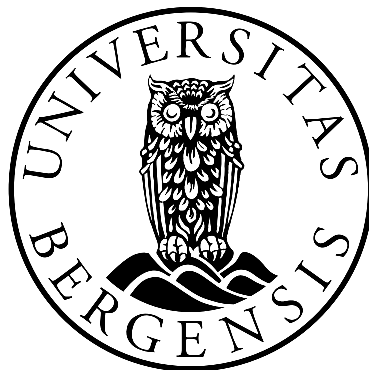
Experiences of Members of a Crisis Resolution Home Treatment Team

Personal history, professional role and emotional support in a CRHT team

Hege Sjølie



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Scientific environment

This dissertation is a product stemming from the research project "Crisis Resolution and Home Treatment in Community Mental Health Services" for which Dr. Hesook Suzie Kim is the project director and Drs. Marit Borg and Bengt Karlsson are the principal researchers. This project is funded by the Research Council of Norway for 2007 to 2011 to Buskerud University College.

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Acknowledgements

The process of this thesis has been about getting to know people, who they are and what they experience. It has been about the participants' experiences, but also about my own experiences and understanding of CRHT work, staff experiences, being a researcher and doing qualitative research.

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A lot of my knowledge of CRHT teams and CRHT work comes from the discussions and collaboration within the research group in the main project, "Crisis Resolution and Home Treatment in Community Mental Health Services". Thanks to all the researchers in the research group and to the participants in the three different sub-projects. Thanks to the University College of Buskerud that provided an environment of research, discussions and learning.

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Abstract

The main aim of this thesis was to explore the characteristics of the work done in a CRHT team, from the point of view of staff members. After an initial literature review, we conducted interviews and participant observation to approach this aim. The interviews were semi-structured and all team members in a specific CRHT team were interviewed. An interview protocol was applied, with a few open questions regarding the participants' personal stories, professional role and their thoughts, if any, on connections between the two. The analysis explored if and how the team members in a CRHT team experience a connection between their personal and professional roles. For the participant observation I accompanied the same CRHT team for 19 days over a period of approximately 4 months. The setting for the observation was at the office and in the car going back and forth to see patients on home visits. Interviews and observations from both studies were analysed from a hermeneutic-phenomenological approach in order to understand the participants' experiences and what was going on in the CRHT team.

In this thesis overview I will discuss how their personal and professional backgrounds, and how they give each other emotional support within the team, might enable them to meet the challenges and see the opportunities within the specific framework of CRHT work.

The first article of this dissertation seeks to give an overview of the literature available on CRHT teams by reviewing and systematizing national and international knowledge about the teams. In the literature review, three main themes are drawn from the systematization of reviewed literature: 1) structure of the characteristic organizational aspects of CRHT teams and services; 2) processes of how the service is provided, and 3) outcome that highlights the effect of the CRHT team work.

The second article is based on interviews. In this article we find five themes that the participants describe, which connect their personal stories to their professional roles: 1) experiences related to the participant as an individual, specified by a) personal qualities, and b) personal interests; 2) profound personal experiences in a work-

related context, and 3) family-related experiences, specified by a) having family members with mental health problems, and b) having family members that have worked in mental health services.

The third article is based on data from the participant observation. It aims to explore the emotional support and "work" with emotions that takes place in a CRHT team. The findings indicate that the team members' emotion work has the five following features: 1) there seemed to be an informal rule that "vulnerable" emotions could be expressed; 2) emotional expression was common when working through and digesting challenging events; 3) emotional expression seemed to fulfill three supportive functions: 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 among team members, and 5) this support seemed to fulfil a function that could only be performed by other team members with the same specific background knowledge as the speaker.

The findings in the articles are discussed and related to established theory, research, and practice. Researcher reflexivity is explored, as well as strengths and limitations of the studies. There is a paucity of studies of the staff perspective for CRHT team members. This study adds to our knowledge via one literature review and two empirical articles. Very few empirical studies have been conducted on CRHT team members' view of their work. This dissertation aims to contribute two such studies.

List of publications

Paper 1: Sjølie, H., Karlsson, B. & Kim, H.S. (2010). “Crisis resolution and home treatment: structure, process, and outcome – a literature review”, *Journal of Psychiatric and Mental Health Nursing*, Vol. 17, Issue 10, 881–892.

Paper 2: Sjølie, H., Karlsson, B. & Binder, P.E. (2013). Professionals’ experiences of the relations between personal history and professional role. *Nursing Research and Practice, 2013*, 12. doi: 10.1155/2013/265247
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Paper 3: Sjølie, H., Binder, P.-E. & Dundas, I. (In review). “Emotion work in a Human Service Setting”

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1. Introduction

My knowledge of CRHT teams started out with a job as an “advisor for academic and research development” at Follo DPS (Community Mental Health Centres [CMHC]). My job was initially to assist all departments, including the CRHT team, in Follo DPS in developing their practice through projects with academic and research themes. At the time I worked there, Follo DPS had a large and well-functioning CRHT team, one of the first in Norway. A part of my job was participating in planning and evaluation of academic and research projects that contributed to development within the team, and in their collaboration with external public and private partners. This taught me a lot about the way of thinking and working in the team. Another part of the job was administration of an education program for other CRHT teams. Reading about CHRT teams gave me an understanding of the historical development of these teams nationally and internationally, and the structure and processes of the teams. Through organizing and participating in the CRHT education program, I met both newly established teams and experienced ones. From the teaching and discussions with team members, I learned about their theoretical background and practical everyday work experiences.

What interested me in particular was how the team members actually worked on a day-to-day basis with acute mental health crises, and how they understood themselves and their role as CRHT members. They worked close to the patients in their homes, out of institutions, giving the patient a larger part and responsibility in the healing process during acute mental health crises than until recently has been common in psychiatric care. This way of thinking and working was different from traditional in-hospital care, and I was curious about who these staff members were, and their way of thinking and working.

I filed an application for a PhD position in the project “Crisis Resolution and Home Treatment in Community Mental Health Service: Development, Practice, Experiences and Outcomes.” while I was working at Follo DPS. This was my introduction to the project that eventually resulted in this dissertation.

The research comprising this dissertation is part of a larger research project which was led by Buskerud University College, and supported by Vestre Viken Helseforetak and several user and carer organizations in Buskerud. The main project consisted of three studies; one on a specific CRHT team, one on service users, and one on all teams from one health region, Helse Sør. This PhD project was connected to the first of these three: the study on one specific CRHT team. Researchers and the other parties supporting or participating in all three studies of the main project met regularly for seminars presenting and discussing findings from the three studies comprising the main project.

My interest was in the practices in the CRHT team, and in who the team members were. What I originally wanted to find out was what the discourses and practices were in the team, and who the people working in the team were. When I started working in the project, multistage focus group interviews (Lerdal & Karlsson, 2008) with the CRHT team with the aim of exploring their practices had started. I got involved in conducting these interviews as a co-researcher. These interviews gave me valuable experiences with the method of focus group interviews (Wibeck, 2000), but also knowledge of this specific team; how they were, their practices and the context for their work. Half way through the 1.5 years of focus group interviews, I started to conduct interviews with all team members in order to explore the team members' experiences and their personal and professional stories. This resulted in paper 2 in this thesis. I conducted 8 of these 13 interviews, while one of the other researchers in the project did the other 5. During the second year of the project, observation of the team commenced, resulting in paper 3. I was the only researcher doing observation in this project. During the observation period, I accompanied the team for 19 days from August to December, at the office, and in the car going back and forth for appointments in the patient's homes. The result was article 3, which focuses on the emotional support in the team.

1.1 Point of departure for this study: The CRHT project

The main project

As mentioned above, this PhD project and data collection were based in the main project “Crisis Resolution and Home Treatment in Community Mental Health Service: Development, Practice, Experience and Outcomes”, and the main project comprised three studies. Study #1 was the study from which this dissertation stems. Study #1 examined one specific CRHT team, and the data collection focused on the processes and experiences of a CRHT team within a local community mental health service centre, from the perspective of the members working in the team. The study was conducted in collaboration with a newly established CRHT team. Study #2 collected data from service users of the same team. It focused on the service users’ experiences of receiving services from the team during a crisis. Study #3 did a quantitative study of some of the teams in one region. It focused on national and regional impacts of CRHT, examining the characteristics and effects of CRHT on community health services and service users.

This dissertation

As mentioned, this dissertation is based on study #1. With a specific focus on the staff perspective, we studied the team members in their day-to-day work life; their individual stories, professional roles, their practices, and more specifically the emotion work within the team. Over a four year period, the project for this theses was written, applications for ethics committees were filed and approved, data collected, and the material analysed and prepared for presentations and articles (Sjølie, Binder, & Dundas, 2014; Sjølie, Karlsson, & Binder, 2013; Sjølie, Karlsson, & Kim, 2010). In collaboration with Dr. Bengt Karlsson, I have had the role of investigator in the project leading to this thesis.

Paper 1 describes the structure, process and outcomes of CRHT teams in general, and is a literature review. This review shows that the main focus of research on CRHT has been on structural and economic aspects of organizing such teams as a part of

mental health services, and less on how members in these teams work (Sjølie et al., 2010).

Paper 2 is a qualitative study based on interviews with the team, exploring the team members' qualities and interests, and their work-related and family-related experiences (Sjølie et al., 2013). We seek to explore how their personal histories are connected to their professional role.

Paper 3 is another qualitative study, based on observation. It focuses on the team members within their professional role. We specifically strive to identify how emotions are expressed and communicated and emotion work is done between team members in a demanding work environment (Sjølie et al., 2014).

Summing up, this thesis covers several broad areas, from a broad overview of external organizational perspective of the CRHT team, via the individual team members' understanding of their personal stories and professional role, to the particulars of how an observer conceptualizes the emotional expression within the team as a kind of "emotion work" that needs to take place in CRHT teams for the teams to function well.

To improve the quality of research, we regularly brought findings back to the CRHT team for discussion, as well as frequently reflecting upon our research (Finlay, 2002, 2003). During the project period 2007–2011, all participants involved in the project were brought together in seminars, as mentioned. This comprised researchers from all three studies, the CRHT team in study #1, service user's organizations, and the CRHT teams from study #3. Findings were presented and discussed by all parties. During the different stages of planning of the project, data collection and analysis, we at times directed our attention towards ourselves and the project, reflecting upon how we individually as researchers influenced the results. This is researcher reflexivity (Finlay, 2002, 2003; Gough, 2003). It is described in more detail in the methods section.

Additional publications from the main project

The main project as a whole has resulted in several additional publications. A few of the articles have general and more overarching objectives. One article is an exploration of emergency care in community mental health in general and a suggestion for an organizational framework for CRHT teams (Karlsson, Borg, & Kim, 2008). A second one addresses a method of examining a practice model developed in a CRHT team incorporating open dialogue, and the open lifeworld approach, with an overall design of action research (Borg, Karlsson, & Kim, 2010). There also is an article presenting a methodology for participatory research, and drawing on the main project as an example for how the method works (Borg, Karlsson, Kim, & McCormack, 2012).

There have been several prior publications based on the broader study #1 from which this dissertation stems, publications not included in this dissertation. Two publications based upon several CRHT teams revolve around questions regarding some of the central practices in the CRHT teams in Norway (Karlsson, Borg, & Sjølie, 2011b), and how these change over a year (Karlsson, Borg, & Emaus, 2012). One article describe the humanistic collaborative practices in one CRHT team (Borg & Karlsson, 2010). A fourth publication analyses the telephone contacts that did and did not result in patient registrations with a medical case report in the same team (Rype, Karlsson, & Borg, 2012). A fifth article explores the team members' understandings of the concept of crisis, and how this is brought into their clinical work (Karlsson, Borg, & Sjølie, 2008). Two further articles describe the concept of hope connected to crisis in a CRHT team (Biong & Herrestad, 2011; Herrestad & Biong, 2011).

A descriptive quantitative study based on a longitudinal survey of patients' data from the same one CRHT team resulted in three publications: one describing the characteristics of the patients at the time of admission and referral to the team (Ness, Karlsson, Borg, Biong, & Hesook, 2012); another describing the types of services provided and the relation between services provided and the clinical assessment of the patient at admission to the team (Karlsson, Borg, Biong, Ness, & Kim, 2012); and

the third one describing the changes in morbidity and clinical problems from admission to discharge, and length of service in the team (Biong, Ness, Karlsson, Borg, & Kim, 2012).

Study #2 is qualitative and uses interviews. It focuses on the service users' experiences with crisis resolution home treatment teams, and what could be a help in crisis situations (Gullslett, Karlsson, Forinder, & Borg, 2013; Winness, Borg, & Kim, 2010), and how the autonomy in the relation between service users and team members in a CRHT team is transformed into practice (Gullslett & Ekeland, 2012).

Study #3 was quantitative, based in a longitudinal survey of five CRHT teams for a period of 18 months. This resulted in a publication that illuminates standardizations and variations of structure and processes within the team's characteristics and the services it provides (Karlsson, Borg, Eklund, & Kim, 2011).

1.2 Characteristics of CRHT teams

During the last years a deinstitutionalization has taken place in western countries. This has resulted in an expansion and development of the community-based mental health care in Norway, as in several other countries (European Commission, 2005; Joy, Adams, & Rice, 2006; Karlsson, Borg, & Kim, 2008). A decision from the government emphasized prevention, integration, increased user perspective, voluntary treatment and the promotion of living in ordinary settings as important to the mental health services (The Norwegian Ministry of Social and Health Affairs, 1997). The government made the 75 Community Mental Health Centres (CMHC) responsible for organizing CRHT teams amongst other services (Karlsson, Borg, & Kim, 2008; St.prp. nr 1, (2004-2005)). A survey from 2008 shows that 35 out of 75 CMHCs at the time had established such teams (Directorate of Health, 2008), and by 2010 a telephone survey showed that 51 CMHC's had established CRHT teams (Karlsson, Borg, & Sjølie, 2011a).

The home treatment service as a forerunner for CRHT as known today, was originally developed in the UK, the US and Australia (Hasselberg, 2012; Johnson, Needle,

Bindman, & Thornicroft, 2008). The UK led in developing the Crisis Resolution Team (CRT) model, also called a CRHT team, as we know it (Hasselberg, 2012; Johnson et al., 2008); this is the model initially introduced in Norway, although with some modifications (The Directorate of Health and Social Welfare, 2006).

Key organizational characteristics of CRHT teams from the UK model are described as:

- being multidisciplinary
- doing intensive home treatment instead of hospital admission when possible
- low patient-staff ratio
- 24-hour availability
- working in partnership with other services
- having a team approach
- psychiatrists as part of the team
- rapid emergency assessments, with responses within an hour when this is needed
- having a gatekeeping role by control access for all local acute inpatient beds
- short term and intensive home treatment program for up to six weeks, and then discharge to other services (Johnson, 2007; Johnson et al., 2008)

Norwegian CRHT teams differ widely in structure of organization (Karlsson, Borg, Eklund, et al., 2011; Karlsson, Borg, et al., 2011b). They also differ from the UK CRHT model in two important aspects; the Norwegian teams are not available all the 24 hours and do not have a gatekeeping role. These two aspects have significant importance for the effect of CRHT work on assessment and admissions.

The team mandate for CRHT teams in Norway is to answer requests from patients experiencing an acute mental health crisis related to mental pain, suicidality, psychosis, family or social crisis (Karlsson, Borg, et al., 2011b; The Directorate of Health and Social Welfare, 2006). The team works with patients living at home, making quick assessments based on the information they can collect in a short period

of time (Johnson, 2007). The work consists of frequent assessments of whether it is safe and a good solution for the patient to stay at home, and what services might be needed to solve the crisis at hand.

The specific team that participated in the research for this thesis provided intensive short term home treatment to patients in an acute mental health crisis. The team members were multidisciplinary with a psychiatrist available on call. It was a low-threshold service where anyone could make the initial contact with the team, and all requests were to be responded to as quickly as possible, but within 24 hours. During the home treatment, team members worked in pairs. The opening hours were 08.00–21.00 on work days and 09.00–16.00 on weekends. The team collaborated with other services when it was needed.

Patients experiencing acute mental health crises are seen as eligible for help from the team. The team members of this specific CRHT team describe four types of crisis: the long term crisis, the acute crisis, the individual crisis, and the social crisis. The experiences of crisis are understood as individual, relational and contextual (Karlsson, Borg, & Sjølie, 2008). Tobitt and Kamboj (2011) have investigated how crisis was understood amongst CRHT team workers by interviewing 39 team members from four different teams. They found that what was described as "characterizing of crisis" was gathered in three clusters: functional disruption, risk of harm and additional support needed (Hasselberg, 2012; Tobitt & Kamboj, 2011).

The patients most often contact the team themselves, or the team are contacted by family or the primary physician. At the time of admission to this team, the majority of the patients were depressed; many had long-term mental health problems although most did not have severe ones at the time of admission; but the patients were nevertheless experienced as having a crisis (Ness et al., 2012). When doing home treatment, the collaboration between the team members, the patient and the network creates an arena where the crisis at hand can be explored by all parties together (Karlsson, Borg, & Sjølie, 2008).

Although not having a formal gatekeeping role, a main agenda for this CRHT team is to prevent admissions to inpatient care when this is not necessary. It is believed that managing to deal with the problems in a home environment is less stressful for the patient, and might represent an opportunity for the patient and the network to gain important experience and learning that may help in future crisis. This is in line with how Bridgett and Polak describes the importance of doing treatment in the patient's home environment (2003a, 2003b).

1.3 Prior research

Internationally on CRHT

A variety of home treatment services have been available in many western countries for decades (Hasselberg, 2012; Johnson et al., 2008). In 2000, a descision was made to establish CRTs throughout the UK (Department of Health, 2001). Since then the UK has been leading the development of what is known as the CRT model (Hasselberg, 2012; Sjølie et al., 2010). Most of the research on this comes from the UK, supplemented by studies from the US and Australia. Most of the research in the CRHT field is quantitative research, but there are occasional qualitative studies. Organizational structure, work processes and outcome in terms of cost-effectiveness, admission rates, and user's experiences have been subjects in the literature (Hasselberg, 2012; Johnson et al., 2008; Sjølie et al., 2010; Winness et al., 2010). This has been described in article 1 in this thesis (Sjølie et al., 2010). Only rarely have the staff experiences regarding working in CRHT teams been emphasized as subject. Literature on the staff perspective will be illuminated a little further on.

Nationally

During the years 2003–2006 a Multicentre Study on Acute Psychiatry (MAP) was planned and conducted in Norway (Ruud, Gråwe, & Hatling, 2006). It used a naturalistic cross-sectional prospective design, and covered 32 different psychiatric emergency service units, including 8 CRHT teams for adults (Hasselberg, 2012; Ruud et al., 2006). The focus of this study was on patient groups, practices for intake, admission and good clinical practices, what role the teams had in the mental health

services, and how the collaboration with other mental health services works. The study also discussed the value of having a network orientation in treatment, and the possibility of preventing unnecessary admission of patients who could be treated in their home environment by the CRHT team (Hasselberg, 2012). This quantitative study is focused on the CRHT team practices and the patients.

In one of the CRHT teams which started early, Follo CRHT, Hultberg and Karlsson (2007) used focus group interviews to explore how other professional partners experienced the contact and collaboration with a CRHT team. Findings were organized as themes describing other partners' expectations of the CRHT teams' availability, expertise and work methods, and the needs the collaborating partners had towards the team. These are all subjects concerning the collaboration with the CRHT team. It affects the staff perspective on how team members collaborate with professionals in other services.

The staff perspective

To my knowledge, prior studies have to a small degree examined the experiences of CRHT staff with regard to their work, with a few notable exceptions.

Freeman, Vidgen and Davies-Edwards (2011) sought to explore staff experiences of working in CRHT. They stated the lack of understanding of employees' experiences of working in a CRHT team, and specifically aimed to explore stress and coping as described by CRHT team members, by investigating the staff experiences (Freeman et al., 2011). Five staff members were interviewed regarding the aspects of work that they found enjoyable and stressful, and how they coped with challenges related to the work. Findings emphasized the themes "motivating factors", referring to aspects of the work that motivated them, "stressors", which referred to aspects that the staff experienced as stressful to them, and "coping", which referred to the individual resources and team resources that they could draw on to help them cope with the day-to-day demands. Freeman et al. (2011) mentions resources individuals and teams have which can be helpful for coping, such as regulating emotions, taking precautions, information, and emotional and management support.

Three articles explore the satisfaction and well-being of team members in CRHT teams. Nelson, Johnson and Bebbington (2009) explored the level of burnout, and sources of satisfaction and stress in CRHT teams and compared it to Assertive Outreach Teams and Community Mental Health Teams. Results indicate that the CRHT teams seem to be sustainable, but that the long term effect of working in the team will have to be assessed further on. One study (Wood et al., 2011) assessed the relationship of job demand, control and well-being between CRHT teams and Community Mental Health teams, and that a combination of low level of demand and high level of control and supportive relationships was good for the well-being of the staff. A third study (Johnson et al., 2012) described satisfaction and well-being, and factors associated with the two in a multisenter study also including CRHT teams.

Three articles explore the skills needed as a CRHT team member. After exploring the profile of patients referred to the teams, one study (Brooker, Ricketts, Bennett, & Lemme, 2007) highlights the value of team members being skilled in conducting risk assessment in an emergency. A second study (Morton, 2009) described that professional function and skill mix was important in the CRHT teams when targeting the patients. One article (Johnson, 2013) mentioned the desire for the team to be multidisciplinary in order to fulfill all parts of assessments and interventions, and that the skills needed are specific to the CRHT worker role, referring to how Ramsey and Shaw describe attributes and skills in CRHT team members (Ramsey & Shaw, 2008).

One article described patterns and trends in the service organization in England (Johnson, Zinkler, & Priebe, 2001). It raised the question of how well-qualified staff members can be recruited and maintained in the CRHT teams, and suggested implementation of staff training, support and retention as possible solutions to the question.

Lack of staff support is referred to as a risk factor for stress (Edwards & Burnard, 2003; Freeman et al., 2011). Mention of staff support often referred to supervision, but it might also be the support provided between staff members (Gilbert, 2004). Research on CRHT occasionally mentioned staff support in connection with

supervision and management support (Freeman et al., 2011). Central research on the field of CRHT including Freeman, Vidgen and Davies-Edwards (2011), Reid et al. (1999b; 1999a) and Nelson, Johnson and Bebbington (2009) all linked support to supervision of the team. As the working environment in a CRHT team is quite challenging mentally to the team members, this connection might be expected. Freeman, Vidgen and Davies-Edwards (2011) show how support might be given between team members in other settings then supervision, referring to support as defined by West (2012). West (2012) understood social support as divided into four main types of support: emotional, instrumental, informational and appraisal support.

There is still a lack of research on staff in CRHT teams. To my knowledge there are no studies focusing on the individual personal and professional resources among CRHT team members. Only limited research is directed towards the support between team members in a CRHT team. This thesis focuses on the staff perspective and explores these two areas further.

1.4 The aim of the study

The main aim of this thesis is to explore the experiences of staff members in a CRHT team, their challenges and opportunities in the CRHT work, the impact and role of their personal and professional stories and how they do emotion work within the team. The motivation for this was to find out more about CRHT teams with a specific focus on the staff perspective. By exploring their former histories and how they give each other emotional support, we want to look more closely at how these elements enable them to meet the challenges and see the opportunities in CRHT work.

2. Theoretical context

When planning this project, we aimed to let the data guide our choice of theory. I began the project with a pre-understanding that theories on interaction and communication would be useful in understanding what I would find. Specifically, Garfinkel's ethnomethodology (1967; Harste & Mortensen, 2000), Goffman's theory on interaction (Goffman, 1992; Goffman, Lemert, & Branaman, 1997; Harste & Mortensen, 2000) and Mead's (Mead & Morris, 1967) theory on symbolic interaction were seen as potentially useful. These theories were part of my background as a sociologist. As we started analysing the data materials, the theoretical concepts from the pre-understanding were replaced by what we saw as more appropriate and data-driven theoretical concepts. The focus shifted from work practices within the team and to the team members – their experiences, how they made connections between their personal and professional histories, and the emotion work in the team. Then theories on narrative, identity and cultural context were more useful in understanding the data.

The interviews were aimed at exploring the personal and professional stories of the team members. In analysing these findings, we found "narrative" (Bruner, 1986, 1990; McAdams, 1996; Polkinghorne, 1988, 1991), "life stories of identity" (McAdams, 1996, 2001, 2005), "life-world" (Schütz & Luckmann, 1973; Schütz & Wagner, 1970) and "knowledge" (Schön, 1983, 1995) to be useful concepts. These concepts sensitized the researcher to who the team members were and their personal narratives.

When starting the observations, the researcher had an open attitude towards registering as many aspects of the practices and the team members as possible. Different topics became useful in the analyses of this data. Based on the data from the team, we focused on concepts of cultural context (Hochschild, 1983, 2001; McAdams, 2001, 2005; Schütz & Luckmann, 1973; Schütz & Wagner, 1970), emotions and mentalizing emotions (Allen, Fonagy, & Bateman, 2008; Goleman, 2006a, 2006b), emotion work and feeling rules (Hochschild, 1983, 2001).

Overall, three significant theoretical elements became helpful from the data material; the narratives, the individual life stories of identity and the cultural context. These concepts first appeared useful in understanding the interviews and then the observation. The semi-structured interview, where participants were asked to describe their personal history and their professional role (Sjølie et al., 2013), often evolved into participants' narratives of their life. Two elements seemed salient in the interviews. First, we noticed their life stories as a way of revealing their identity for us; they presented themselves as individuals, showed themselves as persons. Second, there were elements of the cultural context in their stories. Their stories showed the cultural context that they came from, but also the cultural context of the CRHT team they were a part of as team members. The life stories of identity are explicit in the interviews, while the cultural context is there as a frame to which they relate in their stories.

We saw the concepts of identity and the cultural context as present in the observation material as well. The cultural context of the team seemed to influence, for example, the ways emotions were expressed and worked with in the team. This will be addressed in more detail later in this thesis.

The following is a presentation of theoretical perspective and concepts which have proven useful in elucidating the data material.

2.1 Narrative inquiry

Overarching perspective

The theoretical perspective overarching this thesis is narrative inquiry. 'Narrative' as well as 'narrative inquiry', also called 'narrative analysis', is widely used concepts with a broad range of definitions and connections to different professions and disciplines (Chase, 2011; Loseke, 2007; Polkinghorne, 1995; Riessman, 1993, 2008). Work with the interviews and later on the observation material strengthened my view that we could understand the participants' stories as narratives of their lived

experiences. The concept of narrative inquiry became a useful overarching perspective. This will be described in greater detail in the following.

Narrative inquiry

Narrative analysis or narrative inquiry is an approach within qualitative research (Denzin & Lincoln, 2011b; Riessman, 1993). It concerns the narration of lived experiences as it is done by people who live them. The act of constructing a narrative is defined as making ones's experience meaningful to oneself and others by understanding and organizing experience, actions, objects and life events into a meaningful whole story evolving over time (Chase, 2011). Analysing narratives focuses on how storied data can be organized and interpreted (Riessman, 2008). Researchers using this approach are concerned, not only about *how* events are storied, but also *why* events are storied in that specific way and not in other ways. The analysis may refer to intentions and language as well as the content referred to (Riessman, 2008). Narratives can be extracted from different kinds of data material as interviews, field notes, autobiography, stories, journals and life experiences (Chase, 2011; Riessman, 2008). The narratives in our material are extracted from interviews and observations.

Narrative

During interviews and observation, the participants' stories were interpreted from the material. By organizing stories of life events and their own actions they formulate coherent meaningful stories which can be seen as narratives. The narrative as a concept has several definitions, and Loseke even talks about a wide range of narrative genres (Loseke, 2007). Bruner gives the broad understanding that narratives are understood as the way individuals construct and make sense of reality (Bruner, 1991, 2003). The way Bruner defines the concept, there is an element of making and communicating meaning connected to it (1990). What Bruner calls the "narrative mode" of understanding the world is influenced by the person's wants, needs and striving towards goals (1990). Bruner understand stories as:

> Stories are like doppelgängers, operating in two realms, one a landscape of action in the world, the other a landscape of consciousness where the protagonists' thoughts and feelings and secrets play themselves out … (2003, p. 26) A narrative models not only a world but the minds seeking to give it its meanings (2003, p. 27).

There is more to the story then the event itself; the storyteller has an active part in constructing the narrative.

McAdams (1999) describes stories as follows:

> Stories structure events in such a way as to demonstrate a connectedness and directional movement of human actions and experiences over time. In most literary traditions, it is expected that a story takes place in a particular spatial and temporal 'setting'. The setting establishes a frame of meaning for understanding the story … (1999, p. 480). One of the main things that stories do is to integrate disparate elements of human experience into a more-or-less coherent whole. Stories integrate human action and consciousness in time, provide a sequence of events that specifies beginning, middle, and ending … Stories help to organize the chaos of raw experience into a more-or-less followable narrative form (1999, p. 482).

McAdams claim that narratives "have the capacity to integrate the individual's reconstructed past, perceived present, and anticipated future, rendering a life-in-time sensible in terms of beginnings, middles and endings" (1996, p. 298). He connects narrative to the life story, the individual's identity and the cultural context (McAdams, 1996, 2001, 2005, 2006). He describes stories to be about meaning more than about facts. The validity of a story is judged by criteria as "believability" and "coherence" rather than some "outer reality" (1997). McAdams seems to use narrative as a parallel to the concepts of "life story" or "story", talking about life narrative but also about narrative identity (McAdams, 2005). This is a common way of using the concepts of "narrative" and "story" amongst qualitative researchers working with life history material (Polkinghorne, 1995). Polkinghorne understands

narrative as a story with a plot. The narrative is an organizational scheme expressed as a story; it gives meaning to temporal events; narrative is "texts that are thematically organized by plots" (Polkinghorne, 1988; 1995, p. 5), "linking diverse life events into unified and meaningful wholes" (Polkinghorne, 1991). The terms 'story' and 'narrative' are used as equivalents (Polkinghorne, 1988).

There are different ways of understanding the working definitions of "narrative". Reissman (2008) describes these definitions of narrative as placed along a continuum ranging between, at one end of the scale, the restrictive social linguistics that uses narrative about *a discrete unit of discourse*; and at the other end of the scale, a broad understanding of narrative as *an entire life story*. This latter definition is most often used by anthropologists emphasizing the individual as well as the cultural context in the narrative. Psychologists and sociologists are found in the middle of this continuum. What seems to be common for these understandings is that narratives construct life events, give them meaning and make sense of reality. Narratives are formed by the individual, but in a specific cultural context. The narrative has a temporal ordering of events with a beginning, a middle, an ending and some form of a plot (Bruner, 1986, 1990; McAdams, 1996; Polkinghorne, 1988, 1991). For this thesis, the term "narrative" will be used according to McAdams' understanding of the concept: formed by the individual in a cultural context, being about meaning, and having a temporal ordering and a plot.

Theorists from psychology and sociology will be used to understand the individual and the cultural context of the narratives in this thesis.

Narrative psychology

Bruner, McAdams and Polkinghorne all seem to identify with what is called narrative psychology (Crossley, 2000). Bruner states that narrative analysis has to do with "how protagonists interpret things" (Bruner, 1990, p. 51). Polkinghorne distinguishes between narrative analysis and analysis of narratives (Denzin, 1997; Polkinghorne, 1995). In narrative analysis, the researcher moves from collecting pieces in the form of events and happenings, these are then synthesized into a story or stories by a plot.

In analysis of narratives, on the other hand, the researcher is collecting the narratives, and then analysing them based on theoretical concepts or themes from the data material (Denzin, 1997; Polkinghorne, 1995). In this thesis my approach to the data has been what Polkinghorne calls analysis of narratives.

Narrative ethnography

While Bruner, McAdams and Polkinghorne approach the storytelling and lived experiences with a main focus on the individual story teller, Gubrium and Holstein stress the importance of local context and interactional circumstances for which stories are told. Gurium and Holstein are identified with narrative ethnography, narrative practice and narrative environment (Chase, 2011; Denzin & Lincoln, 2011b). The narratives are stories of lived experiences, but appear in interaction in a cultural context. Within this thesis I use elements from the individuals' storytelling and lived experiences, as well as elements from interaction and the cultural context of the CRHT team, to understand how the stories are told and given meaning.

The narrative gives a possibility of exploring stories of the individuals as psychologists most often do, but also of describing and exploring the larger stories, seeing the individual in relation to others, to the group and the cultural context as sociologists most often do. It enables a description of the individual experience and of the meaning structures that are common among members of a cultural context.

The narratives in this thesis are extracted from interviews and field notes from observation, both contributing to my understanding of the narratives. Sometimes there are continuous narratives and sometimes more fragmented narrative episodes.

2.2 Life stories of identity

McAdams (1995, 1996, 2001, 2005) and Schütz (1970) both focus on life stories. McAdams does this from a psychological standpoint and Schütz from a sociological one. They both relate to the life story of the individual, the individual's experiences, and how the life story is constantly evolving.

The interviews aimed to explore the participants' personal background stories, their professional stories, and whether they saw any connection between the two. From the themes in the material, the personal characteristics, interests, work-related experiences and family related experiences cover the theoretical concepts defined as "life stories of identity" by McAdams or "life-world" by Schütz.

According to McAdams (2005), individual life stories might have several purposes. One of them is forming the identity, others are to entertain, enlighten, instruct, etc. McAdams (1996, 2001, 2005) sketches out how life stories form one's identity and become part of one's personality. McAdams identifies three levels or discourses of personality that may be found in a specific life story. The first level is dispositional traits. Dispositional traits refers to individual differences in thoughts, feelings and patterns of behaviour. The second one, the characteristic adaptation, supplements the first level and includes constructs of personality that are developmental, social and contextual, such as values, motives and goals. The third level is labelled identity. A life story might be used as a metaphor for identity, as if the story is saying: this is my life, this is who I am. McAdams suggests that the meaning of life exists in the stories that the individual constructs and reconstructs. The stories form a narrative identity (1996, 2005). These stories are the life stories of identity, the way the individual presents and stages him- or herself.

We use Schütz' (Schütz & Luckmann, 1973; Schütz & Wagner, 1970) concept of "life-world", which is a complex concept, but one we found useful for the interviews. According to my understanding, he describes the life-world from the perspective of three angels. The first angel is the "natural attitude", described as: "the mental stance a person takes in the spontaneous and routine pursuits of his daily affairs, and the basis of his interpretation of the life-world as a whole and in its various aspects (Schütz & Wagner, 1970, p. 320)." The second angel is described as the long chain of life experiences in the individual's life:

> At any moment of his practical life, a man finds himself not simply in a specific situation which contains the limitations, the conditions, and the

> opportunities for his pursuits; this situation is an episode in his ongoing life. He stands in it as a person having gone through the long chain of his prior life experiences (Schütz & Wagner, 1970, p. 15).

The third angel used to describe the life-world is the "stock of knowledge":

> What a person knows, in toto, is his stock of knowledge. As a whole, this stock is incoherent, inconsistent, and only partially clear. It serves its purposes adequately as long as its recipes yields satisfactory results in acting, and its tenets satisfactory explanations (Schütz & Wagner, 1970, p. 319).

As I understand it, these three angels of the life-world contain individual attitudes, experiences, and the cultural context that add up to material for the personal story. The three dimensions contain within them the individual characteristics and interests as well as the work-related experiences and family-related experiences that were described in the interviews.

Giddens (1991) refers to the concept of "self-identity", sometimes referred to as self-reflexivity, which he defines not as traits but as "the self as reflexively understood by the person in terms of her or his biography" (1991, p. 53). He formulates that "a person's identity is not to be found in behaviour, nor – important though this is – in the reactions of others, but in the capacity *to keep a particular narrative going*" (Giddens, 1991, p. 54). He hereby links self-identity closely to individual reflexivity and to the shaping of one's story, but also states that it varies between cultures.

These theorists all seem to present concepts that show a life story as evolving, constantly being reformulated and storied reflexively in relation to a context that influences the meaning in the story. Life stories of identity have a direction and an intention. The individual is continuously working on a life story of identity. Consciously and non-consciously the life story of identity is an ongoing process (Giddens, 1991; McAdams, 2001, 2005; Schütz & Wagner, 1970). Life stories are the processes through which individuals and groups build their identities.

In different ways these ideas of life stories as a form of building identity are useful to understand what the participants in this study were doing during the interviews and partly in the observation material. The interviews were interactions between interviewer and interviewee that constructed the interviewee's individual narrative. The narrative reflected the meaning they gave to specific events.

When analysing the observation material, we perceived or constructed other aspects of the participants' stories. These other aspects supplemented our understanding from the interviews, since they were not as explicitly storied as the narratives in the interviews. For example, the observation sensitized us to the actual vulnerability that one may experience, but not necessarily put into words, when facing a suicidal client. Thus, the observation supplemented the interviews with additional information, that might have been part of the participants' implicit knowledge, but now became part of our understanding as researchers.

Another concept I found useful in exploring the data, was that of "master stories". The master story, also termed master narrative or formula story, can be understood as stories "of typical actors engaging in typical behaviours within typical plots leading to expectable moral evaluations" (Loseke, 2007, p. 664). In other words, master stories are stories of what is typical for the specific cultural context. Master stories are stories condoned by the culture that the individual lives in. Individual life stories might be in line with, or diverge from, what McAdams calls master stories (McAdams, 2005), and Loseke calls the formula stories (Loseke, 2007, 2012). Master stories are privileged stories that construct cultural identity. Individual life stories reveal the cultural context they are a part of. By what these master stories say or do not say, they might legitimate a story, or illustrate alternatives (McAdams, 2005). The cultural context of a story has significant importance to how it is told.

2.3 Cultural context and identity

The team members are not independent of their surroundings; they are a part of a cultural context that the team constitutes, as well as a wider societal culture. The

individuals and the cultural context mutually affect each other. Bruner (1986) states that emotion, cognition and action are interdependent, and can only be integrated within a cultural system. When the team members form their stories of identity and interact with each other, this takes place within the cultural context of this specific team. It all happens against the background of the individual team members' understanding of what are the goals, expectations, and rules that exist within this team. This is the setting in which they form their stories of identity when they interact in solving their day-to-day work tasks.

As mentioned, McAdams (2005) as well as Schütz (1970) draws attention to the cultural context that frames or is part of the individual life stories. McAdams (2001) places individuals in a context. The construction and reconstruction of stories happens in a cultural context that sets the frame. McAdams (2005) describes the life stories as cultural texts that show the cultural world of the storyteller; what are the master stories, the acceptable stories, and the stories not told in this particular culture. The individual forms the life stories, but always in a context that has cultural rules for what the individual can and cannot say, think, feel or do. The individual and the cultural context both contribute to the life stories.

A big part of the team members' day-to-day work life is the interaction they typically have with each other throughout the day. Schütz (1973; 1970) claims that individuals are intersubjective; only a small part of their life-world is formed within the individual, while a significant part is formed in interaction with the persons' surroundings. The person's "natural attitude" as a toolbox for understanding the world will need a common social world to operate within. Schütz also understands meaning as part of this shared social world. The life-world and meaning cannot be constricted to the individual's understanding, but is formed by our joint experiences (Harste & Mortensen, 2000). In other words, there is a shared world that sets the frame for the story. The story is individually shaped, but in line with the cultural context within the team.

Working teams, such as a CRHT team, are such a specific cultural context, a common social world. As mentioned by Bruner (1986), emotions are one of the elements that constitute a cultural context. West (2012) talks about the working team as a context for emotions and emotional support, referring to Goleman's (2006a, 2006b) understanding of emotions. Emotions are feelings an individual can be aware of within oneself, which give information about needs and "how things are going". On the other hand, emotions can occur in relationships and be qualities of how people interact, such as warmth, empathy and caring, that are directed towards others within an environment (Ekman, 2004; Goleman, 2006b). In both instances, they are all parts of the cultural context.

Within a team, emotional support may be part of the cultural context. Emotions can be expressed, or dealt with privately without being expressed; or people can help each other deal with emotions. Allen, Bateman and Fonagy (Allen et al., 2008; Bateman & Fonagy, 2012) uses the term "mentalizing emotion" to describe a way of dealing with emotions. Mentalizing emotions consists of the three elements: validating emotions, reflecting upon emotions and regulating emotions. We suggest that these ways of dealing with emotions reflect "emotion work" (Hochschild, 1983, 2001) between individuals. The emotion work is illustrated in the observation material by the observed and storied emotional support that took place between members in a team. Mentalizing emotions is dependent on the cultural context, regarding how and what to modulate, express and meet emotions within the team (Allen et al., 2008).

Within this team, as in other cultural contexts, there are some specific rules for reactions and actions. This also goes for the form *emotional support* takes in the team. Hochschild (1983, 2001) defines "feeling rules" as a cultural script or moral stance towards feelings. Within any cultural context, individuals may need to work at managing emotions so that the emotions felt and expressed are in accordance with the prevailing feeling rules. Hochschild describe this managing of such emotions as "emotion work". Emotion work strives to change any deviating emotions either by character or by degree so that the inner emotion fits expectations from the cultural context.

In addition to the concepts described above, we also found the concept of "knowledge" to be relevant in understanding both the interviews and the observation. Knowledge was one topic of the interviews. For example, interviewees spoke of the different kinds of knowledge that they have gained from their earlier life experiences, their wish and need for more knowledge, and the high degree of knowledge amongst colleagues in the team. In the observation material, participants emphasized the importance of trusting the knowledge of oneself as well as colleagues.

The concept of knowledge is relevant in several sociological and psychological theories. For example, Schön (1983) formulates the concepts of knowledge-in-action and reflecting-in-practice. According to Schön a part of being human is the need to try to apply theory to our knowing and transform it into knowledge. To my understanding, the concept of knowledge-in-action consists of implicit or explicit theories, developed from tacit knowing, that professional workers know and use for understanding, interpreting and acting in their day-to-day work. The concepts refer to how practitioners develop knowledge-in-action by reflecting-in-action. This development of knowledge is an individual process, but develops in a context. Practitioners reflect on what they know, their knowledge and their practice. For example, when understanding the need to explore all thoughts and plans when working with a patient who may be suicidal. Schön describes this form of reflection as reflecting-in-practice. I find that the concept of reflecting-in-practice describes the continual work of how to understand and interpret what goes on, that takes place within the individual team members and within the team, in our studies.

Knowledge can also be understood as the stock of knowledge as described by Schütz (Schütz & Luckmann, 1973; Schütz & Wagner, 1970). Stock of knowledge refers to the knowledge that each team member brings with him- or herself from both their personal and professional experiences. Another kind of knowledge is the professional skills an individual acquires through education and professional experiences, as Dreyfus and Dreyfus describe it (Benner, 1984; Carraccio, Benson, Nixon, & Derstine, 2008). It is common to expect the level of skills for a mental health care worker to increase with education and practice. One expects that education and

practice in the long run will result in the former novice becoming an expert. However, recently it has been argued that education and practice in and of themselves do not necessarily help a novice become a skilled mental health care worker. Tracey, Wampold, Lichtenberg and Goodyear (2014) have argued that clinical practice needs to be accompanied by actively asking the patients for feedback on how they are doing for the clinical practice to increase the skill of the mental health care worker. According to Tracey et al. (2014), professionals do not necessarily heighten their expertise through practice in itself; they need very explicit feedback from patients or service users to do so.

Summing up, the participants' narratives and their life stories of identity and cultural context in the team frame this thesis. These are the theoretical themes that became relevant during my analysis and discussion of the findings from the data material, when focusing on the team members' stories and their emotion work within the team.

3. Method

The study is explorative and attempts to stay close to the participants' experiences. I aimed to study the life-world, lived experiences and everyday life of the team members. The methods used in data collection for the project were interviews and participant observation. This places the project in an interpretive and explorative qualitative tradition with a focus on reflexivity (Alvesson & Sköldberg, 2008; Denzin & Lincoln, 2005; Silverman, 2006).

Qualitative research is growing in the mental health service (Moltu, 2011; Rennie, Watson, & Monteiro, 2002). Qualitative research is an overarching umbrella covering a variety of methods or research practices (Denzin & Lincoln, 2011a). These methods and research practices generally aim to explore the meaning of social phenomena as these are experienced by individuals in their natural context (Kvale & Brinkmann, 2009; Malterud, 2001).

In the following I will describe the methodological approach that inspired this thesis, the collection of data, the sample, ethical considerations regarding this research project and how I have attempted to uphold a strict reflexivity during the process.

3.1 Methodological approach of the present study

There are at least two main branches of approaches to theory of science in qualitative research. These are known as the phenomenological approach, which is also called essentialist approaches; and the hermeneutic phenomenological approach, also known as the interpretative approaches (Laverty, 2003; Moltu, 2011). The two directions can be seen as movements. Theorists in each of them share some common ideas. It is crucial to be aware that these movements are not static, but are changing and evolving over time (Laverty, 2003).

Two central exponents for the hermeneutic phenomenological approach were Martin Heidegger and Hans-Georg Gadamer. Heidegger saw the individual as placed in a historical context that influences his/her lived experiences. According to Heidegger,

our understanding is rooted in our practices and actions, and not simply in "knowing" about the world (Laverty, 2003).

Based on this understanding of the self as part of the world, Heidegger states that "pre-understanding is a structure for being in the world" (Laverty, 2003, p. 24). It is a way of existence that is part of the human being (Alvesson & Sköldberg, 2008). The individual is part of the world and of a culture even before being aware of it, and thus the pre-understanding cannot be set aside. The pre-understanding gives meaning to who we are and to what we do. Heidegger describes how "meaning is found as we are constructed by the world while at the same time we are constructing this world from our own background and experiences" (Laverty, 2003, p. 24). According to Heidegger, *interpretation* is crucial to the understanding. Kvale (1996) connects interpretation in hermeneutics to the activity of finding intended and expressed meanings in other people's stories. For Heidegger our preconceptions influence our interpretation. However, our interpretations are not only influenced by our preconceptions, they are also influenced by the context of the other person's statements: for example a sentence in an interview is influenced by the whole of an interview. The hermeneutic circle consists of a movement back and forth between the parts and the whole of the experience, until a sensible meaning is reached (Kvale, 1996; Laverty, 2003).

Hans-Georg Gadamer developed Heidegger's work. He says that "hermeneutics must start from the position that a person seeking to understand something has a bond to the subject matter that comes into language through the traditionary text and has, or acquires, a connection with the tradition from which it speaks" (Gadamer, 1960/2004, p. 295). According to Gadamer, understanding comes from interpretation, and it is generated through language and questioning. Questioning opens up and hence gives the possibility to create meaning. He sees understanding and interpretation as connected to each other and that interpretation is constantly evolving. A consequence is that bracketing is impossible. Understanding has a dimension of historicality (Laverty, 2003). Historicality refers to the perspective on how phenomena are to be understood in a specific historical context.

This project is based on a hermeneutic-phenomenological approach to the empirical material. The hermeneutic element is represented by the interpretations of the experience (Binder, Holgersen, & Moltu, 2012; Kvale & Brinkmann, 2009). The participant makes interpretations when transforming the experience into a narrative; telling it and giving meaning to it. Then again the researcher interprets when analysing and giving new meaning to the material. All interpretation takes place in a cultural context; preconceptions make understanding possible (Laverty, 2003). The phenomenological aspect is represented by the attempt to understand the individuals' experience as it was experienced by oneself (Binder et al., 2012; Riessman, 1993; Van Manen, 1990). As mentioned earlier, the study is based in a hermeneutic-phenomenological approach when it comes to collecting and analysing data. Many of the theorists I draw on have a constructionist perspective (Riessman, 1993), while Shütz (Schütz & Luckmann, 1973; Schütz & Wagner, 1970) is a phenomenologist. This results in an understanding relating both to the hermeneutic and the constructionist perspective, and to the phenomenologist perspective, where the individual itself, the interpretation and construction of stories and meaning all are important.

As mentioned, the theoretical perspective overarching this thesis is the narrative inquiry. Narrative construction of reality can be related to the hermeneutic-phenomenological approach in how each approach considers meaning as constructed, partly from the individual's experience, and partly from the researcher's interpretation of this experience. Participants and researchers both construct narratives, using the stories within a cultural context.

Methodological issues for the current study

Both interviews and participant observation were initially planned with a phenomenological attitude of exploring the lived experiences as described by the team members. During the research process there has been a shift towards a more hermeneutic-phenomenological understanding of the research. The shift in the understanding is due to several causes.

During data collection of interviews and participant observation, as well as during analysis and trying to understand the data material, the interpretive process became clearer to me. I understood more clearly that meaning is co-constructed through dialogue, when, during the interviews, open questions gave possibilities of a conversation where I gave my understanding of what was said back to the participants to get responses on whether they agreed with my interpretation. Their responses nuanced my understanding and interpretation, and I could rephrase what I then understood. This new understanding on my part then seemed to influence their own understanding, influencing my understanding, resulting in more nuanced meanings that neither of us might have formulated without the dialogue with the other. Second, reading and analysing the interviews set off a new round of reflection regarding my own understanding and interpretation. Third, when discussing these understandings and interpretation with my advisors, yet another round was started. Fourth, presenting data material in seminars for all the participants of the project also started a round of reflection. There are three hermeneutic circles here; the dynamic between the part and the whole in an interview and the dynamic between the researcher and the participant, both described by Smith (2007), and the dynamic between the researcher and co-researchers.

Similar to this there was a process during the participant observation. The observation was a combination of observing small parts as, e.g. reflections between two team members on a subject and connecting them to a whole as, e.g. general team discussions on the previously mentioned subject, going back to new small parts, understanding small differences, and going back to a whole with a slightly different understanding. Throughout the whole process, my interpretation was an active part of the observation. This often occurred as an inner process in me, but in some occasions as a dynamic between me as the researcher and the participants, when I asked questions during the participant observation. In a second, I would make some kind of decisions regarding whether I needed confirmation of my understanding or clarifications of what I observed. My influence was manifested through deciding to ask or not to, and the ways I phrased my questions. The interpretative process also

occurred when observing the dynamic between participants. Although trying to write down what I saw and what I heard as free as possible from my own pre-understanding, it became clear that what I saw and what I heard was influenced by my pre-understanding and my ability to understand what was happening in the room. The interpretation and understanding had to be part of something I myself could connect to (Gadamer, 1960/2004). This can be seen as an example of what Schleiermacher called intersubjectivity:

> [Interpretation] depends on the fact that every person, besides being an individual themselves, has a receptivity for all other people. But this itself seems only to rest on the fact that everyone carries a minimum of everyone else within themselves, and divination is consequently excited by comparison with oneself (Smith, 2007; Smith, Larkin, & Flowers, 2009, p. 23).

All researchers, independent of natural or human sciences, are always part of an external world with its culture and historicality. This cannot be separated from the pre-understanding, the understanding and the interpretation of the researcher when encountering for example, as in this study, the interviewee, the participant observation study or a written transcript (Alvesson & Sköldberg, 2008).

Based on the experience that interpretation is a part of data collection and analysis, and that the researcher contributes actively to the whole process of research, a hermeneutic phenomenological approach is selected for this study. This offers an opportunity to engage in active use of reflexivity as a tool when working through the research (Alvesson & Sköldberg, 2008; Finlay, 2003). The hermeneutic element lies in the pre-understanding, the understanding and the interpretation in the dynamic between researcher, participant and the data when creating meaning. The phenomenological element lies in the attitude of getting as close as possible to the lived experiences and letting the participants speak (Van Manen, 1990).

3.2 Collecting and analysing the data

As mentioned earlier the focus of this thesis is the CRHT team, their experiences and practices. Qualitative methods are suitable for exploring experiences, especially when the experiences have not been extensively studied before (Kvale & Brinkmann, 2009). We chose to use interviews and participant observation, in order to explore as many facets of participants' experiences as possible.

My participation in the multistage focus group interviews informally contributed to our knowledge and understanding of the team and the cultural context within which the team members worked, but was not analysed as a part of this dissertation.

Interview

Qualitative interviews are described as an effective way to explore life stories and lived experiences (Kvale & Brinkmann, 2009; Van Manen, 1990). Interviews may increase our understanding of the team members' lived experiences and how they understand these experiences. For example, team members may be asked to describe specific episodes and actions, as well as their own understanding of these episodes and actions. We wanted the participants to tell about their experiences as well as reflect on them, and the interviews gave opportunities for this.

As mentioned in article 2 the interviews were semi-structured, based on an interview protocol with a few open questions regarding the participant's experiences of their personal stories, their professional role and any thoughts they had on connections between the two. I did eight of the interviews, while the latter five were done by the project leader (Sjølie et al., 2013). Both of us knew the participants from other project activities and from the CRHT education prior to the project.

Ideally, interviews may result in rich descriptions of, and reflections on, the interviewee's personal experiences. The quality of the interview is partly dependent on the interviewer's craftsmanship (Kvale & Brinkmann, 2009). The researcher leading the project had more experience in this craft. I myself had limited experience of interviewing. I attempted to compensate for this by good planning, preparation, as

for example, going through the interview guide, and discussions with a supervisor before conducting the interviews.

There are advantages and pitfalls in doing interviews to collect data. The mutual influence between interviewer and interviewee requires the researchers to be reflexive regarding the intersubjective processes during the collection of data (Binder et al., 2012; Finlay, 2003). One element that may influence the quality of interviews is whether the researcher can create an environment of safety and comfort for the participants. Both researchers conducting interviews in this study had a knowledge of the members of the team that went back for some time. As mentioned in the introduction, the team members and researchers knew each other from an education program for CRHT teams, and had participated in multistage focus group interviews monthly for eight months when the interviews started. An advantage from this is that there might already have been a safe relationship between the participants and researchers, that made it easier for the participants to give rich descriptions of their experiences. On the other hand, the participants' knowledge of the researchers might have hindered them from being open on sensitive issues because of the knowledge of the continuing meetings with the researchers. Another pitfall is the possibility that the participants' knowledge of the researcher's point of view regarding the subject would steer them in some specific direction during the interviews, looking for answers that are in line with what seem to be expected.

The interviews were analysed according to a series of steps for qualitative analysis inspired by Kvale and Brinkmann (2009), Van Manen (1990), Finlay (2002, 2003), Binder et al. (Binder et al., 2012; Binder, Holgersen, & Nielsen, 2010), and Malterud (2001, 2003). The steps consist of an alternation of reading, reflecting, discussion and developing units. This is explicitly described in article 2. The process resulted in the categories presented in article 2 (Sjølie et al., 2013).

Participant observation

Observation as a research method may be defined as exploring social practices by observing events and actions in their natural environment (Fangen, 2004).

Observation gives the possibility of getting firsthand information about the social world when questions do not work, and the method is suitable for study of everyday life as it occurs, according to Silverman (Silverman, 2006).

As mentioned, participation in the team education and multistage focus group with this specific team became part of a pre-fieldwork that gave the researcher an understanding of the field (Buckholdt & Gubrium, 1979; Gubrium, 1997; Gubrium & Holstein, 1997, p. 36). This functioned as preparation for the fieldwork by supplying knowledge about the work in the team.

The observation took place during 19 days. Each day lasted from 2 hours to 7.5 hours, with an average of 5 hours. Observation was conducted by the author at the office of the team and in their cars when team members went back and forth from appointments with the patients, as described in paper 3 (Sjølie et al., 2014).

Fieldnotes were written at the scene (Emerson, Fretz, & Shaw, 1995; Fangen, 2004; Gubrium & Holstein, 1997). The researcher paid close attention to reports regarding patients, conversations and collaboration between team members during meetings. She also noted their informal reflections that might be shared in discussions between team members after formal meetings in the office, team members reasoning with patients and discussions between single team members after events had happened (Buckholdt & Gubrium, 1979; Gubrium, 1997; Gubrium & Holstein, 1997, 2009). Field notes were analysed by looking in detail at the events that took place, and discussions that developed between team members, while paying close attention also to the cultural context that these appeared in. The process is described in article 3 (Sjølie et al., 2014).

There is occationally a differentiation in the field between participant and non-participant observation (Atkinson & Hammersley, 1994; Fangen, 2004, pp. 29-30; Silverman, 2006). Participant observation might be defined as an observation where the researcher plays an established role in the situation studied, while non-participant observation is defined as observation where the observer have no recognized role (Atkinson & Hammersley, 1994, p. 248). There are arguments for participatory

observation as well as more distanced, non-participatory observation style. Ideally, being a participant will increase the observer's understanding of the field. The idea is that in order to be able to get firsthand knowledge you have to participate in the field instead of just observing people at a distance. Atkinson and Hammersley (1994) describes participation as a quality of all social research, as we all are part of the social world we study. By doing so they suggest that participant observation is not a specific method, but a way of being present in the world (Atkinson & Hammersley, 1994; Silverman, 2006). My researcher role in this study was non-participant in some aspects and participant in other aspects. It reflects my mode of being present in the world as I observed it. However, I did not have an established role in the organization, other than being an observer and researcher. My role was not as a team member, but as a researcher who had been accompanying the team for some time (Silverman, 2006). My role was to observe from a withdrawn position, trying to just observe for most of the time. The participants knew me as a researcher from before I started the observation, they also knew I was a sociologist, and had no education from clinical practice. Occationally I asked questions to clarify what I saw. My profession of sociologist and not as a health worker opened possibilities for raising naïve questions when I needed to get things clarified. At some times I was also drawn into conversations with the participants, as they asked for my opinions or reflections regarding things that happened. But my position was always to try not to interrupt what was going on between the team members.

3.3 The sample

The sample of this study was defined to be one specific CRHT team. All regular permanent team members at the time the data was collected were recruited to this study, participating in interviews and observation. This means that team members who only were hired for short vacancies, were not included.

There were only very limited changes of the composition of staff during the period of the study, i.e. from when the interviews were conducted until the observation was finished. One team member quit working with the team, and one new one started the

work. As we interviewed both the one that quit and the new staff member, this brings the numbers of team members interviewed up to 13. During the period of observation, the team member who quit had already left, and the new one was present. This gave a total of 12 team members during the observation.

There were two men and eleven women in the sample, and their ages were between 27 and 59 years. Their backgrounds were multidisciplinary: nurses, social workers and psychologists. All nurses and social workers had specialized in one or more courses related to mental health, and had more than two years of work experiences in specialist or community mental health as well.

3.4 Ethical considerations

All team members were given written information about the study and its aims; that they could withdraw without consequences at any time and that results would be published in a form that protected their right to anonymity. All team members consented to participate, and none withdrew their consent.

One might ask whether team members could feel totally free to decline such an invitation, since the research project was approved by their leaders, and the request came from researchers most of them knew from an earlier education program. We did not observe any hesitation from team members. Several of the team members expressed positive experiences of how the interviews made them reflect on themselves, their choices and their work. Also, we believed that the value of doing this kind of research outweighed any light discomfort of having a researcher "look over their shoulder" while they were working, that might have been felt but not expressed by the team members.

When doing research in a health environment, it is necessary to take the patient's interests into consideration. As this study is about the staff perspective and our participants are the team members, it does not involve patients directly. However, while doing interviews and participant observation, there was a risk of getting to know the identity of patients by chance. In such case, the researcher would be

required to comply with the promise of confidentiality she had made, and to protect the identity of patients from reaching other parties. The interviews and field notes did not include any information that could identify patients. The focus of the researchers was always on how the team members reflected and acted in the given situations.

We chose to apply to REK for approval of the project. The application resulted in a dialogue with REK. They questioned the anonymity of the patients that were going to be treated by the team. REK's special concern was the participant observation: whether a participating researcher in reality would not receive knowledge of patient identity. Although we planned that the researcher should at no time be in direct contact with patients, they were worried that by participating in team-discussions and the car when visiting patients, the researcher would receive information about patient identity without patients' approval. REK approved the application, with a remark that the researchers had to apply to Helsedirektoratet for dispensation from the duty of confidentiality. This was done, and Helsedirektoratet approved the project. The researchers received a dispensation for getting knowledge about the patients, but still maintained the duty of confidentiality regarding any such information.

The difficulties regarding the approval for the project are interesting from a research perspective. Research on staff in mental health is important for gaining knowledge on how they think and work. Conducting research involving health workers often involves the researcher getting some knowledge of the patients. One might correctly argue that if this obstacle hinders the research on such subjects, this might reduce the knowledge of what is done in mental health, and secondarily put the patients at an extended risk due to lack of transparency.

3.5 Reflexivity

Reflexivity refers to the process of the researchers reflecting on their own role during the process of creating knowledge. Gough (2003) states that "reflexivity facilitates a critical attitude towards locating the impact of research(er) context and subjectivity

on project design, data collection, data analysis, and presentation of findings" (Gough, 2003, p. 22).

The ideal of pure knowledge production free from subjectivity of the researcher is questionable. Reflexivity may reduce the degree to which researchers unknowingly, and unknown to the public, influence their data in a biased way. The idea is that *known and acknowledged* influence is less detrimental than unknown, or unacknowledged, influence. By reflecting upon their possible bias, researchers may be in a better position to reduce or counter this bias. Also, others might be in a better position to comment upon the possible influence of the researcher bias upon the results. By reflecting upon their own influence and perhaps bias, researchers come closer to presenting "objective"knowledge than if their bias goes unacknowledged or hidden. Kvale and Brinkmann (2009) define this as "being reflexive about ones's contribution as a researcher to the production of knowledge. Objectivity in qualitative inquiry here means striving for objectivity about subjectivity" (p. 242).

Reflexivity is taking into consideration ones own pre-judices as a researcher and a human being in a social world whenever this is relevant for the research project (Kvale & Brinkmann, 2009). As a qualitative researcher, the researcher is always part of the context, situated in the field. The reflexivity makes the situating in the field explicit.

Gough (2003) aknowledges that the research process must include "three distinct but interrelated forms of reflexivity: personal, functional and disciplinary" (p. 23). During the project we repeatedly returned to reflections on these three forms of reflexivity.

The personal reflexivity refers to the researcher's individuality, as for example motivation, interests and attitude, and how this is made visible during the research process (Gough, 2003). For this study the main researcher's education as a sociologist may have been part of the individuality. Coming from a different profession than health professions gave some opportunities, but also some difficulties. I did not have the basic knowledge of illness, diagnosis, medication and expected treatment that was

discussed at the site. At times it might have made me miss important aspects of the discussions. On the other hand it opened possibilities for asking naïve questions: "Can you explain this to me as a sociologist with no health education?" That often resulted in an elaboration of what had been discussed; the participants reflected and explained their thoughts, assessments and understanding of a situation. On the other hand, having the experience of taking part in the education program for the team had given me some knowledge of CRHT work. I could be naïve regarding health questions, but not in the same way when it came to the CRHT work.

Being a sociologist, my professional focus is on the individual in a constant relation to other individuals, groups, cultural contexts and society. This may have influenced what I picked up and understood from the data material during collection and analysis of the data. However, psychological models and theories are also part of the knowledge I apply in this project.

Gough describes functional reflexivity as reflecting upon the roles the researcher takes and how this affects the research process (2003). As mentioned earlier in the introduction, the first time I got to know this specific team was when I worked as an administrator at the CRHT education program. I only worked administratively and not as a teacher in the education program, but the team members might have perceived me as invested in the CRHT team thinking. Informally and formally, I got to know the team members and their work within the team from several vantage points: informally during dinners, lunches and social contact at the education program and later on as a researcher; and formally, as an administrator of the education and as a researcher at project seminars and in research settings. I participated in conducting the multistage focus group interviews, as mentioned before, carried out 8 of 13 interviews and all the observations of the team. I attended regular seminars with co-resarchers and participants who were conducting or participating in other parts of the main project at that time, I listened to their formal presentation of the team work in focus group interviews, and I witnessed the formal and informal presentation and discussion of cases during the period when I undertook the observations. From the perspective that an interviewer by necessity takes part in the meaning that is

constructed from interviews, I got to take part in their presentation of their individual life stories. They introduced me to their thoughts on practices in the team. But I also got to observe first-hand from their side their practices in working with patients, and to observe their emotion work. I heard and saw the individuals, their everyday work days, the practices they were parts of, and the emotion work taking place between the individuals in a specific cultural context. Having both formal and informal contact with the participants might have been helpful for understanding the data they provided. On the other hand it might have made me belive that I understood more about the data then I actually did. My role as a researcher was explicitly formulated before I started out with the data collection. When doing the interviews, this seemed to be a role that they understood. The expectations for the researcher and for themselves as participants seemed to be clear and did not result in questions about the different roles. The observation was different. Even though the participants were familiar with me as a researcher doing interviews, they were uncertain about the role of the researcher as an observer. Several of them expressed their uncertainty directly by asking "What are you doing while you are sitting here?" "What are you writing down?" "Do you write down everything I say?", or even by checking out when they became uncomfortable, "Did you write what I just said?". During the first few days of the observation, participants also tried to include me by asking my opinion when discussing cases, or asked me to answer the phone when they left the office for a few minutes. I understood this as if they were a bit unsure about my role. I responded by clarifying the role of an observer in the different situations. After the first few days these questions stopped, and the role seemed to be clearer to them. Later on in the observation period, I was occasionally invited into discussions with the team members, often when they were alone at the office. The subjects then were their reflections of fundamental questions about their work and the team. During these reflections it was clear that they saw me as an outsider, looking at things from a different angle than themselves.

Disciplinary reflexivity involves having a critical eye towards the place and function of the specific project within the broader debates in the field (Gough, 2003). Both

researchers in this study had to various degrees been working with the Follo CRHT team, which was one of the first CRHT teams in Norway, and both were part of the education programme developed in Norway for CRHT teams. Their opinions regarding CRHT teams, theories and methods were known to the participants in the team when the data collection started. The researchers' stance towards how CRHT teams could work most effectively was in line with the UK model for CRHT teams, and also inspired by CRHT team work from Finland: emphasizing the teams' being mobile, doing home treatment and having a family and network orientation.

4. Findings

The findings are presented in three articles. They are based on a literature review, interviews and participant observation. They all aim to understand the work in a CRHT team from a staff perspective.

4.1 Summary of paper 1

The first article is called "Crisis resolution and home treatment: structure, process, and outcome – a literature review" and presents findings from reviewing existing literature on CRHT teams. The aim of this article is to review and systematize national and international knowledge regarding the CRHT team. The article explores what the characteristics of CRHT teams and services are, how these teams provide services, and what the outcome of the services are. Findings show that previous research highlights three main themes: structure, processes and outcome. *Structure* refers to the characteristic organizational aspects of CRHT teams and services. *Processes* focus on how the service is provided, while *outcome* highlights the effects of the CRHT team work. While there is a broad range of studies regarding structure and outcome, only a few studies describe the processes of intervention methods in these teams. Processes are discussed according to key elements characteristic to CRHT work: being mobile, working in the service user's home, and working together with the person's family and network. Home treatment is described as an important intervention method for these teams, which has essential advantages when working with patients in an acute mental health crisis. There still is a need for more knowledge on the content of intervention in home treatment as performed by CRHT teams. The article has been published in *Journal of Psychiatric and Mental Health Nursing*.

4.2 Summary of paper 2

The second article is called "Professionals' experiences of the relationship between personal history and professional role". It is based on interviews. The aim is to explore if and how the team members in a CRHT team experience the connection

between their personal history and professional role. The article explores whether CRHT team workers see a connection between their personal history and professional role, and if so, how are these diverse experiences related to each other? The findings were organized into three main categories: 1) experiences related to the participant as an individual with individual qualities and interests; 2) work-related experiences, and 3) family-related experiences: either having family members suffering from mental health problems, or family members who have been working in mental health services. Findings shows that team members make a connection between their professional role and the following aspects of who they are: their individual qualities and interests, their work-related experiences and their family-related experiences. By exploring and telling their life stories, they create narratives based on individual experiences and cultural context. The narratives bring meaning to their actions and choices in the work role. The article describes the characteristics of each of the categories, and compares our results to prior empirical data and theoretical concepts. The article has been published in *Nursing Research and Practice*.

4.3 Summary of paper 3

The third article is called "Emotion work in a human service setting". The article presents the analysis of observations of a CRHT in their daily work. The aim is to explore the "work" performed with emotions between team members in a CRHT team. This work comprises what emotions are expressed, when this happens, what purpose the expression of emotions serves, how emotional expressions are received and responded to, and how this support works out in the team. The findings show how validation and reflection between team members is used in an interpersonal form of emotion regulation. This illustrates how emotion work can be done in a specific workplace as a CRHT team. The article discusses these findings in the context of prior research and theoretical concepts. The article has been submitted for publication in an international, peer-reviewed journal.

5. Discussion

Before going into the discussion, I want to remind readers about the research questions posed in the articles, and outline the questions that will be discussed in the following. As just summed up, the articles aim to review the existing structure, process and outcome of CRHT teams, to explore how the team members experience and describe that their personal and professional stories are connected and contribute to their role in the team, and how they do emotion work in the team.

In the following, I discuss two main issues:

1) Which challenges and opportunities do the CRHT team members experience when providing service to persons in acute mental health crises?

2) How may organizational structure and process issues in the CRHT team work, the workers' personal and professional stories, and the emotion work and support between team members affect which challenges and opportunities are seen by the members of this CRHT team?

I will suggest that challenges and opportunities for the team members seem to be connected to and a part of the fact that doing crisis resolution as home treatment is fundamentally different from working in an in-hospital environment. I will also suggest that some of the most challenging aspects of their work are not presented in their master stories, that is: the descriptions they give of CRHT work in general, in the interviews.

5.1 What are the challenges and opportunities the team members experience in working in a CRHT team?

The main findings from articles 2 and 3 introduce some themes which can be understood as opportunities and challenges to the team members when providing service to persons in an acute mental health crisis. The themes are raised by the participants in interviews and observed during a period of observation of the team while they were working.

One of the main findings in article 2 is that the participants feel that their professional stories, personal characteristics, interests, profound work-related experiences and family-related experiences are closely linked. These elements from their life stories form their identity, as described by McAdams (1996, 2001) and Schütz (Schütz & Luckmann, 1973; Schütz & Wagner, 1970). Many of the experiences they convey, both as professionals and as human beings, give meaning, direction and understanding to the stories. The opportunities the individual team members see in CRHT work are expressed explicitly. In addition, there seems to be a common understanding that working in the CRHT team is challenging and requires specific skills and experiences from the individual; but this common understanding is more implicit in the interviews (McAdams, 2001, 2005; Schütz & Luckmann, 1973; Schütz & Wagner, 1970). Their narratives in the interviews are dominated by the possibilities the CRHT work affords. So they seem to know about the challenges, but speak more about the opportunities.

Findings from article 3 make some of the challenges within the team stand out more clearly as specific situations. The team members' emotions and reactions in specific, highly challenging situations are apparent in the observation.

Taken together, the interviews and the observation convey a picture of CRHT work as both challenging and meaningful. The challenges are shown most clearly in the observation, but also sometimes come through in the interviews. The interviews show clearly how the work is perceived as meaningful to the team members.

What are the challenges in this type of work? Findings from the interviews indicate that what the team members perceive as challenging is related to three concepts: knowledge, trust and safety. In the following I will look more closely at these three concepts.

Knowledge, as the team members describe and use this word, is a broad theme covering the individuals' theoretical skills and personal experiences and skills. But in addition, the theoretical skills and personal experiences and skills of the other team members seem to be acknowledged as part of their common "knowledge-reservoir"

or knowledge-base. As mentioned, Schön refers to knowedge-in-action as implicit or explicit theories, developed from tacit knowing, that professional workers know and use for understanding, interpreting and acting in their day-to-day work. Reflecting-in-practice refers to the "work" that the professional workers do when they strive to understand or interpret a specific case or problem (Schön, 1983, 1995). Reflecting-in-practice is relevant for understanding this CRHT team and how they work. By working in mini-teams, reflecting together and using an open dialogue approach (Seikkula, Arnkil, & Andersen, 2007) each team member has access to one's own knowledge, but also to knowledge possessed by other team members. Members need a high level of professional knowledge, the knowledge-in-action, in order to cope with the challenges that they encounter during their working day. In addition to this personal knowledge, they are able to draw upon each other's knowledge through the process of reflecting-in-practice. In the interviews, team members describe this as one of the things they value most highly about their work. They see the opportunity to take part in other team members' knowledge as highly valuable. Together, as a team, they can understand events and react in a professional way. One might say that they experience the full extent of both their personal and team knowledge by discussing events with other team members as they happen, or shortly thereafter. One of the participants states in an interview: "There is an extremely high professionalism in the team. I feel privileged to get to work in such a professional environment".

Knowledge consists of the individual's *professional* theoretical knowledge, skills and experiences. But as the findings in article 2 indicate, it also includes *personal* qualities, interests and family-related experiences. In a team, all team members contribute these forms of knowledge. Goleman (2006b) states that what a team knows is more than the sum of the individuals' knowledge; what he calls the group mind contributes to a better result than each individual by itself. Findings of how the team members reflect and talk in the team indicate that the reflecting-in-action is an important element of this contribution (Schön, 1983, 1995). In difficult cases, where a team member is unsure how to solve a situation, it is brought up for reflection with

another team member or in the team. Different understandings are collected and a solution is found based on the joint reflection.

The team members express how they experience that a high level of knowledge is needed in the team for assuring quality in work, and being able to assess, find solutions and serve the patient in a satisfactory way. When working in home treatment, the immediate understanding, assessment and care of the patient is in the hands of one or two colleagues. This is described as a challenge as well as an opportunity. At a critical point when assessing a patient, you need to remember what you know yourself, what your colleague knows, and what the team might contribute to the case, so that the assessment is good enough to help the patient and secure his or her safety. One needs to have theoretical knowledge, skills and experience to understand, interpret, assess and act on what the patient presents in situ. The team members describe theoretical knowledge as being supported by personal knowledge and one's own experiences. The totality of this knowledge forms the expertise that the individual in the team draws on when assessing the patients, grasping the whole picture of the situation. Team members express the need for such knowledge and understanding in demanding everyday situations. Lack of knowledge or understanding might have fatal consequences when dealing with patients in acute mental health crises living at home.

Goleman (2006b) includes social competence, social skill and communication as different types of knowledge. I believe this is relevant to the findings from both articles 2 and 3, as I will try to show. There is a need for social competence, social skill and communications to get the reflecting-in-practice to work. An important part of the knowledge needed, is to understand what is going on between the team members. It is necessary for all team members to have this type of competence, according to the participants. This competence includes both giving feedback and being able to ask for feedback, as well as being able to take feedback. Findings indicate that the extended use of reflection within the team gives the opportunity to get feedback on one's own assessments regarding patients, hear the thoughts of other team members, and to get support when needed. Due to how the team works, this

seems to be an opportunity to exchange information and develop understandings in situ that exceed what they are used to from in-hospital work.

Based upon what the team members say in the interviews and what I could see during the observation, the level of knowledge that the team members experience and describe in this team is what Dreyfus and Dreyfus describe as the “expert” (Benner, 1984; Carraccio et al., 2008). That involves professional knowledge but also a deeper understanding of the total situation, an intuition exceeding checking out lists of rules.

Findings show that knowledge is stressed in many of the stories from the interviews and from the observation material. The wish for additional knowledge was also expressed by team members. They spoke of the importance of knowledge in general, and the need for knowledge in everyday work life when doing home treatment. Comments regarding each other’s knowledge levels are important parts of the individual team members’ stories. They also seem to be a part of what the team members together formulate as needed for being able to work in a CRHT team, a common story rooted in the cultural context of the team. This might be seen as part of how the team members formulate the master story for the CRHT team (Loseke, 2007, 2012; McAdams, 2005). This part of the master story might be formulated as the possession by the team members of a high level of knowledge, enabling them to address the tasks required in the CRHT work.

As mentioned, the team members experience and describe their own and their colleagues’ high level of knowledge. They also explicitly express a need to be able to trust in a high level of knowledge on their own part and that of the other team members. When they are in critical situations, this makes them trust their own assessments. One might ask whether the feeling of having a high level of knowledge might be a double-edged sword. On one hand it makes the team members trust their own knowledge and be confident in making the right decisions, as described in the data material. On the other hand, one might wonder whether such confidence might sometimes make us, as professionals, think too highly of what we understand. Confidence in our clinical knowledge might hinder us from really listening to the

patient, stop wondering and challenging our own understanding. A high level of knowledge among professionals may include not only having the necessary skills but also being willing to challenge what one already knows (Tracey et al., 2014). As an observer, I did find that the CRHT team also had that ability to question their own knowledge, although they did not discuss it explicitly in the interviews. A poignant example of allowing oneself to challenge what one knows, was when one member of the team asked the challenging question of whether they might have done something differently in order to prevent a recent suicide. Another way of challenging what one knows is to systematically receive feedback from the patient (Tracey et al., 2014).

The second theme found in the interviews, and described as challenging by the team members, is to secure their own and others' safety. Findings from both articles 2 and 3 show that the team members say that an important challenge is the need for feeling personal safety and confidence in one's assessments regarding patients: to be able to trust that the assessments are good enough to secure the patient's safety. The team members say this is about their own safety in situ, as well as being sufficiently confident in the assessment of the patient. The team members describe the need to actually be able to handle the everyday confrontations with difficult situations and assessments, and patients in acute mental health crises. Findings from article 2 focus on the importance of understanding the situation, having enough knowledge and experience to do so, and taking care of oneself and the patient. The observations in article 3 show how important the feeling of understanding and being able to handle a situation in situ is to the team members. The raising of difficult emotions seems to be more frequent and harder to handle when team members are unsure of their own safety, while at the same time trying to understand and assess the patient.

The third theme that the team members describe in the interviews as challenging and important for functioning in the CRHT team was to be able to trust each other. West (2012) describes emotional support as part of social support in a team. Emotional support can be used as a way to communicate validation of emotions (Allen et al., 2008). This might be understood as a way of acknowledging each other's emotions and understanding of the situation, and hereby each other's knowledge as an expert.

By doing this, one validates each other's cognitive understanding and decisions. By acknowledging and validating each other's feelings, one validates the feelings as both understandable, useful as information about the case and perhaps even more important, valid as part of being a professional who is also able to express authentic human feelings. By encouraging and supporting expression of feelings, team members show each other that they value an ability to contain the feelings when facing the patient, while at the same time being able to vent them in appropriate relationships, that is with other team members. Knowledge and trust seem to be closely connected: trusting in each other's knowledge, and knowing one can trust each other.

Perceiving oneself as having sufficient knowledge and skills to cope with one's work, brings about a feeling of security that gives opportunities. An important finding from article 2 describing this is how the team members talk about using their creativity in meeting with the patient. The setting in the home treatment affords opportunities for individual initiatives from the team members. This personal initiative could not have taken place as often if it were not supported by the team culture. In this manner, the team culture lays the basis for individual creativity. Taking the opportunities of individual initiative and creativity in the home treatment makes the team members feel that their work is meaningful, and gives some direction to the life stories in the team (McAdams, 2001, 2005; Schütz & Luckmann, 1973; Schütz & Wagner, 1970).

5.2 How can organizational structure and processes found in CRHT teams in general influence how these particular team members work and what they see as challenges and opportunities?

There are three main findings from article 1. The categories of structure and process are the two that most affect the work of the individuals within the team. The category of outcome has to do with the economy of CRHT teams versus other in-patient services, e.g. hospital readmission rates, enabling early discharge from hospital, and the patient's satisfaction level. As these questions are more related to administration

than to what the team members deal with in their every day work, outcome seems to have a limited effect on what the individual team members see as challenges and opportunities. The outcome as described in article 1 will not be discussed further in this thesis. The structural characteristics of the team and the processes of work life afford freedom as well as vulnerability within the role of the individual.

So how can the organizational structure and processes found in CRHT teams in general influence how these particular team members work and what they see as challenges and opportunities?

The structural elements of a CRHT team are consistently different from those of working with acute mental health crises in-hospital. Findings from article 1 indicate that CRHT teams internationally are flexible in standards and criteria for how they work, but with a baseline characterized by being home-based, multidisciplinary, focused on crisis resolution and offering a broad range of clinical and social services. The structures are less fixed, with fewer frameworks and a greater emphasis on the individual team members' responsibility, initiative and creativity for gaining an overview of the situation, assessing it and come up with possible solutions. Based on one's knowledge, creativity and safety as explored earlier, the individual has a broader range of possibilities for action. Within the framework of professionalism, recognized methods and ethical considerations, there are other and different possibilities in the less strict frameworks.

The framework when doing home treatment lacks the institutional structure of buildings, schedules, routines, different professional groups doing their specialties, and chief psychiatrists or psychologists or managers available at all time. These are frameworks that regulate and give predictability and security for both patient and staff. For the patient it forms a predictable treatment and structures designed to protect from suicidal behaviour. It serves the staff by sketching out a regulated environment with lines of decision, routines and always someone to share the responsibility with. But on the other hand it also sets some limitations for contact

between patient and staff. It puts the meeting between patient and staff members into the structure of regulations and routines.

Working in a less structured framework introduces challenges as well as opportunities. This is the cultural context the CRHT team works in. It sets a different structure for the team work, positioning the team members in a different setting and maybe also in a different social role as McAdams (2001, 2005) describes it, from those frameworks, settings and social roles that have been established in a hospital.

One of the main findings from article 1 is that the processes framing and describing how CRHT teams work are fragmented. There are guidelines as to how a CRHT team should work, but each team adjusts how closely they stick to the guidelines according to what suits them in their work. The clearest guidelines on CRHT work come from Johnson, Needle, Bindman and Thornicroft (2008). But according to the findings in article 1 this way of working is not adapted internationally. Even in Norway, where the CRHT team idea stems from the English model, there are significant deviations from this model, as well as between how different teams work (Karlsson, Borg, et al., 2011a). The process as it is elucidated in article 1 focuses on the elements of being mobile, doing home treatment, and working in a family and network environment. These are elements highlighted in government guidelines in Norway (The Directorate of Health and Social Welfare, 2006). There is an international context as well as a national one lined up for the team but it is fragmented.

The environment in this specific CRHT team might be understood as loosely structured, working with patients in acute mental health crises, doing quick assessments. There are two distinct challenges that become relevant in findings from articles 2 and 3 in accordance with this setting. These are the element of being on your own in situ and in the assessment, and the team member's belief that risk of suicide is higher at home than if the patient were to stay in hospital. Although patients staying in hospital have a higher risk to themselves according to Tomar, Brimblecombe and O'Sullivan (2003), there are more possibilities of executing suicide at home, and the staff members are for this reason more dependent on

discovering suicide risks, in order to protect the patient. These two challenges seem to be important to how the team members work, think and act throughout their everyday work.

Findings from articles 2 and 3 seem to indicate that the participants understand the freedom and possibilities that develop from a less structured work environment as an opportunity in their daily work. This involves freedom to trust and use one's own knowledge, use your own creativity, to act and treat the patient according to what you believe in. Summed up it might be understood as an increased possibility and freedom to involve a larger part of yourself in the role as a mental health worker, playing a more active role in the treatment together with the patient, and in the environment of the patient's everyday life. When the treatment is done in the patients' home environment, the cultural context in which the team members work and their understanding of the patient, is moved closer to the cultural context of the patient, than it is when the treatment is done in-hospital. By doing home treatment, the social role of the team members has new possibilities towards the patient's environment in situ. Concepts of life story are relevant here. In the interviews the participants paint a picture of making a difference.

But on the other hand, this freedom also increases the team members' level of vulnerability. In article 2, one of the findings is the importance of feeling safe oneself, as well as within the situation and with the patient. This corresponds to findings in article 3 of the importance of feeling of safety in the situation with patients, and in trusting one's own and co-workers' ability to make the right assessments in difficult situations.

Being mobile and working in home treatment also means partly "being on your own". Even when working in pairs, there is an element of being on your own. It means being responsible for one's own assessments, trusting one's own and the partner's knowledge, skills and gut feeling. One might seek advice if necessary, but in the moment one encounters the patient there are always just one's own and one's

partner’s assessments to trust. There is a distance between the structure in an in-ward unit and the home treatment done by the team members.

Theories about knowledge are useful in understanding the implications of the difference between working in an institutional structure and a more loosely structured home treatment framework. The change from institutional structure and fixed processes to home treatment with a more flexible way of working raises the need for knowledge: professional knowledge, knowledge of assessment, and knowledge of oneself. The feeling of being on your own, and the need to trust oneself and a co-worker in a mini team in situ makes the need for knowledge more obvious. This is the knowledge described by Schön (1983, 1995) as knowledge-in-action and reflecting-in-practice. These two kinds of knowledge includes professional theories and the ability to use reflection to connect professional theories to specific patients and situations.

Findings from article 3 show how the risk of suicide is an issue that raises the bar for the team members regarding taking responsibility in home treatment. This is a significant challenge in doing home treatment. Risk of suicide challenges the more open structure and process because of how the team members experience an increased level of responsibility for and less control of patients who they fear are in danger of suicide. The experience of often having to do suicide assessments, and constantly having only your own and your co-worker’s assessment to trust in the assessment, might be emotionally draining. The level of stress and challenge in such situations is apparent in the need for a high level of knowledge as noted in article 2, and for emotional support as identified in article 3. A case like the suicide case in article 3 illustrates how reflecting-in-practice (Schön, 1983) is increased within the team.

Walsh and Walsh (2001) find that low support is a factor that contributes to mental health work being psychologically hazardous to staff. For the team members in the CRHT team, the emotional support provided between team members seems to be

helpful in meeting at least some of this need. The importance of the emotional support between team members is stressed in findings from article 3.

There is a freedom in being responsible in these situations: a freedom to decide whether your assessment holds, whether you need to get the opinion of a doctor on call, and whether the situation is too uncertain to leave the patient at home. But there is also a vulnerability of standing alone if the patient were to kill himself. There is a vulnerability regarding being the one in charge of evaluating the patient, a vulnerability of feeling responsible for securing the patient's safety, and a vulnerability associated with wondering whether or not you will get the needed emotional support at the end of a stressful and demanding work day; or if a suicide is to take place. The lack of structural frameworks within the demanding situation adds to the burden of the individual team member.

Being mobile and working in patients' homes is distinctly different from working in-hospital. The difference in the work environment raises other opportunities and challenges for the staff. This results in the freedom but also in the vulnerability that the team members experiences.

5.3 How do the team members experience that their personal and professional history influences how they meet the challenges

We keep in mind that some of the main challenges and opportunities are having sufficient knowledge, staying safe and confident, and working creatively with more freedom to make decisions. This is all happening in an environment where the structure is less fixed and the working processes and conditions facilitate a higher degree of freedom but also increase the vulnerability of the team members. How do the team members experience that their own personal and professional history influences how they meet these challenges?

Their experience of being able to influence other people's lives seems to be meaningful to the participants. The areas where they emphasize their influence are

areas they express as meaningful and important to them: using one's knowledge, making a difference, having the possibility to do what you believe in and seeing the whole person and complete situation of the patient. Based on the interviews and the observation material, their experiences can be condensed and summed up into a main message: something in line with: "Based on my personality and my experiences I can contribute actively and freely in a CRHT team to help patients in acute mental health crises". The meaning in their life stories, as it is condensed and summed up from the data, seems to express something about themselves as individuals; "This is me", "This freedom makes me a good helper", "By being creative I can do a better job"; but also something about the cultural context; "This is what might happen", "This is where I am vulnerable", or "I cannot always help".

As stated in articles 2 and 3, the individuals form life stories that give meaning to CRHT work. They form stories which show that they are in charge of their own lives, careers and feelings. Their choice of working in a CRHT team is built upon specific and clear values. These values are meaningful to the team workers and give their lives direction. These are values such as the importance of seeing the whole patient, doing home treatment, working network-oriented, focusing on the patient's resources, etc.: values that are significant in doing home treatment.

The participants seem to be both strong and vulnerable simultaneously. On one hand, they express the strength and knowledge that comes from themselves, their history and experiences. On the other hand is the expression of vulnerability and need for support in order to be able to tolerate the challenges they meet. When meeting reality in CRHT work, seeing the patient, forming the alliance and providing help in acute mental health crises gives meaning to their work.

Their past has formed them as they express it in interviews and during observation. Through experiences in their own lives as McAdams (1995, 1996, 2001, 2005), Schütz (Schütz & Luckmann, 1973; Schütz & Wagner, 1970) and Bruner (1986, 1990, 1991) sketch out, and through profound work experiences and their professional stories as Schön (1983) suggests, they describe how they draw on these

parts from their life stories in everyday work life. The only reservation they have about drawing on their experiences is that these experiences need to have been "processed" so that they do not interrupt the work without one's knowing it.

According to McAdams, understanding of life stories, a person's answer to the question of what is the meaning of life, is in his or her life stories (McAdams, 1995, 1996, 2001, 2005). This seems to be in line with the project the participants are working on in the interviews in article 2 as they build meaning and direction into their stories. Personal characteristics and interests that strengthen their ability to work in the team are elaborated and emphasized in the stories. They form a reason for their choices and explain why they are especially suitable for the job. Through their stories, they express how their personal and professional histories have made them capable and especially suited for the job in CRHT.

But then something happens when we move over to the findings from the observation material in article 3. Their capabilities are still apparent. This is also shown in how they take care of themselves and the other team members by doing emotion work in a demanding and sometimes critical everyday work life. But in addition the team members also express and show vulnerability and need for emotional support from the other team members.

Summed up, the individuals have their personal and professional stories. They have their individual meaning built into their stories. They act in the cultural context of a team where they get support and do emotion work, but they also have some given structure and process to work within. There are some expectations for what they are supposed to deliver, mean, feel and manage to do. These expectations come from themselves, from within the team, and from outside the team (Johnson, 2007; Johnson et al., 2008; The Directorate of Health and Social Welfare, 2006); maybe even formulated as master stories (Loseke, 2007; McAdams, 2005). These master stories might partly differ from what the individual team members experience in their everyday work life. This will be discussed further on.

Their life stories come from themselves individually, but are also a product of the surrounding context. There are levels of reflexivity in their stories; the stories lead somewhere, they have meaning to them. But when working in what they have described as a meaningful work environment in the CRHT team they also encounter the difficulties and challenges the work situation offers. They show their vulnerability and need for emotional support, and they do an extended amount of emotion work within the team. In the interviews, the participants describe their strength as coping with the challenges; in the observation, they show how they use emotion work to handle their vulnerability. Showing their emotions, admitting the need for support and doing emotion work together is also a part of their strength.

5.4 Existing master stories and elements for a possible new one

The stories told by the participants are personal stories linking events from their lives together and giving it a meaning, forming a coherent personal identity (Loseke, 2007). These stories from the team members depict, according to findings in articles 2 and 3 as shown earlier on, that the team members are knowledgeable, vigorous, able to endure stress, insecurity and seeing pain in the patient, and good at reading people. These seem to be the team members' common master stories (Loseke, 2007; McAdams, 2005) or formula stories (Loseke, 2007). The master stories come from the team, but also from the cultural context of these teams: documents, courses, conferences and meeting places for this and other teams (The Directorate of Health and Social Welfare, 2006). One might say that this seems to be what they experience as expected from them and what they expect from themselves.

Findings from article 2 indicate that the individual team members' life stories to a great extent are in line with this master story. Nevertheless, findings from article 3 show that there are elements to the master story that have not been emphasized up to now, but which play an important role in the team members' ability to fulfil the work tasks over time, namely that their everyday work life demands so much from them that they are highly dependent upon the possibility of getting emotional support from

colleagues and doing emotion work together, in order to function optimally in their work. The team members describe that the other team members' knowledge as well as support is of great importance for the emotion work in the team. This emotion work is not clearly expressed in the master story. The emotion work is apparent in the observation, as the team members frequently express emotions, give each other and receive from the others the emotional support that they need (Sjølie et al., 2014).

The manageable and interesting challenges and opportunities described in their stories from article 2 match their project of providing meaning, purpose and direction to their life stories. They also match the master story that emphasizes this as a good, important, alternative, forward-looking manner of working (Loseke, 2012). But then their need for emotional support and validation, reflection and emotion regulation is brought up in article 3. This illustrates another side to the story that is not presented so openly in the master story (Allen et al., 2008). The cultural context in the team presents a need for validation, reflection and regulation of emotions as a significant part of the environment the individuals work in.

The positive story dominates the presentation in the interviews of choosing CRHT work and the opportunities based on personal characteristics, interests and experiences; the challenges come into the picture mostly as a backdrop that inspires them. But the observation material completes the picture with a more nuanced description of the serious challenges in everyday life in a CRHT team. In this material, the team members show their vulnerability, how they are touched by their emotions at work, how they need to air them, to get emotional support, mentalize emotions and do emotion work together. There seem to be parts of the story about working in a CRHT team that are not clearly formulated in the interviews, but which show up in the observations.

Findings from article 3 indicate that there might be a need to extend the master story with some additional elements in order to fully describe the work of this CRHT team. The mentalizing of emotions through validation, reflection and regulation seem to be quite important for the team members (Allen et al., 2008). According to Walsh and

Walsh (2001), this might even be a significant requirement for the team members to stay healthy themselves despite challenging everyday work life.

New master stories could clarify the diversity in the team members’ everyday work life more explicitly. They possess numerous capabilities and experiences that they bring to the table. But they are only human beings in a challenging and demanding work situation, which they often master on their own. There is an extended need for seeing the individual staff member within the organization, as well as seeing what the team members need in order to be able to perform the work in a CRHT team over time without gambling with their own mental health.

The team members’ individual personal and professional stories, and the meaning these are given illustrate how the team members see the work in a CRHT team; what they value about it, why they do it, and how they believe that they best can contribute to the work. But there is also a need for the cultural context in which they work to provide a structure that facilitates the work the team members do. They need a structure that enables them to perform the tasks, and continue to perform the same tasks over time. This cultural context includes not only the CRHT team itself, but also the wider organizational structure.

The master stories that are presented by the participants throughout the interviews and part of the observation material, documented in articles 2 and 3, are typical. The need for working with strong emotions that is discussed in article 3 might be a door into the stories that are not as openly expressed. These might be the stories of how everyday work life influences the team members: their personal and private thoughts, experiences, feelings, and mental health. Some of these most challenging sides of their work are not presented in their master stories. We find the emotion work in the observation material, but this is not worked into the typical master story by the team members (Sjølie et al., 2014).

5.5 Implications for practice and research

Implications for practice

Knowledge of how the team members relate their personal and professional stories to the work in the CRHT team and the emotion work done in the team is important to the practice of CRHT teams.

The everyday work in a CRHT team is described as demanding and challenging, but is also seen as providing opportunities to do important and meaningful work. The demanding and challenging parts are the continuing meetings with patients in crisis and the unpredictability in every new meeting. The participants are affected by these experiences in their day-to-day work. This everyday work situation reveals a need in the participants for extended attention to the impact of everyday work life on the individual team member, to give the team member the right support when needed.

During their work, the participants describe how they make use of their personal and earlier professional experiences in their work with the patients. The team and the individual members could benefit from extended attention to the life stories of staff working in acute mental health care, which could be a resource in their everyday work life. This is a source that could provide them with a more conscious understanding of their own emotions, how they work with other team members and how they interact with the patients.

Our findings indicate that there are several forms of support, emotional support as well as other forms, which team members give each other. The support seems to play an active role in how the team members help each other address the challenges at work. Any team could benefit from knowing more about the emotions expressed between staff and how these are met by other staff members, how support between staff members can fill a function that adds to that provided by supervision and which probably cannot be replaced by supervision; and the importance of immediate response and support in demanding situations.

Our findings have several implications for practice that could strengthen the team members and the work in a CRHT team. Furthermore, an extended knowledge of the master story could give the team members and their leaders a deeper and more conscious understanding of how the team works together and what they need to function in a demanding work situation. Facilitating and promoting emotion work within the team could strengthen the individual team member, the team as a whole, and the work the team members perform. While these are actions perfomed by the team members and their leaders within the team, supervision from someone outside the team could bring new thoughts and perspectives into the team's work.

Implications for further research

There still is a lack of research on those who constitute the staff working in CRHT teams: their background, the way they work and think in practice, what resources they bring to the team, and what they need from the team to be able to keep up the work.

This study shows that the team members tend to continue to work in the team over a long time in spite of the demanding nature of the work. We explore some of the experiences that the team members highlight as important for the ability to do this. We also describe some of the support the team members give each other at work. However, this is just a small piece of a larger picture.

This study explores the relationship between personal and professional histories by collecting stories from team members in a CRHT team. Further research using other methods could provide extended or different knowledge of this connection. The team members highlight knowledge and support as important aspects of their work. Further research could be done on what kinds of knowledge or support they find they lack in their work. Research on what knowledge is documented to be useful in CRHT work could also be interesting. There is a need for further quantitative research on what knowledge the team members need, but also for further qualitative research on the team members' experience of what they need to know to work in a CRHT team.

5.6 Strengths and limitations

A qualitative study like this one aims to explore the experiences of CRHT team members. Some of the experiences described by the team members might transfer to other CRHT teams or other similar teams. Other CRHT team members might describe similar experiences or other additional ones from those this team shared. To know more about that, further studies are required. The fact that only one team was included in the study is a limitation. Members of other teams might have other individual experiences that would broaden and differentiate the experiences in this study. Other teams might also identify other cultural contexts within and outside the teams themselves, that could have brought up different challenges and opportunities than those confronting the team we studied.

The triangulation of methods in this thesis using both interviews and observation is a strength. It gives researchers the possibility to listen to the participants and observe them in their everyday work life. The strength of this combination of methods is illustrated by how interviews and observation material complement each other, supplying different aspects of the data. On the other hand, we have used only qualitative methods, which is a limitation to the study. Triangulation using different methods, such as for example quantitative ones, would have provided different types of data.

As mentioned earlier, both interviewers were known to the team members before the study started. If we had used interviewers who did not know the team, they might have got other stories from the participants. Unknown interviewers might have given the participants freedom to express other sides of their stories, which could have strengthened the study. On the other hand, not knowing the team members and their work in the CRHT team might also have led unkown interviewers to miss important aspects of the stories. That would have been a limitation to the study.

Accompanying the team over some time made it possible for the researcher to listen to the participants' stories, and then observe how they worked together. It gave us vignettes and glimpses which were then followed by other episodes which were

similar to or diverged from to the ones we had already seen. Collecting data from observation as well as interviews gave us a broader picture than using only interviews would have done. The possibility of accompanying the team over some time is a strength of the study.

My role as a researcher has already been described when discussing the process of reflexivity. The role I took as someone the team members knew, a sociologist and researcher, interested in finding out how they were thinking and acting in different situations, might have made the participants relax, be their usual selves and do what they were used to doing. This might have strengthened the study by gaining access to their usual work life and assessments. But my presence and the fact that they knew me might also have made them cautious in their work and about what they discussed in my presence. If so, that could be a limitation of the study. Being so close to the team members might also have made it difficult for me to challenge the team members about, for example, their self-image when it came to understanding their own level of knowledge. Discussing this theme with the team members could have given more information of their thoughts about it. That might have been a limitation of the study.

6. Concluding comments

The aim of this thesis was to explore the experiences of team members in a CRHT team; the challenges and opportunities in the CRHT work, the impact and role of their personal and professional stories, and the emotion work they did in the team. We interviewed all the team members in one CRHT team, and did participant observation over a period of time. Analysing the data helped us sort out some categories of how to understand the team members' personal and professional stories, how these were connected, and the emotion work that can be done in a CRHT team.

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