On the Receiving End

Sensemaking, Emotion, and Assessments of an Organizational Change Initiated by Others

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This study focuses on the interpretations and experiences of change recipients, those who carry out organizational interventions initiated by others. Based on the ways nurses experienced a shared governance initiative implemented in their hospital, the authors investigated change recipients' sensemaking about organizational change through their ascribed meanings, emotional responses, and perceptions of its impacts on them. Survey data demonstrated how nurses subjectively assessed their gains and losses from the change initiative. Participation in the initiative increased the experience of gains, as did membership in a unit where change was implemented more fully. Textual analysis of open-ended responses to the survey indicated that gains were linked with interpretations of the change initiative and pleasant feelings and that there was considerable emotional contagion within work units. Such effects are particularly likely in employee empowerment initiatives as experiences are linked to interpretation and mood among change recipients.

Keywords: shared governance; sensemaking; organizational change; change recipients; emotion

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Change research gives short shrift to people who implement and live with organizational changes they did not initiate (Balogun & Johnson, 2004; George & Jones, 2001). The experiences of these change recipients are often cast as resistance (Kuhn & Corman, 2003; Oreg, 2003) without further probing. Lacking careful attention to the variety of recipient experiences, change studies focus primarily on change agents, implying that the way recipients of a change understand it is or ought to be similar to the way change agents do.

There is no reason to assume recipients and change agents share the same understandings. Action focus and orientations toward change differ among change agents, implementers, and recipients, creating distinct experiences (Kanter, Stein, & Jick, 1993). The same intervention can be interpreted quite differently by its various constituencies, who ascribe divergent meanings and value even to ostensibly mutually beneficial initiatives (e.g., Moch & Bartunek, 1990). Top managers, often reacting to external conditions less salient to other organization members, may hold radically different ideas from lower level organization members about how best to achieve the goals of change (Bacharach, Bamberger, & Sonnenstuhl, 1996). In fact, gaps in the understanding of organizational change can be considerable even between middle and higher level managers (Balogun & Johnson, 2004).

If little attention has been paid to how change recipients understand a change, even less is given to how they feel about it (George & Jones, 2001). Insofar as recent years reveal a resurgence of interest in emotions in the workplace (e.g., Brief & Weiss, 2002; Fisher & Ashkanasy, 2000; Seo, Barrett, & Bartunek, 2004), there is call to study the role of recipient emotions during organizational change initiatives (e.g., Huy, 1999, 2002; Mossholder, Settoon, Armenakis, & Harris, 2000; Mossholder, Settoon, Harris, & Armenakis, 1995).

The purpose of this study is to increase appreciation of how change recipients make sense of and feel about organizational change and the impacts these may have. We investigate change-related sensemaking and emotional responses to a change, the factors contributing to each, and their outcomes. We do so by means of an in-depth study

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of staff nurse experiences in one hospital's initiation of a widely disseminated participation program called *shared governance* (SG; Porter-O'Grady, 2004; Porter-O'Grady & Finnigan, 1984). This study is distinct from much previous research in its use of multiple assessments, including recipient survey responses, textual coding of open-ended descriptions regarding the recipients' change experience, and archival data and expert ratings regarding change implementation. Through these multiple assessments, we offer researchers and practitioners insight into the dual role of affect and social cognition in the experience of organizational change.

We begin by introducing shared governance as a type of change initiative and summarize how it was implemented in the setting we studied. We then discuss the functioning of sensemaking and emotion in initiatives such as this and how they may link with a change effort and its outcomes.

SHARED GOVERNANCE AS A CHANGE INITIATIVE

A well-known change initiative in nursing, shared governance has been implemented in more than 1,000 hospitals in the United States, including the majority of hospitals participating in the American Nurses' Credentialing Center's Magnet Excellence program (Anthony, 2004; Green & Jordan, 2004; Porter-O'Grady, 1994, 2004), as well as other countries including the United Kingdom and Denmark (e.g., Bamford & Porter-O'Grady, 2000; Burnhope & Edmonstone, 2003; Doherty & Hope, 2005). Its proponents champion nurses as trained professionals whose expertise is vital to hospital effectiveness, advocating that they be treated as such rather than low-skilled hired hands. Nurses share accountability for the quality of care they deliver and ownership over their work where SG is fully implemented. Shared governance is defined as

> a decentralized approach which gives nurses greater authority and control over their practice and work environment; engenders a sense of responsibility and accountability; and allows active participation in the decision-making process, particularly in administrative areas from which they were excluded previously. The primary aim is to support the relationship between the service provider (nurse) and the patient (client). (O'May & Buchan, 1999, p. 281)

Consistent with this definition, SG's guiding principles include nurse autonomy and independence, accountability, and especially participation in decisions that affect individual patient care and group governance (Maas & Specht, 1994; McDonagh, Rhodes, Sharkey, & Goodroe, 1989; Porter-O'Grady & Finnigan, 1984). It thus is included within the category of interventions aimed at empowering its recipients (Force, 2004; Scott & Caress, 2005).

Under SG, point-of-service decision making expands; staff nurses, who are seen as best informed about patients' immediate needs, are expected to influence care delivery strategies. To support point-of-service decision making, information on resources, costs, and outcomes that were previously almost exclusively the province of nurse managers and administrators are disseminated to staff nurses. SG is one manifestation of a trend in health care toward promoting greater nurse control over clinical practice

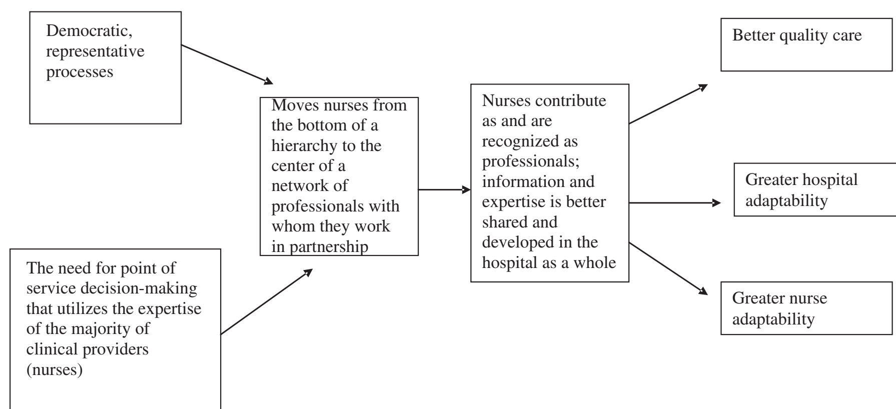

FIGURE 1: Schematic Summary of Porter-O'Grady Model of Shared Governance
SOURCE: Adapted from Porter-O'Grady and Finnigan (1984).

and the structuring and design of the health care work setting (Institute of Medicine, 2004).

Shared governance is typically guided and coordinated by nurse-led councils that deal with practice, quality, research, education, and management. The councils coordinate activities related to their particular domain, informed by input from nurses in the units, in the service of creating more effective nursing practice (Force, 2004; Richards et al., 1999). Nurses at all levels and shifts may serve on the councils.

The outcomes that SG is meant to and often does accomplish include better quality, more cost-effective patient care; greater hospital and nurse adaptability; greater nurse autonomy and development; and higher retention of nurses (e.g., Anthony, 2004; O'May & Buchan, 1999; Stewart, Stansfield, & Tapp, 2004). These are expected to occur because of the greater responsibility, authority, participation, and respect accorded nurses in the delivery of health care as well as the improvement of information feedback loops on care tactics, costs, and outcomes that come from coordination among the different nursing units. Figure 1 summarizes a schematic model of shared governance offered by one of its leading proponents (Porter-O'Grady, 1992).

Although SG is generally described positively (e.g., D. Weber, 2003), it has its critics (e.g., Gavin, Ash, Wakefield, & Wroe, 1999; Hess, 2004). Some authors argue that more cynical motives may be behind SG rather than enhancing care delivery and empowering nurses. For example, SG may serve as "window dressing" to entice new hires to the hospital, give nurses the illusion of empowerment without real influence, and/or fend off unionization efforts (Maas & Specht, 1994). It tends to be implemented more when there are nurse shortages than when there are not (Hess, 2004). Consistent with our concern regarding the perspectives of change recipients, Gavin et al. (1999) cautioned that SG is a managerially driven initiative and the aims of managers and nurses do not always converge.

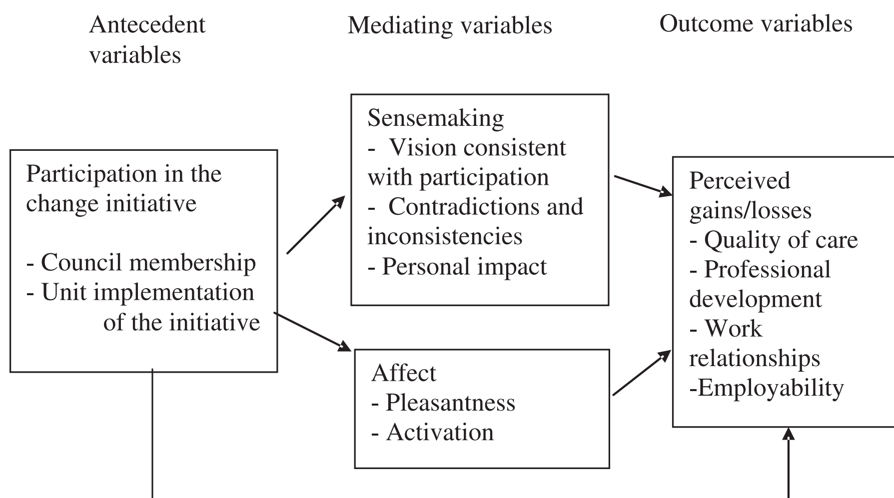

FIGURE 2: Conceptual Model: The Proposed Roles of Sensemaking and Affect on Assessments of Change

CONCEPTUAL FRAMEWORK FOR THE STUDY

A summary model of our predictions regarding the change initiative is shown in Figure 2. We predict, based on scholarly literature regarding planned change in general and SG in particular, that participation in SG will lead employees to understand the initiative as empowering them and will lead them to have positive feelings about it. Such participation, mediated by participants' sensemaking and feelings, should also lead them to experience gains from the initiative.

The Effects of Participation in the Initiative on Sensemaking and Feelings About SG

Major change such as the one we studied typically motivates change recipients for whom the initiative is novel to make sense of what is going on, gathering information and processing it cognitively to create meaning (George & Jones, 2001). In large part, it is through the meanings recipients form regarding a change that change initiatives have the impacts they do (e.g., Bartunek & Moch, 1987; George & Jones, 2001).

Sensemaking regarding change involves an array of information. This information may include, among other components, recipients' understandings of the nature of the change that change agents espouse, appraisal of whether implementation deviates from the articulated plan (contradictions and inconsistencies), and personal impacts of the change.

The degree of participation, or involvement, in a change initiative—particularly when the initiative itself is centered on participation—affects sensemaking about the

change. For example, P. S. Weber and Manning (2001) found that participants who were actively engaged in an implementation of total quality management revised their change schemas more than did those who were not as actively involved in a way that converged over time toward the change agents' vision of the change effort. In general, such effects of participation on sensemaking are expected because of the information that actively involved change recipients derive from experiences with the change itself and their greater exposure to the influence of change agents. This leads to our first set of hypotheses:

Hypothesis 1: Participation in SG affects interpretations of change. That is,

Hypothesis 1a: Participation in SG will be positively related to participants interpreting the change initiative as fostering their empowerment.

Hypothesis 1b: Participation in SG will be negatively related to participants interpreting the change initiative as inconsistent with empowerment.

Recipients do not make sense of a change effort in an affectively neutral way. They have feelings about the change too. To more fully understand impacts of a change on its recipients, it is necessary to understand these feelings.

Considerable evidence suggests that people's emotional experience includes two orthogonal dimensions, degree of pleasantness and degree of activation, or arousal (e.g., Barrett & Russell, 1998; Russell, 1980, 2003). Pleasantness represents how well one is doing in terms of a hedonic valence of pleasant-unpleasant, good-bad, positive-negative, or appetitive-aversive. Activation represents arousal, a sense of mobilization or energy, and reflects one's state in terms of felt arousal or enervation. Together, they combine to create the range of emotions experienced at any given time (Seo et al., 2004).

According to the SG model (e.g., Figure 1), participants' feeling state as a result of participating in SG should be strongly positive. This positive feeling state should result because the enhanced authority they will experience should foster their sense of well-being.

Hypothesis 2: Participation in SG will be positively related to experienced emotions (both pleasantness and activation) associated with the change.

Participation in a change initiative should also affect the perception of gains and losses from the initiative. Bartunek, Greenberg, and Davidson (1999) found that people who actively participated in a change initiative rated it higher. They suggested that this occurred at least in part because people who are active in a change initiative are likely to judge it as positive to maintain a sense of consistency (cf. Festinger, 1957). Based on this reasoning, we hypothesize,

Hypothesis 3: Participation in SG will be positively related to reports of gains from the initiative.

We operationalized participation in this study with two forms of SG participation: whether individual nurses had been part of a council charged with SG implementation and whether they were on a unit in which the change was implemented well. Councils,

the ongoing committees charged with planning and decision making on nursing issues, were the primary structure through which the initiative was implemented. In addition, most of the work involved in SG took place in individual nursing units. This work included accountability for issues such as staff scheduling, equipment budgets and spending, self-assessment of professional skills, and follow-through on issues raised at council meetings and making point-of-service decisions to enhance patient care quality. Units varied in the extent they embraced these accountabilities.

Perception of an Intervention and Its Impact on Perceived Gains and Losses

A typical change agent goal with regard to SG is that nurses understand that the purpose is to increase their own participation and authority over decisions. This understanding is consistent with the change agents' and with the type of changes in behavior that are necessary for success of the change initiative.

Nonetheless, nurses participating in SG (and more broadly, any organizational change effort that includes some type of empowerment initiative) may not experience and make sense of it in the way change agents envision. One reason is that the change agents have not done a good job of conveying the vision. A second is that change recipients may have a particular "prototype" in mind for what a change such as participation will look like in practice. If actual implementation does not correspond with that prototype, the recipient will likely see change agents as acting inconsistently with what they are espousing (Bartunek, Lacey, & Wood, 1992). Third, a current change may be intermingled with a previous change through confusion or poor planning. Recipients may then be confused by the intermingled messages of two or more distinct changes, a problem commonly faced in organizations that change frequently. As in the site we studied, organizations often carry out multiple organizational changes simultaneously, and some of the overlapping changes may contradict each other (Helms Mills, 2003). When such contradictions are present, it is often difficult for recipients of a particular change, especially those not intimately involved in implementing it, to differentiate the participative expectations associated with the focal change from different types of expectations associated with other changes.

Whereas change agents may think almost entirely in terms of organizational outcomes of change, recipients often interpret the change in terms of the difference it makes in their personal experience at work (Rousseau, 1996). Specifically, recipients often gauge organizational change in terms of their own perceived or anticipated gains or losses from it, the extent to which change makes the quality of some aspect of their work or work life better or not (Bartunek & Moch, 1987; P. S. Weber & Manning, 2001). Thus,

Hypothesis 4: Interpretation of the intervention will affect ratings of gains from it. That is,
Hypothesis 4a: An understanding of SG as empowering will be positively related to recipient experiences of gains from the change.

Following on our aforementioned discussion, it is also reasonable to predict that perceptions of inconsistencies, such as change agent or organization actions that do

not fit the employee's perception of the change agents' vision of the change, should dampen perceived gains.

> *Hypothesis 4b:* Understandings of SG that are inconsistent with empowerment will be negatively related to recipient experiences of gains from the change.

Finally, the more recipients interpret a change effort as positive for them personally, the more they should experience gains from it.

> *Hypothesis 4c:* Understandings of SG that are positive for them personally will be associated with recipient experiences of gains from the change.

Affect Regarding Shared Governance and Its Impacts on Perceived Gains

Feelings often function as a judgment-simplifying heuristic device. Schwarz and Clore (Schwarz, 1990; Schwarz & Clore, 1983, 1988), among others, have conducted multiple studies that support their "feelings as information" hypothesis. That is, people often describe the way they think about something, but in fact, the emotional reaction it evokes is what gives rise to their thinking and their judgments. Thus, to understand why change recipients rate a change as they do, it is necessary to understand the affect it elicits for them (George & Jones, 2001).

The property of pleasantness is straightforwardly aligned with how recipients of a change initiative are likely to rate it. Positive feelings about change signal that something is going well, whereas unpleasant feelings signal that a situation is problematic (e.g., Clore et al., 2001). Although this is less obvious on its face, the property of activation, or arousal, is also likely to be aligned with how recipients judge a change effort. Arousal, or activation, can be thought of as energy that urges individuals to take active steps (e.g., Brehm, 1999; Damasio, 1994, 1999; Izard, 1993). Mossholder et al. (2000) viewed activation as interacting with degree of pleasantness to affect attitudes. However, it seems equally likely that activation may have direct impacts on judgment of a change, signaling the need to take active steps to respond to the change. Both pleasantness and activation should positively affect how much recipients experience gains from change.

> *Hypothesis 5:* Emotion (degree of pleasantness and activation) will be positively related to the gains recipients experience from the change.

Sensemaking and Affect as Mediators

Given the central role we postulate for sensemaking and emotion in accounting for the impact of participation on recipients' responses to change, we predict,

> *Hypothesis 6:* Sensemaking and emotion will mediate the relationship between participation in SG and the gains recipients experience from the change.

METHOD

Research Participants and Site

This study uses archival data, external ratings, and primarily data from a survey of registered nurses at a large American hospital that implemented an SG initiative (Rousseau & Tijoriwala, 1999). The survey was completed by 501 nurses, approximately 48.5% of the total number of nurses in the hospital. The nurses represent 34 units of a hospital that employs 5,000 full-time employees and has 746 licensed beds. On average, the units included about 30 nurses. Respondents' average age was 33; 92% were female, and 85% worked full-time. Their average length of employment at the hospital was 7 years; nurses had been on their current units an average of 5 years. The educational demographics of the sample varied: 23% had an RN diploma, 25% an associate's degree, 46% a bachelor's degree, 4% a master's, and 2% had other qualifications.

Measures

Archival data: Council membership. The hospital nursing department kept archival records of membership on all of the nurse councils. Our measure of council membership (n of council members = 28) was taken from these records and was dummy coded, where 2 reflects that the individual nurse had served as a council member and 1 reflects nonparticipation.

Expert ratings: Unit implementation of the initiative. At the time of data collection, SG had been underway at the hospital for 2 years. Interviews conducted by Rousseau and Tijoriwala (1999) with nurse managers and administrators suggested that there was variation in how comprehensively the units had implemented SG.

Four members of the research team, two university researchers and two hospital-based researchers, rated each of the 34 units on their degree of implementation, namely, the extent to which they had SG council decision systems in place. Interrater agreement was perfect for the approximately two thirds of the units falling in the top and bottom of the scales, with the middle third (from ratings 3 to 5) achieving agreement following discussion. Their ratings resulted in a global implementation score for each unit ranging from 1 to 8, with a median of 4. The units rated highest in implementation of the initiative had fully developed SG council decision systems in place; those rated lowest had virtually no SG-related practices in place. These ratings served as an approximation of the "objective" status of the initiative and participation in it in each unit.

Survey: Structured and open-ended questions. Respondents completed a questionnaire voluntarily, usually on the job. The questionnaire included several sections, including quantitative ratings of the degree to which nurses viewed a number of specific gains as having been achieved and open-ended (qualitative) questions asking nurses to describe how they viewed the SG initiative.

Nurses were asked to assess their personal gains and losses from shared governance in the following four areas: quality of care, professional development, work relationships, and employability. The first three areas correspond to the benefits typically anticipated from SG (e.g., Porter-O'Grady, 1992). First and foremost, SG is designed to increase the quality of care delivered. This improvement is expected to result in large part from SG's fostering nurses' professional development and improving work relationships among nurses and between nurses and the administration. The fourth area, employability, addresses nurses' employability in their profession.

For each of these indicators, assessments were framed by asking respondents to consider the following: "What is the impact, that is, the gains and losses, of Shared Governance for you personally? Compare your present situation to what it was before Shared Governance was introduced." Responses were assessed on 5-point Likert scales ranging from 1 (*much less*) to 5 (*much greater*). Although these individual scales clearly range from losses (1) to gains (5), in discussing the hypotheses we address them in terms of gains for the sake of clarity.

Quality of care was assessed by the following three items: understanding of how to do my job well, performance quality, and ability to produce quality care ($\alpha = .71$). Professional development was assessed by the following seven items: skills used in the job, professional status, personal development, leadership development, control over important aspects of my work, understanding my role as a nurse, and greater self-esteem ($\alpha = .86$). Work relationships were assessed by the following four items: socializing on the unit, friendship on the unit, relations with nursing coworkers, and relations with other coworkers ($\alpha = .81$). Employability was assessed by two items, job security and employability throughout your career ($\alpha = .67$). All measures had been subjected to exploratory and confirmatory factor analyses and met accepted standards for construct validity.

Lastly, the survey asked respondents an open-ended question about shared governance: "In your own words, what do you believe Shared Governance 'means?'" We derived both our sensemaking and affect measures from responses to this question.

To assess sensemaking regarding SG, especially the extent to which it included perceptions of empowerment, perceptions of inconsistencies, and perceived impacts on change recipients personally, two of the authors constructed a combined list of all the different responses to the question. Each one independently content analyzed 50 responses to arrive at a preliminary list of descriptive codes (Miles & Huberman, 1994), and then they checked for agreement. They agreed on 70% of the responses and discussed other responses until they agreed. One author then content analyzed the remaining responses to expand the preliminary list of codes, checking with the other author whenever there was some ambiguity. The authors coded all responses, even if they were given only once. This coding process led to a list of 55 different meanings of SG. We then used qualitative factoring (Miles & Huberman, 1994) to identify and group responses by similar underlying themes. Some respondents mentioned a similar theme multiple times. We recoded the resulting variables to indicate simple yes/no ratings whether the respondent mentioned the theme one or more times or not.

We analyzed all the meanings mentioned by at least 15% of respondents. (The next most frequently mentioned meaning was mentioned by only 8% of respondents.) These responses provided our measures of sensemaking, comprising the following three categories of SG meanings:

1. Empowerment: Nurses have more say over decisions (51% of respondents). This meaning includes "Members of a unit work together to make decisions" and "Nurses have more control and autonomy, more voice, and more accountability." This category reflects the SG vision proposed in the SG literature and by hospital change agents.
2. Inconsistencies: Contradictions (18% of respondents). This meaning includes "Nursing staff works on decisions while the administration really makes the decisions" and "Staff have responsibilities that nurse managers once had as a way to decrease middle management." This category reflects the inconsistencies, contradictions, mixed messages, or perceived dishonesty noted by recipients.
3. Personal impact: Increased workload (15% of respondents). This meaning includes "More work without more recognition" and "Too much work and responsibility for the amount of time we have." This category represents the most prevalent personal impact respondents experienced.

Affect regarding the SG initiative was measured using this same open-ended response as scored through Dictionary of Affective Language (DAL; Whissell, 1989, 2001; see http://www.hdcus.com/manuals/wdalman.pdf for an updated version of the dictionary). This dictionary, developed by Whissell and used by Whissell and her collaborators, is based on the premise that words possess meaning on multiple levels and that even words that do not specifically describe an emotion can convey an affective tone. The conceptual basis for the dictionary is Russell's (1989, 2003) model of emotion with its dimensions of pleasantness and activation. The DAL contains an "ecologically valid sample of some 8700 words . . . each word in the dictionary has been rated by several people in terms of its pleasantness (and) its activation. Pleasantness and activation are assessed on separate three-point Likert scales" (Whissell, 2001, p. 461).

The DAL has been used in a wide range of studies exploring word use as an indicator of affect, including for example William Blake's poems (Whissell, 2001) and the titles of articles in a particular journal (Whissell, 2004). Mossholder and his colleagues (1995, 2000) used an earlier version of the DAL in studies of affect associated with attitudes related to organizational change and found that the emotion revealed by the dictionary successfully predicted attitudes associated with a particular change.

All the words in these open-ended responses were scored for the degree of pleasantness and activation they conveyed. Professor Whissell, blind to the purposes of the study at the time of coding, scored the open-ended responses.

RESULTS

We first summarize SG implementation at the field site and then present the statistical analyses conducted to test the study's hypotheses.

Implementation of Shared Governance at the Research Site

Although SG has been successfully implemented in numerous hospitals across the United States, our results must be understood in the specific context studied. Interviews with several senior nurse managers charged with overseeing SG in the hospital we studied (Rousseau & Tijoriwala, 1999) suggested that the intent of implementation at the hospital was consistent with the positive expectations sketched out in our introduction. Hospital change agents emphasized the following outcomes in their meetings with nurses: increased professionalism, including point-of-service decision making; increased nursing responsibility and accountability; improved quality and cost-effectiveness of patient care; improved communication across nursing units and thus improved work relationships; and shared decision-making processes between staff and administration. Councils were developed as a means to facilitate these changes. As noted earlier, change agents and hospital leadership agreed that some nursing units were more effective than others in implementing the councils and other SG-related practices.

SG is not simple to implement (Burnhope & Edmonstone, 2003; Scott & Caress, 2005), and senior nurse managers noted that the intervention encountered a number of difficulties. Rank-and-file nurses at the hospital tended to blame SG for changes that were the result of other initiatives recently or concurrently being carried out in nursing. These included restructuring nursing administration by removing a layer of supervision within each unit, downsizing by voluntary attrition and transfer, and transitioning to a new patient care model. The intermingling of these initiatives blurred the boundaries among them and added to the difficulties recipients had in responding to any one of them. In particular, the restructuring of the nursing department removed first-line managers early on in the SG implementation process before nurses were trained in self-management skills and left them without daily coaching in these skills. Increased patient ratios in some units—the result of downsizing—left many staff nurses feeling that they had to struggle to keep up with the patient care load on top of the new managerial and planning duties SG instituted. Education preceded implementation of new processes, so nurses viewed the content as largely hypothetical. Moreover, the small amount of education provided on SG and the skills needed to carry it out were unavailable to newcomers hired subsequently.

In consequence, SG's implementation at the hospital was more complicated and problematic than the ideal change agents and SG consultants portrayed. Insofar as actual implementation is often more difficult than it is portrayed, sensemaking and affect associated with the intervention are of prime importance in understanding the change recipient experience.

Statistical Analyses

Means, standard deviations, and correlations among all the measures are shown in Table 1. Mean scores indicate that the overall feeling associated with SG was mildly pleasant (1.86 out of 3) and mildly activated (1.76 out of 3). However, no measure of

TABLE 1
Means, Standard Deviations, and Correlations of All Measures

								Affect		*Meanings*			*Gains in*			
Measure	*Mean*	*Standard Deviation*	*Intraclass Correlation (1)*	*Intraclass Correlation (2)*	*Council Membership*	*Unit Rating*	*Imple-mentation*	*Pleasant-tness*	*Activation*	*Empower-ment*	*Contra-dictions*	*Increased Workload*	*Quality of Care*	*Professional Development*	*Work Relation-ships*	*Employ-ability*
Council membership	1.06[a]	0.23	.00	.00			–.03	.10	–.01	.10**	–.05	.00	.13***	.12***	.01	.05
Unit rating implementation	4.72	1.32						–.01	.00	–.06	–.03	–.05	.07	.11**	.17***	.22***
Pleasantness	1.86	0.09	.39	.76					.29***	.27***	–.16***	–.32***	.14**	.16***	–.02	.06
Activation	1.76	0.11	.41	.77						.09	–.09	.02	.14***	.09	.11**	.05
Empowerment	0.51[b]	0.50	.04	.35							–.16***	–.34***	.17***	.20***	.09**	.18***
Contradictions	0.18	0.39	.01	.10								–.09**	–.16***	–.12***	–.08	–.04
Increased workload	0.15[b]	0.36	.05	.43									–.25***	–.24***	–.15***	–.16**
Quality of care	2.69	0.67	.03	.27										.65***	.50***	.32***
Professional development	2.98	0.63	.01	.07											.49***	.40***
Work relationships	2.71	0.61	.05	.40												.33***
Employability	2.44	0.84	.05	.41												

a. Council membership = 2, no membership = 1.
b. Not listed as a meaning = 0, listed as a meaning = 1.
$^{**}p < .01$. $^{***}p < .001$.

gains/losses had a mean rating of higher than 3 (the midpoint of the 5-point scale). In effect, respondents experienced the initiative as mildly positive in affective tone but involving losses more than gains.

Although our predictions were in terms of individual respondents, the SG intervention was carried out in a hospital in which there were multiple units; one of our ratings of participation (unit implementation) was unit based. There was a possibility that the recipients' ratings of the change effort were not independent of those of their other unit members. If this were the case, it would be appropriate to analyze the data using aggregated unit-based rather than individual-based measures. We ran intraclass correlation (ICC)(1) tests to determine the degree to which there was agreement within units on the different measures and ICC(2) tests to determine the extent to which there were reliable differences between units on the measures (Bliese, 2000). The results of both of these tests (for all measures except unit implementation, which was assessed at the unit level) are included in Table 1.

Although there is not unanimous opinion about this, Klein et al. (2000) indicated that one suitable way for determining whether aggregation of individual ratings is appropriate is by determining whether the group means on the aggregate variables can be reliably differentiated. Common practice suggests that if scores on the ICC(2) are above .70, individual ratings should be aggregated to the group or in our case unit level.

Table 1 indicates that the ICC(1) scores for the two affect measures, pleasantness and activation, were comparatively high (.39 and .41, respectively), whereas the ICC(1) scores for the other variables were very close to zero (ranging from .00 to .05). In addition, the ICC(2) scores for pleasantness and activation, .76 and .77, were high enough to justify aggregating these scores. Again however, the ICC(2) scores for the other measures (ranging from .10 to .43) were sufficiently low to indicate that aggregating them would not be appropriate. Klein et al. (2000) stated that in terms of implications for aggregating data, "Values [of the ICC(2)] lower than .50 are poor" (p. 518).

Thus, to test most of our hypotheses we conducted the analyses at the individual level. However, we tested hypotheses involving affect or pleasantness at the unit level. For these analyses we calculated unit means on the measures of gains/losses, and we also calculated how many council members belonged to each unit. In Table 2 we present the unit-level correlations among the measures.

Hypothesis 1 predicted that participation in the change effort would have positive impacts on experiences of change. That is, (Hypothesis 1a) participation would be positively related to participants interpreting the change initiative as empowering them, and (Hypothesis 1b) participation would be negatively related to participants interpreting the change as inconsistent with empowerment.

We used logistic regression to determine the relationship of our participation indicators with empowerment as a meaning (Hypothesis 1a) and contradictions as a meaning (Hypothesis 1b). Results of these analyses, shown in Table 3, indicated that council membership had a significant impact on SG being perceived as empowering ($\beta = .95$, $p < .05$). However, neither participation variable affected contradictions as a meaning.

Hypothesis 2 predicted that participation in the change initiative would be positively related to experienced emotions associated with the change. As noted earlier,

TABLE 2

Means, Standard Deviations, and Correlations Across Unit-Level Measures

				Affect		*Meanings*			*Average Gains Across/Within Units*			
Measure	*Mean*	*Standard Deviation*	*Average Council Membership per Unit*	*Pleasantness*	*Activation*	*Empowerment*	*Contradictions*	*Increased Workload*	*Quality of Care*	*Professional Development*	*Work Relationships*	*Employability*
Average council membership per unit	0.82	.90										
Pleasantness	1.86	.04	–.19									
Activation	1.77	.06	–.19	.47**								
Empowerment	0.53	.17	–.10	.47**	.21							
Contradictions	0.18	.12	.16	–.41*	–.36*	–.45**						
Increased workload	0.12	.13	.30	–.20	–.18	–.23	.42*					
Quality of care	2.71	.21	–.53**	.28	.18	.28	–.42*	–.53**				
Professional development	2.99	.18	–.32	.33*	.08	.34*	–.33	–.44**	.65***			
Work relationships	2.72	.22	–.33*	.11	.09	.04	–.15	–.32	.44**	.425*		
Employability	2.47	.36	–.23	.03	–.04	.20	–.20	–.29	.39*	.376*	.345*	

*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 3
Logistic Regression: Meanings Attributed to Change Regressed on Participation

	Meanings Attributed to Shared Governance	
Participation Indicator	*Empowerment*	*Contradictions*
Council membership		
B	.95	–1.00
SE	.46	.75
Wald chi-square	4.32*	1.80
Unit implementation		
B	–.09	–.07
SE	.07	.09
Wald chi-square	1.45	.58
Log likelihood	649.21	448.66
Model chi-square	32.36*	7.45

*$p < .05$.

because the affect measures were best understood as unit-level indicators, to test Hypothesis 2 we regressed unit-level pleasantness and activation on number of council members from each unit and on ratings of unit implementation of the SG initiative. We found no significant relationships, and thus Hypothesis 2 is rejected.

Hypothesis 3 predicted that participation in SG would be positively related to reports of gains from the initiative. Results of the regression analyses assessing the impact of participating in the SG initiative on the four perceived gains are shown in Table 4. Consistent with Hypothesis 3, both council membership and unit implementation significantly affected perceived gains from the intervention. First, they affected ratings of quality of care ($R^2 = .03$, $p < .001$). For this variable, council membership ($\beta = .16$, $p < .001$) was a significant individual predictor. Second, they affected ratings of professional development ($R^2 = .03$, $p < .001$). For this variable, both council membership ($\beta = .14$, $p < .001$) and unit implementation ($\beta = .11$, $p < .05$) were significant individual predictors. Third, they affected ratings of work relationships ($R^2 = .03$, $p < .001$). For this variable, unit implementation was a significant predictor ($\beta = .17$, $p < .001$). Finally, they affected ratings of employability ($R^2 = .05$, $p < .001$). For this variable, unit implementation was a significant predictor ($\beta = .22$, $p < .001$).

Hypothesis 4 predicted that interpretation of the intervention would affect ratings of gains from it. That is, (Hypothesis 4a) understanding SG as implying empowerment would be positively related to recipient experiences of gains from the change, (Hypothesis 4b) understanding the change as inconsistent with empowerment would be negatively related to recipient experiences of gains from the change, and (Hypothesis 4c) understanding the change effort as benefiting them personally would be associated with experiences of gains from the change.

Regression results in Table 5 indicate some support for Hypothesis 4a. When recipients viewed the change as empowering, they reported significantly higher gains in

TABLE 4
Multiple Regression of Gains/Losses on Participation

	Perceived Gains From Shared Governance			
Participation Indicator	*Quality of Care*	*Professional Development*	*Work Relationships*	*Employability*
Council membership	.17***	.15***	.03	.07
Unit implementation	.07	.11*	.17***	.22***
Multiple *R*	.17***	.17***	.17***	.23
R^2	.03	.03	.03	.05***

NOTE: Standardized Beta coefficients are shown.
**p* < .05. ****p* < .001.

TABLE 5
Multiple Regression of Meanings on Perceived Gains

	Perceived Gains From Shared Governance			
Meaning	*Quality of Care*	*Professional Development*	*Work Relationships*	*Employability*
Empowerment	.06	.11**	.04	.14*
Contradictions	–.12*	–.07	–.06	.00
More work	–.22**	–.18***	–.18**	–.12*
R^2	.10***	.08****	.05**	.04*

NOTE: Standardized Beta coefficients are shown.
**p* < .05. ***p* < .01. ****p* < .001.

professional development ($\beta = .11, p < .01$) and employability ($\beta = .14, p < .05$). When recipients interpreted the SG initiative as contradictory (Hypothesis 4b), they reported fewer gains in quality of care ($\beta = –.12$; $p < .05$). Finally, (Hypothesis 4c) there was no frequently stated meaning of a positive personal impact from the change. However, perception of an increased workload resulting from the change was a negative personal impact, which should be related to dampened perceptions of gains from the change. The regression results in Table 5 support Hypothesis 4c: They indicate that interpreting the intervention as meaning an increased workload had a significant negative impact on perceived gains on all four indices of gains and losses, specifically, quality of care ($\beta = –.22$; $p < .01$), professional development ($\beta = –.18$; $p < .001$), work relationships ($\beta = –18$; $p < .01$), and employability ($\beta = –.12$; $p < .05$).

Hypothesis 5 predicted that both indicators of emotion, pleasantness (Hypothesis 5a) and activation (Hypothesis 5b), would be positively related to gains. As appropriate, we tested this prediction using unit-level data. Table 6 indicates that the relationship between pleasantness and one outcome measure, professional development,

Table 6
Multiple Regression of Unit-Level Gains/Losses on Affect

	Unit-Level Perceived Gains From Shared Governance			
Unit-Level Affect Indicator	*Quality of Care*	*Professional Development*	*Work Relationships*	*Employability*
Pleasantness	.25	.38*	.09	.06
Activation	.06	–.01	.05	–.07
Multiple *R*	.29	.34	.12	.07
R^2	.08	.17	.01	.00

NOTE: Standardized Beta coefficients are shown.
*$p < .10$.

approached significance ($\beta = .38$; $p < .06$), partially supporting Hypothesis 5a. Activation was not related significantly to any outcome variable.

However, the unit-level correlations in Table 2 indicated significant relationships between the measures of emotion and two of the meanings of the intervention. That is, pleasantness was positively correlated with a unit-level index of empowerment as a meaning, $r(33) = .47$, $p < .01$, and negatively correlated with a unit-level index of contradiction as a meaning, $r(33) = –.41$, $p < .02$. Activation was also significantly correlated with a unit-level index of contradiction as a meaning, $r(33) = –.36$, $p < .04$. In addition, Table 1 indicates that individual-level pleasantness was significantly correlated with all three meanings of the intervention: empowerment, $r(376) = .27$, $p <.001$; contradictions, $r(376) = –.16$, $p <.001$; and increased workload, $r(376) = –.32$, $p < .001$. Thus, affect, pleasantness in particular, was clearly associated with the meanings that participants attributed to the intervention.

Hypothesis 6 predicted that sensemaking and affect would mediate the relationship between participation in SG and the gains recipients experience from the change. Testing mediation is appropriate when (a) an antecedent has significant impacts on an outcome, (b) there is a significant relationship between an antecedent and the proposed mediator, and (c) the mediator has significant impacts on the outcome variable (Baron & Kenny, 1986). There was only one instance in which all three relationships were significant, and that was the path from council membership to perceptions of empowerment to gains associated with professional development. To test whether empowerment as a meaning mediated the relationship between council membership and perceived professional development, we followed the procedure set out by Kenny (1987). Our analysis indicated that when empowerment as a meaning was added to the equation predicting professional development from council membership, council membership continued to have a significant impact, $\beta = .11$, $p < .05$, but its impact was significantly reduced, $t(463) = 2.40$, $p < .05$. Thus, empowerment as a meaning partially mediated the impact council membership had on professional development as a gain. A model that portrays these significant results is shown in Figure 3.

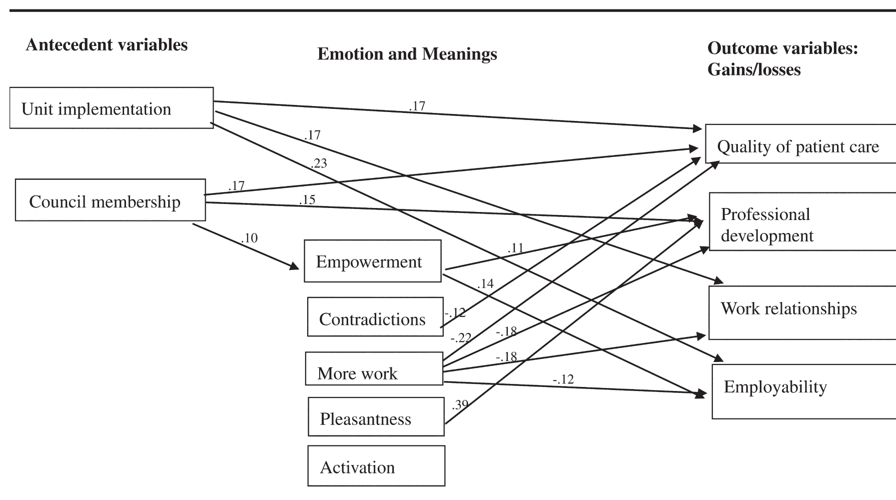

FIGURE 3: Observed Relationships Among Participation, Sensemaking and Emotion, and Perceived Gains/Losses
NOTE: All numbers represent standardized beta coefficients. Only significant relationships are shown.

DISCUSSION

In this study, unlike most organizational change research, we explored a change initiative from the change recipients' point of view. We assessed the degree to which their participation in the change affected its impacts on them, the meanings they made of the change, their feelings about it, and their change-related gains and losses. This approach enabled us to take a much more complete look at the kind of vision promulgated by change agents, its enactment in an organizational setting, and the meanings, feelings, and outcomes these generate in recipients. This may be the only extant study that empirically links recipients' affect and sensemaking to the change agents' explicit intervention model and to experienced gains and losses that flow from that intervention. Our results indicate a more complicated pattern of change recipient experience than what change agents claim.

If aspirations of change agents had been entirely met in the hospital we studied, the meaning associated with it would have been consistent with its stated aims (empowerment), affect about the SG initiative would have been pleasant and activated, and participants would have experienced gains from the intervention. Moreover, these would all be linked: Greater participation in the initiative would foster sensemaking consistent with the initiative's espoused mission as well as positive and activated affect, and these in turn would create gains.

Some of these effects were realized (Figure 3). There was mild positive affect about the initiative, and the most frequent meaning of the initiative (stated by more than half of our sample), that it increased nurses' empowerment, was consistent with the change agents' vision. Council membership enhanced understanding of the intervention as empowerment and increased the perception that the intervention led to gains in the

quality of patient care and in professional development. Unit-level pleasant affect was associated with perceived gains in professional development. The impact of council membership on professional development was partially mediated by the belief that the intervention was empowering. Furthermore, nurses on units that more fully implemented SG experienced it as creating more gains in their professional development, work relationships, and employability. Thus in many ways, the change agents' vision and intervention model were validated.

But these were not the only impacts of the intervention. Several participants perceived it as contradictory and as implying more work for them, and the perception that it caused more work had more impact on their experienced gains and losses than did any other meaning. Moreover, some of the individual predictors of impacts did not hold. We will discuss these results below.

The Role of Participation

Both participation measures, council membership and rating of unit implementation, were positively related to experiencing gains, as intended by the intervention. Moreover, council members were more likely than others to view empowerment as a key meaning of the intervention, and this meaning was a mechanism through which they came to perceive the intervention as fostering their professional development. This is consistent with the results of other studies assessing the impact of participation on meanings of change and perceived outcomes from it (e.g., Bartunek et al., 1999).

The Role of Sensemaking

The meanings change recipients construct about a change initiative may be consistent with its designers' meanings (e.g., that SG signals increased empowerment) but may also in combination be more complex than what the change agents intended. For example, the contradictions that our respondents noted were likely associated with the impacts of multiple change initiatives taking place at once, which sometimes meant that the kinds of events that would be expected as a normal part of SG, such as adequate and timely training, did not occur as scheduled. An increased workload is not a part of proponent portrayals of SG, and in fact, issues such as employee workload may not be salient to many change agents advocating a change initiative. However, many organizational change initiatives that foster empowerment increase the workload of change recipients, who may be particularly attuned to this personal impact.

The results of our study underscore the value of considering the three categories of meaning that emerged among the change recipients we studied: (a) meanings consistent with the change agents', (b) perceptions of inconsistencies or contradictions with the aims of the change agents, and (c) perceived personal impacts of the change initiative. These are all useful categories for exploring the types of meanings a change initiative may have for those involved.

Interestingly, although our findings indicate the importance of perceiving the intervention as fostering empowerment, this perception has less impact on perceived gains and losses from the change than does the personal impact of change, in this case,

the extra work the change initiative required of change recipients on top of their regular duties (Parker, 1998), which affected all the perceived gains. Our findings also highlight the dangers of inconsistency between how a change initiative is presented and perceived. Mismatches between what is espoused by change agents and what is perceived to take place likely violate expectations, tacit psychological contracts (Rousseau, 1995) about how change is supposed to occur.

The Role of Affect

In this study, affect was not impacted by participation. Degree of pleasantness had an impact only on the degree to which the change effort led to gains in professional development, whereas activation had no significant impacts on perceived gains.

However, emotion played another role in the change effort. Pleasantness and activation were the only variables that strongly showed unit-level effects; both their ICC(1) and ICC(2) values (Bliese, 2000) were sufficiently high to warrant aggregating individual ratings within units. In other words, there appears to have been a kind of emotional contagion (Barsade, 2002) that occurred within the different units. Barsade defined emotional contagion as “a process in which a person or group influences the emotions or behavior of another person or group through the conscious or unconscious induction of emotion states and behavioral attitudes” (Schoenewolf, 1990, p. 50). She noted that the transfer of feelings among group members tends to differ from the transfer of cognitions. Emotional contagion most often occurs at a significantly less conscious level than shared cognition based on automatic processes and physiological responses. Thus, even though it was only partially reflected in gains, there was significant shared emotion present.

Our focus in this study was on the relationship between emotion and perceived gains. However, it would also be consistent with the feelings as information hypothesis (Schwarz, 1990; Schwarz & Clore, 1983, 1988) we discussed earlier that affect might be related to understandings of the change, and indeed, as both Table 1 and Table 2 indicated, there was some relationship between affect and understandings of the intervention. Although this is speculative, it may be that a primary role of the affect experienced by individuals and spread through their work unit was to provide an affective undertone to the meanings of the intervention.

Implications

These results have important implications for both practitioners and theorists of change. For both groups, the results make evident how recipients’ impressions of an intervention may be both consistent with and diverge from what change agents intend. Change agents will be well served to actively solicit and then work to understand and address understandings of a change initiative held by its recipients as the initiative progresses. These sometimes positive, sometimes negative, and sometimes contradictory perceptions may contain valuable information that can allow change agents and change recipients to work together in devising midcourse corrections.

Researchers can also benefit by developing a more complete understanding of the dynamics through which a particular change intervention is experienced, including the affect it generates and the ways this affective experience may be contagious within work units. It seems possible from our results that even if understandings of a change are primarily individual, affect about the change may be shared by members of a workgroup, and this affect may play its own unique role in a change initiative.

As we noted earlier, one of the concerns about the SG initiative we studied was that there was inadequate, infrequent, and poorly timed education about it. This was likely a reason for the relatively lukewarm reception the intervention received. Our results suggest the importance of education about an intervention that incorporates clear rationales, distinguishes one change effort from others that may be under way, and is repeated at key moments when nurses are attempting to become active in carrying out unfamiliar aspects of the initiative. When researchers are exploring a change initiative or when change agents are introducing one, it is important to attend to how effectively and clearly the intervention is presented over time by its agents. This will likely have a strong impact on how it is received.

Limitations

We were not able to record all the ways change agents presented SG, so we do not know exactly how the change was described in every instance. In addition, we cannot assert unequivocally that the direction of causality is the one we have portrayed in Figure 2; the meanings and affect data were from the same questionnaire as were the ratings of gains and losses. We compensated for this by using open-ended measures of sensemaking that allowed participants to express themselves broadly, thus avoiding percept-percept problems often associated with data from the same source. Lastly, the same recipient responses provided both meaning and affect measures, which may have dampened their independent contribution to the prediction of gains and losses and heightened the relationship between them. Using the same measure however is consistent with Whissell's (2001) argument that words possess meaning on multiple levels and can convey an affective tone as well as provide cognitive sense. In future studies it would be valuable to use additional measures of affect.

CONCLUSION

Change recipients are not solely passive recipients of change. They play active roles in organizational change processes—making sense of them, having feelings about them, and judging them—and these activities of theirs encompass much more than "resistance." It is crucial for change agents and for change researchers alike to develop more adequate understanding of the roles that recipients' sensemaking and affect play in change initiatives.

In this study we have indicated some of what is included in change recipients' engagement with one particular change initiative and on the basis of our findings have proposed some implications for theory and practice. We hope that this work will help

to foster additional research on and appreciation of the roles of these very important participants in change efforts.

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