Title

Emotion work in a human service setting

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Abstract

The purpose of this article is to describe emotion work within a crisis resolution home treatment (CRHT) team. As defined by Hochschild, emotion work refers to the managing of one's emotions according to what is culturally acceptable within a particular situation. A CRHT team is of particular interest when studying emotion work, since it represents a working environment where mental health crises and suicidal threat are common and where a managing of the accompaning emotions are necessary for the team to function well. Our aim was to expand current knowledge of the particular ways through which emotion work may be done by observing and describing the daily work of such a team. Analysis showed that the team members' emotion work had the following features: (1) there was an informal rule that "vulnerable" emotions could be expressed, (2) emotional expression was common, (3) emotional expression seemed to reflect the speaker's need for validation, regulation of emotions, and help in mentalizing and developing a reflexive stance towards her own and the patient's emotions, (4) emotional support was freely given (5) and this support seemed to fulfil a function that could only be performed by other team members. An implication of these findings is that informal exchanges of emotion are a necessary part of the work and cannot be done outside of the work context.

Keywords

Mental health; crisis resolution; home treatment; staff; emotion work; observation

Introduction

CRHT team workers daily make decisions of crucial importance. The team mandate is to respond to requests from patients experiencing an acute mental health crisis related to mental pain, suicidal thoughts, psychosis, family or social crisis (The Directorate of Health and Social Welfare, 2006; Karlsson et al., 2011). The team works with patients who live at home, making rapid assessments based on the information they can collect in a short period of time (Johnson, 2007). The work consists of frequent assessments regarding whether it is a safe and appropriate solution for the patient to remain at home, and what services might be needed to solve the crisis at hand. Suicide assessments are a weekly, if not a daily routine, included in a substantial number of the assignments the team undertakes.

In order to be able to make good decisions, the team members are dependent on their ability to deal with strong emotions, both within themselves and in others, so that these emotions do not interfere with the decision-making, but can rather be used as information which can strengthen their decisions. Therefore it is of great importance that the team members have functional ways of managing their own and others' emotions.

From a sociological point of view, Hochschild (2001) has focused on the significance of managing emotions that deviate from the cultural script or moral stance that she calls "feeling rules". She describes the managing of emotions as "emotion work" (Hochschild, 1983; Hochschild, 2001). Emotions or feelings are signals of the individual's inner perspective (1983). As mentioned, emotion work refers to the act of trying to change the emotion or feeling, either by degree or by quality (Hochschild, 2001).

According to Hochschild (1983), every context will have specific "feeling rules" that give direction to emotions by providing social guidelines for how we try to feel (Hochschild, 2001). The culture sets a framework for what is an acceptable emotion in a particular situation, and efforts are made to direct emotions which deviate from this towards this framework.

Psychological theories have focused on how individuals can help each other regulate emotions which do not fit within the cultural norms described by Hochschild (1983; Hochschild, 2001), or which can be so overwhelming that they impede health workers' ability to make good decisions. This phenomenon may be described as "interpersonal emotion regulation". "Mentalizing" emotion is one description of how emotions may be regulated within interpersonal relations (Allen et al., 2008; Bateman and Fonagy, 2012). Mentalizing emotion can be defined as identifying, modulating and then expressing emotions in an appropriate manner (Allen et al., 2008; Bateman and Fonagy, 2012).

Another concept that is relevant for understanding emotion work is the concept of "social support". West (2012) identifies four main types of social support: emotional, instrumental, informational and appraisal support. Individuals can support each other's attempts to regulate emotions so that they are in accordance with the existing "feeling rules".

To summarize, this article aims to study the emotion work performed in a CRHT team, using the concepts of emotion work (Hochschild), interpersonal emotion regulation (mentalizing), and social support, specifically emotional support, within the team.

Prior studies relevant to the topic of emotion work in mental health teams

To our knowledge, studies on emotion work or managing of emotions in mental health teams seldom have been conducted prior to this study (Freeman et al., 2011). However, research indirectly relevant to this topic can be found. Several studies document stress amongst healthcare workers in different mental health service contexts (Edwards and Burnard, 2003; Reid et al., 1999; Sørgaard et al., 2007; Radeke, 1998). Examples are unpredictability, high caseload, increased level of responsibility, lack of staff support and unmet supervision needs (Edwards and Burnard, 2003; Freeman et al., 2011). Stressors may evoke emotions that need to be worked with and managed. Support in this emotion work may come from supervisors, leaders or other team members. Most research has focused on the necessity of support from supervisors and leaders. For example, Richardson, West and Cuthbertson (2010) found that support from supervisors and leaders increases the quality of decision making in an intensive team in a hospital.

Freeman, Vidgen and Davies-Edwards (2011) sought to explore staff experiences of working in CRHT teams in general. On the basis of interviews with five workers about their experiences, Freeman et al. report that participants spoke positively about the support provided by other team members and through supervision. Team members also spoke about coping strategies for regulating emotions in difficult situations. Examples provided were: “moving on” emotionally, acceptance and humour.

The results of Freeman et al. (2011) were based on interviews with team members. We base our results on observation, including verbal exchanges between observer and the team. The observer did not only observe silently, she also asked questions of team members in order to clarify her understanding of what was happening. This enables a study not only of what team members can verbally express,

but also of interaction that can be observed by a third party, for example emotion work. Emotion work is an abstract concept that is probably not explicit in the participants' minds, but may be elicited from the observational field notes made by a third party, as in the present study.

Specifically, we analyzed the field notes with the following questions in mind: (1) which emotions are expressed; (2) when these emotions are expressed, and (3) what purpose this emotional expression might serve for the individual. Finally we ask (4) how these emotions are received and responded to, and (5) how this support functioned for the team. In summary, the aim of this article is to examine the emotion work of a CRHT team.

Method

Design

The method used was participant observation (Fangen, 2004), conducted by the first author. The observer documented her observations by writing field notes, reflections and clarifications of conversations with the team members (Fangen, 2004; Emerson et al., 1995; Gubrium and Holstein, 1997). Field notes were taken at the scene during meetings and conversations. The work was inspired by Gubrium and Holstein (Gubrium and Holstein, 2009; Gubrium and Holstein, 1997; Buckholdt and Gubrium, 1979; Gubrium, 1997) in that the observer paid close attention to how her own and the participants' understanding of what had happened during an event was developed and nuanced through conversations between team members after the event.

The observer followed the team in their day-to-day work at the office and from the back seat of the car going back and forth when visiting patients. She was allowed to

observe meetings, discussions, reflections and interaction during the teams' daily routines at work. As mentioned, she mostly just listened and watched, but sometimes asked for clarification.

The observation was conducted over a period of four months, between August and December 2009, including 19 days of observation. A typical day of observation was around five hours in length, ranging from 2 hours to 7.5 hours. Ethical approval for the project was obtained from the regional research ethics committee. The notes that comprised the data were anonymized for ethical reasons, and one instance was removed from the account at the request of one participant. Observations were not made with patients present in order to avoid disturbing the team in their work.

Setting and participants

Data was collected as part of a project that had the overall aim of better understanding the work of CRHT teams. A local hospital's CRHT team which was involved in the project was selected for closer study, since it represented a typical Norwegian CRHT team. It was typical in that it participated in an official training program for CRHT teams, involved members with different professional backgrounds, was mobile, carried out home treatment and worked in a network-oriented manner. There were no medical doctors on the team, but a medical doctor from the hospital occasionally participated in team meetings, and was available on call when needed. Team members had to make important decisions regarding patient care while visiting patients, or while talking on the phone with patients, relatives or others.

Thirteen team members participated, 11 women and 2 men. Participants were aged between 27 and 59 years. Their professional backgrounds were multidisciplinary,

comprising nurses, social workers and psychologists. All nurses and social workers had completed one or more extended courses on mental health issues, such as psychiatric nursing, cognitive therapy or family therapy. All but one team member had more than two years of work experience related to mental health, both hospital and community-based. All but two had attended a course of training in CRHT, and had been members of the team since it was newly established in October 2007.

The context of the observation in this study was one particular CRHT team and the arenas where the team worked. The actual places of observation were the team office and the car going back and forth to the patients' homes. In the office environment the number of workers present varied from two to several throughout the day. The office consisted of a large meeting room with a kitchen and a small connected telephone room. There were no individual offices. In the car there were usually two team members together.

The team was organized as an independent unit, consisting of 12 team members and a team leader. The team leader had responsibility for the CRHT team and one additional team. One of the team members was responsible for the daily operations of the CRHT team; her title was "team manager", but tasks involving responsibilities for the personnel remained with the team leader. Additionally the team had access to medical doctors when they needed to discuss patient-related matters.

The team leader maintained an office on the building's second floor. The team manager had no office of her own and worked in the same first-floor office landscape as the rest of the team. The medical doctors had their offices in various buildings across town, and were available on the phone or came in for morning meetings with the team.

Analysis

The method of participant observation may be used to capture the activity of everyday life as it happens in a natural environment (Silverman, 2006; Gubrium and Holstein, 1997; Holstein and Gubrium, 1995; Gubrium and Holstein, 2009). Realizing our own part as observers of the stories when the participants construct their realities, we strive to be reflexive regarding our own common-sense understanding of what is going on, and as far as possible to bracket this analytically as we try to grasp how the participants construct their realities (Gubrium and Holstein, 1997; Holstein and Gubrium, 1995). The aim of this study was to explore what was going on within the CRHT team, specifically how emotions were expressed and dealt with.

The analysis of the field notes was carried out after the observation had been made, with NVivo 8 computer software (QSR, 2009). The first two authors commenced by examining the field notes, identifying themes related to emotion work in the material, and looking for contexts and situations as well as interaction between team members. For us, "support" was one of the themes that appeared in the material in different forms. We chose to focus on contexts, situations and interactions where emotions were expressed and emotional support was given, or not given. We read the field notes and looked for emotions and emotion work. By keeping in mind the context as well as the individual stories and the interaction between team members, we looked for how this played out between the team members in their everyday work (Holstein and Gubrium, 1995; Gubrium and Holstein, 2009) .

The analysis indicated that the feelings expressed appeared to be what we have chosen to call "vulnerable" feelings, e.g. unease, worry or insecurity. We use the word "vulnerable" since we believe these feelings will be more easily expressed in close

relationships where participants are confident that they do not need to protect themselves against harsh criticism, ridicule or loss of status if such inner feelings are expressed. A closer inspection of the field notes with Hochschild's concepts in mind indicated to us that, in order to understand how such feelings could be so easily expressed, we had to assume the existence of certain informal feeling rules that allowed and perhaps even encouraged this type of emotional expression. When we analyzed the field notes with the aim of describing how the expression of such "vulnerable" feelings was responded to, they indicated that this expression was consistently responded to with support, as defined by West (2012). We then went on to try to understand the nuances of how this support was practiced, and what role it had for the functioning and work of the individual team members and the team as a whole; here we found the concepts of Allen, Bateman and Fonagy (Allen et al., 2008; Bateman and Fonagy, 2012) to be useful. Finally, the field notes were reexamined to check on their agreement with the concepts that had been chosen by the researchers during the analysis.

Findings

The setting: In her observations, the first author started with the general aim of observing and describing how team members worked, i.e. their communication and practices during working hours. It was immediately evident that there was a social climate with a great deal of emotional, informational and appraisal support. Additionally, a seemingly wide range of feelings were freely expressed.

The workday was typically divided into time at the office with other colleagues, sometimes in phone calls with patients or the network, time in the car going back and forth to home visits, and time at the patients' homes. These various settings offered

different challenges and possibilities of registering one's own feelings, expressing them, and getting a response and support for them. The day usually started with a morning meeting. This meeting was used for reviewing and discussing cases, expressing thoughts, feelings, reflections, needs and getting feedback and support.

(1) Which emotions could be expressed?

We observed an environment within the team where "vulnerable" emotions, such as insecurity, were expressed. In no instance did the first author observe a team member reject or ignore another team member's expression of vulnerability or insecurity. Humour was observed - not as a protection against emotions - but as a tension-reducing strategy after stressful and vulnerable emotions had been expressed.

An illustration of this arose during a meeting with the doctor who assisted the team, two days after a suicide. The suicide had occurred after the two team members with the major responsibility for the patient paid him a visit, and then left him alone, based on an assessment that there was no immediate risk of suicide. Naturally, this suicide evoked strong emotions and led to the team members questioning themselves and whether they could have seen this coming. These emotions were expressed freely. During the discussion one team member raised the question of what might happen if the authorities found that their documentation of the case and their evaluation of suicide risk had not been satisfactory. The doctor answered that he and the team leader would receive a reprimand. A team member quickly replied, "We can live with that", and there was general laughter. The other team members seemed to be relieved that they themselves would not be reprimanded, and there was acceptance even for expressing relief that the local leaders would take the blow.

In summary, the feeling rules in the team appeared both to allow and encourage the expression of a range of feelings, including vulnerable feelings. Even "unacceptable" feelings, such as satisfaction with the prospect that others than oneself might need to take a reprimand from the authorities, are met with recognition and laughter.

(2) In which situations were emotions observed, and what emotion work was performed in those situations?

Emotional expression was common when discussing challenging events or specific patients. Team members who were unsure about such events or patients commonly expressed vulnerable emotions.

One example of a situation in which vulnerable emotions were expressed, was an experienced team member's admission of having been shocked and sleepless after the suicide mentioned above. During a formal meeting with the consulting doctor, the team member admitted to not having slept well during the two days that had passed since the incident, but added that she felt well taken care of through the debriefing. Later that day, a second team member remarked to the first that she fully understood the feeling she had expressed, and they went on to reflect upon the difficulty of the incident and how it had touched them both emotionally. They seemed to find some solace in reminding each other that the patient had had a long life. They also reflected upon whether anybody could have done anything differently, and came to the conclusion that they probably could not, since the patient had rejected very clear attempts to help him, and the criteria for involuntary hospitalization had not been met. One of them stated: *Death*

is what touches us all the most; our own things, fear, thoughts and our loved ones. It is the deepest part of us, and it affects us all.

Another example of how emotion work in this team included expressing and discussing difficult emotions was when one team member raised the question of whether the suicide had been provoked by something they had said or done. Even though there was a received knowledge that bringing up the subject does not increase the risk of suicide, one team member expressed her fear that talking about suicide might have contributed to it. This elicited reflection and support from co-workers.

Thus, an incident that might have been traumatic to live with was worked through and made less traumatic by speaking with each other. This working through resembled that which a close relative might need to undertake in similar circumstances. They touched upon the possibility of guilt: "Could I have done something to prevent this?" as well as on sorrow: "This is sad, the only solace is that he lived a long life," and the acceptance of these feelings as common to all: "It affects us all."

*(3) What function did emotional expression have for the team members**?***

Emotions were expressed as a form of "working through", digesting or processing the event with the help of a fellow team member. We define working through as expressing and discussing one's reactions with a sympathetic other or thinking through the incident, so as to be able to come to terms with one's feelings around the event, and to be less bothered by intrusive thoughts and feelings associated with it - perhaps feelings of responsibility or guilt, thoughts such as: "Should I have done anything differently?", "Why did he say that?", "How did he feel when I said that?", "Why did I get so upset?", and so on.

The “working through” sometimes involved the speaker trying to figure out whether her response in a challenging situation had been adequate. In other instances, it was more a question of a supporter expressing concern for the speaker. An example of the latter was the following:

There was an informal team rule that members work in pairs in patients’ homes, but due to a low staff ratio they occasionally had to conduct home treatment alone. During a morning meeting one participant described a situation where she had been alone at a challenging patient’s home for hours. The team member related the following to the others:

> *Finally I thought I just have to try to leave. Then maybe his paranoia will calm down. But it was almost like he tried to hold me back physically by standing in the doorway in front of me. I have tried to remember if he was grabbing me, but I cannot remember that he did. Maybe he held my jacket. He kept close to me, standing right next to me. It gave me the feeling that he was holding me back. I did not feel worried about my own security, but about being alone in making the decision to leave him. I discussed it with the doctor afterwards. He thought that the patient was not a danger to himself, and I agreed with that.*

In this situation, the speaker may be implicitly asking for feedback or validation that her response in this situation was understandable and adequate. She was worried about making the right decision. She had received validation from the doctor, but since she brought the situation up again, she might have needed an additional opportunity to work through this concern.

(4) How were emotional expressions responded to?

In the above example, vulnerable emotions were only alluded to: "*I was not concerned about my own safety, but I was concerned about whether I could leave or not*." Nevertheless the question of safety was picked up on and responded to by her fellow workers. One of her colleagues expressed worry about the risk of being in such a situation, saying that she did not like that the participant had been alone in the patient's home. She added that the team needed to discuss the risk involved in going alone to carry out home treatment with patients.

Thus, the emotional support involved being heard, accepted, and taken seriously. The response also contained concern for the other person and support regarding her level of experience and how that had contributed to solving the situation. There was an attitude of mutual concern within the team. This concern was also made concrete as emotional support.

The following is another example of a response to emotional expression. One of the team members stated that she was anxious because the treatment of a specific patient did not seem to work the way they had hoped. A second team member replied by confirming that she understood the worry and concern expressed. This illustrates how emotions were heard, recognized and validated by others in the meeting.

The observations showed that support is needed in this kind of work even by experienced team members. As mentioned above, the team experienced its first suicide during the period of observation. The team member who had to conduct the next suicide assessment expressed insecurity or possibly fear of trusting the routines for such assessments, and doubt about being competent to make the right assessment. She added

that she tried not to let her raised level of awareness about the possibility of suicide take control over her. Thus, the suicide seemed to raise doubts and emotions about having sufficient competence to fulfill the job. The emotions arising in the aftermath of this suicide remained for some time, even for professionals who deal with these questions in their day-to-day work.

Such feelings were discussed openly in the meeting room between a few team members who remained seated at the table after the conclusion of a formal meeting. The immediate reactions to the patient's suicide were described as shock, and a feeling they carried throughout the day and until walking into a new appointment, a reaction to the unexpected and sad message.

These feelings were met by validating each other's feelings and assessments of the case. No one stated that anyone could have seen this coming. On the contrary, team members repeatedly said that nothing could have been done to prevent the suicide. Emotions, thoughts and reactions were aired and shared, both in team meetings and informally.

To summarize, there seemed to be a need for team members to deal with their own feelings and receive emotional support from colleagues. Most of the emotions discussed arose after difficult meetings with patients, and involved feelings of being uneasy, worried, insecure, empty, or helpless. Overall, emotional expression was responded to with validation and support. Emotional support was freely given between team members.

(5) What function did this support have for the team's work?

The function of the support and validation seemed to be to restore confidence in the

team as competent workers. For example, after the suicide, the support seemed to help team members regain the confidence necessary to continue their work and conduct the next suicide evaluations without too much self-doubt.

In addition to the "after-the-fact" working through of emotions, emotional support also had the function of enabling a team worker to retain her confidence and effectiveness *during* contact with patients. Some elements of the support shared between members of this team were given *in situ* during the home treatment, when taking turns talking to the patient. For example, a team member related an incident where she felt supported by her fellow team member in a discussion with a patient. The patient had become verbally abusive of the first team member, and the second had told the patient that she had to stop. The presence of another team member who could silently validate the first one's feelings of being verbally abused by the patient, and verbally define the situation as unacceptable to the patient, probably gave the first team member time to think and regain her composure.

Thus, validation and reflection from the second team member helped regulate the emotions within the situation. The validation exchanged between team members may be validation of emotions, as in, "Your feelings are okay," but it may also be validation of team members' understanding of the situation, as in "You have correctly understood the patient."

There were frequent invitations by team members to share and talk about feelings associated with difficult situations.

In one example a team member expressed that strong emotions in meeting with one particular patient made her feel helpless. In discussing the situation after the fact, other team members understood and validated her feeling of helplessness as being quite

adequate. This may have boosted the first team member's confidence so that she could continue to try to help this patient and others, in spite of feeling helpless at times.

The validation was most often made as a factual statement, rather than a statement reflecting pity for the worker who expressed a problem. This could be seen as mutual respect, and recognition and acceptance of being in difficult work situations, rather than pointing to a lack of the individual skills to handle the case.

In brief, the support seemed to fulfill a function of mutual assistance towards greater understanding of the situation. It also seemed to help the workers in regaining control of their inner feelings and outer conduct. We believe that this assistance could only be offered by other team members with the same background knowledge as the speaker.

Discussion

In this study, we analyzed the field notes from the observations for (1) which emotions are expressed. On the basis of this analysis, we will discuss which feeling rules may be operating. We further analysed the observations regarding (2) when these emotions are expressed and (3) what purpose this emotional expression might fulfill for the individual. On the basis of the analysis we will discuss how this emotional expression might be useful for team members in coping with the emotional demands of their work. Finally we asked (4) how these emotions are received and responded to, and (5) what functions this support may have from the vantage point of the team's work with patients in crisis. On the basis of this analysis, we suggest some conditions which need to be in place in order for the team to function well.

We first asked (1) which emotions are expressed. There seemed to be an informal feeling rule that "vulnerable emotions" could be expressed freely. Emotions observed were unease, being upset, descriptions of worry or being anxious, feeling unsafe, vulnerable, helpless, and uncomfortable.

Even emotions that seemed to challenge what the team believed to be true were tolerated. In the team, there was a "received knowledge" that talking to a patient about suicide will *not* increase the risk of it. However, one member mentioned a fear that bringing up the subject could actually have contributed to the recent suicide of a patient. The expression of such a thought calls attention to the intensely uncomfortable question of whether team members may have provoked the suicide. As we see it, this suggests a perception that it is legitimate to bring up "not accepted" thoughts such as, "Could we have provoked the suicide, after all?", along with emotions such as guilt or insecurity, as they are experienced by the team members. This generally indicates a fundamental feeling of security within the team – a confidence that emotions can be expressed openly, even feelings that are uncomfortable for the team. This indicates that even expressing doubt regarding the teams practice was acceptable.

The emotions that were expressed were, as mentioned, emotions of "vulnerability". This is striking, since emotional expressions, especially those of insecurity and vulnerability, may often be frowned upon in other contexts, and it is not uncommon to hear receivers of emotional communication during a discussion react by ignoring it, asking the emotional individual to calm down, take it easy or "not to think about it".

In contrast, there seemed to be a feeling rule in this team that vulnerable emotions such as sorrow and insecurity should be expressed freely, and that support and

validation should be given. However, the absence of confrontations and angry feelings between team members during the observation period makes one wonder whether there is also a feeling rule that expressions of anger and criticism are to be avoided.

Perhaps such a feeling rule, allowing vulnerable feelings, but prohibiting criticism, anger and confrontation, is necessary for a feeling of emotional safety within the team, enabling vulnerable feelings to flourish. When team members are confident that they will not be harshly criticized by fellow team members, they might be better able to work through potentially traumatic events, such as the suicide experienced by this team. Dealing with such experiences may involve self-questioning: “Should I have foreseen this event?”. Self-questioning may easily trigger self-criticism: “How could I be so stupid as not to understand that this would happen?”. The lack of criticism from others, and the support given, may reduce individual team member’s risk of experiencing dysfunctional thoughts, rumination and self-criticism after a traumatic event.

The facilitation of vulnerable feelings in the team studied is interesting, especially since it seems to be in contrast to what might be common in other types of teams working with emergencies and crises, such as medical teams working in intensive emergency hospital units. Feeling rules that prevent, rather than facilitate, expression of vulnerable feelings may be important to the functioning of emergency units, at least during the emergency itself. Avoiding the processing of other’s physical pain may at time be necessary for medical personnel (Decety et al., 2010).

In summary, we suggest that feeling rules that encourage expression of “vulnerability” are encouraged within this CRHT team, in spite of working with crises

and challenges that might, in other settings, have invited "tougher" kinds of self-protection and defenses.

We further analysed the observations regarding (2) when these emotions are expressed, and found that emotional expression was common when discussing, working through and digesting challenging events or particular patients, and went on to ask (3) what purpose this emotional expression might serve for the individual.

Emotional expression seemed to reflect a need on the part of the speaker for three different types of support: validation, regulation of emotions, and help in mentalizing and developing a reflexive stance towards their own and their patients' emotions

Validation, regulation of emotions and help in understanding might be useful in regulating emotions so that they do not become overwhelming and lead to burn-out. Thus, emotional expression might meet the purpose of helping individuals to cope with the emotional demands of their work without succumbing to burn-out or becoming traumatized (Freeman et al., 2011).

We then asked (4) how these emotions were received and responded to. We found that the responses were warm, empathic and caring, involving an active and open listener, providing the space for speakers to express their emotions, a sense of caring, but not giving advice or a direction for the other person's emotional pain. According to West, these are common characteristics of emotional support in teams (2012).

We further asked (5) what functions this emotional support might have in helping the team do its work. We found that the support communicated back to the speaker that the feelings were understandable, and in this sense, validated by feelings (Allen et al., 2008; Bateman and Fonagy, 2012). In no instance did we find team members

responding to each other's emotional expression by trying to change the character of the emotions.

Instead, team members seemed to help each other mentalize or process their own and their patients' emotions. The most common way to provide emotional support was through validation of emotions (Allen et al., 2008; Bateman and Fonagy, 2012). There was a frequent sharing and airing of experiences. Emotional expressions were often met with a confirmation of recognition; the emotion was heard, understood and accepted. These validations seemed to be needed when dealing with specific, perhaps challenging, patients or situations. They might have elements of helping the team member understand and evaluate herself, the patient and the situation at hand (Goleman, 2006). By receiving a confirmation of the appropriateness of their emotions, the team members received support that might be useful in understanding the needs of the patient and making accurate decisions about them.

This validation may sometimes counteract a tendency to become self-critical, for example by thinking: "I shouldn't have reacted that strongly." Instead, the feelings were validated as reasonable and understandable, which may be a first step in using them in a constructive manner to understand oneself and the patient.

According to Allen, Fonagy and Bateman (Allen et al., 2008; Bateman and Fonagy, 2012), validating emotions in order to help the other mentalize them is an important aspect of interpersonal emotional regulation. This type of validation was found frequently within the team, and seemed to help the speaker reflect upon her own feelings, and on those of the patients, developing what Fonagy calls a "reflective stance" towards one's own and other's thoughts and feelings at a particular moment in time. As mentioned in the introduction, "mentalizing" emotion can be defined as

identifying, modulating and then expressing emotions in an appropriate manner (Allen et al., 2008; Bateman and Fonagy, 2012). Mentalizing and taking a reflective stance involves being able to think in spite of strong emotions. It involves a self-understanding as well as an understanding of others. Being helped to mentalize may calm overwhelming emotions in both oneself and the other person. The ability to mentalize represents an important skill for these team members. They faced frequent encounters with patients involving strong emotions where the patient did not seem able to think clearly. When able to mentalize in spite of strong feelings, team members become better able to make decisions that are not directed solely by their own or their patients' emotions. The decisions they make, take their own and the patients' emotions into account. In addition, the team member can think clearly without being overwhelmed by confusing emotions, so that he or she take into account also the outer realities of the situation.

Thus we suggest that one function of the support given was that it helped team members regulate their own emotions in order to think clearly and with confidence. When emotions were expressed and validated within the team, this became possible.

Who can provide such support to team members? We believe that this support needs to be provided by fellow team members, rather than non-professionals outside the team such as family and friends. Team members experience situations involving patients that cannot be shared with individuals outside of the team. The duty of confidentiality prevents them from talking freely to others about the crises they need to cope with. In addition, the history of shared experiences between team members build up a knowledge base that is not available outside of the team. Thus, it might not be possible to receive the understanding and support that team members can provide for

each other from people outside of the team. We believe that this support for the type of vulnerable feelings expressed could only be provided by other team members with the same background knowledge as the speaker.

On the basis of these observations, we suggest that this mutual support has an important function in this team's work with patients. We agree with West (2012) that emotional support is necessary for teams such as this to work well, and add that this support might sometimes best be given by other team members.

We suggest that the ability to accept and communicate difficult feelings and vulnerability is a prerequisite for the team to function adequately. The team needs to cope with potentially traumatic experiences without reacting by avoiding or trying to suppress their own or others' emotional reactions. It must also be able to express vulnerable feelings in order to receive feedback from others regarding personal feelings and imaginings about patients and events. In order to work constructively within a team such as this one, a member needs to be able to receive and give emotional support.

One may wonder what might happen to a member who does not admit to vulnerable feelings, and who does not obey the rule of not expressing aggression or criticism towards other team members. According to Hochschild (2001), following the rules for expressing emotion gives protection from disrepute. Perhaps team members who do not honour such unspoken emotion rules and instead expresses non-validating criticism and aggression against fellow team members, will be the target of disrepute.

By abiding by the feeling rules, the team protects its members against criticism and self-criticism. The emotional understanding and support received from other team members, protects their confidence in their ability to do their work, in spite of instances of aggression and rejection from patients and in spite of feelings of helplessness at

times. These same feeling rules may expose those members who do not follow them to possible disrepute and isolation. This avoidance of "non-support" and aggression may be necessary in order for the team to survive and function as intended under the stress of sometimes very critical, rejecting and distressed patients living in situations where helping them may be difficult.

To sum up, the observations suggest that the support provided enabled an emotional regulation, mentalizing, and reflective stance that enabled team members to avoid being overwhelmed by their own or patients' feelings, and to be able to think clearly in order to find thoughtful solutions to the patients' crises. The presence of such support appears to be important for the team to function well.

Strengths and limitations of this study

Spending time in the work environment, and watching and hearing what goes on between the team members provides a new perspective on the interaction and stories that evolve, and makes them available from an external (although also participatory) perspective. On the other hand, there are limitations to this method. As an observer one cannot manage to take in all the accessible information. There is a constant need to select what information is registered from the situation being observed. As the field notes are written down and not sound-recorded, there are also some limitations on noting down everything that happens. What transpires is a selection of what is said, what is shown by body language, and what happens within the room. There is a restriction on how much the observer registers of what is going on (Fangen, 2004; Emerson et al., 1995; Gubrium and Holstein, 1997).

The different fields of study within the research team were psychology and sociology. This provided us with different theoretical perspectives when analyzing the material. This can be seen as an advantage in that it broadened our understanding and view of what we saw. It allowed the possibility of drawing on theories from both fields, as we have done, inspiring us to explore the individual as well as the context.

We did not test our understanding and interpretation of the material by referring it back to the informants. This might be a limitation, but on the other hand it is not always possible for the participants to observe or comment on emotion work among themselves.

Conclusion

Observation of a CRHT team working with patients in acute mental health crises on a day-to-day basis shows that a wide range of "vulnerable" emotions regarding their daily work are expressed within the team. These emotions are received within the team and emotional support is given between the team members. The expression of emotions and the emotional support perform important functions for the team members. They cover a need that cannot easily be filled by someone outside the team who lacks the same knowledge and experience of the situations that the team encounters in its work. These findings also indicate that to be able to work in a CRHT team, the team members cannot avoid their own emotions and need to do important emotion work. There is a need for the team members to endure the emotional pressure of their work life, and to be able to regulate their emotions in a functional way, both interpersonally and individually.

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