REGULATING EMOTIONS IN TIMES OF CRISIS

A QUALITATIVE STUDY OF HEALTHCARE MANAGERS' INTERPERSONAL EMOTION REGULATION IN THE SWEDISH INTENSIVE CARE DURING THE COVID-19 PANDEMIC

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Abstract:

Crises pose challenges for organisations, generating heavy emotional tolls on employees and other organisational stakeholders. Within these contexts, leaders shoulder a crucial responsibility in regulating negative emotions to ensure organisational survival and success. However, scholars have devoted limited attention to this area of research. This paper examines a contemporary crisis, the COVID-19 pandemic, and how healthcare managers in Swedish intensive care regulated the emotions of their employees during this time. The study was conducted using semi-structured interviews with 13 healthcare managers that had worked in Swedish intensive care during the COVID-19 pandemic and adopted a theoretical framework integrating models from the field of emotion regulation and job demand-resources theory. According to the research, managers used four main strategies to regulate employee emotions: cognitive change, attentional deployment, situation modification, and response modulation. Additionally, it was found that an imbalance between job demands and job resources negatively impacts the interpersonal emotion regulation process through exhaustion and reflective processes through time constraints. The paper reduces existing gaps in the emotion regulation literature and has implications relevant to healthcare managers and organisational decision-makers seeking to address the regulation of emotions during crises.

Keywords:

Emotion Regulation, Interpersonal Emotion Regulation, Crisis Leadership, Crisis, Healthcare

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Arvid and Harry

Definitions

Table 1

An overview of definitions

Concept	Definition
Intensive care	Healthcare involving meticulous monitoring and advanced treatment of critically ill patients (SIR, 2020).
Interpersonal emotion regulation	Regulating the emotional expressions and experiences of others (Troth et al., 2018).
Intrapersonal emotion regulation	Regulating one's own emotional experiences and expressions (Gross, 2015).
Organisational crisis	Events that are unexpected, highly salient, and potentially disruptive to organisations and their stakeholders (Wu et al., 2021).
Caesarean section	A C-section, short for caesarean section, is a surgical procedure that involves delivering a baby by making an incision in the mother's abdomen and uterus (NHS, 2023).

Abbreviations

Table 2

An overview of abbreviations

Abbreviation	Meaning
ER	Emotion Regulation
IER	Interpersonal Emotion Regulation
HCM	Healthcare Manager
HCW	Healthcare Worker
ICU	Intensive Care Unit
PPE	Personal Protective Equipment
JD-R	Job Demands-Resources
GDPR	General Data Protection Regulation

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1. Introduction

1.1. Background

Over the past few years, a series of crises including pandemics, economic recessions, and military conflicts have caused significant disruptions to the routines of individuals, organisations, and societies. One of the most notable examples is the COVID-19 pandemic, which has upended the daily lives of people around the world and prompted organisations to reassess their strategies. In Sweden, the impact has been significant, generating a dramatic loss of human life (Ludvigsson, 2023).

Early on, Swedish healthcare providers were placed under immense pressure following the massive influx of patients infected with the virus (Ludvigsson, 2023). In particular, the intensive care units (ICUs) faced a significant "capacity surge" stemming from a spike in patients experiencing serious illness (Rosenbäck et al., 2022). Simultaneously, healthcare organisations struggled with challenges such as acquiring personal protective equipment (PPE), sharing knowledge via digital platforms, and staffing appropriate personnel within intensive care operations (Ludvigsson, 2023). Because of the deficiencies, Swedish healthcare workers (HCWs) experienced immense physiological and emotional stress (Mynak, 2022) causing the need for emotional support from healthcare managers (HCMs) to increase drastically (Björk et al., 2023).

While the significance of managerial support during times of crisis in the healthcare sector is recognised by many (e.g. Jonsdottir et al., 2021), there is still a dearth of research on how managers in the healthcare industry and other sectors undertake this particular task (Wu et al., 2021). This paper dissects the strategies used by Swedish HCMs to regulate subordinate emotions and explores how contextual factors influence this task using 13 interviews with HCMs active during the COVID-19 pandemic.

1.2. Research Gap

Leaders adopt multiple strategies to regulate emotions in their interactions with followers, as noted by Diefendorff et al. (2008). Yet, few systematic examinations of leader-facilitated interpersonal emotion regulation (IER) strategies exist (Thiel et al., 2015), and, consequently, further theoretical and empirical investigation of the subject is required (Torrence & Connelly, 2019). One crucial aspect that requires attention is how contextual variables impact IER (Troth et al., 2018).

In particular, Wu et al. (2021) argue that crises represent contexts in which emotion regulation (ER) research is notably deficient despite the multitude of emotions the events commonly generate. While multiple studies have been conducted on intrapersonal emotion regulation during crises (e.g. De Clercq et al., 2022; Luu, 2021; Restubog et al.,

2020), only a few studies have dissected IER in crisis contexts. Furthermore, they either apply a simulated crisis and/or are not using a workplace sample (e.g. Temiz & Elsharnouby, 2022; Thiel et al, 2015; Uhrecký et al., 2021) or are quantitative studies exploring multiple leadership variables in relation to performance (e.g. Adams & Webster, 2022).

While few studies have been conducted on IER in crisis contexts, several studies have dissected leadership in the Swedish healthcare sector during the COVID-19 pandemic (e.g. Gadolin et al., 2022; Skagerström et al., 2023) and some in Swedish intensive care specifically (e.g. Andersson et al., 2022; Bergman et al., 2021; Hallgren et al., 2022). However, to the authors' knowledge, no studies have directed attention to the domain of IER, generating uncertainty about how emotions were managed in Swedish healthcare during the COVID-19 pandemic.

1.3. Research Purpose and Research Question

Further research is necessary to deepen the understanding of how IER is conducted in crises, particularly within Swedish healthcare during the COVID-19 pandemic. Since Swedish intensive care was faced with significant challenges during the COVID-19 pandemic (Rosenbäck et al., 2022) the context constitutes a particularly intriguing research environment.

Research on the topic could help bridge the existing research gap, offer HCMs valuable insights on how to manage HCW emotions, and shed light on the factors that contribute to the success of IER in crisis contexts. The importance of this line of research cannot be overstated, as effectively managing the negative emotions of co-workers has been proven to be critical in various contexts, including establishing leader-follower relationships (Little et al., 2012). Furthermore, as Coombs and Holladay (2005) have pointed out, stakeholder emotions towards an organisation can significantly impact its success and survival.

As a result, the objective of this study is to investigate the methods employed by managers in the Swedish healthcare sector's intensive care operations to regulate their employees' emotions amid the COVID-19 pandemic.

The research question is:

> *In what ways did healthcare managers in the Swedish intensive care regulate employee emotions during the COVID-19 pandemic?*

1.4. Delimitations

The study is delimited to HCMs' conscious IER of HCWs' emotions in Swedish intensive care settings during the COVID-19 pandemic. While ER occurs both consciously and unconsciously (Gross, 1998), researchers within the field tend to focus on consciously activated ER strategies (Gross, 2015) justifying the adoption of the same approach for this study.

The study investigates the perspectives of HCMs and not HCWs to deepen the understanding of the antecedents behind chosen IER strategies as perceived by the executors of the strategies. Furthermore, the focus is necessary given the scarce knowledge about the situation of HCMs during the pandemic (Björk et al., 2023).

The underlying mechanisms behind the formation of employee emotions are not deeply examined as it is deemed to be of psychological nature and thus out of scope for managerial studies. Further, the study does not disregard positive emotions but will be centred around the regulation of negative emotions as this constitutes the most common goal of ER processes in everyday life (Gross, 2015).

2. Literature Review

2.1. Emotion Regulation

ER has been conceptualised and operationalised in a multitude of manners, but is generally defined as "the experience and expression of emotions as determined by the activation of emotion regulation strategies" (Troth et al., 2018, p. 523). Emotions, in turn, relate to either positive or negative affective states which typically are triggered by particular occurrences, and result in inclinations towards certain behavioural reactions (Gross, 2015). As pointed out by Lawrence et al. (2011), different strategies to regulate emotions are inclined to be connected to specific negative emotions and emotion-generative events. These ER strategies generally aim at increasing, maintaining, or decreasing components of such emotions (Lawrence et al., 2011), facilitating practical responses catered to the needs of the ever-changing environment (Aldao, 2013).

The topic of ER originates from social psychology, where Gross's (1998) process model of emotion regulation quickly popularised the field of study (Lawrence et al., 2011). Lawrence et al. suggest that Gross derived inspiration from developmental psychology and, for instance, integrated psychologist Sigmund Freud's concepts on emotion generation and processing into his research. Since then, ER has expanded from psychology to many other fields such as biology, health and clinical studies (Gross, 2015). In particular, the topic is gaining ground in the organisational field, as proposed by Troth et al. (2018) referring to works from Little et al. (2012), Niven et al. (2012a,b), Zaki and Williams (2013), Côte´et al. (2013), and Kafetsios et al. (2014), which apply ER concepts to examine and explain workplace phenomena.

Within the field of organisational psychology, emotional regulation has evolved into two related directions: intrapersonal emotional regulation and interpersonal emotional regulation (Troth et al., 2018). Intrapersonal emotion regulation refers to strategies that help individuals to regulate their own emotional experiences and expressions (Gross, 2015). On the contrary, IER can be defined as applying strategies to regulate the emotional expressions and experiences of others (Troth et al., 2018).

2.2. Organisational Crises

Academics have embraced a multitude of definitions pertaining to crises. Wu et al. (2021) highlight that some scholars adopt general crisis definitions (e.g. James & Wooten, 2010) others have adopted context-based definitions and, for instance, identified business crises (e.g. James et al., 2011), economic crises (e.g. Lee & Makhija, 2009), and organisational crises (e.g. Bundy et al., 2017). For this paper, the conceptualisation of crises in the context of organisations and their environment is fitting. Wu et al. (2021, p.2) combine

the firmly established definitions of organisational crises offered by Pearson and Clair (1998) and Bundy et al. (2017) to define organisational crises as "events that are perceived by leaders and organisational stakeholders as unexpected, highly salient, and potentially disruptive".

The impact of the COVID-19 pandemic on Swedish hospitals and ICUs specifically shows similarities to the definition of organisational crises by Wu et al (2021). First, the effect of the crisis was sudden as the few first cases were registered in February 2020 and two months later, approximately 50 patients were registered into the units every day (Socialstyrelsen, 2023). Second, the crisis was also highly salient and disruptive to ICUs as the simultaneous admission of critically ill patients forced the units to reconcile organisational practices related to staffing, managerial systems, and organisational structures (Rosenbäck et al., 2022).

2.3. Crises and Emotions

While crises might generate positive emotions such as interest, love, and gratitude among involved individuals (Fredrickson et al., 2003), an organisational crisis typically generate a multitude of negative emotions (Humphrey, 2002; Lewis, 2000; Tiedens et al., 2000; as cited in Thiel et al., 2015) such as anxiety, fear and an increased need for trust (Blstakova et al., 2021). In line with these observations, the COVID-19 pandemic has been linked to increased emotions of fear and sadness across occupations and regions globally (Vemprala et al., 2021).

In the healthcare context, HCWs have experienced greater levels of emotional exhaustion during the COVID-19 pandemic compared to ordinary operations (Lin et al., 2021). Apart from emotional exhaustion, HCWs have predominantly experienced negative emotions such as fear and anxiety during the crisis, although some degree of positive emotions has been recorded as well (Sun et al., 2020). In the Swedish context, HCWs experienced multiple challenges during the COVID-19 pandemic such as high workplace demands, exposure to infected patients, a lack of competence, a lack of PPE, a lack of social support, and stigmatisation generating symptoms of mental health issues (Mynak, 2022), which can be assumed to include negative emotional displays.

2.4. Leaders' Interpersonal Emotion Regulation

As proposed by George (2000), managing individual and counterparties' emotions is crucial and should therefore be regarded as a centrepiece of effective leadership. Furthermore, Toegel et al. (2013) suggest that the crucial role of IER is magnified by an expectation from employees of their leaders to support them on an emotional level. In fact, as pointed out by Diefendorff et al. (2008), leaders apply different ER strategies in different contexts.

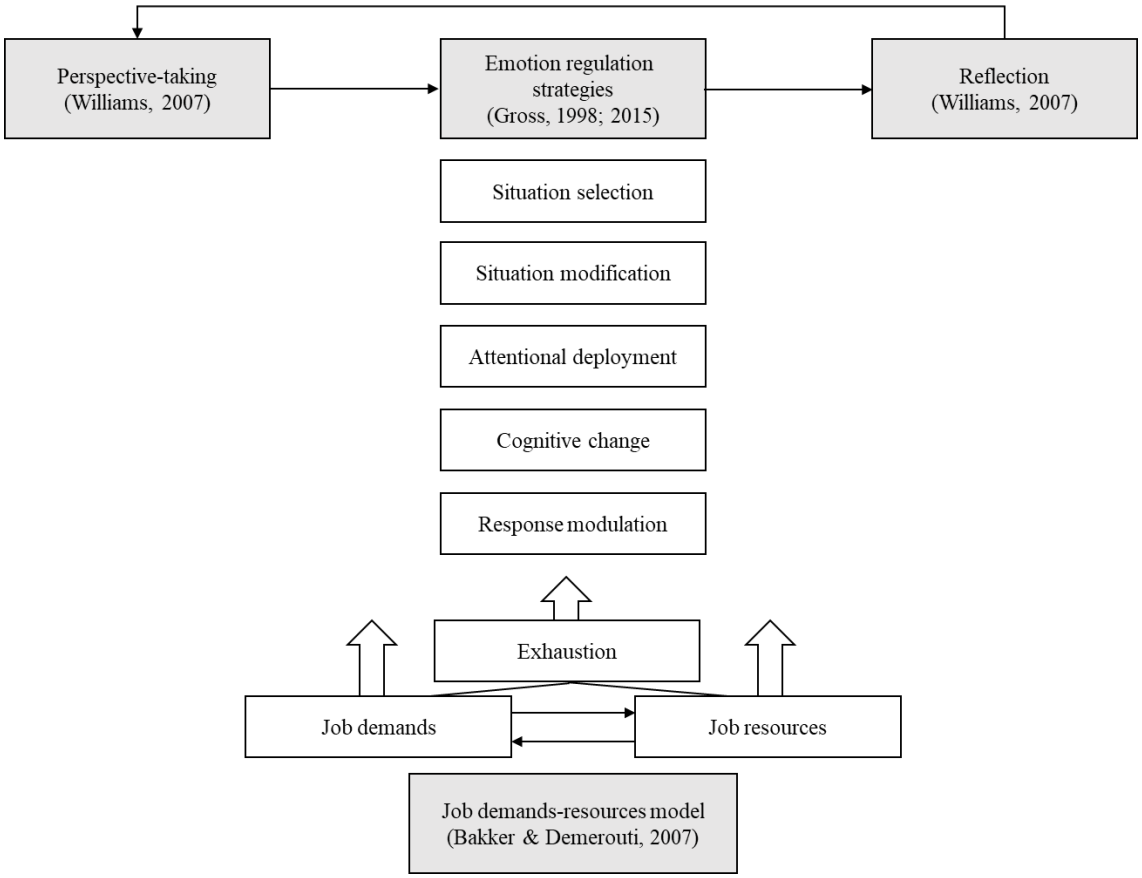
In times of crisis, such as those studied by Vemprala et al. (2021), negative emotions tend to be heightened among employees. Followingly, it becomes critical for leaders to provide emotional and psychological support to their employees, ultimately ensuring the survival of the organisation (Beilstein et al., 2021). Also, in the context of the COVID-19 pandemic in Sweden, the event seems to require clear and present leadership, with regular communication and good psychosocial support directed at HCWs (Mynak, 2022).

3. Theoretical Framework

The study integrates three theoretical models: Gross's (1998; 2015) *process model of emotional regulation*, Williams's (2007) *interpersonal threat regulation model*, and Bakker and Demerouti's (2007) *job demands-resources* (JD-R) *model*, (Figure 1). The process model of emotion regulation sets a suitable theoretical foundation for the study since it outlines fundamental ER regulation strategies. Williams's model complements Gross's model by adding two components crucial for effective IER, perspective-taking and reflection, allowing for a deeper understanding of the IER process. Finally, the JD-R model facilitates insights into how IER is affected by contextual factors inherent to the crisis.

Figure 1

Summary of the theoretical framework integrating models from Gross (1998; 2015), Williams (2007), Bakker and Demerouti (2007), edited by Nygård and Wink (2023)



3.1. The Process Model of Emotional Regulation

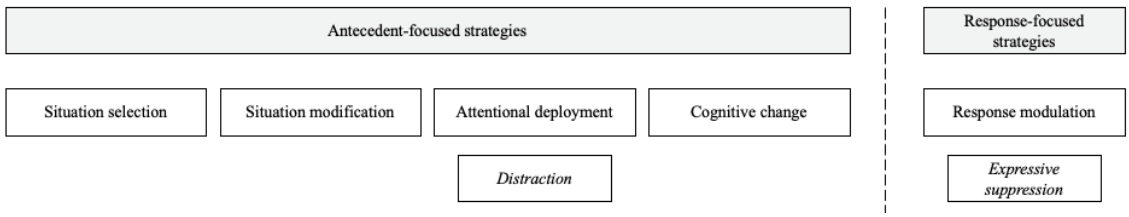
The process model of emotional regulation (Figure 2), is applied to set a strong theoretical basis for a systematic examination of leader facilitated IER as requested by Thiel et al. (2015).

The model originates from Gross's (1998) integrative review of emotion regulation. It is the most adopted framework for studies on ER within the organisational field (Troth et al., 2018) and has received significant empirical support (Little et al., 2012). Although Gross's work from 1998 still constitutes the foundation of the model, it has been refined continuously (e.g. Gross & John, 2003; Gross, 2014) to, for instance, incorporate IER (Gross, 2015).

According to the process model of emotion regulation, emotions can be regulated at five stages of the emotion-generative process (Gross, 2015). These five stages correspond to five main ER strategies: situation selection, situation modification, attention deployment, cognitive change, and response modulation, which an individual can use to affect personal emotions or the emotions of others (Gross, 2015). At the broadest level, Gross distinguishes between antecedent-focused strategies (actions conducted before an emotional response is fully activated or changed) and response-focused strategies (actions taken when emotions are fully developed).

Figure 2

The process model of emotional regulation (Gross, 2015), edited by Nygård and Wink (2023)



Situation selection refers to taking or avoiding actions that increase or decrease the likelihood to appear in a situation that could awaken desirable or undesirable emotions (Gross, 2015). An example could be when a leader transfers an employee from a department where issues have arisen, removing the employee from the emotion-generative situation.

Situation modification concerns taking action to change a certain situation to affect its emotional impact (Gross, 2015). The modifiable situation in this process is according to Gross external: it relates to physical environments and not thoughts (i.e. an internal situation). Reducing anxiety by rescheduling a meeting to take place virtually instead of physically when an issue has arisen exemplifies such a modification (Gross, 1998).

Attentional deployment refers to purposefully influencing emotions by directing the attention of a counterparty (Gross, 2015). A common strategy in this process is *distraction* (i.e. redirecting attention in a situation). Distraction could, according to Gross, be achieved by redirecting one's gaze (e.g. making someone look away from a situation), but also by shifting internal focus, for instance, by using humour to make employees laugh during a boring meeting (Little et al., 2012).

Cognitive change involves reframing one's perception of a situation to change its emotional effect (Gross, 2015). For instance, a manager could reframe a reduction in salary as a measure to prevent layoffs to change employees' emotional responses (Williams, 2007).

Response modulation involves exerting direct influence on various components of an emotional response once the emotion has fully developed (Gross, 2015). Prompting a stressed employee to calm down exemplifies this process (Little et al., 2012). *Expressive suppression* is a response modulation strategy focusing on withholding emotional expression in a situation (Gross, 2015), such as maintaining a neutral facial expression and neutral tone of voice during a frustrating meeting.

3.2. The Interpersonal Threat Regulation Model

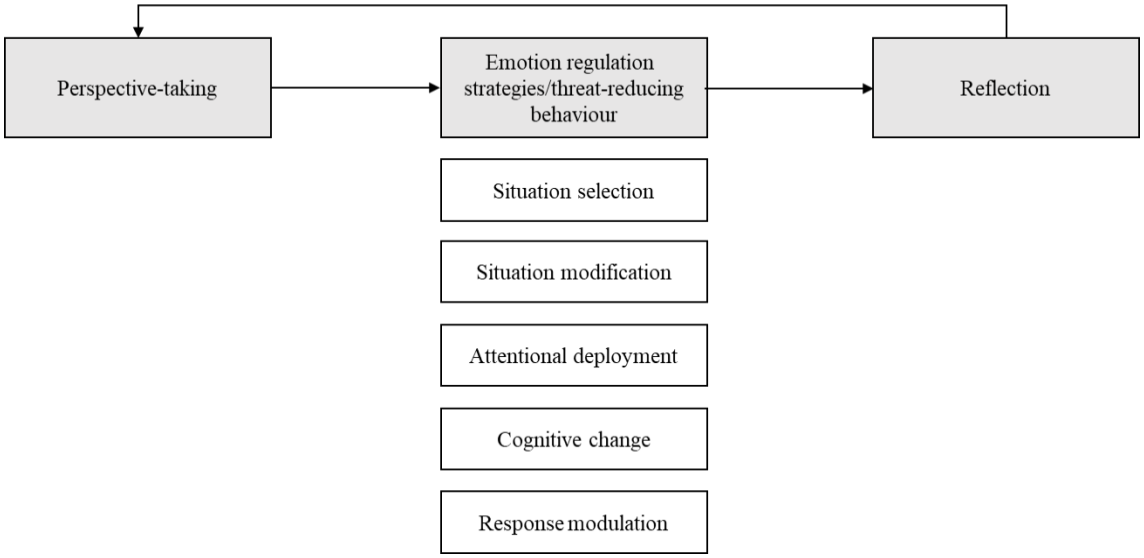
The interpersonal threat regulation model (Figure 3) is applied to extend Gross's model by incorporating perspective-taking and reflection as additional processes in IER. These additions deepen the systematic review of IER requested by Thiel et al. (2015).

Building on Gross's process model of emotion regulation, Williams (2007) developed a framework dissecting how individuals can manage others' negative emotions that arise from threats (Troth et al., 2018). Further, Williams argues that threat regulation influences the emotional responses of counterparties and the development and sustainment of counterparties' trust.

Williams's framework, the interpersonal threat regulation model, has become a ground pillar in the study of IER (Little et al., 2012; Adams & Webster, 2022), a development which Williams (2007) promoted by defining the concept as a dimension of IER. The model consists of three main processes: perspective-taking, threat-reducing behaviour, and reflection.

Figure 3

The interpersonal threat regulation model (Williams, 2007), edited by Nygård and Wink (2023)



Perspective-taking is a process by which individuals attempt to envision how events might affect others' goals, concerns, and well-being (Williams, 2007). Williams suggests that this process generates an understanding of others' probable experiences of threat and consequent emotional reactions, which is crucial information in the later selection of an appropriate IER strategy.

Threat-reducing behaviour refers to actions taken to alter a counterparties' perceptions that an event could negatively affect their goals, concerns, and well-being (Williams, 2007). Gross's (2015) ER strategies are central in this part of Williams's model. Although Williams only highlights four of the aforementioned strategies, all of Gross's ER strategies have been included in this study.

Reflection entails evaluating the impact of the applied ER strategy by analysing the counterpart's emotional and behavioural responses (Williams, 2007). Williams argues that the reflective process plays a critical role in effective ER as it enables corrective actions to be taken upon resuming the process on another occasion.

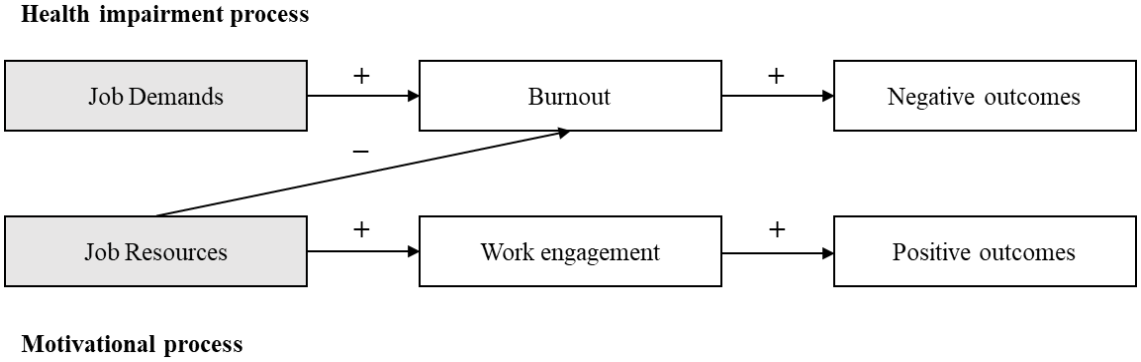
3.3. The Job Demands-Resources Model

The job demands-resources model (Figure 4) is applied to complement the previous models with additional insights into how contextual factors have influenced leaders' ability to perform IER at all, disregarding the specific strategies used. This addition is necessary to gain insight into how contextual factors influence IER as requested by Troth et al. (2018).

The JD-R model has received significant empirical support for its hypotheses via studies in various contexts (Bakker & Demerouti, 2007). For instance, in their review, Schaufeli and Taris (2014), found that twelve of sixteen studies provided full support for its key hypotheses whereas the remaining four provided partial support.

Figure 4

The job demands-resources model (Bakker & Demerouti, 2007), edited by Nygård and Wink.



The JD-R model highlights how job characteristics either can be categorised as job resources or job demands depending on the nature of the situational variables. Aspects of the job that require sustained cognitive or emotional efforts are categorised as job demands whereas job aspects that, for instance, facilitate goal-acquisition, reduce job demands, or foster learning can be categorised as job resources (Bakker & Demerouti, 2007). Followingly, examples of job demands could include emotional demands, high workload, and role ambiguity whereas job resources could consist of supportive colleagues, performance feedback and role autonomy.

The JD-R model also highlights how job demands and job resources interact in two dual processes to produce different personal and organisational outcomes. First, high job demands and low, buffering, job resources produce negative organisational outcomes via mental exhaustion (burnout) such as impaired job performance (Taris, 2006; Bakker et al., 2008), and reduced prospects for effective leadership (Shanafelt et al., 2020). Second, when job resources are high, positive personal and organisational outcomes are to be expected as mediated via increased engagement stemming from the resources (Bakker & Demerouti, 2007).

3.4. Theory Discussion

The application of Gross's and Williams's models could be critiqued as they do not incorporate the responses of the IER target but treats IER as extrinsic and response-independent which might not serve the true nature of reality according to other models (e.g. Côté et al. 2013; Zaki & Williams, 2013). Nevertheless, the response-independent

ER models constitute the most viable and widely applied models for researching one-way ER (Troth et al., 2018) as is aligned with the leader-centric focus of this study.

Additionally, critics might argue that Williams's interpersonal threat regulation model has limited applicability beyond its original purpose of analysing trust-building in collaborative projects. Although the model has been applied for this purpose in many studies (e.g. Little et al., 2012) influential works on IER have, much like this paper, used the model to analyse relationships between the application of some IER strategies and emotional displays (e.g. Little et al., 2013). Therefore, this study disregards the second component of Williams's model which primarily concerns the impact of threat regulation on the counterpart's development and sustainment of trust.

Concerns could also be raised against the application of the JD-R model to investigate the impact of context on IER processes as the model has not previously been applied to serve this purpose. However, the JD-R model has been applied to gauge various types of performance across multiple contexts and occupations (e.g. Bakker et al., 2004; Bakker et al., 2008), leadership performance as related to positive organisational outcomes (e.g. Lattrich & Büttgen, 2020) and even leadership success among Swedish HCMs during the COVID-19 pandemic (Björk et al., 2023). In light of IER being acknowledged as a pivotal aspect of leadership (George, 2000), the research topic bears resemblance to the one investigated by Björk et al. (2023). Hence, it is reasonable to employ the JD-R model in this paper as well.

4. Methodology

4.1. Research Philosophy

The paper adopts an interpretivist research philosophy, specifically within the strand of phenomenology which is particularly concerned with dissecting and interpreting the lived experiences of individuals (Saunders et al., 2019). Followingly, the study rests on a subjectivist ontology, where reality is viewed as socially constructed and complex, aligned with the view of IER as embedded within a sociocultural context (Thiel et al., 2015). The epistemological approach revolves around gathering and interpreting the perceptions of HCMs to generate new knowledge and a deeper understanding of HCMs' perspectives. Finally, the axiology rests on value-bound research where the researchers themselves constitute a part of the subject being researched as their interpretations guide the analysis of empirical material.

4.2. Methodological Choices

Qualitative research methods are typically employed when researchers need to explore the interpretations and meanings of a complex phenomenon (Frostling-Henningsson, 2017) and enable participants to express themselves candidly (Fossey et al., 2002). As such, this study employs a qualitative approach to gain a deeper understanding of the phenomenon under investigation. Quantitative measures, such as Emotion Regulation Questionnaires (Gross & John, 2003), are useful for identifying ER strategies at a broad level. However, when exploring ER in greater depth, as done in this study, such quantitative tools may not be as effective.

IER in crisis contexts constitutes a relatively unexplored field (Wu et al., 2021). Followingly, the study has been conducted in an exploratory manner, adjusting the research direction considering new insights, as is suitable for understudied research areas (Saunders et al., 2019). The study adopts a cross-sectional research design, which was reasonable given time- and resource constraints.

4.3. Approach to Theory Development

The study was conducted using an abductive approach, whereby empirical data and theoretical framework were developed concurrently. As Alvesson and Sköldberg (2017) argue, such an approach allows for an alternation and successive reinterpretation of theory and empirics, which was deemed suitable given the study's exploratory approach and the interlinked need to stay alert for new empirical and theoretical findings. Subsequently, the theoretical framework initially integrated the ER models by Gross (2015) and Williams (2007), however, upon an examination of the empirical data, the JD-R model

(Bakker & Demerouti, 2007) was added to aid the understanding and analysis of the research phenomena.

4.4. Data Collection and Analysis

4.4.1. Data Collection Technique

The study was conducted using a mono-method approach, applying semi-structured interviews as the single data collection technique. Conducting semi-structured interviews was deemed appropriate as they effectively generate an understanding of the factors contributing to participants' decisions, attitudes, and opinions (Saunders et al., 2019), which aligns with the study's phenomenological paradigm. Further, semi-structured interviews offer flexibility for the interviewer to explore topics they deem significant (Leavy, 2020) and, on the opposite side, for the interviewee to express recollections and interpretations they value (Bell et al., 2019).

4.4.2. Sampling Technique

Given time, resource and practicality constraints, a census was ruled out in favour of sampling the target population. Specifically, Robinson's (2014) four-point approach to sampling (defining the sample universe, deciding sampling size, selecting sampling strategy, and sampling sourcing) was applied as it is suitable for qualitative research projects.

To define the sample universe, a range of inclusion criteria was created (Table 3). This formed a sample group of various leaders in intermediate management positions that had led subordinates within intensive care settings during the COVID-19 pandemic.

Table 3
Overview of Inclusion Criteria

Inclusion criteria
Managerial position within intensive care
Active during the COVID-19 pandemic
Swedish or English speaking
Personnel responsibility

The group exhibited homogeneity given that all participants shared the experience of the pandemic and had similar occupations on similar hierarchical levels during the crisis. Simultaneously, the group exhibited demographic, geographic, physical, and psychological heterogeneity, allowing for a display of various worldviews. In particular,

the informants displayed geographical heterogeneity, belonging to a range of different hospitals in different regions of Sweden. To effectively sample this group, a sample size of 10-15 participants was set.

The inclusion criteria informed a purposive homogeneous sampling strategy as is reasonable to still the need for applicable information-rich empirical data (Robinson, 2014), fits practicality constraints and, according to Saunders et al. (2019), suits explorative studies. The sampling sourcing process relied on information accessible via public search engines and ultimately generated a sample universe of 49 prospective participants. The prospective participants were contacted through an outreach email (Appendix A).

The researchers conducted 14 out of 15 scheduled interviews, as they determined that theoretical saturation had been achieved. One interview was excluded from the study as the informant was found to have limited experience from working in intensive care. In total, participants from 10 different hospitals in 10 different regions across Sweden were interviewed (Appendix B).

4.4.3. Interview Process

An interview guide consisting of broad questions was designed in preparation for the interviews (Appendix C). When structuring the guide, light questions were placed first to establish rapport, which is highlighted as crucial to achieving cognitive access by Saunders et al. (2019). Gross's (2015) and Williams's (2007) theories served as an inspiration for the key topics. The interview guide was not treated as a fixed blueprint but rather used as a flexible guide, enabling exploration and follow-up of emerging themes in alignment with the exploratory research approach. When new or vague insights emerged, probing follow-up questions were asked to clarify meaning.

All interviews were conducted via internet-mediated forum, Microsoft Teams, with both authors being present to ask questions and take notes (Appendix D). This approach was suitable given the geographical disparity of the target population and that internet-mediated interviews enable both the researcher and participant to stay within their own secure and comfortable environments (Hanna, 2012). After all interviews had been conducted, transcripts were returned to informants to allow them to comment, correct, and validate their accuracy, aligned with the process of participant validation (Saunders et al., 2019).

4.4.4. Data Analysis Method

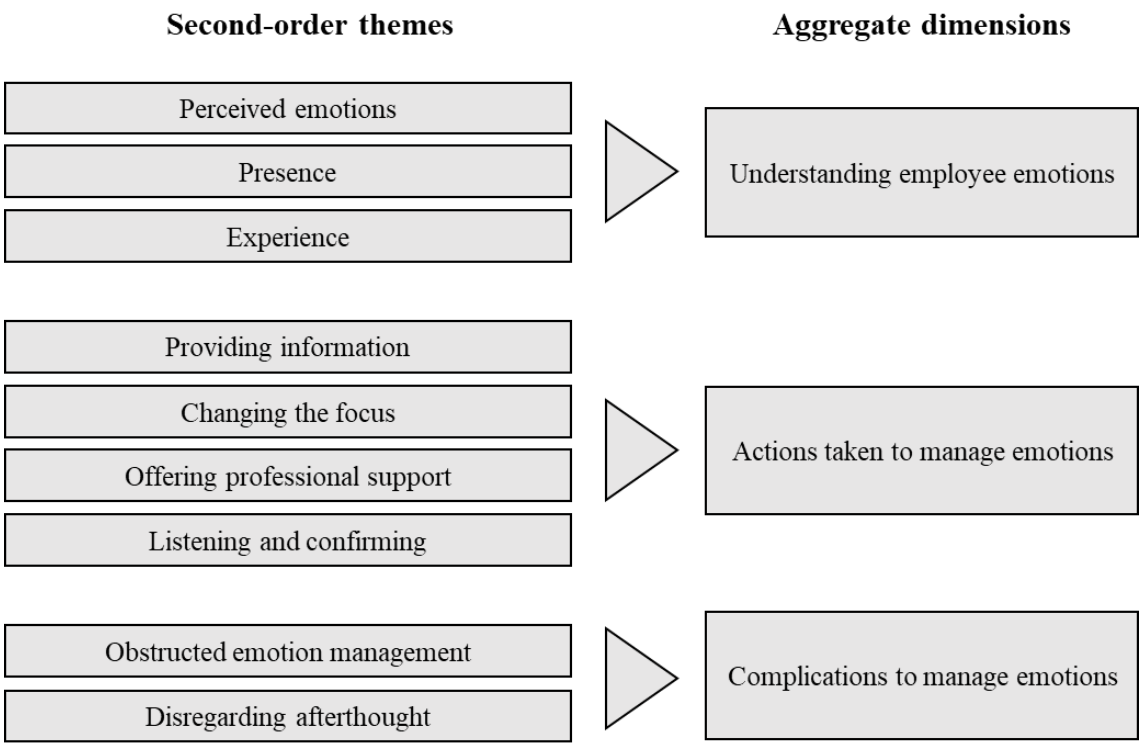
After consent from the interviewees, all interviews were recorded and transcribed. To avoid influencing each other's understanding of the data and consequently risk neglecting important data, the empirics were initially reviewed individually by the authors. The transcribed text data was then analysed in unison using thematic analysis.

As suggested by Saunders et al. (2019), and given the study's abductive approach, the search for themes was guided by theory and the research purpose, but along the data analysis, themes were continuously altered or added. Data was reviewed continuously along the research process in a recursive fashion, allowing old and new data to refine the search for themes. This helped the authors to remain alert for alternative explanations to patterns and theory throughout the process, thereby avoiding narratives supported only by the authors' values (Saunders et al., 2019), as is aligned with a reflexive research process.

Underlying the exploration of themes was a coding process (Appendix E). All transcripts were coded guided by the research purpose, question, and theory. The list of codes was expanded during the process, and when new codes were added, transcripts were re-coded, aligned with the concept of constant comparison (Saunders et al., 2019). The identified codes were transformed into first-order concepts, which were then aggregated into nine second-order themes, and finally, into three aggregated dimensions.

Figure 5

Overview of the empirical material



4.5. Ethical Considerations

4.5.1. The Ethical Position

The research paper adopts a deontological ethical positioning, implying that formal rules have guided the researchers' conduct (Saunders et al., 2019). The rules include the student handbook of the Stockholm School of Economics, national regulations, and international regulatory frameworks such as the General Data Protection Regulation (GDPR).

4.5.2. Voluntary Participation and Informed Consent

Internet-mediated methods were used to gain multi-organisational access to primary data sources. The participants were informed of the voluntary nature of their participation and their right to withdraw provided data at any time under GDPR requirements. Ahead of the interview, it was also required that participants signed a consent form reiterating the rights of participation. In addition, sufficient information about the project including the confidentiality of participation, the format of data collection, the estimated time frame of interviews, and the interview topics were provided. This procedure ensured that the principle of informed consent was met (Saunders et al., 2019). Responsible behaviour was exercised at all times, including exercising appropriate internet netiquette.

4.5.3. Privacy and Confidentiality in Data Management

Ensuring anonymity was vital in this paper due to the nature of the information disclosed by participants, which included data about themselves and third parties. Followingly, the names of the participants and other identifying details were disguised in transcripts and final material. The data was stored on a password-secure computer only accessible to the researchers.

Personal data in the form of names, email addresses and occasionally telephone numbers were collected through publicly available information databases. The collection of personal data was restricted to minimal contact information.

4.6. Method Discussion

To maintain *credibility* and mitigate eventual bias, the authors exercised responsible behaviour (section 4.5.2) and conveyed confidentiality (section 4.5.3) at all times. These measures should also have increased trust, which is crucial as Saunders et al. (2019) argue that building rapport with interviewees can increase credibility by reducing interviewer and response bias. In fact, the authors noticed in multiple interviews that leaders became emotional when discussing the matter, tearing their eyes, and enthusiastically conveying their perceptions on the topic. This sign of vulnerability could imply a successful establishment of trust (Nienaber et al., 2015). Additionally, the authors' application of

constant comparison (section 4.4.4), being two interviewers, and conducting participant validation (section 4.4.3) should have increased the credibility further (Saunders et al., 2019). While all these measures increased the *authenticity* of the study, Shannon and Hambacher (2014) highlight how participant validation is especially important in generating an authentic representation of viewpoints.

The study's interpretivist nature, application of semi-structured interviews, and cross-sectional design, challenge the study's *transferability* since the research captures socially constructed interpretations of the participants within a specific context and time (Saunders et al., 2019). To mitigate this, the authors have with full transparency provided an extensive description of the research design, question, context, and findings, as suggested by Saunders et al. Moreover, the inclusion of participants from diverse geographical locations enhances the transferability of findings by capturing additional contextual variations. This, in combination with thorough descriptions and argumentation for data collection and analysis, is provided to increase *dependability* as a response to the low standardisation of semi-structured interviews that Saunders et al. highlight.

The authors had no personal relationships or previous experience within the research area that could have steered the research in any predetermined direction. Additionally, all empirical data has been recorded, transcribed, and then analysed according to Saunders et al. (2019) procedure of thematic analysis to maintain *confirmability.* This procedure allowed different viewpoints of the informants to be incorporated into the study, ultimately strengthening its authenticity.

5. Empirics

For transcription symbols, see Appendix F.

5.1. Understanding Employee Emotions

5.1.1. Perceived Emotions

HCM perceived that their employees frequently expressed fear about being infected with the virus and spreading the disease to relatives in the initial stage of the crisis. According to the managers, these emotions were amplified by healthcare resources that were perceived as lacking and a general uncertainty about the effectiveness of organisational routines.

> *"They were worried about their health, they were worried about… their families because, during the first wave, it was unclear whether one would get seriously ill or if they would bring the infection to their loved ones. It was a bit unclear what measures we should take to prevent the spread and if those measures were sufficient." - Manager A*

HCMs recollected how employees grew increasingly agitated and worried with the changing workplace routines during the next-coming stages of the crisis, commonly complaining about new schedule structures and longer work hours.

> *"So from one day to another we had to say, tomorrow your schedules won't apply anymore and we will work twelve-hour shifts and you'll work two weekends every month. The single parents who had children cried and said, this will never work, we won't be able to manage our lives." - Manager K*

> *"Some of those who worked Monday to Friday suddenly had to do shift work and work on weekends and at night, we simply had no choice. That was something that created irritation and aggression." - Manager I*

HCMs reported that employees were feeling exhausted as the crisis progressed further, citing the ongoing demanding workload and the need to mobilise repeatedly as the reasons behind their drainage of energy.

> *"[...]but when it was time to mobilise again, it was not the same enthusiasm… they were quite tired because people had worked so much and the patients were so ill… there were also significantly more patients per staff member than what they were used to." Manager D*

Irrespective of the phase in the crisis, HCMs noted that their employees expressed anxiety-ridden emotions in relation to the compromises of healthcare quality that had to made to treat more patients. These emotions were commonly referred to as ethical stress.

> *"I believe that intensive care nurses experienced the greatest ethical stress because they did not feel that they were providing the same level of good care (as they did before)." - Manager E*

> *"[...] intravenous drips weren't changed as often, medications weren't diluted as often, maybe the patients weren't washed as often, and as a nurse used to being in control of everything and accustomed to carrying out their work exemplarily… they know that it's important, and that it's truly vital to provide that care, so the ethical stress was burdensome for many staff members." - Manager C*

5.1.2. Presence

As can be inferred from previous recollections, HCMs exhibited an extensive perception of different emotional states of their subordinates at different stages of the crisis. When explaining the emotions they perceived and how they were able to gauge them, HCMs often referred to their experiences from supporting employees emotionally on the ground.

> *"It was very clear (the emotional expressions), actually. I remember a time when I was about to enter a room for a meeting to inform everyone about how we would proceed. And when I opened the door, it felt like I was cutting through ice. It was such an uncomfortable atmosphere, and you could really feel how worried everyone was and how heavy it was." - Manager I*

> *"[...] I was in the break room at the ICU talking to them during the day, we talked about how everything was. My room was located between the intensive care unit and the operating room, so people could pass by. So, you see, it's not like I was somewhere else, but I was right in the middle of it." - Manager F*

5.1.3. Experience

Further, HCMs could often utilise their experience from working clinically to understand the emotions felt by newly transferred personnel. Manager E illustrates this as she explains how she put herself in the shoes of a newcomer when a pregnant woman infected with the COVID-19 virus passed away after an emergency caesarean section was performed.

> *"There I had to step back because I realised that... many of us who were there (regular intensive care personnel), we perform caesarean sections almost every day. We don't consider caesarean sections as surgery at all, but suddenly we realised that it's another level here, it's not just about taking care of a sick young person, but*

actually, many of those here, despite being nurses, specialised nurses, nursing assistants, have never seen a surgery in their entire life, especially not a caesarean section which is very… tangible, so to speak."

HCMs clinical experience also made it easier for them to comprehend the emotions of regular intensive care employees. One example concerns inadequate healthcare resources, such as PPE.

"The employees suffered from extensive anxiety concerning the face masks because they did not trust them. Initially, we had quite tight and sturdy face masks, all of which had a filter attached. They disappeared quite quickly, and it was difficult to get good masks, and later some that were called coffee filters came along. It was a big difference, and the staff didn't feel calm and secure with them because when you tied them on, they didn't fit tightly, and you could feel them slipping." - Manager C

5.2. Actions Taken to Manage Emotions

5.2.1. Providing Information

At the beginning of the crisis, HCMs emphasised the importance of providing as much information as possible to HCWs both about the virus and what procedures were thought to help tackle the spread of the disease, as illustrated by Manager C.

"To go out and try to calm them down, inform them about what applies, what I know about this disease right now, and that we are not in any way risking anyone's health, but rather, what we are doing is based on what we know and that they can feel safe in the knowledge that we would not do anything else, I think that was super important."

Manager E also highlights the importance of providing information to individuals in unfamiliar situations as she reflects on the incident with the caesarean section. While this information concerned the procedures of intensive care operations rather than the COVID-19 virus, they illustrate the same concept.

"[...] I just brought the whole group into a room and explained to them why we did this. Because if you don't have the knowledge, it feels completely unnatural. When you have just gotten used to having patients lying in a supine position intubated, and then you have to be involved in a caesarean section."

5.2.2. Changing the Focus

During the next-coming stages of the crisis, leaders emphasised the need to change subordinates' focus from the challenging situations at their departments, commonly

highlighting the crucial role of healthcare personnel in battling through the crisis for the sake of the citizens to their employees.

> *"[...] you need to get people to understand that we have a mission and that we need to rethink and let all distractions outside of the mission find their place, we're still here to do our job, here to do this job that we have been assigned. We understand that everything else has an impact, but it's important that when we are at work, we need to focus on the task." - Manager A*

> *"At the same time, you must keep people in good spirits, and then you have to simply say that normally we do it this way, now that's not possible, so we do the best that we can (for the patients) and you can't do more than your best. So even if you thought this is bad, it's not bad because if we hadn't done anything, it would have been even worse." - Manager B*

5.2.3. Offering Professional Support

In the later stages of the crisis, as employees became increasingly drained of their energy, HCMs provided emotional support by calling in external expertise such as psychologists and unit counsellors.

> *"And then the other thing that got a lot better, and it was also during the second wave, was that we had a counsellor who worked at the hospital, but who was then dedicated to the ICU. She wasn't there all the time, but she held debriefing conversations after… you could go and talk to her after your shift or during your lunch break." - Manager K*

> *"So… we had supervision two days a week here with a counsellor to discuss the issues that we actually can't influence, but that we feel frustration, sadness and powerlessness about." - Manager I*

5.2.4. Listening and Confirming

HCMs generally emphasised listening to employees and confirming their emotions as crucial throughout the crisis and something they performed continuously in various contexts.

> *"I tried all the time to be there for them and their emotions, they could vomit (emotions) on me… in a way that you may not to colleagues. Everyone needs somewhere to vomit when there are difficult emotions, and I was good at receiving vomit and being a shelter so to speak, and that often sufficed." - Manager G*

> *"I got to listen a lot, really a lot, and just let them be mad and say: well, put it on me then if it feels better for you, put it on me." - Manager I*

Moreover, HCMs underscored the significance of refraining from exhibiting their own negative emotions to employees to prevent their transmission. According to many of them, this approach allowed them to effectively handle the multitude of emotions conveyed by HCWs.

> *"My job during the day was to be strong when facing my employees. It's still a conviction of mine… it's not that I can never show vulnerability as a boss, but if they are to come to me, I can't sit there and cry. You see, it's not possible, so I had to be the strong one." - Manager G*

> *"This is a job, I step into that role. And my role at work is to do this job. Then I put my emotions aside. [...] Many times it simply required an approach where in order to manage people, emotions, and the mission, I had to enter this role." - Manager A*

5.3. Complications to Manage Emotions

5.3.1. Obstructed Emotion Management

The HCMs expressed how they, at times, found it challenging to manage the emotions of their employees during the crisis. These difficulties were mainly attributed to the demanding nature of the managerial roles, particularly the heavy workload which resulted in limited attention being given to the employees.

> *"However, the staff needed a lot of support in the situation. It was a strange situation. We all worked a lot. So, gradually, I became quite exhausted as well. And it was difficult to provide support because I was so tired because we in the management team worked a lot more than everyone else." - Manager H*

> *"I didn't really have the opportunity to take care of the staff because… us managers were also working around 80-hour weeks. We were working all the time and on weekends as well. The days were very long, but unfortunately, there wasn't enough time to be there for the staff as we would have needed to" - Manager D*

In relation to this challenge, HCMs often highlighted a lack of emotional and administrative support from their own managers and other hospital functions. A condition that they reckoned further hindered them from managing employee emotions at all.

> *"I did not have a present boss, and I probably needed a mentor or someone to confide in or someone who could just be there sometimes and say I understand your feelings, but pull yourself together and keep going. Sometimes you just need to hear it." - Manager G*

> *"(support) was not something that we were offered, and I do have a boss. I think it took three weeks before that boss called and asked how things were. It was pretty absurd." - Manager L*

"And all the practical stuff, it fell on us managers. We didn't get any help from HR with scheduling, arranging transportation, nothing - everything was on us. And if I didn't need to deal with that, then I could have spent more time among the staff and just been there." - Manager K

HCMs commonly expressed how these conditions collectively impacted their own well-being, often highlighting emotions of exhaustion.

"It was an incredibly large amount of work. So, one was quite exhausted, I believe we worked around 80-hour weeks for a longer period. It was very long days. So naturally, one didn't feel very energetic." - Manager D

"I was really tired and I remember that I was sitting and crying at some meeting because I was just so damn tired. I said, I can't take it anymore, I'm going to quit." - Manager J

5.3.2. Disregarding Afterthought

Many HCMs emphasized that, if they were not too exhausted to manage employee emotions, the sheer volume of tasks often made it challenging to thoroughly review the ways in which they did it. Consequently, such processes were frequently postponed to a later time.

"We didn't even have time for it (reflection). There wasn't much reflection on it (emotion management practices) at the time, actually, because there were so many pieces overall to address and just getting everything to work with the staff." - Manager D

"To be honest, I don't think that at the time I reflected on it (emotion management practices) that much. There was a lot of work during the pandemic. There wasn't much reflection then. You just kept going, so to speak." - Manager L

6. Analysis

6.1. Perspective-Taking

HCMs demonstrated extensive perceptions about employee emotions, what had caused them and how they should be managed. This process of imagining and understanding others' emotions implies that HCMs were heavily engaged in the process of *perspective-taking* (Williams, 2007).

Importantly, the empirics support that two specific enablers strengthened HCMs' ability to engage in perspective-taking: presence and experience. The enablers aided HCMs in two different manners; an extensive presence allowed HCMs to pick up emotional displays, while their experience provided a deeper understanding of the underlying factors behind emotional displays as they had undergone similar events themselves.

Williams (2007) argues that perspective-taking provides the necessary information about the target to select suitable responsive actions. Followingly, the extensive engagement in perspective-taking adequately explains why the empirics show that HCMs were able to act and regulate the emotions of HCWs later in the IER process.

Subconclusion: HCMs were consistently capable of understanding the meaning that different situations held for subordinates via extensive experience and presence that facilitated proper perspective-taking, in turn allowing for thoughtful activation of IER strategies.

6.2. Interpersonal Emotion Regulation Strategies

A pattern of specific IER strategies can be connected to specific emotional expressions perceived by HCMs throughout the pandemic. According to Williams (2007), these emotional expressions can be understood as the outcomes of anticipated threats to subordinate (1) goals, (2) concerns, and/or (3) well-being.

6.2.1. Cognitive Change

In the early phases of the crisis, emotions of fear were commonly perceived by HCMs. These emotions can be linked to the risk of becoming infected with COVID-19 resulting from a lack of organisational resources. According to Williams (2007), these expressions of fear can be interpreted as the result of an anticipated threat to the physical well-being of oneself and others.

To manage these emotions HCMs provided extensive information regarding what they knew about, for instance, the disease and practices to hinder the spread. By providing information, the HCMs perceived that they could positively modify the employees'

appraisal of the external situation, qualifying the strategy as one aligned with *cognitive change* (Gross, 2015).

Subconclusion: At the beginning of the crisis, emotions of fear were prominent, explained by a threat towards the HCWs' physical well-being. HCMs managed these emotions by providing information to ultimately alter subordinate appraisal of situations.

6.2.2. Attentional Deployment

During mid-crisis, empirics show that fear was increasingly switched out for emotions of anger and worry. These emotional displays were frequently connected to changes in workplace routines. Followingly, these emotional displays can, using William's (2007) model, be interpreted as connected to a perceived threat to mental well-being.

To regulate these emotions, HCMs conveyed the importance of focusing on saving patients and citizens, reaffirming the crucial role employees were filling for the sake of society. This suggests managers perceived that they could redirect the employees' focus from changed routines to saving lives, implying that the HCMs used *attentional deployment* (Gross, 2015). This can be seen as an internal *distraction* since HCMs shifted the thoughts of the employees rather than redirected their physical gaze (Gross, 2015).

Subconclusion: To manage emotions of anger and worry related to the threat to mental well-being at the later stages of the crisis, the attentional deployment strategy in the form of internal distraction was frequently applied.

6.2.3. Situation Modification

In the late phases of the crisis, emotions of exhaustion had been drastically amplified as multiple demands interacted to grow increasingly tiresome. From the perspective of Williams (2007), these more prominent emotional expressions can be linked to an elevated threat to mental well-being.

In response, HCMs more frequently utilised professional resources such as external psychologists and unit curators, in favour of the HCWs. Adding professional resources to the physical environment would, according to Gross (2015) suggest that the HCMs used *situation modification* since the situation was physically modified for the employees when the availability of support increased.

Subconclusion: As the crisis progressed, an elevated threat to mental well-being caused emotions of exhaustion. HCMs responded by modifying the workplace situation for employees by increasing the professional support mandated to employees.

6.2.4. Response Modulation

Unrelated to any individual threat and phase of the crisis were actions revolving around actively listening, confirming, and accepting employee emotions of different natures as they were expressed to HCMs. These relate to threats to ethical concerns as sprung out of compromised healthcare, physical well-being, and mental well-being at different times during the crisis.

Actively listening, confirming, and accepting employee emotions could only be achieved when the emotional response of the employees was already developed. Followingly, this approach is deemed a response-focused strategy, and in particular, the strategy of *response modulation,* allowing the HCMs to influence the employees' emotional responses by listening to HCWs' stories and processing them together (Gross, 2015).

The empirics also show that HCMs actively withheld their own emotional expressions to allow employees to openly convey their emotions to the HCMs. This implies that HCMs used *expressive suppression* (Gross, 2015) to facilitate interpersonal response modulation.

Subconclusion: HCMs used response modulation to manage the emotions of employees throughout the crisis in relation to all three primary threats, as facilitated using personal expressive suppression.

6.2.5. Exhaustion and Interpersonal Emotion Regulation Strategies

The empirics indicate that the high workload, at times, posed challenges for the HCMs to engage in IER at all. According to the JD-R model (Bakker & Demerouti, 2007), the high workload generated by increased administrative pressures can be considered as an extensive job demand imposed by the crisis. In contexts of high job demands it is crucial to have buffering job resources to hinder burnout and boost personal engagement (Bakker & Demerouti, 2007). However, instead of having such buffering resources at hand, HCMs mention a lack of administrative support and emotional support to counter these demands. Thus, buffering resources were the most limited when they were needed the most.

This interaction between extensive job demands and limited buffering of job resources predicts leaders could experience multiple negative outcomes, most prominently experiencing exhaustion (Bakker & Demerouti, 2007), a tendency displayed in the empirics. Exhaustion has been linked to impaired job performance (e.g. Taris, 2006; Bakker et al., 2008) and reduced prospects for effective leadership (Shanafelt et al., 2020) and in this study, impaired prospects of engaging in IER as leaders lacked the capacity to apply IER strategies.

Subconclusion: The crisis context imposed extensive job demands related to a high workload, which in combination with a lack of buffering job resources generated exhaustion among HCMs that, at times, hampered the activation of IER strategies.

6.3. Reflection

When IER processes were not obstructed by exhaustive emotions, empirics highlight how follow-up processes on IER still were more limited than compared to normal operations due to the high workload and limited support provided to HCMs. This indicates that *reflective* processes, the third process in Williams's (2007) framework, were hindered by the conditional factors.

The extreme workload and lack of support conveyed by HCMs, which according to Bakker and Demerouti (2007) can be viewed as an imbalance between job demands and buffering resources could also explain the impaired reflective process. However, this effect cannot be clearly linked to exhaustion based on the empirical material, but rather that the conditions reinforced time constraints that hindered HCMs from engaging in reflection.

Followingly, the HCMs indicated a limited capability to directly assess the emotional responses to their implemented strategies, also reducing the possibility to self-correct for insufficient, inaccurate or inappropriate IER (Williams, 2007). Since lacking corrective actions, the prospects for continuous effective regulation of employee emotions were worsened (Williams, 2007).

Subconclusion: When emotions of exhaustion did not fully obstruct the IER process, reflective processes often were still impacted due to the imbalance between job demands and job resources reinforcing time constraints. Followingly, conscious adjustments of IER strategies were limited, in turn leading to worsened prospects for continuous IER improvement.

7. Discussion and Conclusion

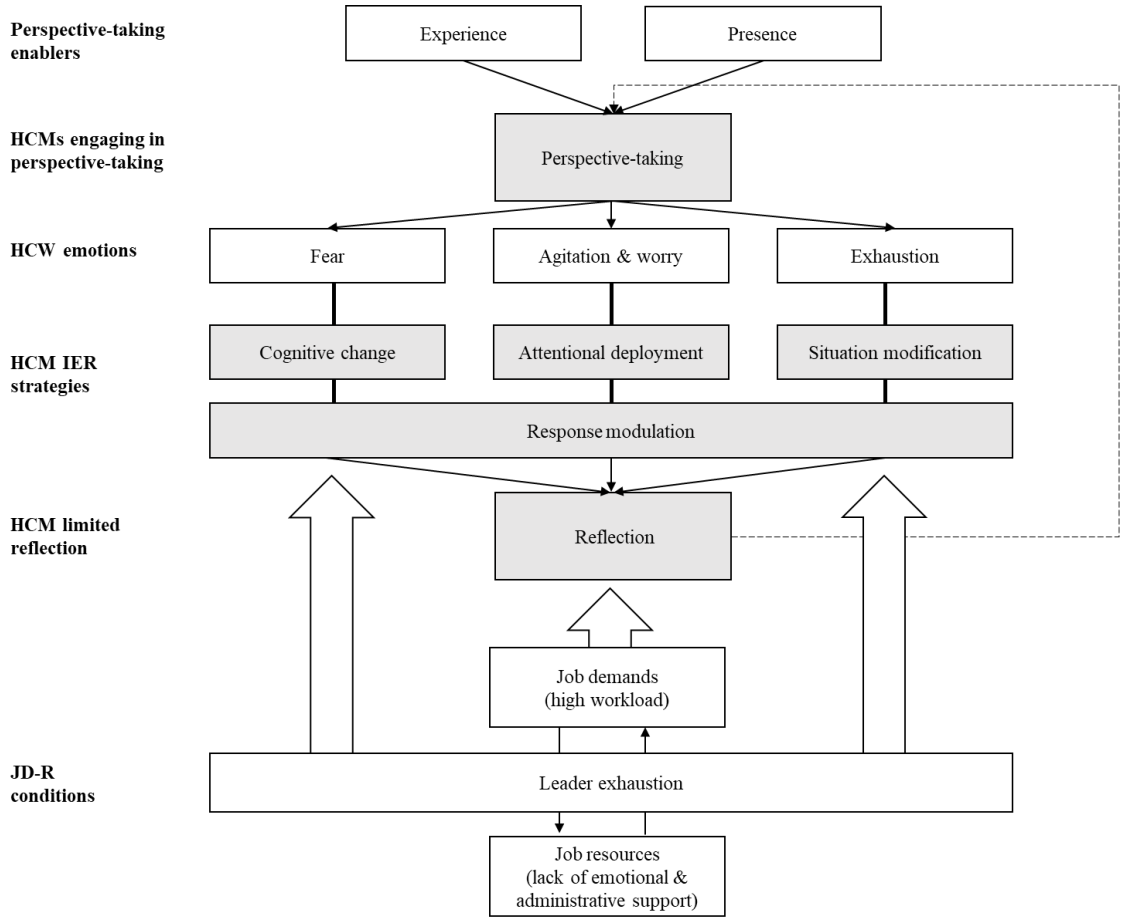
7.1. Answer to the Research Question

This study has examined how managers in the Swedish healthcare industry operated to manage their subordinates' emotions in a crisis context by investigating the research question:

> *In what ways did healthcare managers in the Swedish intensive care regulate employee emotions during the COVID-19 pandemic?*

Figure 6

An overview of how HCMs regulated employee emotions during the crisis



First, engaging in perspective-taking allowed HCMs to comprehend the emotions that the crisis awakened among the employees, which guided the later activation of an IER strategy catered to the specific emotional response. The perspective-taking process was facilitated by being present in the workplace and utilising professional experience. Followingly, the HCMs could primarily perceive emotions of fear in early crisis stages,

agitation and worry in mid-crisis phases, and exhaustion in the later stages of the crisis. These emotions have been found to mainly originate from perceived threats towards physical well-being, mental-wellbeing, and ethical concerns.

Second, the HCMs applied four main IER strategies that allowed them to regulate employee emotions. Activating cognitive change by providing information reduced employees' fear. Conveying the importance of saving lives implied a strategy of attentional deployment in the form of distraction which lessened agitation and worries. Situations were modified by providing professional support, reducing employee exhaustion from the perspective of HCMs. Additionally, one strategy, response modulation, was applied continuously during the crisis to regulate emotions by actively listening, confirming, and accepting employee emotions. This was facilitated by the HCMs' own expressive suppression.

Third, HCMs could not always regulate employee emotions due to a combination of extensive job demands and limited job resources, generating exhaustion which limited the HCMs' capacity to apply IER strategies. In addition, assuming they were not too exhausted to enter the IER process, the imbalance between job demands and resources created time constraints which reduced the ability for HCMs to engage in reflection. Followingly, their possibilities for corrective actions of the activated strategies were hindered which likely worsened their prospects for improvement of IER.

7.2. Contributions to the Literature

Few studies exist on IER in crisis contexts (Wu et al., 2021), and to the authors' knowledge, IER in Swedish intensive care during the COVID-19 pandemic is unexplored. This study reduces this literature gap by providing a systematic examination of leader-facilitated IER as requested by Thiel et al. (2015), but in the context of the COVID-19 pandemic. Additionally, the paper contributes with an understanding of how job demands and job resources impact IER in response to the call made by Troth et al. (2018) for more insight into the effect of contextual variables on IER.

It is discovered that reminiscent of studies of IER in other, simulated crisis contexts (e.g. Thiel et al., 2015; Uhrecký et al., 2021), IER strategies are applicable in real-life crises as well. Specifically, Gross's (2015) strategies of cognitive change, attentional deployment, situation modification, and response modulation are possible to apply to reduce negative employee emotions. In addition, the perspective-taking process, as proposed by Williams (2007), is complemented by two facilitators: presence and experience, allowing for effective perspective-taking.

Similar to Björk et al. (2023) it is found that contextual factors such as an increased workload and few remedial resources strained the Swedish HCMs' work situation during the COVID-19 pandemic. Our study expands on these findings by adding that the

imbalance in job demands and resources also obstructed the HCMs' activation of IER strategies via exhaustion. Additionally, the extensive job demands were found to limit the phase that Williams (2007) terms reflection by generating time constraints for HCMs that were not too exhausted to enter the IER process and apply strategies.

7.3. Practical Implications

7.3.1. Implications for Healthcare Managers

The research provides valuable knowledge about the IER strategies implemented by HCMs during the COVID-19 pandemic. These insights can help HCMs expand their repertoires of applicable IER strategies in times of organisational crises. Considering that the study captures insights from widespread geography, these strategies should be extendable beyond specific applications.

Additionally, the study underscores the significance of experience and presence in facilitating the essential process of perspective-taking. HCMs are advised to heed this guidance and proactively cultivate experience to improve IER ahead of organisational crises. Furthermore, in the event of an organisational crisis, HCMs should make a concerted effort to be present in the workplace to gain a comprehensive understanding of their employees' emotional states.

7.3.2. Implications for Organisational Decision-Makers

Together, these insights can inform recruitment practices for leadership positions, and provide guidance to organisational training programs. Additionally, this paper offers actionable recommendations to organisational decision-makers within Swedish hospitals on how to enhance the potential for successful IER among their HCMs during crises. These advice include providing both administrative and emotional support as well as, if possible, relieving HCMs of some workload, ultimately creating a workforce better prepared to practise IER and continuously reflect on its effectiveness. As mentioned previously, given the geographical heterogeneity of participants, these conclusions should cater to most caregiving healthcare institutions across Sweden.

7.4. Discussion of Limitations

The study has certain limitations that should be acknowledged. First, HCM recollections may have been skewed as the study was performed after the most intense episodes of the COVID-19 pandemic. Second, only four of 13 interviewees were male, potentially leading to an underrepresentation of certain perspectives due to a lack of diversity. Third, as HCMs themselves were responsible for regulating employee emotions, leaders may have had motives to exaggerate or downplay certain aspects of reality to favour their position.

7.5. Further Research

Previous research has examined relationships between broad ER strategies and variables such as stress (Thiel et al., 2015), trust (Niven et al., 2012a), and friendship (Niven et al., 2012b). Thus, future research efforts should use the findings of this study to assess the effectiveness of the specific strategies used by HCMs in other contexts as measured through variables such as the aforementioned. This effectiveness could be examined from the perspective of various stakeholders, such as employees and other organisational members.

In addition, further research should investigate what other job demands and job resources impact IER at large and the reflective process in isolation. Studies could, for instance, examine the implications of lacking reflective processes in different organisational contexts.

The researchers noticed that leaders had been utilising intrapersonal expressive suppression during the crisis, which, at times, was associated with negative personal well-being. As previous research efforts have established a connection between the two variables (e.g. Moore et al., 2008), future research projects should explore this phenomenon further.

7.6. Conclusion

Amid the COVID-19 pandemic, the Swedish healthcare industry in general and intensive care in particular, faced unprecedented challenges, sparking a range of negative emotions among HCWs. Bearing the ultimate responsibility for their subordinates, HCMs were tasked with the crucial mission of managing the multitude of emotions that suddenly were thrown at them.

This study set out to explore in which ways Swedish HCMs regulated the emotions of their subordinates. The findings reveal that leaders relied on extensive perspective-taking facilitated by experience and presence to understand their employees' emotions and applied four main IER strategies: cognitive change, attentional deployment, situation modification, and response modulation to manage them. Additionally, the paper highlights how increased job demands combined with few buffering resources reinforced leader exhaustion which worsened the overall prospects to engage in IER and hindered reflective processes by imposing time constraints.

By understanding how to regulate the emotions of their employees in times of crisis, leaders can learn how to better respond to the challenge. Furthermore, organisational decision-makers can bolster organisational resilience by leveraging these insights to support leaders in preparing for forthcoming crises.

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Appendix

Appendix A. E-mail to Prospective Interviewees, Translated to English

Dear [name of recipient],

We are two students at the Stockholm School of Economics, Arvid Nygård and Harry Wink, who are writing a bachelor's thesis on how leaders handle employees' emotions in crisis contexts. We have seen that there is a lack of research in this area, and given the crisis situation that the healthcare system faced during the COVID-19 pandemic, we believe that it would be interesting to hear your reflections on the subject.

Therefore, we wonder if you or any other leader you believe would be suitable, would like to participate in an interview on the topic. We are focusing particularly on intensive care, so if you have experiences from that or any contacts there who would be interested in participating, that would be great. The interview is expected to take approximately 60 minutes to complete. We are flexible on the date, but prefer to conduct the interviews between week 8 and week 10. Your anonymity will be maintained in the study, and all data collected will be treated confidentially according to GDPR. You will have access to the study when it is completed.

If you are interested in participating in our project or have any questions, please contact us by replying to this email or by phone at [personal phone number]. We will follow up on this email within two weeks.

Thank you in advance.

Best regards,

Harry Wink and Arvid Nygård

Appendix B. Participant Characteristics

No.	Code	Role	Gender
1	A	Section Manager	Male
2	B	Operations Manager	Male
3	C	Section Manager	Female
4	D	Section Manager	Female
5	E	Chief Nurse	Female
6	F	Operations Manager	Female
7	G	Operations Manager	Female
8	H	Operations Manager	Male
9	I	Section Manager	Female
10	J	Operations Manager	Female
11	K	Section Manager	Female
12	L	Operations Manager	Male
13	M	Section Manager	Female

Appendix C. Interview Guide, Translated to English

Ethics

Participation in this study is entirely voluntary, and you have the opportunity to interrupt or end the interview at any time without having to provide a reason. You also have the freedom to choose not to answer any question without providing any further explanation. If you decide to discontinue your participation in the study, all data collected from you will be permanently deleted.

In our research, which is part of our bachelor thesis in Management at the Stockholm School of Economics, both you and your employer will remain anonymous. We will not disclose any information about other participants to anyone. We would like to request your permission to record the interview so that we can transcribe it at a later time.

Do you have any questions before we continue?

Introductory questions:

1. Can you briefly tell me about yourself?
2. Could you briefly describe the role you had during the COVID-19 pandemic and the role you have now?
3. What made you apply for a job in the healthcare sector?
4. What kind of leadership do you strive for?
5. What do you like the most/least about your job?

The COVID-19 pandemic and the organisation

6. How did the COVID-19 pandemic affect the hospital and especially your hospital department?

Perceptions of employees' emotions during the COVID-19 pandemic

7. What types of emotions among staff did you encounter the most during the COVID-19 pandemic?
8. Did you observe any changes in emotional expressions among your staff during the COVID-19 pandemic compared to a pre-crisis context?

Understanding of emotions

9. What did you do to understand your employees' emotions?
10. How did you know when an employee was experiencing strong emotions?

Managing emotions during the COVID-19 pandemic

11. How did you manage your employees' emotions during the COVID-19 pandemic?
12. What do you think is the ultimate goal of managing employees' emotions?

13. Can you tell me about a time during the COVID-19 pandemic when you felt you successfully managed an employee's emotions?
14. Conversely, can you tell me about another time during the COVID-19 pandemic when you felt you did not handle an employee's emotions well?
15. Did your approach to managing your employees' emotions change over time during the COVID-19 pandemic? What led to these changes?
16. Did your approach to managing employees' emotions vary depending on the individual?
17. Can you discuss any challenges you encountered in managing your followers' emotions during the crisis? How did you handle these challenges?
18. How did you know whether your approach to managing your employees' emotions was effective/ineffective? Did you conduct any specific follow-ups?

Contextual factors

19. How did the COVID-19 pandemic affect you?
20. Did your own feelings and experiences during the COVID-19 pandemic affect how you managed your employees' emotions? How?
21. How did you balance the need to provide emotional support to your team with the demands on yourself and your responsibilities during the COVID-19 pandemic?

Appendix D. Interview Information

No.	Code	Time	Date	Place
1	A	[48:49]	[2023-02-22]	Video Conference
2	B	[49:23]	[2023-02-22]	Video Conference
3	C	[48:53]	[2023-02-23]	Video Conference
4	D	[43:27]	[2023-02-24]	Video Conference
5	E	[50:57]	[2023-02-27]	Video Conference
6	F	[44:24]	[2023-02-28]	Video Conference
7	G	[54:56]	[2023-03-01]	Video Conference
8	H	[56:03]	[2023-03-02]	Video Conference
9	I	[42:40]	[2023-03-03]	Video Conference
10	J	[51:58]	[2023-03-07]	Video Conference
11	K	[47:52]	[2023-03-08]	Video Conference
12	L	[55:30]	[2023-03-10]	Video Conference
13	M	[58:16]	[2023-03-10]	Video Conference

Minimum	[42:40]
Maximum	[58:16]
Average	[50:14]
Median	[49:23]

Appendix E. Example of Coding Process, Translated to English

Q: How did this change when it came to the second and third waves? Did it become a different type of emotional expression that you experienced from the employees, or was it the same?

A: First of all, the staff received this landing gear for the summer, and then when it was time to mobilise again, there wasn't the same enthusiasm... people were quite tired because they had worked so much and there were such heavy patients... they also had significantly more patients per staff member than usual. Many also had difficulty... as an ICU nurse, you want to have complete control over your patients with everything, and that wasn't possible in the same way... because we wouldn't have been able to save as many if we had done everything we would have done otherwise. But, absolutely, people were tired, frustrated, sad. Then they also had good support from each other by checking in, maybe after their shift, and I think they were helped by talking to each other, and then there was also more help from the emergency department with counsellors and things like that that they could get support from during the second wave.

Codes:
Feelings exhaustion ICU personnel
Ethical stress ICU personnel
Feelings agitation ICU personnel
Feelings sadness ICU personnel
Emotion regulation peer support
Emotion regulation expert

Appendix F. Overview of Transcription Symbols

Symbol	Explanation
.	Full stop: indicates the end of a sentence.
,	Comma: indicates a pause in a sentence.
…	Three dots: indicates a longer pause in a sentence.
[...]	Ellipsis in brackets: indicates omitted words in a quote.
(text)	Text in parentheses: indicates added information in a quote.
?	Question mark: indicates a question.