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How do you feel today? Managing patient emotions during health care experiences to enhance well-being

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ABSTRACT

Health care customers (patients) experience heightened emotions due to high stakes from risks to life, health, and well-being. Understanding and managing emotions during service experiences is an important area of inquiry because emotions influence customer perceptions, future intentions and behaviors. Yet despite its significance, research focusing on the impact of emotions on customer experiences remains fragmented, lacking a theoretically based conceptual framework. The authors attempt to fill this gap by addressing two important research questions contextualized in health care: (1) How can health care organizations better understand patient and family emotions during health care experiences? and (2) How should health care organizations use this understanding to design and better manage patient experiences to enhance patient well-being? The authors propose a new theoretically based framework on emotional responses following triggering events to enhance outcomes. Recommendations designed to enhance health care customer well-being are provided, as are directions to guide future work.

1. Introduction

> *"In that setting [as a patient], my emotions tumbled and gyrated to a degree that I have not experienced before. I spun through anger (mostly at myself), dejection, loathing, irritability, acute anxiety, and flights of elation that were often disproportionate and sometimes inappropriate to my situation. I did not think at the time that I was afraid of dying, but memories of the effusive thanks I offered caregivers persuade me in retrospect that I was."*
>
> [[Extract from Hansen-Flaschen, 2016 p.755].]

As illustrated by the patient quote above, understanding and managing customer emotions during service experiences is an important area of inquiry for services researchers and practitioners (Ostrom, Parasuraman, Bowen, Patricio, & Voss, 2015), as emotions affect those involved both directly and indirectly (Fredrickson & Joiner, 2002; McColl-Kennedy, Patterson, Smith, & Brady, 2009). This is particularly true in health care, where patients can feel a wide variety of emotions, producing a profound effect on service processes and patient-relevant outcomes (Berry & Bendapudi, 2007; Berry, Davis, & Wilmet, 2015; Gallan, Jarvis, Brown, & Bitner, 2013). Highly emotional health care service encounters can revolve around issues ranging from acute to chronic, reflecting a minor illness or a life-threatening disease. Arguably, there is no other service setting in which emotions are more relevant than in health care. Patients often feel powerless, lacking control over their bodies, psyche, and the service process itself. This can lead to passivity, neglect of health-maintenance activities, resistance or refusal of treatment and advice, impaired immune response, loneliness, and depression (Faulkner, 2001). Further, dealing with customers' heightened emotions during these difficult events is stressful not only for family members but also for frontline service employees. These factors often result in significant emotion regulation effort and employee stress (Grandey, Dickter, & Sin, 2004; Rupp & Spencer, 2006), and increase the probability of the occurrence of malpractice (Mor & Rabinovich-Einy, 2012).

Services researchers have long acknowledged the power of health care patients' emotional states during their journeys (McColl-Kennedy

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et al., 2012), the effects of service providers on customer emotions (Berry & Bendapudi, 2007; Delcourt, Gremler, van Riel, & van Birgelen, 2016), and the impact of shared experiences with friends and loved ones (McColl-Kennedy, Hogan, Witell, & Snyder, 2017a). Yet, despite its importance, research that focuses on the specific impact emotions have on customer experiences remains fragmented (McColl-Kennedy et al., 2015), lacking a theoretically based conceptual framework. In particular, a customer's emotional responses during a service experience, and how feelings unfold across multiple emotion events over time is not well understood. Moreover, how emotional responses impact customer experience, a transformative service research issue, has not been elucidated. This paper addresses these issues.

Studying the experiences of health care patients across time is important. Health care customer experiences often unfold over a series of interactions involving a range of health care services and providers. When emotion is elicited by a trigger event that is of affective significance to the individual, such as the diagnosis of a chronic disease, it often leads to an unfolding series of sub-events that also have affective relevance (Fridja, 1993). These sub-events might take the form of a visit to a general practitioner, an emergency department admission, and/or an in-patient hospital stay which combine to form an emotion episode which revolves around the initial triggering event. Importantly, during this emotion episode an individual is in a state of "continuous emotional engagement" or a heightened level of arousal (Fridja, 1993, p. 387) meaning that emotions may be felt more intensely and diversely than normal which can have a substantial impact on well-being.

Emotion episodes thus reflect the ebb and flow of emotion experiences over time (Weiss & Cropanzano, 1996). They combine to form the basis of the patient's health care journey. If the journey unfolds over a long time horizon, it is likely that the patient will experience many of these emotion episodes and each will play a part in weaving the fabric of the patient's health care experience. In addition, there are likely to be risk factors or pressures from every-day-life (e.g., financial stress, education levels, family structure and support) that interact with trigger events to heighten the emotions experienced during an emotion episode. There is no doubt that being diagnosed with a life-threatening illness is made all the more stressful by loss of income or disintegration of the family structure due to the stress and pressure of the situation. Finally, as most people live within a social network of family members, friends, and/or the wider community, the emotions of these individuals will also be affected by the health care experience of their loved ones, and in turn these emotions are likely to impact the patient.

The purpose of this research, therefore, is to critically review disparate theories of emotions in order to conceptualize a new framework of emotional responses that impact patient experiences in health care. We provide a detailed illustrative example of the emotion elicitation process in health care focusing on a trigger event and several sub-events. We explore the key emotions patients and family members may feel, the processes that elicit these emotions, and responses that impact health care customer experience outcomes.

Moreover, we provide specific recommendations for health care organizations designed to better manage patient and family emotions to enhance patient experiences. As such, we address the following research questions: (1) How can health care organizations better understand patient and family emotions during health care customer experiences? (2) How should health care organizations use this understanding to design and better manage patient experiences to enhance health care customer well-being?

Our article contributes in three important ways. First, we review disparate literature on emotions, and use this literature to advance knowledge on health care customer experience management. Second, we provide directions to guide future research. Third, drawing on extant emotions literature (c.f. McColl-Kennedy & Smith, 2006), we provide guidelines for health care professionals and organizations to design services in order to enhance patient experiences. Practical implications include recognizing, empowering, and supporting patient and family emotions through improved service processes; [*re*]designing the physical environment to provide a servicescape that is supportive; and, re-imagining the roles of human resources, including staff, caregivers, volunteers, clinicians, and others who provide emotional support to patients and their families.

2. Conceptual development

2.1. Nature of patient experiences

Health care is a complex service with multiple actors involved in service provision and with the patient playing an active role in this process (Sweeney, Danaher, & McColl-Kennedy, 2015). A patient is likely to draw on a network of resources that extend well beyond the focal firm to include interactions with other firms (Arnould, Price, & Malshe, 2006) such as complementary therapies, interactions with private sources such as peers, family, friends, and even other patients (Black & Gallan, 2015). Health care experiences also involve self-generated activities, such as positive thinking, reframing, and sense-making (Sweeney et al., 2015).

Health services are high emotion services, because they tend to be unfamiliar, the stakes are high, and the patient is at risk of mortality or impairment if procedures go wrong (Berry et al., 2015). Additionally, patients often feel powerless and do not have control over what is happening to their bodies and psyche (McColl-Kennedy et al., 2012). Health services are as variable as the needs that drive their delivery. Services may be accessed in emergency situations or under a planned management program where the patient attends a clinic or is admitted to hospital as an inpatient. In all cases, health care services are highly personal, often times invasive or intrusive, and as a consequence, emotionally charged.

Indeed, it is the very mission of health care to "do no harm," which constitutes a commitment to many aspects of patient well-being. One important aspect of well-being is the patient's emotions. Physical and psychological health deeply impacts one's emotional state and vice-versa. While under the direct care of health care professionals, patients' emotions should be managed carefully and intentionally in order to facilitate a broader definition of health and subjective well-being (Lee et al., 2013).

While the services literature in health care (e.g., Berry et al., 2015) has focused on describing patient experiences and highlighting the significance of emotions among patients, to our knowledge a theoretical rationale is lacking for: (1) how and why emotions are *elicited* across a patient's journey; and (2) how emotions can be *regulated* to improve emotional well-being. The current paper also provides a conceptual framework that draws on emotion theory primarily from psychology, organizational behavior and sociology. Specifically, Cognitive Appraisal Theory, Conservation of Resources (COR) Theory, and Affective Events Theory are utilized to help explain emotional elicitation. Additionally, Emotion Regulation, Emotional Contagion, and Affect Control Theory are introduced to explain how emotions can be regulated by patients and managed by service providers. Table 1 summarizes these key theories.

2.2. Emotion elicitation

An important question is *how* and *why* emotions are elicited. Emotion is usually seen as episodic with the change in an individual brought about by some triggering event (Fridja, 1993), which can be external (such as the behavior of others, a change in current situation, or a novel stimuli) or internal (such as thoughts, or memories of thoughts). The emotion event is expected to last for some time and then fade away

Table 1
Summary of key emotion theories.

Theory	Theory originator	Academic discipline	Overview of theory	Perspective	Level of analysis	Unit of analysis	Representative articles
Emotion elicitation							
Cognitive Appraisal Theory	Philosophy	Psychology later Marketing later Service Research	The cognitive appraisal of a situation causes an affective state based on that appraisal. Emotions are "mental state[s] of readiness that arise from cognitive appraisals of events or one's own thoughts" (Bagozzi et al., 1999, p.184). It is not the event itself that generates the emotions, but the way individuals appraise (evaluate) the event.	Static	Individual	Individual	Lazarus (1991) Bagozzi et al. (1999) Schneider and Bowen (1999) Moors (2009)
Conservation of Resources Theory	Theory of stress and coping	Psychology later Service Research	The basic tenet of COR theory is that individuals "strive to retain, protect and build resources and that what is threatening to them is the potential or actual loss of these valued resources" (Hobfoll, 1989, p.516). When valued resources are threatened or lost negative emotions will result.	Dynamic	Individual	Individual	Hobfoll (1989) Surachartkumtonkun et al. (2015)
Affective Events Theory	Theories on job satisfaction, emotion theories	Org. Behavior	The event *itself* triggers affect (emotions and mood). Employees respond to discrete "affective events" in the work environment that result in affective responses (or feelings) that in turn lead to attitudinal and behavioral outcomes. These are momentary variations of emotions and mood. AET adds *time* as an important parameter when examining affect reflecting that affect levels fluctuate over time.	Static or dynamic according to the researchers choice	Individual or multilevel	Person group organization	Weiss and Cropanzano (1996) Fridja (1993)
Emotion regulation							
Emotion Regulation	Dramaturgical theory, theory of alienation	Sociology later Org. Behavior	Emotion regulation is a central aspect of an individual's affective functioning, influencing well-being (Verzeletti et al., 2016). This influence can be positive or negative depending on how effectively people manage their emotional responses to events (Verzeletti et al., 2016).	Static	Individual	Individual	Gross (1998) Verzeletti et al. (2016)
Emotional Contagion	Emotion theories, neuroscience	Social Psychology later Org. Behavior and Service Research	Emotional contagion may be defined as "the tendency to automatically mimic and synchronize facial expressions, vocalizations, postures, and movements with those of another person and, consequently, to converge emotionally" (Hatfield et al., 1994, p. 153). Put simply, it is "catching" the other's affective state (Dallimore et al., 2007, p. 79).	Static or dynamic	Individual	Individual	Hatfield et al. (1994) Hennig-Thurau et al. (2006) Dallimore et al. (2007)
Affect Control Theory	Symbolic interactionism	Psychology	ACT models the formation of emotions on the meaning of the self in encounters with others. Emotions are thought to be verbally framed social experiences that foster certain impressions of self along the dimensions of pleasantness, activation, and dominance, and predictions about emotions can be derived from the impressions produced by an event.	Static	Individual	Individual/dyadic	Heise (1979) Heise and Weir (1999)

(Fridja, 1993). It is assumed that emotions are usually triggered by stimuli or events that are of major significance for the individual (Lazarus, 1991). Health care presents an obvious context in which trigger events are likely to be of great significance to the individual as health is directed at the body and mind of the patient, and its outcomes can result in life or death. If a goal (such as being healthy) is important and the event (being diagnosed with an illness) is incongruent with the goal, then negative emotions such as anger, rage, fear, and sadness can result (Schneider & Bowen, 1999). In the context of health care, an important goal is to be well, including well emotionally. Being diagnosed with an illness clearly thwarts the goal of being well, and thus intense negative emotions are likely to be experienced.

Cognitive Appraisal Theory (CAT), originating from the work of Lazarus (1991), argues that emotions are elicited by a cognitive (not necessarily conscious) evaluation of antecedent situations and events, and that the pattern of reactions in the different response domains (expression, action tendencies, feelings) is determined by the outcome of the evaluation process. Lazarus pioneered the notion of subjective appraisal, which includes the significance of an event for an individual and the individual's ability to cope with the event. Bagozzi, Gopinath, and Nyer (1999) extended CAT to define emotions as a "mental state[s] of readiness that arise from cognitive appraisals of events or one's own thoughts […]" (p.184). It is *not* the event itself that generates the emotions, but rather the way individuals evaluate or appraise the event. This means that different individuals may have a different emotional reaction (or no emotional reaction at all) to the same event (Bagozzi et al., 1999). For example, two health care patients react after hearing that their blood test results indicate improving immune function; one feels relieved and happy that the results indicate a positive trajectory, while the other feels anxious and disappointed that the results did not show complete recovery of the immune function.

An alternative conceptualization to Cognitive Appraisal Theory is Hobfoll's (1989) theory of Conservation of Resources (COR). COR theory builds on Lazarus and Folkman (1984)'s theory of stress and coping and offers a compelling framework to help explain negative emotion elicitation. The basic tenet of COR theory is that individuals "strive to retain, protect and build resources and that what is threatening to them is the potential or actual loss of these valued resources" (Hobfoll, 1989, p.516). These resources may be:

(1) "objects", such as pharmaceutical drugs or medical equipment; (2) "conditions" such as healthy states or well-being; (3) "personal" or "psychological" resources (Surachartkumtonkun, McColl-Kennedy, & Patterson, 2015), such as a positive sense of self, or self-esteem and a sense of justice; and (4) "energies," or economic resources such as time and money. Any threat to these resources is, in essence, a trigger event that gives rise to emotion elicitation. For example, if hospital staff do not respond quickly enough to the medical needs of a patient it is likely that the patient will feel that their health is under threat, and in turn respond with a range of negative emotions including anxiety, stress and even rage.

Affective Events Theory (AET) examines the structure, causes and consequences of affective experiences and views events as proximal causes of affective reactions (Weiss & Cropanzano, 1996). AET also explicitly adds time as an important factor when examining affect. Thus, AET recognizes that emotions fluctuate over time (Weiss & Cropanzano, 1996). According to AET, when specific positive affective events occur, individuals experience higher levels of the distinct positive affective states (i.e. enthusiastic, excited, and happy) than when there are no specific positive affective events reported. When specific negative affective events occur, individuals experience higher levels of distinct negative affective states (i.e. angered, worried, and exhausted).

At the core of these three theories is a common emotional elicitation process. The process begins with a trigger event be that a diagnosis of a terminal illness (threat to health), or loss of income due to illness (personal resources), which results in an appraisal of the event that in turn elicits an emotional response (Weiss & Cropanzano, 1996). This initial appraisal then leads to elicitation of more specific, discrete emotions like anger, sadness, joy or delight (Weiss & Cropanzano, 1996). A fundamental difference in these theories is that COR theory is a stress and motivational theory that explains negative emotion elicitation. CAT and AET examine the elicitation of both positive and negative emotions as a result of appraisals of an event with AET additionally considering *time* as a key parameter when examining affect.

CAT, COR and AET theories all suggest that emotion is elicited by a trigger event. Fridja (1993) suggests that a single event of affective significance to the individual often leads to an unfolding or dynamic series of sub-events (subsequent emotional experiences) that also have affective relevance. These sub-events combine to form an emotion episode. Each sub-event may result in a distinct, and importantly even opposite, emotional reaction but the full episode is driven by a core relational theme (Fridja, 1993). Critically, during this emotion episode an individual is in a state of "continuous emotional engagement" or a heightened level of arousal (Fridja, 1993, p. 387). A key outcome of this type of emotional engagement is that an individual may experience more intense and diverse affective reactions than normal (as captured by CAT and AET theory) (Weiss & Cropanzano, 1996) and these reactions may deplete resources (as per COR theory), directing them away from other important tasks, and may lead to an overreaction to emotion events unrelated to the underlying core theme (Weiss & Cropanzano, 1996).

2.3. Emotion regulation

Emotion regulation is conceived as "the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals" (Thompson, 1994, p. 27). Emotion regulation is a process that is activated at any phase of emotional responding, through strategies that involve conscious or unconscious processing (Verzeletti, Zammuner, Galli, & Agnoli, 2016). Importantly, emotion regulation refers both to how individuals influence their own emotions and to how they influence other people's emotions (Gross, 1999). For example, a patient may want to avoid telling their family about the seriousness of an illness and will "put on a brave face" to try to protect their family.

Regulating emotions, including which emotions individuals have, when they have them, and how they express these emotions (Gross, 1999), is difficult and requires significant effort (Sweeney et al., 2015). The emotion regulation process is often seen as encompassing two strategies: cognitive reappraisal and expressive suppression (Gross, 1998; Gross & John, 2002; John & Gross, 2004). Cognitive reappraisal is defined as a form of conscious cognitive change that involves construing the emotion-eliciting situation in a way that changes its emotional impact (Verzeletti et al., 2016). The aim is to decrease negative emotions and/or make negative emotions more positive. Cognitive reappraisal is an effective way of modifying the impact of an emotional experience. Expressive suppression, on the other hand, is a form of response modulation that involves inhibiting the ongoing emotion-expressive behavior in the situation. This strategy does not modify the impact of the emotional experience, it simply suppresses the expression of the felt emotion.

An important learning from organizational behavior literature relevant to health care settings is the notion that individuals can "catch" the emotions of others, that is, emotional contagion. Emotional contagion is defined as "the tendency to automatically mimic and synchronize facial expressions, vocalizations, postures, and movements with those of another person and, consequently, to converge emotionally" (Hatfield, Cacioppo, & Rapson, 1994, p. 153). Put simply, it is "catching" the other's affective state (Dallimore, Sparks, & Butcher, 2007, p. 79). Just as some illnesses can be caught and spread throughout a community, so too can emotions. Most research in this area has centered on positive emotional contagion. This is not surprising as purposeful displays of positive emotions by employees can engender positive feelings in customers, and subsequently increase positive evaluations of the service provider (Hennig-Thurau, Groth, Paul, & Gremler, 2006; Luong, 2005; Pugh, 2001; Tsai & Huang, 2002). However, in highly emotive services like health care negative emotions are often displayed by patients and their families and these are also likely to be subject to emotional contagion. Imagine the emotions displayed in a waiting room at a major hospital where one family is waiting for news about a loved one undergoing planned minor surgery while another family sitting nearby is waiting for news of a patient who was in a car accident and needed life-saving emergency surgery. In these situations, the emotional reaction of one customer (and their family) can greatly impact the experience of others.

Affect Control Theory (ACT) (Heise, 1979; MacKinnon, 1994) helps explain how affect regulates social life through verbal expressions. ACT postulates that verbally framed social experiences foster certain impressions of the self along the dimensions of pleasantness, activation, and dominance, and that predictions about emotions can be derived from the impressions produced by an event. For example, being praised by a dietitian makes a patient feel good and elicits pleasantness or happiness. In contrast, being reprimanded by the dietitian makes a patent feel bad, and deactivated; consequently, the patient is prone to emotions including sadness and shame. ACT's basic motivational axiom is that individuals seek experiences in which the impressions generated by the events confirm their sentiments. This implies that each individual is likely to act so as to produce impressions that confirm their self-identity (Heise & Weir, 1999).

3. Well-being

Subjective well-being reflects the quality of an individual's life (Lee et al., 2013). Well-being thus encompasses what it means to be functioning as a healthy person across multiple domains including physical, social, psychological, and emotional domains (Pressman, Kraft, &

Bowlin, 2013). Physical well-being reflects an individual's physical functioning such as fatigue, sleep quality, health problems, and self-care behavior such as exercise, nutrition, recreational activities and rest (Glajchen, 2012). Social well-being comprises social support such as feeling cared for and valued as a person as well as social function/adjustment which considers the role of satisfaction with relationships, and performance in social roles (Hahn, Cella, Bode, & Hanrahan, 2010; McDowell & Newell, 1996). Finally, emotional well-being refers to the "emotional quality of an individual's everyday experience, the frequency and intensity of experiences of joy, stress, sadness, anger, and affection that makes one's life pleasant or unpleasant" (Kahneman & Deaton, 2010 p. 16489). This last dimension is the one on which this paper focuses, in an attempt to tie emotional elicitation to enhance emotional well-being through the management of service delivery during the health care experience.

4. Emotion events, emotions, emotion regulation and well-being

AET focuses on events as proximal causes of emotional reactions (Weiss & Cropanzano, 1996). Importantly, experiences have a direct effect on attitudes and behavior (Weiss & Cropanzano, 1996). The emotions we feel are very important to our emotional and physical well-being (Verzeletti et al., 2016). Imagine a situation where a patient's cancer is in remission and the patient has an MRI every three months to determine disease progression. Now imagine that it is the week before the MRI and the patient's thoughts are increasingly on the outcome of the MRI. Anxiety and fear are likely to increase over the days leading up to the MRI, and even may manifest physically in the form of loss of appetite, insomnia, and fatigue. There is no doubt that the negative emotions experienced in this situation impact both the emotional and physical well-being of the individual. While emotions themselves directly impact well-being, so too does the act of emotion regulation.

Emotion regulation is a central aspect of an individual's affective functioning, influencing well-being (Verzeletti et al., 2016). This influence can be positive or negative depending on how effectively people manage their emotional responses to events (Verzeletti et al., 2016). For instance, imagine a situation where a mother with young children has been diagnosed with a chronic illness. She may regulate her emotions so that she appears "normal" in front of her children but may cry when no one is around. The regulation of emotions in this way is taxing, and may lead the young mother to experience longer or more severe negative affect (e.g. anger or/and anxiety), interpersonal difficulties with her children and those around her, behavioral and health problems such as a lack of sleep from anxiety, and lesser resilience to 'other' stressful events occurring in life (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Gross, 2007; Moore, Zoellner, & Mollenholt, 2008; Webb, Miles, & Sheeran, 2012).

As outlined earlier, emotion regulation often involves cognitive reappraisal and expressive suppression (Gross, 1998; Gross & John, 2002). Several studies show that cognitive reappraisal is positively associated with psychological health, including greater life satisfaction (e.g. Haga, Kraft, & Corby, 2009), positive affect (e.g. Balzarotti, John, & Gross, 2010), self-esteem, better social relationships (John & Gross, 2004), and reduced stress-related symptoms (e.g. Lougheed & Hollenstein, 2012; Moore et al., 2008). On the other hand, expressive suppression is linked to lower life satisfaction (e.g. Haga et al., 2009), social support, greater negative social interactions with others (John & Gross, 2004; Lebowitz & Dovidio, 2015), and with a higher risk of developing and maintaining depression (e.g. Moore et al., 2008). Thus, emotional regulation can result from emotion elicitation as well as be the cause of an emotive reaction.

5. Illustrative health care customer's (patient's) journey map

While it is important to understand the underlying emotion theories that predict emotional responses, it is imperative to contextualize emotional responses to gain insights into how to manage and enhance patients' emotional well-being. In this section, we present a series of patient journey maps to provide insights into emotion episodes, trigger events, sub-events and responses. The journey maps include support from underlying theoretical insights and practical recommendations for managing patient and family emotions. The first of these journey maps captures an entire emotion episode triggered by a specific event, as seen in Fig. 1. Sub-events are highlighted in this map and Figs. 2, 3 and 4 offer a more granular lens through which to view these sub-events. In this illustration we will focus on three main sub-events - a primary care visit, an emergency

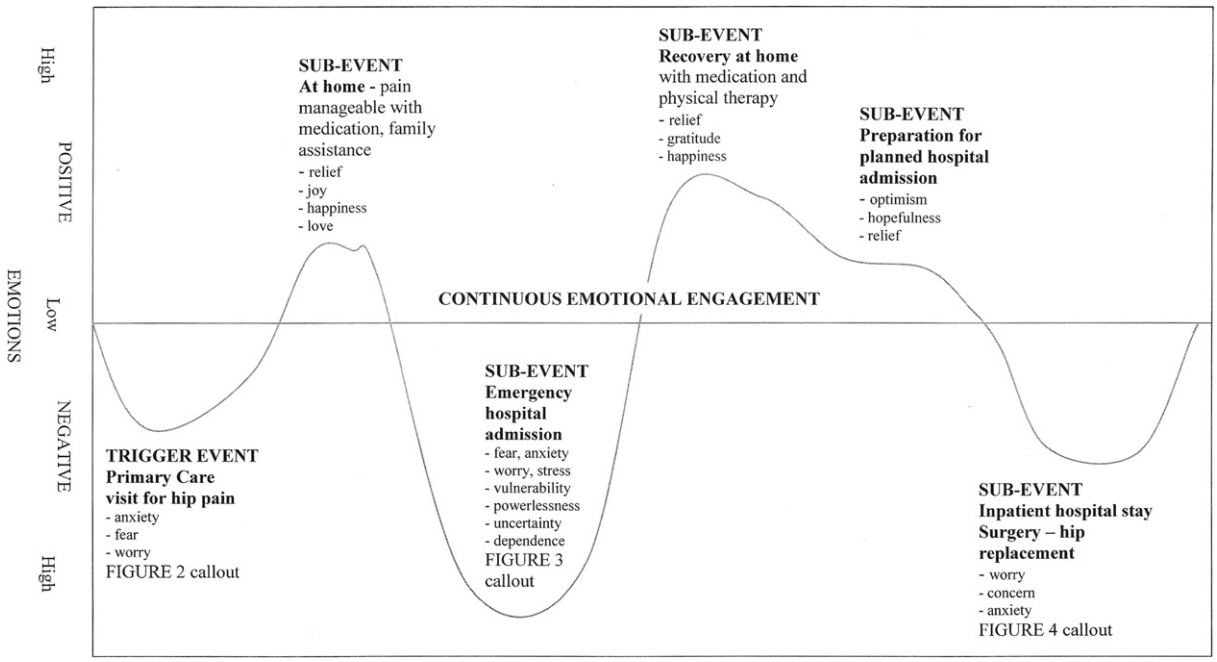

Fig. 1. Overall illustrative health care customer journey map – trigger event (hip pain) and sub-events.

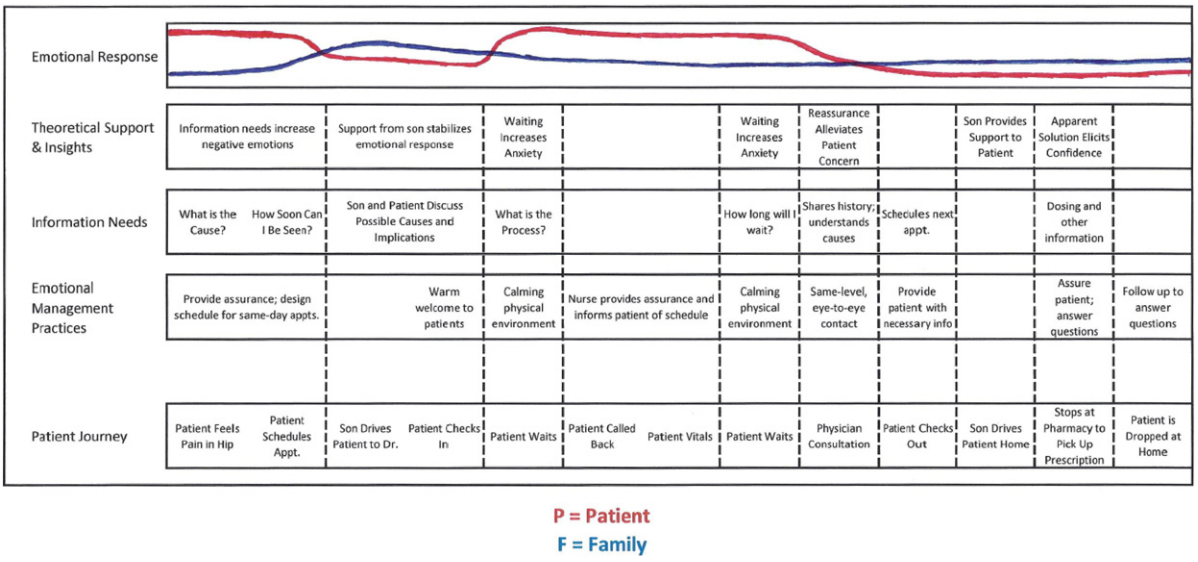

Fig. 2. Model of appointment with primary care physician for hip pain.

department visit and an in-patient hospital stay for surgery as they occur and elicit emotions within the overall emotion episode. Each sub-event represents a situation that can elicit both positive and negative emotions. Moreover, throughout the patient's journey we note that they are likely to be in a state of continuous emotional engagement as they move from sub-event to sub-event within the one overarching emotion episode that was triggered by a specific emotion event. This is important because it means that the patient's emotions are already heightened making any emotion sub-events more impactful.

To illustrate our maps with a specific patient journey imagine an elderly patient who is experiencing hip pain. Hip pain is the event that triggers the emotional episode. This event is clearly relevant to the well-being of the individual and will thus elicit an emotional reaction. Sub-events arising from the patient's hip issues occur and each of these will have emotional implications. The patient's overarching journey is captured in Fig. 1 and the sub-events can be clearly seen. Moreover, Figs. 2, 3 and 4 provide an intimate view of each of these sub-events. Looking through the lens of the first sub-event (highlighted in Fig. 1 and shown in detail in Fig. 2) the patient has gone to their primary care physician for a check-up and advice about their hip pain (the onset of hip pain being the trigger event). This may lead to some anxiety and worry. However, this may also result in positive emotions, such as relief and gratitude when the doctor prescribes pain relief medication and a referral to a physical therapist for treatment. Further, during this time the patient may reach out to their family for assistance and reassurance and this may produce a positive emotional reaction (e.g., feelings of love, happiness and security). However, at some point in the future the patient experiences a fall. The patient is rushed to the emergency department (ED) by ambulance and admitted to hospital (highlighted

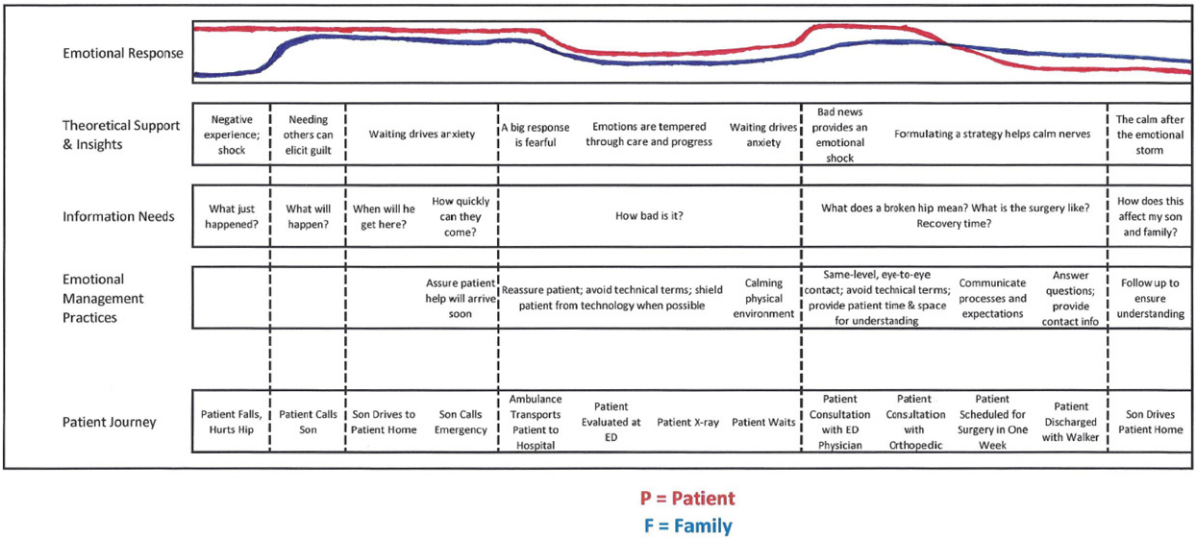

Fig. 3. Model of visit to emergency department, broken hip from fall.

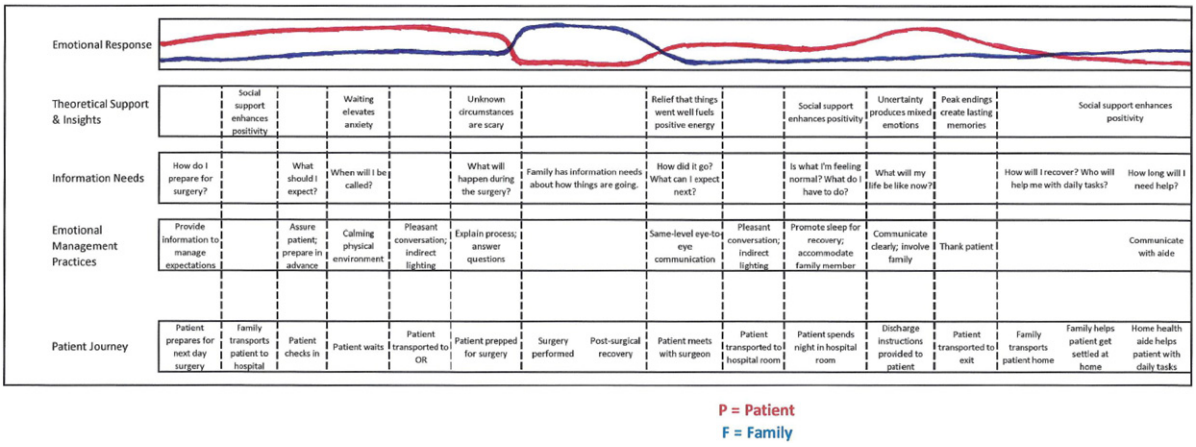

Fig. 4. Model of hospital stay for hip replacement surgery.

in Fig. 1 and shown in detail in Fig. 3). This sub-event is likely to result in high levels of fear and anxiety as well as feelings of powerlessness and uncertainty but recovery and discharge from hospital may again elicit positive emotions such as relief, gratitude and happiness. Finally, a third sub-event occurs with a planned admission to hospital for hip replacement surgery (highlighted in Fig. 1 and shown in detail in Fig. 4). The patient may feel optimistic and hopeful for the future while the actual admission itself and surgery may elicit worry, concern and anxiety. Throughout their stay in hospital emotions will fluctuate, produced for instance, by the thoughtfulness of a nurse during a painful procedure, a visit by a loved one that offers support and reassurance, or the kind words of a consulting physician that brings relief. Finally, discharge brings relief, excitement, joy and hope for the future as well as anxiety about coping alone at home and for the coming weeks of rehabilitation. In each of the sub-event journey maps (Figs. 2, 3 and 4) the patient's families' emotions are also captured to show their interconnectedness. In sum, each of the sub-events noted in Fig. 1 and captured in detail in Figs. 2, 3 and 4 details fluctuating emotions within the wider context of the emotion episode itself.

6. Conceptual framework

The theories reviewed earlier suggest that emotions are usually triggered by an event that is of major significance for the individual (Bagozzi et al., 1999; Lazarus, 1991). Similarly, Fridja (1993) suggests that a single event of affective significance often leads to an unfolding or dynamic series of sub-events (subsequent emotional experiences) that have emotional relevance. When discrete emotions are triggered by an event (and subsequent sub-events), they are likely to be short-term and transient. However, as a patient and their family will experience many different emotions during their medical journey (as captured by our journey maps) it is likely that the patient and family will remain in a state of continuous emotional engagement thus amplifying any emotion sub-events that may occur (Fridja, 1993).

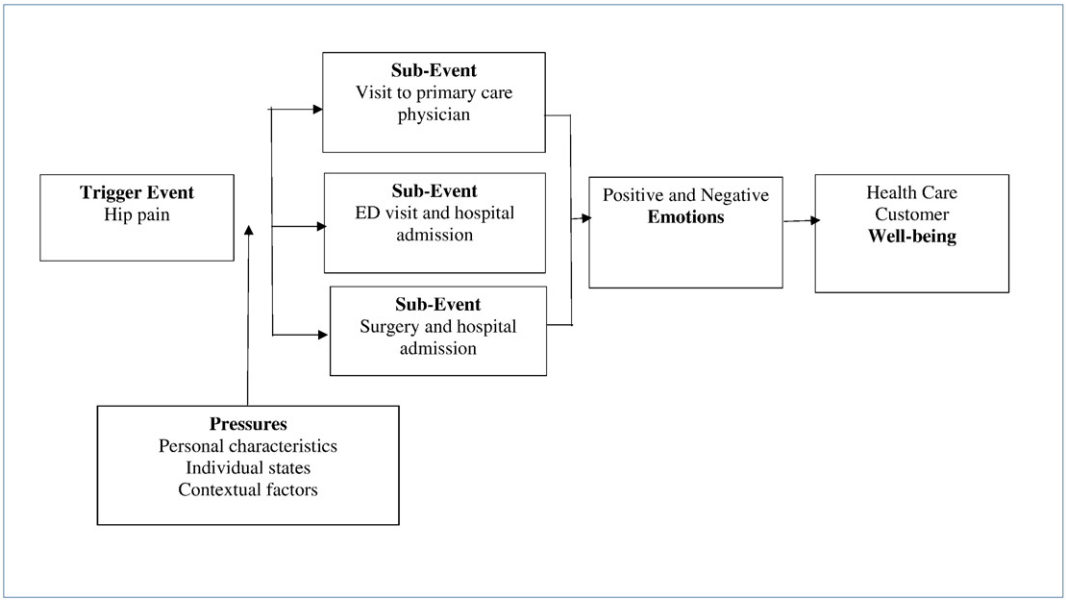

Fig. 5. Conceptual framework: elicitation of emotions in health care service experiences.

While some of these emotion experiences will be predictable, for example, admission to hospital for hip replacement surgery, others will occur at unpredictable moments, such as when the patient in our illustration ended up in the emergency department after a fall. Further, the intensity with which emotions are felt will vary greatly depending on the trigger event and the respective sub-events. In our illustration the emotions experienced by our patient when visiting their primary care physician are likely to be much less intense then those experienced when they were rushed to the ED and admitted to hospital. Emotions are likely to be heightened in the latter instance for the family of the patient as well. Indeed, an emergency trip to the ED involves greater uncertainty, elicits feelings of powerlessness and vulnerability, and places the patient and family in a state of dependence on the medical system – that is, they lack control over what is happening and are reliant on the health care system to take charge and manage a situation that could have profound consequences. These effects are captured in our Framework in Fig. 5.

As well as depending on the nature of the trigger event (or sub-event) the intensity of elicited emotions will also hinge on characteristics of the individuals themselves. There are many additional pressures that can exacerbate the emotions felt by patients and their families when a trigger event occurs. These include: (1) personal characteristics, such as age, education, socio-economic status and income; (2) individual states, like divorce and stress; (3) contextual factors arising from the environment itself including for examples assumed hierarchies, access to medical care and facilities, and asymmetry of information (Baker, Gentry, & Rittenburg, 2005). These pressures of everyday life will interact with the event that triggered the emotion episode to intensify the emotions experienced. In our illustration, imagine that the elderly patient has limited transportation and does not have comprehensive health insurance. When the patient needs to visit their primary care physician because of hip pain this elicits worry and anxiety but add on the patient's concerns over transportation to the clinic and the cost of the visit and the added pressure arising from these factors exacerbates the emotions the patient is already feeling, further adding to their worry and anxiety. Finally, it is reasonable to expect that more than one risk factor (e.g., low education levels combined with limited financial resources and lack of transportation) may interact leading to increasingly negative emotions being elicited. These effects are captured in the framework shown in Fig. 5.

Understanding trigger events and sub-events and the nature of the emotion elicitation process in health care is important because affective reactions are likely to drive well-being. Indeed, feeling anxious and fearful can manifest physically through a lack of sleep, reduced appetite, loss of energy, and ultimately diminish resilience and well-being (Hafen, Karren, & Frandsen, 1996; Rogers, 1997). Negative emotions can also lead to feelings of hopelessness and to the development of learned helplessness (Seligman, 1975) where the health care customer essentially 'gives up' believing that they have no control over their own situation (Faulkner, 2001). This passivity can result in neglect of health-maintenance activities, impaired immune response, loneliness and depression (Faulkner, 2001). As a result, asking questions, raising concerns, and actively engaging in sharing in decision making is unlikely to occur. Further, patients and their families might dis-attach or sever emotional bonds and distance themselves from others including other oncology patients as well as their own families and friends (Baker et al., 2005). They may also engage in emotion regulation sacrificing their own needs for support to protect those around them from the anxiety of their situation, and use fantasy and other means to divorce themselves from their current reality (Baker et al., 2005). Finally, negative emotions can discourage health care customers and their families from taking responsibility for their own health maintenance leading to reduced adherence to medical recommendations, and resistance to, or refusal of, treatment and advice (Faulkner, 2001).

7. Practical implications

Thus far, we explore the key emotions patients and family members may feel, the processes that elicit these emotions, and responses that impact health care customer experience outcomes. We now provide specific recommendations for health care organizations to better manage patient and family emotions thus addressing our research questions of how health care organizations can better understand patient and family emotions during health care customer experiences, and how they can use this understanding to design and better manage patient experiences to enhance health care customer well-being. We believe that health care providers and organizations can enhance patient and family emotional well-being by recognizing, supporting, and eliciting positive patient and family emotions. The specific actions that can be taken to provide conditions under which patients can emotionally flourish include: improving the design of the physical environment (servicescape); purposefully designing service processes to provide emotionally supportive actions; and, re-imagining employees' roles in order to create a supportive culture for all people involved in care (Dasu & Chase, 2013; McColl-Kennedy et al., 2017b).

A significant improvement that health care organizations can make is to improve the emotional well-being of their staff. Through emotional contagion, staff can positively influence patients and families' emotions through their own positive emotions. Often, staff in health care can become emotionally exhausted, caring for patients and supporting their needs. Resiliency is required for staff to continuously bounce back in order to be emotionally fresh for new encounters. This can be accomplished through a structured program such as Schwartz Rounds, monthly meetings where "individual staff members could feel free and safe to express and understand their feelings about the care of a particular patient" (Pepper, Jaggar, Mason, Finney, & Dusmet, 2012, p. 94). This initiative can help staff gain an appreciation for their feelings, witness support for their efforts, and to help them feel that they are not alone. In turn, research has shown that staff who participate in Schwartz Rounds experience less stress, are better able to cope with job demands, and demonstrate more empathetic behaviors (Lown & Manning, 2010). Programs such as this can impact patient care by supporting the very people who are charged with providing that care, with much of the focus on recognizing, supporting, and sharing emotions.

Appendix 1 provides illustrative examples of some best practices related to patient experience management that enhance emotional well-being in three key areas: (1) physical environment; (2) processes and routines; and (3) people. While the list is not designed to be exhaustive, it provides contemporary empirical cases from health care organizations in order to show connections between emotional theories, the conceptual frameworks developed, and real-world practice. For example, regarding the physical environment, noise reduction can help reduce anxiety and distress, while interior design elements such as color, furniture and carpet can promote healing. Navicent Health has demonstrated this in their neonatal intensive care unit, reducing stress and anxiety for both the newborn and parents, thus facilitating healing, growth, and bonding.

In terms of processes and routines, Stanford Medicine has significantly reduced the time from door-to-doctor in the emergency department, decreasing wait times, emotional stress, and patients who leave without being seen. The redesigned process that produced these effects also increased patient health outcomes and patient survey scores. Finally, regarding people, Sykehusklovnene pediatric hospital in Norway has engaged a wide variety of people in enhancing the emotional well-being of their patients. Professional actors and clowns interact with patients, reducing negative feelings,

Table 2
Directions for future research.

Key research domains	Proposed research questions
Dynamics of emotion	1. What specific emotions are elicited during emotion events and sub-events? 2. What specific emotions are felt by the patient, service employee, caregiver, family, and friends? 3. How intensely are emotions felt at key emotion events? 4. How do emotions evolve over multiple events and interactions with different parties (patients and service employees, patients and caregivers, patients and family and friends)? 5. What is the interplay between emotions from different parties including emotional contagion, labor and regulation? 6. What is the 'structure' of emotions? 7. Is there a hierarchy of emotions? 8. Can a hierarchy of emotions be flowcharted across the health care journey? 9. How can emotions be purposefully elicited to bring about positive feelings and/or reduce negative feelings?
Factors that drive emotions in health care	1. What are the key factors including illness and disease factors, psychological factors that drive emotions in health care? 2. In what ways does the physiological effects of illness (e.g., physical symptoms like pain) impact emotions? 3. How does culture impact emotional responses, regulation and communication patterns? 4. How do trigger events, emotion events and sub-events interact to impact well-being? 5. How does being in a state of continuous emotion regulation impact emotion elicitation, well-being and behaviors?
Pressures that moderate the effect of the trigger event on sub-events	1. How does the financial burden associated with illness impact emotions e.g., cost of health care, lost income from time away from work? 2. Personal characteristics: how do individual factors such as (a) locus of control; (b) coping style; (c) self-efficacy and (d) emotional regulation impact emotions? 3. Individual states: what and how are the individual states, such as e.g. divorce or stress affecting the relationship between the trigger event and sub-events? 4. Contextual factors: how are emotions experienced for different forms of illnesses such as (a) discrete versus on-going health care situations; (b) acute versus chronic medical conditions; (c) life threatening versus non--life threatening situations?
Emotions and outcomes	1. How do emotions impact physical, psychological, social well-being? 2. Do emotions impact life satisfaction and quality-of-life perceptions? 3. How do emotions impact shared decision making, patient compliance, engagement, co-production and co--creation in health care? 4. What is the role of emotion in transforming lives?

enhancing joy and appreciation, and providing respite from emotionally exhausting events. These examples, and those provided in Appendix 1, demonstrate that health care organizations can purposefully re-design the physical environment, design processes and routines, and engage a wide variety of people to manage and enhance patient and family emotional well-being.

8. Directions for future research

There is no doubt that emotions play an important role in health care and that there is substantial opportunity for future research in this area. Table 2 highlights potential avenues for future research across four main domains. The first domain explores the dynamics of emotion itself, raising questions about the nature of emotions in health care and how emotions evolve across multiple encounters and over time. Health service research should take into consideration the nuances of health care situations and contexts themselves. Emotions are going to be felt differently in acute emergency contexts than they are in on-going chronic health management contexts.

Research contributions may also arise from examining the interplay of emotions between different actors such as patient and doctor, and between the patient and their family. A key question revolves around how multiple actors experience emotions and the interaction of these emotional responses. This gives rise to further questions about emotional contagion and emotion regulation within health care. It is also likely that a hierarchy of emotions exist and that emotions can be flowcharted across the health care journey. This can be overlaid with the emotions of other parties to understand the interplay of emotions. It would be valuable for researchers to examine if there are particular types of emotion events or emotional reactions that have a greater impact on outcomes than other events.

The second domain in which future research can contribute revolves around examining the factors that drive emotions in health care. If we understand what influences emotions then we can develop strategies and activities to help individuals cope with the emotions they are experiencing. Many factors are likely to impact on health care emotions including illness and disease factors, psychological factors, and interactions and relationship with different actors such as professionals, family, friends, support groups and the wider community. Further, how specific events and sub-events work together to create emotional engagement needs further elicitation – some events are likely to trigger stronger emotions than others. The impact of being in a state of continuous emotional engagement or the cumulative effect of felt emotions on behavior also requires research.

Third, the pressures of everyday life such as financial status, personal states, and environmental conditions can heighten emotions. In particular, the financial impact of illness, especially in the case of ongoing illness or terminal disease, is an additional burden that patients must face and undoubtedly impacts emotions. For instance, the scenario of a person experiencing financial stress from low income or having had to reduce work hours due to their physical health or not being able to get suitable work given their illness and has no transport. This worry and associated impending surgery heightens their negative emotions. Further, the individuals themselves have internal resources or capabilities that will impact emotional responses to health care and so future research could explore individual characteristics. The way health care is delivered, including the quality of the service, the physical environment (servicescape) in which care is rendered, how technology is used and leveraged, and the way in which admission, discharge, and medical procedures and processes are enacted will likely impact emotion.

Finally, the impact specific emotions have on important outcomes warrants the attention of future research. Much more needs to be done to understand how emotions impact on well-being including physical, psychological and social well-being and thus their role in transforming the lives of individuals. Further, it is hard to imagine that emotions do not drive quality of life perceptions, engagement, co-production and co-creation activities, yet we know very little about how emotions drive these important outcomes. We call for future researchers to consider these areas of research so that we can contribute positively to the lives of individuals and their respective families as they journey through their health care experiences.

Appendix 1. Selected best practices in managing the emotional well-being of patients and families.

	Company	Health Care Context	Country	Brief Description	Reference	Emotional Impact
Physical Environment						
1	Navicent Health	NICU	USA	The NNICU supports your new baby in a healing environment by using sophisticated technology such as specialized flooring which reduces noise, acoustic ceiling tiles, infant music therapy, and indirect lighting to promote healthy brain development.	https://www.navicenthealth.org/childrens/nicu	Reduces stress and anxiety for both the newborn and the parents, thus facilitating healing and bonding.
2	Nationwide Children's Hospital	Pediatric Hospitals	USA	Children's hospitals are transforming their approach to care, replacing outmoded facilities and adopting family friendly policies to make an often-painful experience less traumatic for parents and children. In a review of more than 300 studies it was found that steps such as noise reduction can help reduce anxiety and distress, while interior-design elements such as color, furniture and carpet can promote healing.	http://www.wsj.com/articles/SB10001424127887324581504578235592251544284	Creates a welcoming environment for pediatric patients and their families, thus facilitating a positive emotional environment.
3	Dignity Health	Hospitals	USA	Hospitals are replacing overhead staff paging systems with wireless headsets, and allowing patients to shut room doors and post a Do Not Disturb sign. Designated sleep hours in some units mean there are no routine checks of vital signs unless necessary. Some hospitals are installing ambient white-noise machines and sound-absorbing ceiling tiles and carpets in rooms and corridors. They are offering televisions with closed-circuit "relaxation programming" of soothing music and nature imagery. "Quiet Kits" with sleep masks, earplugs and crossword puzzles help patients tune out intrusive sound.	http://www.wsj.com/articles/SB10001424127887324634304578537350035525538	Less noise means more sleep and rest, which facilitates healing, emotional calm, and increased communication.
4	The Brain Bank	Hospitals	UK	Sleep is an essential biological function and lack of it has been associated with a range of adverse outcomes including; altered immune function, metabolic dysfunctions and psychological disturbances including depression, stress and anxiety. Noise reduction also impacts staff effectiveness.	http://thebrainbank.scienceblog.com/2014/03/03/night-nurse-the-problem-of-night-time-noise-in-hospitals/	
5	Cleveland Clinic	Hospitals	USA	Interactive digital kiosks at entrances allow visitors to chart the course to their destination. At the Cleveland Clinic, the kiosks have a talking avatar that responds to touch-screen commands. It gives estimated walk times and allows users to print directions or send them to their phone.	http://www.wsj.com/articles/SB10001424052702303743604579355202979035492	Reducing a feeling of being lost allows patients to focus on moving forward and taking charge of their situation.
6	Cleveland Clinic	Hospitals	USA	Researchers are learning more about the precise ways paintings and other works of art help patients and families in the healing process.	http://www.wsj.com/articles/more-hospitals-use-the-healing-powers-of-public-art-1408404629	With studies showing a direct link between the content of images and the brain's reaction to pain, stress, and anxiety, hospitals are considering and choosing artwork based on the evidence and giving it a higher priority than merely decoration for sterile rooms and corridors.
7	Prescott Nursing and Rehabilitation Center	Nursing Home	USA	Comfort dogs help the elderly.	https://www.youtube.com/watch?v=FlwvEmNf_MU	Interacting with animals can reduce stress and facilitate a feeling of being connected with life.
8	Hands On Exotics	Nursing Home	Canada	Exotic animals are brought to nursing homes to comfort the elderly.	https://www.youtube.com/watch?v=-jhpJaGk2yM	
9	Life Center of Nashoba Valley	Nursing Home	USA	Llamas are used in therapy programs, brightening up residents' days. Animal-therapy programs are said to decrease agitation in many nursing home residents and to increase participation. The animals are sometimes able to bring the residents out of their shells in ways that previously seemed impossible.	https://www.youtube.com/watch?v=UBWI11vbObs	
10	The Center for Health Design and The Robert Wood Johnson Foundation	Hospitals	USA	Light impacts human health and performance by enabling performance of visual tasks, controlling the body's circadian system, affecting mood and perception, and by enabling critical chemical reactions in the body.	https://www.healthdesign.org/sites/default/files/CHD_Issue_Paper2.pdf	Effects on the ability of patients and visitors to relax and heal.

Processes and Routines						
11	Henry Ford West Bloomfield Hospital	Hospitals	USA	At the Henry Ford West Bloomfield Hospital outside Detroit, patients arrive to uniformed valets and professional greeters. Wi-Fi is free and patient meals are served on demand 24 hours a day. Members of the spa staff give in-room massages and other treatments. Medical researchers say such amenities can improve health outcomes by reducing stress and anxiety among patients, while private rooms can cut down on the transfer of disease.	http://www.nytimes.com/2016/08/02/business/making-hospitals-more-like-hotels.html	The routines of a patient's day are often filled with pleasant surprises, which can elevate the emotional state of patients and families.
12	Stanford Medicine	Emergency Department	USA	Since Fast Track and Team Triage were introduced to the ED, the median door-to-doctor time has dropped from 45 minutes to 18 minutes. The number of patients who leave without being seen has dropped from the industry average of 2 percent to 0.65 percent. Overall, the ED staff is far less stressed, because they can handle the higher patient counts so much more efficiently. And, in surveys returned by discharged patients, the change in wait time is clearly appreciated: The likelihood of Fast Track patients to recommend the ED is in the 99th percentile. The likelihood of patients to recommend the ED overall has risen from the 55th percentile to the 95th percentile since the changes were instituted.	http://med.stanford.edu/news/all-news/2013/02/new-emergency-department-programs-shorten-wait-times.html	Eliminating stressful waiting can help patients feel as though they are making real progress toward a solution.
13	Oslo University Hospital	Breast Cancer Screening	Norway	Redesign reduces waiting times to schedule a breast cancer screening, reducing worrying time and emotional burden.	http://www.norskdesign.no/2013/designed-away-health-care-queue-article25511-9062.html	
14	Medical Center of Delaware	Outpatient	USA	Utilize handouts and questionnaires for new patients in order to reduce anxiety in the waiting room.	http://www.aafp.org/fpm/1998/0200/p54.html	Useful distractions can help patients feel as though they are contributing to the quality of the process.
People (Staff and Others)						
15	Sykehusklovnene	Pediatric Hospitals	Norway	NGO with 25 professional actors/clowns; visits are now a regular part of daily life for the children at the hospitals we visit. Through improvisation and interaction with patients, carers and health workers, our clowns offer a positive respite in an otherwise challenging hospital experience.	http://www.sykehusklovnene.no/english/	Laughter can have positive emotional, psychological, and physiological effects.
16	The Mount	Nursing Home	USA	A Seattle seniors home is bringing together the very young and the very old.	https://www.youtube.com/watch?v=3LGSfgOi9UU	Knowledge sharing creates empathy and appreciation.
17	Valley Hospital	Intensive Care Unit	USA	Some hospital intensive-care units are bucking tradition by allowing patients' family and friends to visit for unlimited hours. Research showing intensive-care patients may actually fare better with more outside visitors has prompted some hospitals to lift restrictions.	http://www.wsj.com/articles/icus-ease-restrictions-on-visitors-1470073304?tesla=y	Evidence suggests that "flexible visitation decreases anxiety, confusion and agitation, reduces cardiovascular complications, decreases length of ICU stay, makes the patient feel more secure, increases patient satisfaction, and increases quality and safety."
18	Alfred I. duPont Hospital for Children	Hospitals	USA	When a child faces cancer or another serious illness, the main focus, of necessity, is on a cure. What is often overlooked in the maze of medical treatments is the emotional and psychological toll on families. More hospitals are working to prevent such headwinds by formally assessing families for concerns ranging from financial worries and child-care gaps to sibling problems, depression, and anger-management issues.	http://www.wsj.com/articles/hospitals-help-families-cope-the-psychological-toll-of-a-childs-illness-1428945584	Now, evidence shows that problems coping can interfere with medical care and families' adherence to treatment. And emotional issues can cause longer-term complications for both parents and children.

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