Chapter 3
Showing You Care: Emotional Labor and Public Service Work

Sharon Mastracchi and Yvonne Sawbridge

3.1 Introduction

This chapter examines the importance of recognizing the emotional labor inherent in public service delivery and suggests several approaches that organizations can use to support emotional labor demands on staff, with an emphasis on health and social care. Emotional labor has been identified as a key element of future public service work (Needham and Mangan 2014). Whilst a country's policy context highlights the importance of delivering public services that meet the needs of the recipients, this may do little to support implementation. This chapter outlines the need to recognize that delivering services is hard emotional labor, and that organizations need to support their workforce to enable them to do this well.

Indeed, the workforce are the only vehicle through which patients, clients, and service users receive compassionate public services, and our public services can only be compassionate if we support public servants to care. Their interaction with recipients is the embodiment of whether the individual feels cared for or listened to. Delivering services compassionately is a key role requirement, demands training and support as most complex technical skills do, and yet is often overlooked as a core skill. Gabriel (2015, p. 618) observed, "in the case of health service[s], reading the emotions of patients and their loved ones, responding to them and managing them becomes as important as drawing blood with syringes or performing mastectomies." There is a reasonable expectation that doctors are trained to perform mastectomies, but emotion management is rarely discussed. As public services develop, with greater emphasis on digital encounters, citizens and patients more

S. Mastracchi (✉)
Department of Political Science, University of Utah, Salt Lake City, USA
e-mail: mastracc@uic.edu

Y. Sawbridge
National Health Service, London, UK

H. Dickinson et al. (eds.), *Reimagining the Future Public Service Workforce*,
SpringerBriefs in Political Science, https://doi.org/10.1007/978-981-13-1480-3_3

than ever need public servants to be able to act as humans, interacting on a human-to-human level and to be supported in that approach.

3.2 Emotional Labor Explained

Emotional labor is the effort to suppress inappropriate emotions and/or elicit appropriate emotions within oneself or in another person, where "appropriate" and "inappropriate" are dictated by the demands of the job. Because it is part of the job, emotional labor is part of the exchange between employee and employer. In public service work, emotional labor represents a substantial part of that exchange (Guy et al. 2008). Brunetto et al. (2014, p. 2347) define emotional labor as taking place when 'employees are expected to regulate their feelings and expressions in accordance with their employers' expectation when exposed to emotionally-demanding interactions on a daily basis'.

Brunetto et al. (2014), Guy et al. (2008) and others observe that this often remains unremunerated and unrecognized, and its significance poorly understood by managers. As long as emotion is perceived contrary to reason, emotional labor will not be taken seriously. Display rules govern when, where and how employees should express emotion. Different professions use diverse emotion management strategies to navigate display rules. Workers subject to display rules can convince themselves that display rules are true (deep acting) or they can fake it (surface acting). Surface acting is more stressful and produces more negative outcomes, and display rules prohibiting negative emotional expression increase exhaustion (Lu and Guy 2014). Examples of emotional labor might include nurses who have experienced personal bereavements: they will display compassion and concern when working with dying patients and their families, and even when their true feelings are of extreme distress and grief, they will keep them in check. Another might be social workers who do not display the discomfort or even fear they feel when visiting hostile families, but act instead with professionalism, calm and inquiry. Given the potential impact on mental and physical well-being, supporting the emotional labor of public servants is essential.

3.3 Interventions to Support Public Servants with Emotional Labor

Through working in this field for a number of years we have identified different interventions that would appear to afford some protection to those required to perform emotional labor as part of their role (which we would argue applies to most public-sector workers). Although many of the interventions we will describe here have been used in UK healthcare services, we believe there are generalizable

principles: readers can adopt and adapt these practices to suit their context. The evidence base for these varies, so they should be considered as potential tools for organizations to use, and not one-size-fits-all solutions.

While many of the interventions differ, an underlying principle for many is Reflective Practice. Reflective Practice "places an emphasis on learning through questioning and investigation to lead to a development of understanding … [and] is important in sustaining one's professional health and competence and that the ability to exercise professional judgment is in fact informed through reflection on practice" (Loughran 2002, p. 34). Reflective Practice has been implemented in one form or another across a range of professions (medicine, law, engineering, nursing, teaching, etc.). Schon (1987, p. 233) underscores the promise of Reflective Practice in organizations: "the enhancement of reflection-in-action is part of a larger program, liberating the capacity of human beings to think reflectively and productively about their own work." We now move on to set out a number of different emotional labor interventions, many of which embody reflective practice approaches.

Creating Learning Environments for Compassionate Care (CLECC) was developed at Southampton University by Bridges and Fuller (2014). The aim is to promote compassionate care for older hospital patients by working with ward teams. A practice development practitioner/nurse delivers classroom training, reflective discussions, facilitates action learning sets and coordinates the practice observations. The focus is on developing the relational capacity of individuals and teams and supporting leaders to create workplace learning environments which support the development of relational practices across the work team. By providing this menu of reflective learning and mutual support, the aim is to embed compassionate approaches in staff/service-user interaction and practice. The implementation program takes place over a four-month period and is designed to lead to a longer-term period of service improvement. Several key activities over this program include:

- Monthly ward manager action learning sets
- Team learning activities, including local team climate analysis and values clarification
- Peer observations of practice and feedback to team by volunteer team members
- Classroom training (8 h)
- Daily five-minute team cluster discussions; and twice weekly team reflective discussions.

Throughout the implementation period, ward managers and their teams develop a team learning plan, which includes a plan for inviting and responding to patient feedback, and puts in place measures for continuing to develop and support manager and team practices that underpin the delivery of compassionate care. Minimum conditions required for success include consistency of Ward leader; ability to release staff; a designated room available for reflective discussion, and protected time for peer observations of practice. Often these seemingly-minor requirements are not in place, and represent a significant risk to program success. Resources

required include creating time and space for reflective discussion and practice observations, creating a practice development nurse/practitioner post, and educational support costs. In practice, for some teams finding a suitable, available space can be as challenging as finding the time in busy working days.

The impact of the CLECC program will be gauged by a large-scale evaluation funded by the National Institute for Health (NIHR), which is currently in progress. Preliminary evidence of effectiveness shows that developing relational capacity in teams and leaders supports the delivery of compassionate care (Bridges and Fuller 2014). This finding has the potential to support staff to address widely-documented variations in care quality.

Relation-Centered Leadership (RCL), developed by Dewar and colleagues at Edinburgh University in partnership with NHS Lothian, is a three-year participatory action research project to identify and support individuals within teams to develop compassionate care practices through a number of action projects. Hospital ward teams are the focus and supporting the development of leadership skills in compassionate care is one of these approaches.

RCL was a year-long program using the principles of appreciative relationship-centered leadership to enable all participants (86 staff, including all clinical nurse managers, charge nurses/ward managers and other staff nurses across all patient areas in NHS Lothian, approximately 10% of the nursing workforce) to build on existing skills, knowledge and experience and work within a framework of relationships. Participants explored relationships with self, patients and families, teams and the wider organization. This involved several work-based activities, including:

- Valuing feedback from staff, patients and families using short feedback forms that asked 'what works well for you?' and 'how can your experience be improved?'
- Emotional touch-points to learn from the experiences of others in a structured way that focused on the feelings associated with the experience.
- Feedback fortnight—where staff were asked to invite four colleagues to provide feedback on their performance at work.
- 'Huddles' (informal daily short meetings) to discuss with staff the things that had worked well and those things that could be improved upon.
- Using the 'All about me' tool to find out more about staff, patients and families as people.
- Using observations of interactions to highlight positive, neutral and negative interactions.

As with CLECC, requirements for the program included available room space and ability to undertake work-based learning activities. A "Staff culture" questionnaire was completed at the start of the program and profiled what was currently happening, and informed areas of focus for subsequent development. All staff who commenced the program (n = 86) completed this, as well as some staff in each participating area (n = 319). Reflections following action learning indicated new learning about participants' relationship with self, patients and families, the team

and/or the organization. The program supported participants to think in different ways and be reflective. It engaged participants in shaping the cultural climate in which compassionate relationship-centered care can flourish. Participants are empowered to optimize their leadership capability using autonomous motivation as a personal resource.

RCL was a large research project and funding included five full-time staff. In addition, a Lead Nurse and four Senior Nurses in Compassionate Care were required to support this research. This resource level may be unobtainable for many teams, but as it demonstrated changes in the work environment, some principles and practices may be adaptable for teams to use locally. Challenges to success included staff turnover at the senior level, combating staff time pressures, full engagement and contact with middle managers, which was crucial to sustaining work, sharing of good practices and culture change, maintaining the energy of project staff, focusing on continual reflection, taking action, and opportunities for giving feedback and engagement. Despite these challenges, strengths of RCL include an increased self-awareness on the part of staff, enhanced relationships among staff, enhanced reflective thinking, and an enhanced focus on staff and patient needs.

Group Supervision was developed by Smojkis at the University of Birmingham, and is founded on the idea that clinical supervision is fundamental to health and social care practice and continuing professional development. This model of group supervision is based on a Reflective Practice process, originally part of a standalone module run by the University of Birmingham, and developed to enable staff to share the challenges and successes of practice in a safe, supportive and confidential environment. Practitioners in health and social care professions comprise the target audience for Group Supervision.

Wellbeing and resilience are important factors for staff to enable them to work alongside patients, service users, and colleagues. Being a reflective professional in health and social care rests on the ability to be critical within an environment of substantial uncertainty and change (Light et al. 2009). This model was developed by integrating the three main functions of supervision: education, support and management (Kadushin 1976; Hawkins and Shohet 2013). Reflective Practice Teams have evolved from family therapy practice and supervision. The solution-focused reflecting team was developed for use in group clinical supervision for social workers (Norman 2003, pp. 156–167) and was adapted for newly-qualified mental health professionals on the interdisciplinary preceptorship program in a local mental health Trust. Groups of three to twelve members meet once every two weeks for 90 min. Groups and their facilitators adapt an action learning set process with one person presenting, followed by colleagues clarifying, affirming and reflecting. It ends with each presenter responding to the discussion and setting personal goals.

A formal evaluation at the end of the program assesses impact, which has consistently emphasized the value of taking part in the Reflective Group, having contact with peers, and sharing issues around the shock of being newly qualified. Informal discussion around the impact on staff retention is positive. Participants value the regular opportunity to meet with peers and share issues relating to practice

in a closed group that is facilitated by an experienced practitioner/academic. The initial outlay for an organization is the cost of a facilitator. Challenges include ensuring that staff members are released from clinical practice to participate on a regular basis. Experience has shown that it has been difficult for staff to do this once they have left the program, reinforcing the need for a purposeful and systematic approach to staff support schemes, if they are to be effective. It needs to be built into job descriptions, and time must be created accordingly, though evidence suggests this is far from a reality for many.

This type of opportunity to develop a sense of community, sharing the positives and negatives of everyday practice, is important in the well-being of staff. This sense of community and connection is fundamental to building a resilient, competent, and confident workforce. The process assists in preventing burnout, compassion fatigue, and sickness levels, and therefore impacts positively on the provision of health and social care. This method has been used with newly-qualified mental health professional in one mental health Trust for 14 years. It has also been introduced in the Reflective Practice, Wellbeing and Resilience for Managers in the Work Place module for health and social care managers at the University of Birmingham and many participants use it in their organizations.

Mindfulness is a self-directed practice for relaxing the body and calming the mind through focusing on present-moment awareness. Its origins are in Buddhism and it is a form of meditation. Mindfulness is a technique that has the potential to help anyone. It is not an approach that has been developed specifically for use in health or social care, although it has been introduced in a range of organizations and therapeutic encounters. Through the practice of mindfulness, people are provided with the skills to train themselves to achieve greater maintenance of attention and develop more control in focusing their attention.

Typically, mindfulness practice involves sitting with your feet planted on the floor and the spine upright. The eyes can be closed or rest a few feet in front while the hands are in the lap or on the knees. The attention is gently brought to rest on the sensations of the body: feet on the floor, pressure on the seat and the air passing through the nostrils. As thoughts continue, you return again and again to these physical sensations, gently encouraging the mind not to get caught up in the thought processes but to observe their passage. The development of curiosity, acceptance and compassion in the process of patiently bringing the mind back differentiates mindfulness from simple attention training. Mindfulness can be practiced for a few moments as a breathing pause in the middle of a busy day, or for half an hour in a quiet place first thing in the morning. A program might involve eight 2.5 h weekly group sessions, a daylong silent retreat, and a commitment to practice mindfulness activities for 45 min, 6 days a week. However, there are many variations in the training approach. There are also a number of approaches that can be included under the broad heading of mindfulness, including mindfulness-based cognitive therapy, mindfulness-based relationship enhancement, mindfulness-based wellness education, mindfulness-based eating, and mindfulness-based medical practice.

Improvements in the health and well-being of staff, in terms of reduced stress and anxiety, are typically the reported benefits of mindfulness approaches.

Transport for London employs more than 20,000 people and in 2014 introduced a Mindfulness-Based Stress Reduction (MBSR) program. Long-term benefits included reduced employee absence caused by stress, anxiety, and depression by 71% over three years, decreased absence for all conditions by 50% over the same time, and a 53% increase in reported happiness and engagement. Mindfulness has also been found to reduce distress in support staff caring for people with intellectual disabilities (McConachie et al. 2014), and to improve mental performance, emotional wellbeing, and physical health. As well as feeling calmer, participants also reported increased capacity in effectively single-tasking, rather than ineffectively multi-tasking. They also reported an increased capacity for more creative and open-minded thinking including possibilities they had not considered before (Pykett et al. 2016).

The primary challenge with mindfulness approaches is the lack of time to practise in a busy practice setting. Organizations and managers often expect public servants to keep busy, so the idea of stopping and being 'still' may be interpreted as "doing nothing". People who have never experienced mindfulness may be cautious about practising it, and staff may feel uncomfortable. It also needs to be practised regularly to be effective. Developing this "habit" is often a challenge. Despite these caveats, many healthcare organizations have made this an integral part of their staff well-being strategies; some offer sessions at work whilst others purchase mobile apps for individuals to use in their own time. If organizations fully accept responsibility for the well-being of their staff, this latter approach would seem curious, as they address the physical dangers of work much more actively through their corporate structures (for example, panic buttons fitted in Social Work environments; hoists provided to lift patients on wards, etc.)

Restorative Supervision, developed by Wallbank (2013), is a model of supervision designed to support professionals working within roles which have significant emotional demands. Over 60 NHS Trusts across the UK and Ireland have employed Restorative Supervision. In the West Midlands, the target audience has been Health Visitors, but it is applicable to all staff groups, particularly those in which time for supervision is already established practice.

Restorative Supervision involves training both the supervisor and supervisees initially, so that they jointly understand this co-coaching approach to supervision. When professionals undertake complex clinical work, they move between anxiety, fear, and stress. If they can process these natural feelings about work, they can focus on learning needs and development, and then enter a creative, energetic, and solution-focused zone. The training program can be varied according to the needs of the organization/staff, but generally consists of one day spent training supervisors or groups to use co-coaching methods, followed by six sessions. Skilled supervisors train others so that the program will become self-sustaining, using internal resources only. Impact is measured through a combination of qualitative and quantitative measures, including stress, burnout, compassion fatigue, and compassion satisfaction. Feedback suggests improved levels of confidence and reduced anxiety. A number of studies have found reduced stress and burnout and increased levels of compassion satisfaction due to this approach (Wallbank 2013).

For staff groups in which supervision is not currently offered, releasing staff time for regular supervision, coupled with the time for the initial training, is challenging. For staff groups in which supervision is already offered, there is no need for additional resources once the training program has taken place. This suggests it could be adopted in Social Work practice, where supervision is a recognized and regular activity for many. The existing supervision model could be changed to a co-coaching approach and existing evidence indicates that staff well-being would increase.

Samaritans Volunteer Support System. Established in 1953 by founder Chad Varah, Samaritans provided the first 24-h helpline in the world for people needing to talk confidentially, free from judgement or pressure, and aims to reduce their isolation. Currently 15,700 listening volunteers answer a call, email, or text every six seconds. In order to provide emotional support for volunteers, Samaritans developed a system to reduce the likelihood that they leave a shift feeling anxious or distressed. Every volunteer call handler has access to this support system.

Each volunteer undergoes a period of training prior to taking calls. Each shift is between three and five hours, and the volunteers never work alone. Callers are often in a highly distressed state, and the volunteers are actively encouraged to share the last call with their partner in the 'down times' between calls. If the volunteer needs longer to debrief, telephones are turned off to enable this to happen (it is rare that this action is required as most debriefs are possible in a few minutes). However, it signifies the importance with which the organization regards the emotional health of volunteers. It is recognized that if volunteers are not cared for then they cannot care for the callers. At the end of each shift, the volunteer 'offloads' to the shift leader. This process involves the volunteer summarizing the types of calls taken and their feelings about them. The leader assesses the emotional health of the volunteer, and if they feel they were particularly affected, they will arrange for further support to be offered, either by doing so themselves, or through the volunteer support team.

While no formal evaluation has been made of this system, it has been used for many years, and informal testimonies attest to its effectiveness. For example, one volunteer took a call from a caller in the act of suicide, and was required to just be there for him until he was no longer able to respond. She reported how the support system enabled her to sleep that night, and contrasted this with her experience as a mental health nurse when she often felt unable to sleep after a shift, even if the stresses of the day seemed less acute than this telephone call.

Sawbridge and Hewison (2012) undertook a research project to implement a similar, though heavily adapted, 'buddying' scheme on hospital wards for nurses. As this scheme involves predominantly a mindset change, rather than a specific set of actions, it can feel intangible, and needs specific support and role modelling of behavior changes. It also has logistical barriers: systematically debriefing at the end of every shift was countercultural for staff who just wanted to go home. Protected space for this discussion was also an issue, as was enabling nurses to raise issues and discuss their feelings rather than problem solve. The main strength of this system is that it does not require staff to leave the ward (or community/mental health clinic) for regular periods, as with supervision and some other models.

It requires them to 'be with' each other in a different way, and have different conversations throughout the day, once the initial training and support has taken place. It does not require large amounts of resources or equipment. Embedding this mindset change is the key. Despite lack of formal evidence, this approach shows considerable promise for a number of settings in which public servants work with colleagues, though without time out for regular supervision, as colleagues could actively care for each other as well as the people they serve.

Schwartz Rounds were adapted in the UK by the Point of Care Foundation (PoCF), and provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. They are led by PoCF-trained facilitators. The purpose of Schwartz Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care.

Rounds follow a standard model to ensure they are replicable across settings, and normally take place once a month for an hour with catering provided. Once the Round starts, three or four staff share their experiences for the first 15–20 min. Each group ideally includes a mix of clinical and non-clinical staff with different levels of seniority. A Round can either be based on different accounts of a case, or can explore a particular theme such as 'when things go wrong' or 'a patient I'll never forget'. Experiences are shared from the perspective of the staff member, not the patient, and the emphasis is on emotional impact. The remainder of the hour features trained facilitators leading an open discussion. They ask participants to share their thoughts and reflections on the stories. The key skill is for facilitators to steer the discussion in such a way that it remains reflective and does not become a space to solve problems. The target audience is all staff, clinical and non-clinical, in a healthcare organization. Rounds are led by a facilitator from within the organization who will already have some experience of facilitating groups, and a senior clinician from within the organization.

The underlying premise for Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work. Feedback is collected at the end of every Round from all participants using a standardized form provided by PoCF. Local evaluations have been published and a national evaluation is about to be published, led by Professor Jill Maben[1] and covering 146 organizations in the UK, including acute trusts, community and mental health trusts, and hospices. Over 400 healthcare organizations in the US use Schwartz Rounds, and evidence shows that staff who attend Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care.

Adopting Schwartz Rounds requires contracting with PoCF in the UK in order to ensure the process is implemented in a consistent and measurable manner and complies with organizational needs for ownership, oversight, and confidence in the

[1] https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/130749/#/.

impact of their investment. Rounds require commitment from Chief Executives/Boards, a steering group to support the facilitator and clinical lead, willingness to work to make Rounds sustainable, and an agreement on the time commitment required for the facilitator. Listening to colleagues describe their work challenges helps to normalize emotions, which are part and parcel of working in healthcare but may be buried. This shared understanding manifests in improved communication between colleagues and a greater sense of teamwork. Seeing beyond colleagues' professional identities allows staff to feel more connected to one another. Participation in Rounds also helps to provide staff with greater insight into how all colleagues, regardless of role, play a vital part in patient care.

Critical Incident Stress Debriefings (CISDs) and ***Self-Care Plans*** have been developed and employed by emergency response organizations in the US. Target audiences have been police, fire, and emergency medical technicians, but the intervention could be applied in other settings. In a CISD, staff assemble to discuss a call and examine their reactions, much like the approach taken in Samaritans and Schwartz Rounds. CISDs are mandatory so no individual feels conspicuous in asking for a session. Self-care plans were developed by Cathy Phelps, executive director of the Denver Centre for Crime Victims (US). Within the first 30 days of employment, employees are required to create a plan and articulate measureable, outcome-oriented goals. Annual performance appraisals cover progress on self-care plans, which can include physical, emotional, financial, intellectual or spiritual health, such as quitting smoking, finishing a university course, and running a marathon. Attending to the whole worker underpins this approach.

Table 3.1 summarizes the various interventions we have discussed in this chapter and their various aims, conditions for success and resources required.

3.4 What Do These Examples Tell Us About Managing for Emotional Labor?

Emotional labor is a combination of self-awareness and empathy (Mastracci 2015). Self-awareness can be enhanced formally by employers that foster an environment to support the emotional labor demands on their employees, or informally by individuals emphasizing task interdependency (Grant and Patil 2012; Madden et al. 2012). Organizations can foster such an environment by recruiting and hiring individuals who are aware of their emotional responses at work and who can gauge their emotional status at any given time, and by implementing practices to cultivate emotional self-awareness and ongoing emotional management such as those listed above. Through these processes organizations can cultivate an 'ethic of care' (Lawrence and Maitlis 2012, p. 641).

To adequately recruit, train, develop and support employees, organizations must address the whole person. In a reimagined public service, public servants must be able to suppress, control and elicit their and others' emotions as the job requires,

Table 3.1 Summary of Emotional Labor interventions

Intervention	Aim	Process	Activities	Conditions for success	Resources required	Impact
Creating Learning Environments for Compassionate Care (CLECC)	To embed compassionate care approaches for older people in hospital through staff/service-user interaction and practice	Practice development practitioner/nurse delivers classroom training, reflective discussions, facilitates action learning sets and coordinates the practice observations	Action learning sets, team learning activities, peer observations of practice, reflective discussions and daily five-minute team clusters	Consistency of lead, ability to release staff; designated room available for reflective discussion, and protected time	Practice development nurse/practitioner post, and educational support costs	Developing relational capacity in teams supports the delivery of compassionate care
Relation-Centred Leadership (RCL)	To develop leadership skills in compassionate care	Appreciative relationship-centred leadership	Exploring relationships with self, patients and families through feedback including forms, feedback fortnight, daily huddles, observations	Consistent senior staff, engagement from middle managers, focusing on continual reflection, and opportunities for giving feedback and engagement	Room space	Increased self-awareness, enhanced relationships among staff, enhanced reflective thinking, and an enhanced focus on staff and patient needs
Group Supervision	Supports ability to be critical within an environment of substantial uncertainty and change	Focus on three main functions of supervision: Education, support and management	Action learning groups meet fortnightly	Staff released from clinical practice to participate on a regular basis	Facilitator	The process assists in preventing burnout, compassion fatigue, and sickness levels and therefore impacts positively on the provision of health and social care

(continued)

Table 3.1 (continued)

Intervention	Aim	Process	Activities	Conditions for success	Resources required	Impact
Mindfulness	Self-directed practice to focus attention through focussing on present-moment awareness	Can be practised at any time. Formal programmes might involve eight 2.5 h weekly group sessions, a daylong silent retreat, and a commitment to practice mindfulness activities for 45 min, 6 days a week	A range of approaches	Providing time and space to practice. Regular practice is needed to develop a 'habit' of mindfulness	Time and space	The health and well-being of staff in terms of reduced stress and anxiety. Long-term benefits included reduced employee absence caused by stress, anxiety, and depression
Restorative supervision	Co-coaching approach to process natural responses to complex clinical work to create a solution focused approach.	One-day training on co-coaching. Trained supervisors train others so that the programme will become self-sustaining	Six sessions of co-coaching	Releasing staff time for regular supervision	None after initial training	A number of studies have found reduced stress and burnout and increased levels of compassion satisfaction.
Samaritans Volunteer Support System	Support emotional health of volunteers through focus on feelings rather than problem solving	At the end of each shift, the volunteer 'offloads' to the shift leader	Volunteer summarises calls and their feelings about them. Leader assesses the emotional health of the volunteer, and if they feel they were particularly affected,	Mindset change including persuading people to stay to debrief at the end of a shift	Protected space	No formal evaluation of approach

(continued)

Table 3.1 (continued)

Intervention	Aim	Process	Activities	Conditions for success	Resources required	Impact
			they will arrange for further support			
Schwartz Rounds—Point of Care Foundation (PoCF)	To understand the challenges and rewards that are intrinsic to providing care	Structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare	Rounds take place once a month; mixed group of staff share their experiences followed by group discussion on emotional impact	Keeping a focus on reflection rather than problem solving	Contract with PoCF in the UK in order to ensure the process is implemented in a consistent and measurable manner. Commitment from senior staff	Staff who attend Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care
Critical Incident Stress Debriefings (CISDs) and Self-Care Plans	To support emotional health of staff attending critical incidents	Staff assemble to discuss a call and examine their reactions	In US these are mandatory With self care plans employees are required to create a plan and articulate measureable, outcome-oriented goals		Mandatory nature ensures complete take up	

and be rewarded for doing it well. Interventions such as those listed above support the emotional-labor demands of the reimagined public service. Organizations acknowledging the emotional dimensions of work and the emotional labor demands on their employees provide the context within which workers engage in emotional labor and minimize risk of burnout. Workers in a reimagined public service develop healthy boundaries so that they may engage in emotional labor without work becoming all consuming.

This chapter has focused on helping professions where self-awareness is integral to emotional labor and the expression of compassion because "individuals who know 'who they are' have a stronger sense of self-worth, hence, they will be less threatened and overwhelmed by another's suffering" (Atkins and Parker 2012, p. 536). As self-awareness and compassion increase, cognitive dissonance and burnout decrease (Hsieh et al. 2016). Gabriel and Diefendorff (2015) studied call center workers and observed that they were routinely engaged in 'emotion work' and undertook 'emotional labor' to manage this requirement, which was a hard task. Public servants are similarly required to manage their emotions, and require support to do this well, and protect their well-being in the meantime. They deserve nothing less.

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Sharon Mastracchi is a Professor in the Department of Political Science at the University of Utah (US). She studies emotional labor in public services, specifically among first responders and public servants in local government service delivery. She was a Fulbright Scholar to the UK in 2015 at the University of Birmingham and is part of a larger team of researchers studying emotional labor in public services across several countries, including China, South Korea, the UK and US.

Yvonne Sawbridge is a Registered General Nurse and Health Visitor by profession, and worked in the NHS for over 30 years in a variety of roles—her last post as Director of Quality and Executive Nurse in South Staffs PCT. Her move into academia afforded her the opportunity to combine her experience and expertise of practice with the rigour of a research and teaching environment and the opportunity to learn new skills. Yvonne designs and delivers a number of leadership programmes, both national and local, and her interest lies in enabling leaders to create the right environment in which practitioners can deliver of their best to patients/service users. Her main research interest focuses on the importance of emotional labor in nursing (and other health and social care professions) as a component of delivering compassionate care. Her work has reinforced her belief that well cared for staff provide the only route through which all patients can be given the care and compassion they require at their time of need. She works with organisations to share and apply this learning in practice, working through challenges together.