that depicts a process in which sensemaking, sensegiving, emotion work, and emotion dynamics are critically interconnected. As Figure 1 illustrates, mediators cycled through two types of sensemaking interactions, tabula rasa and exclaiming interactions, which led to the development of an empathetic account. Once this empathetic account was constructed, mediators pivoted toward one of two types of sensegiving interactions: directing or re-narrating interactions. Inflaming interactions, prompted by emotion triggers, could derail mediators' intervention in collective sensemaking during either sensemaking or sensegiving interactions.

This model helps to explain the process of intervening in collective sensemaking to mediate client conflicts by showing how mediators move between sensemaking and sensegiving interactions to develop and then deploy aspects of an empathetic account. The process of intervening in collective sensemaking began with tabula rasa interactions, in which mediators engaged with clients to encourage emotion-rich accounts. Each tabula rasa interaction generated an emotion-rich account, which provided mediators with a wealth of discursive and emotional cues about which to make inferences. As indicated by the gray arrow, mediators engaged in multiple tabula rasa interactions, with each interaction generating provisional accounts that were partial, in that they represented one person's account of a conflict. Constructing an empathetic account necessarily entailed seeking out multiple clients who could offer their own accounts of the conflict, which in turn helped the mediator revise, refine, or expand their developing account. When mediators *own* high activation or negative emotions were provoked by tabula rasa interactions, they turned to their peers to elaborate their account in exclaiming interactions; they discussed linkages between provisional accounts as well as their own and their peers' reactions. Exclaiming interactions not only furthered the mediators' sensemaking about the conflict, but also mitigated their own emotions, enabling them to re-engage in interactions with clients.

The mediators cycled through tabula rasa and exclaiming interactions until they had developed an empathetic account, one that reflected emotional empathy for and cognitive understanding of clients. For mediators, *empathetic accounts* enabled practical action in that they were a flexible discursive resource endowed with emotional and cognitive resources, which they could strategically deploy in sensegiving interactions. The development of the empathetic account allowed mediators to confidently pivot from sensemaking to sensegiving interactions.

Mediators re-engaged clients in directing interactions, telling abridged accounts, and mitigating clients' emotion through expressions of sympathy or empathy for those who had experienced pain and suffering, or emotional neutrality to those who had not. When clients resisted mediators' sensegiving, mediators engaged in re-narrating interactions, telling an empathetic version of the account from another client's perspective. This, in turn, provoked surprise and updating in the client. When sensegiving had been successful, mediators observed cues indicating that the sense they had conveyed had been accepted or was being acted upon by the client.

On occasion, mediators were not successful in their sensemaking and sensegiving interactions. In inflaming interactions, clients' negative interactions were prompted by an emotion trigger, causing negative emotions to amplify. As indicated by the arrows, the interaction—and the mediators' involvement in sensegiving—ended, or mediators attempted to recover in re-narrating interactions.

DISCUSSION AND CONCLUSIONS

My study of patient advocates' mediating work produced a process model of how mediators intervene in the collective sensemaking process that emerged around client conflicts. Through analysis of qualitative data sources, I found that emotion work, and the emotion dynamics they prompted, were an integral part of sensemaking and sensegiving interactions. In this section, I discuss how my findings extend and enrich theory and practice.

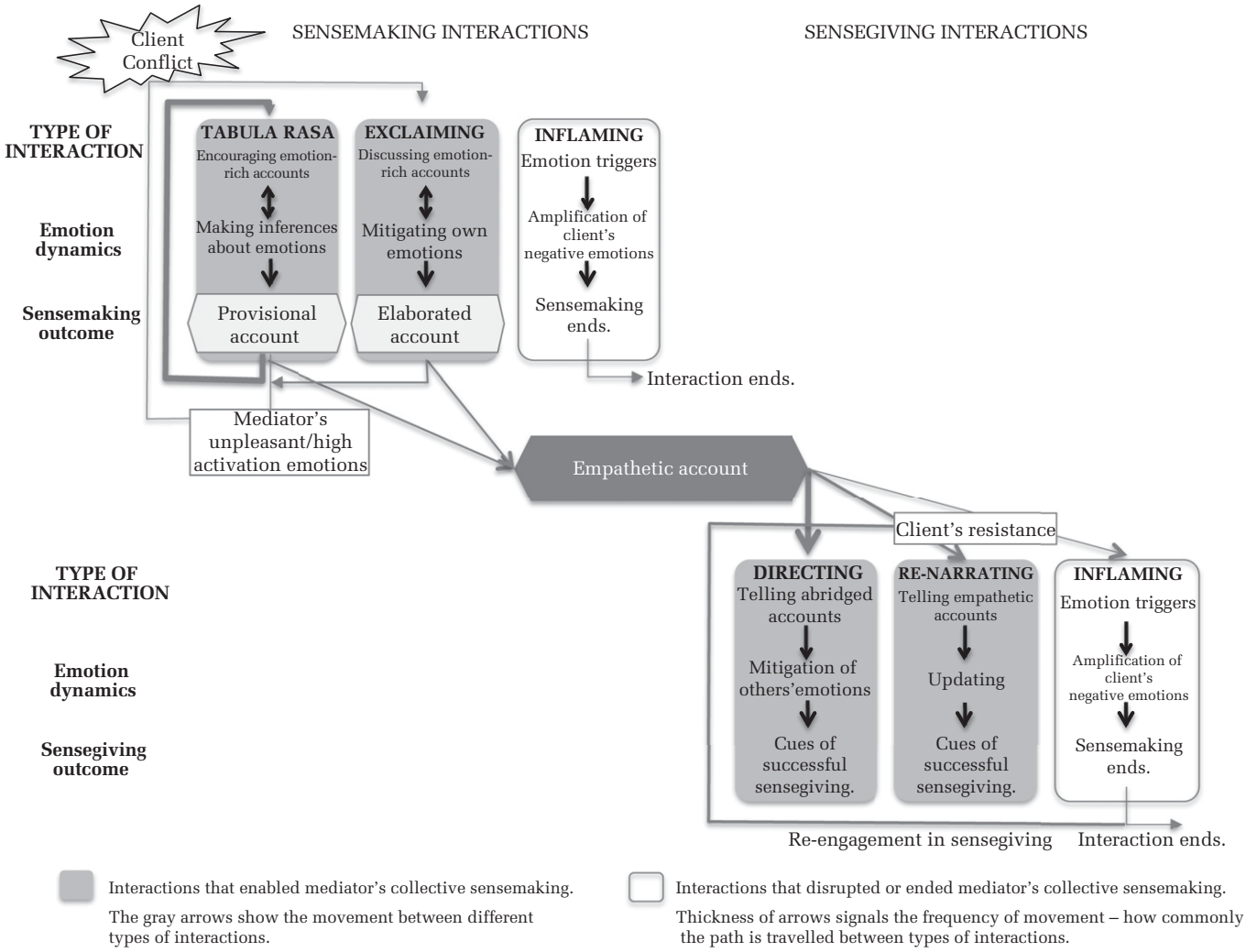
TABLE 8
Inflaming Interactions

Second-order themes	First-order concepts	Evidence
Emotion triggers	Mediator's emotional expressiveness	One of the things I have learned is . . . I can't sit here and say to a patient, or to you, or to anyone, "I understand how you feel." Because most likely, I don't. I don't understand what it feels like to have an amputated leg. I don't understand what it feels like to have cancer, because I've not experienced those two things. And so I try never to say, "I understand how you feel." *(Interview)*
		As the family told Florence their story, they began to blame nurses for failing to inform them about the process they should have used to become "next of kin." Instead of maintaining her emotional neutrality, Florence became defensive and agitated on behalf of the nurses, arguing that the nurses had indeed done their job, and emphasizing the precarious legal position of the family members in her office. *(Shadowing)*
	Dissatisfaction with response to problem	I certainly think there are some people for whom no outcome is adequate and that is very frustrating. *(Interview)*
		That was a case where I felt like, every time he had a question, I was able to go get an answer for him. And I felt like we had done everything right. I had good answers for him. And so I thought that that case had gone really well, but then learned later that it hadn't. *(Interview)*
	Clients who "push and push and push"	I have a patient I'm working on now, and nothing is specific enough for her, nothing is detailed enough for her, none of the doctors right enough for her. And she wants, oh, everything in healthcare changed to be more specific. And she's just one of these people who just pushes and pushes and pushes. *(Interview)*
		And they just, you know, just push and push. There's not a lot of those, but they're challenging. *(Interview)*
Amplification of client's negative emotions	Client's negative emotions escalate	After arguing about who was to blame for several minutes, one of the family members abruptly said, "we're done here!" and walked out of the mediator's office in disgust. The rest of the family soon followed. *(Shadowing)*
		I think that's the most frustrating, when you are willing to help them, could help them, and they get angry . . . and walk off. *(Interview)*
	Mediator becomes target for client's anger	You got to be very careful not to make somebody defensive . . . For example, with one [physician], I wanted to give a heads up [about a family's complaint] and she was mad because the family didn't tell her, and she went off on me, "Why wasn't I given the heads up on Friday?" *(Interview)*
		Mediator told me that she'd written a lovely letter, but this person was not happy with the letter and yelled at her . . . He had a complicated case. It involves alcoholism and a few other things, but he got really good care, and he had to come back one month later for a liver function tests, and he was charged for that. He was supposed to pay $15, and he didn't feel that he should have to. *(Shadowing)*

Theoretical Contributions

Theorizing a process of organizational responsiveness to client conflicts. The process model I developed stands in contrast to the traditional images of how organizational employees respond to client conflicts. Research on interactive service work tends to focus on the outcomes of either control over others' behavior and emotions *vis-à-vis* dyadic interactions (Hochschild, 1983; Wharton, 2009) or how performing emotional labor influences the employee (Grandey & Gabriel, 2015). In contrast, this research shows how mediators engaged simultaneously in emotion work *and* sensemaking and sensegiving, in attempts to develop and deploy understanding. These interactions were not contained in one dyadic interaction, but unfolded over multiple interactions with multiple clients who occupy a variety of roles. As a result, this model provides insight into how organizations not only control, but also can be responsive to client conflicts in a dynamic process, by providing "a systematic way to articulate and accommodate multiple points of view, each with the potential to add value. . ." (Gittell & Douglass, 2012: 724). Decades of research have shown how interactive service work varies according the level of occupational prestige and privilege (Wharton, 2009) and organizational context (Lopez, 2006). This research expands our perspective on interactive service work by demonstrating how it can also vary by the extent of

FIGURE 1
Intervening in Collective Sensemaking to Mediate Client Conflicts



sensemaking involved. Future research can explore how outcomes and mechanisms associated with emotional labor and interactive service work research are affected by sensemaking-intensive contexts.

Emotion work and emotion dynamics in sensemaking. This research contributes to our understanding of the role of emotions in sensemaking in several ways. First, one of the most well-known findings regarding emotion and sensemaking involves the contagion and amplification of intense, negative emotion, which has been found to disrupt individuals' and collectives' ability to engage in sensemaking (Cornelissen et al., 2014; Weick, 1993). Confirming this previous research, I found that when the amplification of negative emotions occurs, mediators' sensemaking—and their ability to intervene in the client's problematic situation—is indeed disrupted. However, the triggers for amplification are different. In previous studies, the overwhelming nature of the crisis—an external event—triggered a mostly automatic process of emotional contagion and amplification of intense negative emotions. In contrast, the emotion triggers here were more minor and could be prompted as a result of the mediators' own subtle emotions expressed in interactions. Yet, the effect on collective sensemaking is the same; interactions end abruptly, disrupting the social processes necessary for sensemaking.

My analyses identify several additional emotional dynamics, the emotion work that prompted them, and their generally salutary effect on sensemaking and

sensegiving. First, in tabula rasa interactions, mediators encouraged clients to express emotion-rich accounts. Encouraging emotion-rich accounts stands in contrast to traditional perspectives on emotional labor (Hochschild, 1983; Wharton, 2009), in which employees try to influence the content of others' emotional expressions. Mediators, in contrast, did not want to influence the content of the emotional expressions, but rather were trying to facilitate the controlled release of those emotions so that the mediator could engage in sensemaking about the conflict. Mitigation, or the lessening or reversing of negative emotions (Hadley, 2014), is a second emotional dynamic identified. Mediators' mitigation of their *own* emotions was critical for elaborating the account and readying themselves to continue to engage in sensemaking. Mediators also engaged in emotion work during sensegiving interactions to prompt mitigation of *others'* emotions; this made sensegiving targets more receptive to the mediator's sensegiving. This portrait of mitigation suggests that sensemaking and the acceptance of sensegiving are facilitated by mitigation of emotions. Third, in re-narrating interactions, mediators' provoked surprise in resistant sensegiving targets by drawing on the empathetic account they had developed, prompting the target to see the conflict from another perspective, and to update their understanding. This dynamic was only possible because mediators had developed rich accounts that they could selectively draw on as they engaged with different clients and stakeholders. This finding helps deepen our understanding of a relatively understudied process of sensemaking—updating (Christianson, 2009; Rudolph, Morrison, & Carroll, 2009)—and in particular, how new understandings can be transferred across collectives (Maitlis & Sonenshein, 2010) with the aid of skillful mediators (Strike & Rerup, 2016). In sum, this research has broadened the emotional dynamics scholars can attend to by identifying amplification, encouraging emotion-rich accounts, mitigation, and the provocation of surprise.

Finally, by following the mediators throughout the process of handling conflicts, the process model I developed shows how these interactions fit together into a larger pattern, which contributes to an important frontier in emotions research, emotion cycles (Hareli & Rafaeli, 2008: 36), or how "one person's emotion is a factor that can shape the behaviors, thoughts and emotions of other people, and that emotion operates in cycles that can involve multiple people in a process of reciprocal influence." Empirical research on emotion cycles is relatively rare (for exceptions, see Huy, 2002; Liu & Maitlis, 2014; Maitlis & Ozcelik, 2004), and with one exception (Huy, 2002), these studies tend not to focus on how actors attempt to *purposefully* influence the social, emotional, and sensemaking dynamics. In the findings presented here, we see a skilled practitioner attempting to calibrate the emotions with different parties involved in the conflict so as to engage in sensemaking and sensegiving. Yet they recalled in interviews (and I witnessed while shadowing cases) instances in which their intervention into collective sensemaking was unsuccessful and their ability to engage in sensemaking or sensegiving was derailed. This variation helps to explain how emotions influence sensemaking by linking the emotion work mediators do, the emotion dynamics engendered, and the cycles of interactions mediators engage in, to mediate in a collective sensemaking process.

Emotions and the plausibility of accounts. In the sensemaking perspective, the pivot from sensemaking to sensegiving occurs when the sensemaker develops a plausible account. This research extends our understanding of the role of emotions in plausibility in three ways. First, the findings here confirm that plausible accounts facilitate practical action (Sonenshein, 2007; Weick et al., 2005), but they also suggest that the emotions embedded in an account may be an important explanation for *why* practical action is facilitated. Mediators' empathetic accounts enabled them to engage constructively in a variety of sensegiving interactions with multiple stakeholders. The empathetic account became a sensegiving resource that could be selectively and flexibly drawn upon. By selectively drawing on this empathetic account, they could influence the emotions and the cognitions (i.e., the sense made) of others. Empathetic accounts may be particularly relevant for people in mediating roles, because empathy facilitates relating (Stephens, Heaphy, & Dutton, 2011). But, future researchers may identify other roles or settings in which plausible accounts are endowed with different emotions. A person who has experienced a denied promotion might benefit from a plausible account of their experience that is characterized by hope (e.g., Vough & Caza, 2017), while a leader of an organizational change may benefit from a plausible account of the change featuring positive emotions (e.g., pride or excitement) that might serve as a resource throughout

a change process (Adler et al., 2008). Future research might examine *which* emotions are embedded in accounts, the *process* through which those emotions become embedded in the accounts, and how those emotional qualities provide more or fewer resources for individuals engaging in sensegiving.

Second, scholars have theorized that sensemakers go through a process of developing intermediate accounts on the way to developing a plausible account (Abolafia, 2010; Garud et al., 2011; Maitlis et al., 2013). Further, Maitlis and colleagues (2013: 18) recently theorized that individual sensemakers should accept or reject accounts "based on the degree to which their interpretation, action orientation, and felt emotion cohere." My findings provide empirical support for this view, suggesting that mediators felt and expressed a wide range of emotions, and worked on those emotions, molding them toward an empathetic account over time. Having peers to process one's own emotions was critical for developing empathetic accounts. This suggests that having other people with whom emotions can be processed may be an important resource for developing accounts that emotionally resonate as plausible.

Third, the findings also help us to understand the similarities and differences between developing accounts that are for a mediator's use rather than broad public consumption. Specifically, this study's findings resemble Brown's (2004) research on how public inquiry texts convey authority. Brown (2004: 100) argued that readers of public inquiry reports will believe them to be true, in part, when they "invite the reader's sympathetic engagement," and provide micro-situational detail and vicarious experience. Yet, while Brown (2004) examined how texts convey authority to the public writ large, here mediators were developing a sense of empathy for clients for their own use, not for broad public consumption. Indeed, mediators attempted not to activate the emotions of others when sharing their abridged accounts, only attempting to provoke empathy when they faced resistance. This contrast highlights that intervening in ongoing collective sensemaking appears to require different kinds of engagement with sensegiving targets compared to the post-crisis setting studied in Brown's research.

Compassion. This study also has implications for the study of compassion in organizations. First, while compassion often occurs informally, it can also be formalized and institutionalized into roles and programs (Lilius et al., 2012). What is notable about the mediators studied here is while a mediator often felt a wide variety of emotions during this process, they only expressed empathy—the defining emotion in compassion— in select interactions. This suggests that future research on the institutionalization of compassion should attend to how the compassion providers' internal experience differs from its public display. Second, compassion scholars have recently theorized that sensemaking is an important component of compassion and that both the compassion provider, as well as sufferer, engage in sensemaking (Atkins & Parker, 2012; Dutton et al., 2014; Simpson, Clegg, & Pitsis, 2014). This research begins to shed some light on how sensemaking suffuses the compassion-providers' experience and how sufferers might influence the provision of compassion, namely through inflaming interactions from which they opt to exit and prevent the mediator from intervening. This is one step toward understanding more about how compassion targets actively participate in sensemaking.

Broader Implications and Future Research

Investigating how patient advocates in hospitals engage in mediating client conflicts is particularly well-suited to generate insights into how mediators intervene in collective sensemaking. Patient advocates' work allows a degree of transparency into the felt and expressed emotions of a variety of stakeholders. Patient advocates discussed their work with peers, and had to document their accounts in written documents, which meant that I had multiple ways to assess their activities, experiences, and meanings. The frequency with which patient advocates handle new cases, and the formal time limits that put boundaries around how long it takes to resolve a case, provided an excellent and rare (i.e., Strike & Rerup, 2016) vantage point from which to learn about how emotion work influenced the sensemaking and sensegiving process across many cases. Finally, by asking about and observing many cases, I had direct access to study mediators who were experts at handling problems, while also, as a contrast, soliciting stories about and occasionally observing failures.

Despite these strengths of the patient advocate role for generating insights, it is important to consider how the findings and theorizing presented here compare to other work contexts. Given my

qualitative field methods, I focus on describing how the insights about collective sensemaking and emotion work can be transferred (Lincoln & Guba, 1985; Lincoln & Guba, 2002) from this empirical context to similar ones. Like other recent studies of how individuals respond to surprise or conflict on behalf of organizations (Bechky & Okhuysen, 2011; Strike & Rerup, 2016), and unlike traditional occasions for sensemaking that are triggered by unexpected events, such as crises, patient advocates are expected to engage in sensemaking and sensegiving interactions, thus enabling them to be ready to manage their own and others' emotions. We might expect, therefore, that the interaction types and emotion dynamics might be transferable to situations in which actors expect to intervene in collective sensemaking, as opposed to those in which sensemaking is a surprise.

The medical setting is a highly emotional context, in which patients and families are grappling with emotional experiences, and hospital staff expect to engage with their own and others' emotions. While research on emotions has shown us that emotions suffuse organizational life, it has also taught us that the norms regarding emotional expression vary tremendously across and within organizations and occupations (Martin et al., 1998; Meyerson, 1994). Future research should examine how variation in the emotionality of the context influences this process. In low emotion contexts, for example, the tabula rasa interactions may look quite different. For example, instead of expressing emotional neutrality, mediators may need to engage more actively to provoke emotions (e.g., create anxiety), create bounded times and spaces to encourage the full expression of emotions (Huy, 2002; Kahn, 2001), or purposefully connect people, rather than separate them, to generate the emotional activation and expression necessary for mediators to engage in sensemaking. Given the lower intensity of emotions, the process of developing an empathetic account may take longer, as mediators have to engage with more people who are willing to share their emotions. Thus, while we may expect to find these types of interactions and their emotional dynamics in a variety of settings, there may be different temporal ordering or additional interaction types when the level of emotionality is lower.

While I believe my findings have implications for mediators and other conflict-handling work in organizations, particularly those with the characteristics described above, exploring the limitations of my sample and context opens up possibilities for future research. For example, the data collection focuses on the patient advocates' perspective, supplemented by observational data of clients. While I believe that observational data provide a strong basis for understanding the role of emotion work and its effect on sensemaking and sensegiving, scholars have recently suggested that it is important to attend to the dyadic nature of such interactions (Dutton et al., 2014: 296). Future research might consider how clients actively shape collective sensemaking as individuals or through extra-organizational forums (e.g., online support groups).

Implications for Practice

Mediators intervene in others' sensemaking in highly emotional settings on a regular basis. While these findings are sure to be of use to those employees who mediate conflicts on a full-time basis, many of us intervene in collective sensemaking occasionally, whether it is as a teacher intervening in a student dispute over a class project, managers handling employee "disturbances" (Frost, 2003; Mintzberg, 1973), peers attempting to provide assistance in employee support programs (Bacharach, Bamberger, & McKinney, 2000), or teaching or parenting children. The findings presented in this study can help inform practice about how to engage in such conflicts. While in many contexts there are strong cultural and organizational norms pushing people to ignore or minimize emotions (e.g., Dougherty & Drumheller, 2006), this research suggests that it may be beneficial to develop the skills of emotion work. Further, organizations should consider how they might institutionalize a mediating capacity to engage in sensemaking and emotion work among constituents.

CONCLUSION

That clients, customers, and employees experience emotion-laden problems and conflicts in organizations is a timeless issue. How organizations *respond* to such problems and conflicts, however, may shift over time. The research presented here expands our traditional perspective on interactive service work, which emphasizes routinization and a lack of cognitive engagement, by investigating a context in which a high degree of responsiveness, sensemaking, and sensegiving was necessary. The result is a model of intervening in

collective sensemaking to mediate client conflicts that integrates research on sensemaking, emotion work, and emotion dynamics in novel ways. My hope is that the theoretical model that emerged will stimulate research on the subtle, complex, and important interpersonal work that is accomplished in contemporary organizations.

REFERENCES

Abolafia, M. Y. 2010. Narrative construction as sensemaking: How a central bank thinks. ***Organization Studies***, 31: 349–367.

Adler, P. S., Kwon, S.-W., & Heckscher, C. 2008. Professional work: The emergence of collaborative community. ***Organization Science***, 19: 359–376.

Afifi, T., Afifi, W., Merrill, A. F., Denes, A., & Davis, S. 2013. "You need to stop talking about this!": Verbal rumination and the costs of social support. ***Human Communication Research***, 39: 395–421.

Antaki, C. 1994. ***Explaining and arguing: The social organization of accounts***. London: Sage.

American Hospital Association. 2002. ***In the name of the patient***. Chicago, IL: American Hospital Association.

Ashforth, B. E., & Humphrey, R. H. 1993. Emotional labor in service roles: The influence of identity. ***Academy of Management Review***, 18: 88–115.

Atkins, P. W. B., & Parker, S. K. 2012. Understanding individual compassion in organizations: The role of appraisals and psychological flexibility. ***Academy of Management Review***, 37: 524–546.

Bacharach, S., Bamberger, P., & McKinney, V. 2000. Boundary management tactics and logics of action: The case of peer-support providers. ***Administrative Science Quarterly***, 45: 704–736.

Balogun, J., Bartunek, J. M., & Do, B. 2015. Senior manager' sensemaking and responses to strategic change. ***Organization Science***, 26: 960–979.

Balogun, J., & Johnson, G. 2004. Organizational restructuring and middle manager sensemaking. ***Academy of Management Journal***, 47: 523–549.

Balogun, J., & Johnson, G. 2005. From intended strategies to unintended outcomes: The impact of change recipient sensemaking. ***Organization Studies***, 26: 1573–1601.

Barrett, M., Davidson, E., Prabhu, J., & Vargo, S. L. 2015. Service innovation in the digital age: Key contributions and future directions. ***Management Information Systems Quarterly***, 39: 135–154.

Barsade, S. 2002. The ripple effect: Emotional contagion and its influence on group behavior. ***Administrative Science Quarterly***, 47: 644–675.

Bartunek, J. M., Balogun, J., & Do, B. 2009. Considering planned change anew: Stretching large group interventions strategically, emotionally, and meaningfully. ***The Academy of Management Annals***, 5: 1–52.

Bechky, B., & Okhuysen, G. A. 2011. Expecting the unexpected? How SWAT officers and film crews handle surprises. ***Academy of Management Journal***, 54: 239–261.

Benner, P., Tanner, C. A., & Chesla, C. A. 1996. ***Expertise in nursing practice: Caring, clinical judgment, and ethics***. New York, NY: Springer Publishing Company.

Boje, D. M. 1991. The Storytelling Organization: A study of story performance in an office-supply firm. ***Administrative Science Quarterly***, 36: 106–126.

Boje, D. M. 2001. ***Narrative methods for organizational and communication research***. London: Sage.

Bolton, S. C. 2000. Who cares? Offering emotion work as a "gift" in the nursing labor process. ***Journal of Advanced Nursing***, 32: 580–586.

Bolton, S. C., & Boyd, C. 2003. Trolley dolly or skilled emotion manager? ***Work, Employment and Society***, 17: 289–308.

Bowen, D. E. 2016. The changing role of employees in service theory and practice: An interdisciplinary view. ***Human Resource Management Review***, 26: 4–13.

Brown, A. D. 2004. Authoritative sensemaking in a public inquiry report. ***Organization Studies***, 25: 95–112.

Charmaz, K. 2006. ***Constructing grounded theory: A practical guide to qualitative analysis***. Thousand Oaks, CA: Sage.

Charters, M. A. 1993. The patient representative role and sources of power. ***Hospital & Health Services Administration***, 38: 429–442.

Christianson, M. K. 2009. ***Updating as part of everyday work: An interactional perspective***. Ann Arbor, MI: University of Michigan.

Cornelissen, J., Mantere, S., & Vaara, E. 2014. The contraction of meaning: The combined effect of communication, emotions, and materiality on sensemaking in the Stockwell shooting. ***Journal of Management Studies***, 51: 699–736.

Cunha, M. P., Clegg, S., & Kamoche, K. 2006. Surprises in management and organization: Concept, sources and a typology. ***British Journal of Management***, 17: 317–329.

Dougherty, D. S., & Drumheller, K. 2006. Sensemaking and emotions in organizations: Accounting for emotions in a rational(ized) context. ***Communication Studies***, 57: 215–238.

Dutton, J. E., Workman, K. M., & Hardin, A. E. 2014. Compassion at work. ***Annual Review of Organizational Psychology and Organizational Behavior***, 1: 277–304.

Edmondson, A. C. 1996. Learning from mistakes is easier said than done: Group and organizational influences on the detection and correction of human error. ***The Journal of Applied Behavioral Science***, 32: 5–28.

Edmondson, A. C., & McManus, S. E. 2007. Methodological fit in management field research. ***Academy of Management Review***, 32: 1155–1179.

Ekman, P. 1992. Facial expressions of emotion: New findings, new questions. ***Psychological Science***, 3: 34–38.

Elsbach, K. D., Sutton, R. I., & Principe, K. E. 1998. Averting expected challenges through anticipatory impression management: A study of hospital billing. ***Organization Science***, 9: 68–86.

Fineman, S. 1993. Organizations as emotional arenas. In S. Fineman (Ed.), ***Emotion in organizations***: 9–35. London: Sage.

Fineman, S. 2003. ***Understanding emotion at work***. London: Sage.

Frost, P. J. 2003. ***Toxic emotions at work: How compassionate managers handle pain and conflict***. Boston, MA: Harvard Business School Press.

Garud, R., Dunbar, R. L. M., & Bartel, C. A. 2011. Dealing with unusual experiences: A narrative perspective on organizational learning. ***Organization Science***, 22: 587–601.

Gioia, D. A., & Chittipeddi, K. 1991. Sensemaking and sensegiving in strategic change initiation. ***Strategic Management Journal***, 12: 433–448.

Gittell, J. H., & Douglass, A. 2012. Embedding reciprocal relationships into roles: The relational bureaucratic form. ***Academy of Management Review***, 37: 709–733.

Goffman, E. 1952. On cooling the mark out: Some aspects of adaptation to failure. ***Journal for the Study of Interpersonal Processes***, 4: 451–463.

Grandey, A. A., & Gabriel, A. S. 2015. Emotional labor at a crossroads: Where do we go from here? ***Annual Review of Organizational Psychology and Organizational Behavior***, 2: 1–21.

Gross, J. J. 2014. Emotion regulation: Conceptual and empirical foundations. In J. J. Gross (Ed.), ***Handbook of emotion regulation***: 3-20. New York, NY: Guilford.

Gross, J. J., & John, O. P. 1995. Facets of emotional expressivity: Three self-report factors and their correlates. ***Personality and Individual Differences***, 19: 555–568.

Hadley, C. N. 2014. Emotional roulette? Symmetrical and asymmetrical emotion regulation outcomes from coworker interactions about positive and negative work events. ***Human Relations***, 67: 1–22.

Hareli, S., & Rafaeli, A. 2008. Emotion cycles: On the social influence of emotion in organizations. ***Research in Organizational Behavior***, 28: 35–59.

Hatfield, E., Cacioppo, J., & Rapson, R. L. 1992. Primitive emotional contagion. In M. S. Clark (Ed.), ***Review of personality and social psychology: Emotion and social behavior***: vol. 14: 151–177. Newbury Park, CA: Sage.

Heaphy, E. D. 2013. Repairing breaches with rules: Maintaining institutions in the face of everyday disruptions. ***Organization Science***, 24: 1291–1315.

Heaphy, E. D., Locke, K., & Booth, B. 2016. Embodied relational competence: Attending to the body in the boundary-spanning work of patient advocates. In K. D. Elsbach & B. Bechky (Eds.), ***Qualitative organizational research: Best papers from the Davis Conference on Qualitative Research***, Vol. 3: 161–197: Charlotte, NC: Information Age Publishing.

Hochschild, A. 1983. ***Managed heart: Commercialization of human feeling***. Berkeley, CA: University of California Press.

Hoffman, M. L. 2008. Empathy and prosocial behavior. In M. Lewis, J. M. Haviland-Jones & L. F. Barrett (Eds.), ***Handbook of emotions, Vol. 3***. New York: Guilford Press.

Hulsheger, U. R., Alberts, H. J., Feinholt, A., & Lang, J. W. 2013. Benefits of mindfulness at work: The role of mindfulness in emotion regulation, emotional exhaustion, and job satisfaction. ***The Journal of Applied Psychology***, 98: 310–325.

Hunter, B. 2001. Emotion work in midwifery: A review of current knowledge. ***Journal of Advanced Nursing***, 34: 436–444.

Huy, Q. 2002. Emotional balancing of organizational continuity and radical change: The contribution of middle managers. ***Administrative Science Quarterly***, 47: 31–69.

Huy, Q. 2011. How middle managers' group-focus emotions and social identities influence strategy implementation. ***Strategic Management Journal***, 32: 1387–1410.

Kahn, W. A. 2001. Holding environments at work. ***The Journal of Applied Behavioral Science***, 37: 260–279.

Karambayya, R., & Brett, J. M. 1989. Managers handling disputes: Third-party roles and perceptions of fairness. ***Academy of Management Journal***, 32: 687–704.

Keltner, D., & Haidt, J. 1999. Social functions of emotions at four levels of analysis. ***Cognition and Emotion***, 13: 505–521.

Kendra, J., & Wachtendorf, T. 2006. The waterborne evacuation of Lower Manhattan on September 11: A case of distributed sensemaking. Preliminary paper 355. University of Delaware Disaster Research Center.

Kirkman, B. L., & Chen, G. 2011. Maximizing your data or data slicing? Recommendations for managing multiple data submissions from the same dataset. ***Management and Organization Review***, 7: 433–446.

Kolb, D. M. 1985. To be a mediator: Expressive tactics in mediation. ***The Journal of Social Issues***, 41: 11–26.

Kolb, D. M., & Bartunek, J. M. 1992. ***Hidden conflict in organizations: Uncovering behind-the-scenes disputes***. Newbury Park, CA: Sage.

Korczynski, M. 2003. Communities of coping: Collective emotional labor in service work. ***Organization***, 10: 55–79.

Langley, A. 1999. Strategies for theorizing from process data. ***Academy of Management Review***, 24: 691–710.

Leidner, R. 1993. ***Fast food, fast talk: Service work and the routinization of everyday life***. Berkeley, CA: University of California Press.

Lewicki, R. J., Weiss, S. E., & Lewin, D. 1992. Models of conflict, negotiation and third party intervention: A review and synthesis. ***Journal of Organizational Behavior***, 13: 209–252.

Lilius, J. M., Kanov, J., Dutton, J. E., Worline, M. C., & Maitlis, S. 2012. Compassion revealed: What we know about compassion at work (and where we need to know more). In K. S. Cameron & G. Spreitzer (Eds.), ***The handbook of positive organizational scholarship***. New York, NY: Oxford University Press.

Lincoln, Y. S., & Guba, E. G. 1985. ***Naturalistic inquiry***. Thousand Oaks, CA: Sage.

Lincoln, Y. S., & Guba, E. G. 2002. Judging the quality of the case study report. In A. Huberman & M. Matthews (Eds.), ***The qualitative researcher's companion***. Thousand Oaks, CA: Sage.

Liu, F., & Maitlis, S. 2014. Emotional dynamics in strategizing processes: A study of strategic conversations in top team meetings. ***Journal of Management Studies***, 51: 202–234.

Locke, K. 1996. A funny thing happened! The management of consumer emotions in service encounters. ***Organization Science***, 17: 40–59.

Locke, K. 2001. ***Grounded theory in management research***. Thousand Oaks, CA: Sage.

Lofland, J., Snow, D., Anderson, L., & Lofland, L. H. 2006. ***Analyzing social settings: A guide to qualitative observation and analysis*** (4th edn). Toronto, ON: Wadsworth.

Lopez, S. H. 2006. Emotional labor and organized emotional care: Conceptualizing nursing home care work. ***Work and Occupations***, 33: 133–160.

Mailick, M. D., & Rehr, H. 1981. ***In the patient's interest: Access to hospital care***. New York, NY: Prodist.

Maitlis, S. 2005. The social processes of organizational sensemaking. ***Academy of Management Journal***, 48: 21–49.

Maitlis, S., & Christianson, M. 2014. Sensemaking in organizations: Taking stock and moving forward. ***The Academy of Management Annals***, 8: 57–125.

Maitlis, S., & Lawrence, T. B. 2007. Triggers and enablers of sensegiving in organizations. ***Academy of Management Journal***, 50: 57–84.

Maitlis, S., & Ozcelik, H. 2004. Toxic decision processes: A study of emotion and organizational decision making. ***Organization Science***, 15: 375–393.

Maitlis, S., & Sonenshein, S. 2010. Sensemaking in crisis and change: Inspiration and insights from Weick (1988). ***Journal of Management Studies***, 47: 551–580.

Maitlis, S., Vogus, T. J., & Lawrence, T. B. 2013. Sensemaking and emotion in organizations. ***Organizational Psychology Review***, 3: 222–247.

Martin, J., Knopoff, K., & Beckman, C. 1998. An alternative to bureaucratic impersonality and emotional labor: Bounded emotionality at the Body Shop. ***Administrative Science Quarterly***, 43: 429–469.

McDonald, S. 2005. Studying actions in context: A qualitative shadowing method for organizational research. ***Qualitative Research***, 5: 455–473.

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

Mintzberg, H. 1973. A new look at the chief executive's job. ***Organizational Dynamics***, 1: 20–30.

Morrill, C., & Rudes, D. S. 2010. Conflict resolution in organizations. ***Annual Review of Law and Social Science***, 6: 627–651.

Orr, J. E. 1996. ***Talking about jobs: An ethnography of a modern job***. Ithaca, NY: Cornell University Press.

Pentland, B. 1992. Organizing moves in software support hot lines. ***Administrative Science Quarterly***, 37: 527–548.

Rouleau, L. 2005. Micro-practices of strategic sensemaking and sensegiving: How middle managers interpret and sell change every day. ***Journal of Management Studies***, 42: 1413–1441.

Rouleau, L., & Balogun, J. 2011. Middle managers, strategic sensemaking, and discursive competence. ***Journal of Management Studies***, 48: 953–983.

Rudolph, J. W., Morrison, J. B., & Carroll, J. S. 2009. The dynamics of action-oriented problem solving: Linking interpretation and choice. ***Academy of Management Review***, 34: 733–756.

Russell, J. A. 2003. Core affect and the psychological construction of emotion. ***Psychological Review***, 110: 145–172.

Sandberg, J., & Tsoukas, H. 2014. Making sense of the sensemaking perspective: Its constituents, limitations, and opportunities for further development. ***Journal of Organizational Behavior***, 36: 6–32.

Simpson, A. V., Clegg, S., & Pitsis, T. 2014. Normal compassion: A framework for compassionate decision making. ***Journal of Business Ethics***, 119: 473–491.

Smith, A. I., & Kleinman, A. 1989. Managing emotions in medical school: Students' contacts with the living and the dead. ***Social Psychology Quarterly***, 52: 56–69.

Smith, C. A., & Ellsworth, P. C. 1985. Patterns of cognitive appraisal in emotion. ***Journal of Personality and Social Psychology***, 48: 813–838.

Sonenshein, S. 2007. The role of construction, intuition and justification in responding to ethical issues at work: The sensemaking-intuition model. ***Academy of Management Review***, 32: 1022–1040.

Sonenshein, S. 2010. We're changing or are we? Untangling the role of progressive, regressive, and stability narratives during strategic change implementation. ***Academy of Management Journal***, 53: 477–512.

Spradley, J. P. 1979. ***The Ethnographic Interview***. New York, NY: Holt, Rinehart, & Winston.

Stenross, B., & Kleinman, S. 1989. The highs and lows of emotional labor: Detectives encounters with criminals and victims. ***Journal of Contemporary Ethnography***, 17: 435–452.

Stephens, J. P., Heaphy, E. D., & Dutton, J. E. 2011. High quality connections. In G. Spreitzer & K. S. Cameron (Eds.), ***Oxford handbook of positive organizational scholarship***: 385–399. Oxford: Oxford University Press.

Stigliani, I., & Ravasi, D. 2012. Organizing thoughts and connecting brains: Material practices and the transition from individual to group-level prospective sensemaking. ***Academy of Management Journal***, 55: 1232–1259.

Stinchcombe, A. L. 1990. ***Information and Organizations.*** Berkeley, CA: University of California Press.

Strauss, A. L., & Corbin, J. 1997. ***Grounded theory in practice***. Thousand Oaks, CA: Sage.

Strike, V. M., & Rerup, C. 2016. Mediated sensemaking. ***Academy of Management Journal***, 59: 880–905.

Sullivan, M. 2003. The new subjective medicine: Taking the patient's point of view on health care and health. ***Social Science & Medicine***, 56: 1595–1604.

Sutcliffe, K. M., Vogus, T. J., & Dane, E. 2016. Mindfulness in organizations: A cross-level review. ***Annual Review of Organizational Psychology and Organizational Behavior***, 3: 55–81.

Sutton, R. I. 1991. Maintaining norms about expressed emotions: The case of bill collectors. ***Administrative Science Quarterly***, 36: 245–268.

Tucker, A. L., Edmondson, A. C., & Spear, S. 2002. When problem solving prevents organizational learning. ***Journal of Organizational Change Management***, +±: 122–137.

Van de Ven, A. H., & Poole, M.S. 1995. Explaining development and change in organizations. ***Academy of Management Review***, 20: 510–540.

Vogus, T. J., Rothman, N. B., Sutcliffe, K. M., & Weick, K. E. 2014. The affective foundations of high-reliability organizing. ***Journal of Organizational Behavior***, 35: 592–596.

Vough, H., & Caza, B. 2017. Where do I go from here? Sensemaking and the construction of growth-based stories in the wake of denied promotions. ***Academy of Management Review***, 42: 103–128.

Wall, J. A., & Dunne, T. C. 2012. Mediation research: A current review. ***Negotiation Journal***, 28: 217–244.

Walsh, I. J., & Bartunek, J. M. 2011. Cheating the fates: Organizational foundings in the wake of demise. ***Academy of Management Journal***, 54: 1017–1044.

Weick, K. E. 1993. The collapse of sensemaking in organizations: The Mann Gulch disaster. ***Administrative Science Quarterly***, 38: 628–652.

Weick, K. E. 1995. ***Sensemaking in Organizations***. Thousand Oaks, CA: Sage.

Weick, K. E., Sutcliffe, K. M., & Obstfeld, D. 2005. Organizing and the process of sensemaking. ***Organization Science***, 16: 409–421.

Wharton, A. 2009. The sociology of emotional labor. ***Annual Review of Sociology***, 35: 147–165.

Wharton, A., & Erickson, R. J. 1993. Managing emotions on the job and at home: Understanding the consequences of multiple emotional roles. ***Academy of Management Review***, 18: 457–486.

Whittle, A., & Mueller, F. 2012. Bankers in the dock: Moral storytelling in action. ***Human Relations***, 65: 111–139.

Yagil, D., & Medler-Liraz, H. 2013. Moments of truth: Examining transient authenticity and identity in service encounters. ***Academy of Management Journal***, 56: 473–497.

Yin, R. K. 2009. ***Case study research: Design and methods***. Thousand Oaks, CA: Sage.

Zapf, D. 2002. Emotion work and psychological well-being: A review of the literature and some conceptual considerations. ***Human Resource Management Review***, 12: 237–268.

Emily D. Heaphy (eheaphy@uri.edu) is an assistant professor at the University of Rhode Island. She received her PhD from the University of Michigan. Her research examines social relationships, emotions and the human body at work.

APPENDIX A

INTERVIEW PROTOCOL FOR INTERVIEWS WITH PATIENT ADVOCATES[3]

Introduction

I am interested in learning about your work as a patient advocate.

Warm-up Questions

(1) What was your path to your current job?
(2) Please tell me about the hospital where you work.
(3) I would like to learn about a typical day in your life as a patient advocate. Can you walk me through a day-in-your-life, to help me understand what you do?

Key Questions

(4) Please tell me a story about a time when you felt like you handled a case really well.
(5) Please tell me a story about a time when you had a really difficult time with a case.
(6) Please tell me about a time when you had a patient or family member who wasn't sure what they wanted or needed help with.

Closing Questions

(7) Before we end the interview, I wanted to just ask you a few quick questions.
   (a) How long have you been in your current position?
   (b) Are there other patient advocates at your facility?
   (c) What kind of patient complaints and issues do you most often deal with?
   (d) Does your hospital have particular specialties?
   (e) Is your job title "patient advocate" or something else?
   (f) Who do you report to?

[3] This interview protocol includes only those questions used for this study.