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“When They Say, ‘I Hear You,’ They Truly Hear Me”: An Application of Theories of Resilience to Occupational Trauma Exposure

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ABSTRACT

”WHEN THEY SAY, ‘I HEAR YOU,’ THEY TRULY HEAR ME”: AN APPLICATION OF THEORIES OF RESILIENCE TO OCCUPATIONAL TRAUMA EXPOSURE

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Trauma workers, or those who regularly encounter psychologically distressing situations as part of their job, are at increased risk of mental illness, PTSD, and emotional burnout. However, not all trauma workers develop PTSD despite their regular exposure to traumatic scenes. This study sought to answer the question of how trauma workers’ co-worker relationships contribute to their resilience (i.e., their ability to buffer the negative psychological effects of their work) and the ways in which trauma workers communicate about their work and their stressors with one another. In-depth, semi-structured interviews with 17 trauma workers sought to identify processes involved in trauma co-worker relationships that theoretically impact trauma worker well-being. Participants shared various aspects of their relationships with co-workers, such as how the job is framed communally versus individually, their relational maintenance behaviors with co-workers, their conversations about work-related stress, and experiences of conflict with co-workers. Participants reported framing their relationships with their co-workers in two ways: “in the trenches” together and building community outside of the trenches. Relational maintenance among these trauma workers spanned four categories: sharing responsibilities, emotional support, verbal appreciation, and gift giving. Trauma workers shared four ways they discussed work-related stress with their co-workers: debriefing, foregrounding patient humanity, using humor, and providing time alone. Lastly, participants reported two commonalities in

experiences of workplace conflict: hierarchy as silencing and backgrounding petty disputes. The current study included primarily white women who work in healthcare. Future research should explore other types of trauma work outside of healthcare to examine expansions to these findings as well as commonalities shared among various types of health care workers.

Keywords: trauma work, resilience, theory of resilience and relational load, communication theory of resilience, qualitative interviews, co-worker relationships

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Chapter One: Introduction & Literature Review

Trauma exposure can be distressing for anyone who may experience it; however, those who regularly encounter traumatic events, such as trauma workers who encounter violence and death, are at increased risk of developing long-term negative mental and emotional effects (Sawicki, 2019; van Dernoot Lipsky & Burk, 2009). Due to the demands of their profession, trauma workers are tasked with successfully navigating traumatic events while also managing the emotions that arise while on the job (Sawicki, 2019; van Dernoot Lipsky & Burk, 2009). Despite regular exposure to traumatic situations, not all trauma workers develop post-traumatic stress disorders (Sawicki, 2019). This suggests the presence of protective factors that safeguard some trauma workers from the mental and emotional risks of their profession. Theories of resilience offer frameworks for assessing how trauma workers cope with occupational trauma exposure and related stressors. However, resilience theories within the communication discipline most often study family or interpersonal contexts (e.g., Afifi et al., 2021; Afifi et al., 2019b; Afifi et al., 2020b; Guntzviller & Wang, 2019; Haas & Lannutti, 2022; LaFreniere, 2022; Lillie et al., 2018; Pangborn, 2019) with additional research studying contexts such as refugee camps (Afifi et al., 2019a), migration (Scharp et al., 2021), and pandemic narratives (Lillie et al., 2021; Scharp et al., 2022). Existing research surrounding resilience in trauma work suggests the presence of a communal component to how trauma workers manage emotions and build resilience in anticipation of and following trauma exposure (Freedman, 2004; Rice & Jahn, 2020). For example, research on disaster relief teams suggest that workers collectively and actively reflect on past events as they prepare for future distressing encounters as a way of building communal resilience (Rice & Jahn, 2020). Though resilience theories provide appropriate frameworks for exploring interpersonal processes that contribute to trauma worker resilience, to date no

comprehensive theory has been used to understand how trauma co-worker relationships promote resilience on the job.

To better explore the resilience practices involved in trauma work, this study involved interviews with trauma workers about their relationships with co-workers and how these relationships serve to protect them mentally and emotionally. The goals of this study were to expand resilience research to include occupational trauma exposure and to elaborate on the uses of co-worker relationships as a tool to assist trauma workers in successfully navigating occupational trauma exposure. In the following sections, relevant research regarding trauma, trauma work, and resilience are presented.

Trauma & Exposure

The term 'trauma' is an overarching term that covers several different types of experiences. However, many scholars agree that a traumatic event is one which is "extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological symptoms" (p. 10) such as child abuse, witnessing another person's death, war and torture, mass violence that occurs outside of the context of war, natural disasters, large-scale transportation accidents, fire and burns, motor vehicle accidents, physical and sexual assault, and trafficking (Briere & Scott, 2015). Though exposure to any of these events may be considered traumatic, not everyone who is exposed to potentially traumatic events will develop a trauma response. Multifinality suggests that two individuals who experience the same event may have different responses (Cicchett & Rogosch, 1996; Nolen-Hoeksema & Watkins, 2011), meaning not everyone who experiences a traumatic event will develop a trauma response. Further details about trauma responses are discussed below. As mentioned in the above

conceptualization of trauma, to be considered a traumatic event, the experience must cause lasting psychological symptoms such as the trauma responses, which will be described below.

Following exposure to traumatic events, individuals may experience a range of psychological symptoms or trauma responses. Trauma responses are conceptualized as psychological and behavioral signs of distress that appear as reactions to various traumas (Briere & Scott, 2015; Lanktree & Briere, 2016). Common trauma responses include the following: experiences of fear and anxiety around situations and stimuli that are similar to the original traumatic event; re-experiencing the trauma through unwanted or intrusive thoughts, flashbacks, and nightmares; increased arousal and hypervigilance in various environments that may trigger fight (i.e., confront), flight (i.e., flee), freeze, and fawn (i.e., accommodate) responses; avoidance of situations and stimuli reminiscent of the original traumatic event; expressions of anger and irritability; feelings of guilt and shame; increased feelings of depression; and negative alterations to self-image and views of the world as untrustworthy (Briere & Scott, 2015; Lanktree & Briere, 2016). While each of these behaviors can be symptomatic of a distressed individual responding to a traumatic event, these behaviors on their own are not enough to qualify as a maladaptive trauma response. In order to determine if an individual is coping with trauma exposure in healthy or unhealthy ways, further evaluation from a trained professional is needed (American Psychological Association, 2013; Briere & Scott, 2015; Lanktree & Briere, 2016).

Though trauma responses are not something that can be easily predicted, literature suggests specific factors that can protect or put an individual at risk of maladaptive responses. Risk factors range widely across contexts but maintain some commonalities. In a study on ICU workers in the first wave of COVID-19, some risk factors associated with the development of PTSD included psychological stress, experiencing additional difficult events during the crisis,

high perceived stress related to the assigned workload, and experiencing emotional burdens from patients and their families (Laurent et al., 2021). Other studies have pointed to high caseloads, intense caseloads, workplace isolation (Najmabadi et al., 2023), working as emergency workers as compared to working in non-emergent situations, unexpected events, lack of protective equipment (Maiorano et al., 2020), and external stressors such as mental health diagnoses (Higgins et al., 2020) as potential risk factors in the development of posttraumatic stress disorders. Conversely, literature has also highlighted protective factors that make an individual less susceptible to maladaptive trauma responses and posttraumatic stress disorders. Such protective factors include developed self-regulation and problem-solving skills (Bonanno, 2004; Laurent et al., 2021; Madsen & Abell, 2010), positive beliefs about the self and life, socioeconomic advantages (Bonanno, 2004), participation in spirituality (Bonanno, 2004; Madsen & Abell, 2010), strong relationships and communities (Madsen & Abell, 2010) such as those with co-workers (Laurent et al., 2021), families (Daniels & Bryan, 2021), and peers (Bonanno, 2004), passion for the work (Moreno-Jimenez et al., 2019), and resilience and positive coping strategies (Bonanno, 2004; Carmassi et al., 2020; Maiorano et al., 2020; Najmabadi et al., 2023).

Trauma Work

The general public commonly assumes that trauma exposure is limited to personal life events, such as emotional and physical abuse, sexual assault, and life-threatening accidents (Briere & Scott, 2015). However, trauma exposure is also inherent within certain occupations (e.g., hospice work, firefighters, nurses). For the purposes of this dissertation, this study defines trauma work as any profession or occupation that involves regular and expected exposure to primary or secondary trauma. According to the *Diagnostic and Statistical Manual of Mental*

Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013), both primary and secondary trauma exposure can lead to development of post-traumatic stress disorders. Primary trauma exposure includes directly experiencing a traumatic event (e.g., actual or threatened death, serious injury, or sexual violence) and witnessing a traumatic event as it occurs to others, whereas secondary trauma exposure includes learning that traumatic events occurred to a close family member or friend and "repeated or extreme exposure to aversive details of traumatic events" (American Psychiatric Association, 2013, p. 271). Under these classifications, the label of 'primary trauma workers' includes first responder professions such as firefighters, police officers, emergency medical and trauma services, hospice workers, 911 operators, and disaster response teams. Similarly, the label of 'secondary trauma workers' includes professions such as social workers, forensic investigation teams, crime scene cleanup crews, therapists, and victim advocates.

To distinguish trauma exposure in personal life compared to trauma exposure on the job, the term occupational trauma exposure will be used to describe trauma exposure that occurs as part of a person's profession. Depending on the specific form of trauma work, trauma workers might be regularly exposed to primary and/or secondary traumas. For example, forensic teams might encounter secondary traumas as they comb through the details of traumatic events that have already occurred, whereas firefighters might encounter primary traumas as they respond to emergency calls (e.g., entering burning buildings potentially exposes them to trauma). Additionally, trauma workers who directly encounter traumatic events are at higher risk of experiencing secondhand trauma, specifically learning that a traumatic event has occurred to a co-worker or friend while on the job (American Psychiatric Association, 2013). Though trauma exposure will vary depending on the type of trauma work and the ways in which trauma workers

encounter traumatic events, each type of trauma exposure places trauma workers at risk of developing a post-traumatic stress disorder.

Following trauma exposure, some individuals develop a post-traumatic stress disorder such as PTSD or acute stress disorder (American Psychiatric Association, 2013; Sawicki, 2019). While PTSD is a more common disorder resulting from trauma exposure, acute stress disorder may also occur and is characterized by earlier onset of negative effects (American Psychiatric Association, 2013). PTSD and acute stress disorder are similar disorders with similar presentations but differ in time since exposure. Acute stress disorder is diagnosed when symptoms appear between three days and one month after the traumatic event whereas PTSD is diagnosed when symptoms last longer than one month (American Psychiatric Association, 2013). In either case, diagnosed individuals may experience a variety of symptoms ranging from intrusive symptoms (e.g., intrusive thoughts, flashbacks, and night terrors), persistent avoidance of events and situations similar to the related traumatic event, negative mood and cognitions (e.g., negative beliefs about oneself, feelings of detachment, persistent negative emotional state, and an inability to experience positive emotions), and distinct changes to arousal and reactivity (e.g., hypervigilance, self-destructive behavior, sleep disturbances, difficulty concentrating, and irritability or angry outbursts) (American Psychiatric Association, 2013, pp. 271–272). Additionally, presentation of PTSD or acute stress disorder may be accompanied by dissociative symptoms such as depersonalization (i.e., feeling disconnected from one's sense of self, or as though observing oneself from outside of their body) and derealization (i.e., feeling as though the world around oneself is unreal, distorted, or dreamlike) (American Psychiatric Association, 2013). Among these symptoms, there is a common theme of emotional reactivity, increased experiences with negative emotions, and diminished experiences of joy or pleasure. These

emotional effects of post-traumatic stress disorders indicate that those who struggle to adjust following trauma exposure may have a difficult time connecting to and relating with others (American Psychiatric Association, 2013). Because after-effects of trauma exposure are unique to the individual who experienced the trauma, it can be difficult for others who did not experience the trauma to adequately empathize and offer support, thus creating an emotional wedge between relational partners (van Dernoot Lipsky & Burk, 2009). Though presentation of these symptoms may vary across individuals, each diagnosis of PTSD or acute stress disorder is a reasonable signal that the individual needs help processing their experience(s) with trauma (American Psychiatric Association, 2013; Sawicki, 2019).

Resilience

Though each experience with trauma may be distressing, not all who are exposed to trauma develop a post-traumatic stress disorder. For example, according to recent statistics, military service members returning from combat experience PTSD rates ranging from 20-30% (Reisman, 2016). This statistic suggests that trauma workers, such as military service members, engage in protective factors such as resilience practices that limit the long-term effects of trauma exposure. Much of the resilience research suggests that communal approaches to stressful events mitigates maladaptive responses (Afifi et al., 2016; 2020a; Guntzviller & Wang, 2019; Haas & Lannutti, 2022; Rice & Jahn, 2020; Richardson & James, 2017; Richardson & Maninger, 2016; Sawicki, 2019). Therefore, it can be speculated that emotion management and socialization (Huffman, 2017; Way & Tracy, 2012), as well as collective resilience (Rice & Jahn, 2020) or communal coping (Afifi et al., 2020a), are partially responsible for protecting trauma workers from developing post-traumatic stress disorders.

Emotional Socialization in Organizations

In any line of work, one of the first steps to starting a new position is to become socialized into the organization (Bauer & Green, 1994). Organizational socialization often includes processes such as new members familiarizing themselves with the organization, adjusting to their new social environment, and becoming part of the organization (Bauer et al., 2007). However, for more emotionally laborious areas of work (e.g., healthcare and first responders), the socialization process also includes learning to manage emotions appropriately while on the job (Ashforth & Kreiner, 2002; Bauer & Green, 1994; Cepale et al., 2021; Choi, 2018; Scott & Meyers, 2005). In specific industries, such as healthcare, workers face clearly defined regulations for emotional expressions (Carminati, 2021; Choi, 2018; Rafaeli & Sutton, 1987). Despite emotionally strenuous situations, such as helping patients in critical care and families in emotional distress, healthcare workers are required to maintain professionalism, thus limiting the external expressions of emotions employees may experience while on the job (Carminati, 2021; Hsieh & Nicodemus, 2015; Martin et al., 2015; Rafaeli & Sutton, 1987). In order to manage unprofessional emotional expressions in the workplace, healthcare workers often suppress felt emotions, such as anxiety, sadness, and frustration, while masking to display more appropriate emotions such as compassion and empathy (Carminati, 2021; Dowrick et al., 2021; Martin et al., 2015).

This form of emotion management is not individually learned, but rather a collaborative socialization process through which new employees learn appropriate workplace emotion management from their co-workers (Carminati, 2021; Choi, 2018; Scott & Meyers, 2005). They turn to each other to resolve emotional distress (Carminati, 2021; Clark-Hitt et al., 2012; Dowrick et al., 2021; Martin et al., 2015; Scott & Meyers, 2005) because those outside of the

organization might not understand the emotional demands of their work. It therefore becomes important for co-workers in emotionally strenuous lines of work, such as trauma work, to be able to create a sense of community where support is readily available. Previous research has shown that a communal approach to resilience within trauma work is crucial for employee well-being (Freedman, 2004; Scott & Myers, 2005). Similarly, the communal coping model presents a framework to further unpack the role of communal approaches to resilience (Afifi et al., 2020a) and the need for community as a protective factor against occupational trauma exposure.

Communal Coping

The theoretical model of communal coping involves two primary components: shared appraisal and joint action (Afifi et al., 2020a). The concept of shared appraisal refers to the ability to collaboratively assess the surrounding situation and interpret the onus of the situation as belonging to the collective whole, rather than any one individual (Afifi et al., 2020a). The shared appraisal aspect of communal coping highlights communal orientations as rooted in a shared understanding that the situation is to be approached with joint action, rather than separately (Afifi et al., 2020a). For example, when approaching the scene of a housefire, firefighters engage in shared appraisal by working in tandem and designating roles to manage the fire, rather than each firefighter approaching the house in individual attempts to reduce the flames. Through this shared appraisal, team members can acknowledge a collaborative approach and designate shared responsibilities (Richardson & James, 2017). In a more emotional application, communal coping can be demonstrated through a community navigating the aftermath of a natural disaster. Following destruction of homes and property, community members may engage in shared appraisal wherein they recognize the need to connect with others to recover. While some community members might choose to recover without external

assistance, those who turn to each other for support and recovery are more likely to recover and even thrive (Richardson & Maninger, 2016).

The second concept of the theoretical model of communal coping, joint action, refers to the collaborative approach that teams take when addressing a situation (Afifi et al., 2020a). Whereas shared appraisal refers to the communal understanding of teamwork, joint action refers to the actions that follow this acknowledgement. Referring back to the house fire example, joint action occurs when each fire fighter fulfills their responsibilities within their designated role to contribute to the team effort. Within the example of a community hit by a natural disaster, joint action would reflect the efforts made by community members to remove debris and share resources until long-term fixes can be made. In contrast, those who attempt to recover individually, rather than communally, might take longer to recover and might aggravate their own stress in doing so (Richardson & Maninger, 2016). To engage in a communal approach, team members must demonstrate both the shared understanding of the need for teamwork as well as the ability to act as a cohesive group, rather than as autonomous individuals (Afifi et al., 2020a; Richardson & Maninger, 2016). Though limited, existing research on resilience practices of trauma workers forefronts the importance of self-care as necessary for adequate job performance and employee well-being (Sawicki, 2019).

In addition to the concept of emotional socialization within organizations and the model of communal coping, there are currently two primary resilience theories that originate from within communication that have potential utility for understanding the experiences of trauma workers: Buzzanell's communication theory of resilience (CTR; Buzzanell, 2010; 2018) and Afifi's theory of resilience and relational load (TRRL; Afifi et al., 2016). CTR conceptualizes resilience as being achieved through five reframing processes used to respond to triggering

events, while TRRL presents resilience as an outcome of relational supports and stressors. Despite differences in foci (i.e., discourses versus relationships), CTR and TRRL have potential to work in tandem to provide a more holistic understanding of the ways in which individuals use and communicate within relationships to enact resilience. Both CTR and TRRL will be explored in the present study to examine places of overlap in trauma work enactments of resilience.

Communication Theory of Resilience (CTR)

Developed by Buzzanell (2010; 2018), CTR situates resilience as occurring in the everyday conversations individuals have with one another. CTR argues that individuals construct resilience through five communication processes (e.g., crafting normalcy, foregrounding productive action while backgrounding negative feelings, affirming identity anchors, using and maintaining communication networks, and putting alternative logics to use) following a triggering event (Buzzanell, 2010; 2018). In the following section, the major components of CTR (i.e., triggering events, communication processes, and anticipatory resilience) are defined as well as connected to the context of trauma work.

Triggering Events. In CTR, stressful events are framed as "triggering events" to which individuals respond (Buzzanell, 2010; Buzzanell, 2018). Triggering events are conceptualized as any event that is disruptive to daily life (Buzzanell, 2010). While some triggering events can be predicted (e.g., graduating at the end of a school program), others can appear more suddenly such as unexpected job loss (Kuang et al., 2023). Existing literature using CTR has explored a variety of triggering events such as migration to a new country (Scharp et al., 2021), becoming first-time parents (Lillie et al., 2018), and transitioning to college (Rossetto & Martin, 2022). In the context of trauma work, triggering events are likely to range by specific occupation to

include encountering large-scale natural disasters, mass transportation accidents leading to multi-patient deaths, and witnessing the death of a loved one seeking emergency services.

Communication Processes. CTR conceptualizes resilience as rooted in human interaction, specifically through five reframing processes: "crafting normalcy, foregrounding productive action while backgrounding negative feelings, affirming identity anchors, maintaining and using communication networks, and putting alternative logics to work" (Buzzanell, 2018, p. 100). It is through each of these processes, Buzzanell (2018) argues, that resilience can be communicatively constructed between individuals through the ways in which situations are framed. By reframing triggering events to create a sense of normalcy and focus on realistic steps a person can take, rather than negative feelings they are experiencing about such events, individuals are able to regain a sense of control over otherwise distressing situations. Individuals can also use other communicative processes to regain agency and composure, such as connecting to strong identity markers, relating with others who have previously or are currently going through similar experiences, and seeking alternative perspectives on the situation. Engaging in each of these communicative processes helps individuals manage a triggering event in ways that are productive rather than in ways that will be detrimental (e.g., ruminating over stressful and negative emotions and maintaining pessimistic narratives).

Crafting Normalcy. One process through which individuals construct resilience is crafting normalcy. Crafting normalcy occurs when individuals reframe a stressful event to normalize the situation in order to create a sense of regularity (Buzzanell, 2010). Crafting normalcy can include moments where individuals establish new routines to incorporate the triggering event into normal life (Turner et al., 2022). Existing CTR literature has conceptualized the communicative process of crafting normalcy as engaging in normal life as much as possible

during hardships (Lillie et al., 2018), forming new relationships (Scharp et al., 2020), and developing and implementing new routines such as masking during the COVID-19 pandemic (Turner et al., 2022). Considering that experiences such as death and dying are a regular occurrence within trauma work, it is expected that trauma workers create a sense of normalcy around their work wherein potentially traumatic events become part of trauma workers' everyday routine. By normalizing these otherwise distressing events, trauma workers can minimize the degree to which the event is upsetting. Because trauma workers can expect to encounter triggering events regularly, there may exist discourses that frame their work as normal in order to minimize the emotional distress that may otherwise be associated with the potentially traumatic experiences that trauma workers see daily. Such discourses may include framing their work, and thus the potentially traumatic experiences, as part of the job or emotionally distancing themselves from patients. The existence and functionality of such discourses is yet to be explored.

Foregrounding Productive Action While Backgrounding Negative Feelings. A second communicate process in CTR, foregrounding productive action while backgrounding negative feelings, involves redirecting attentions towards more positive and actionable aspects of a situation and away from negative or obstructive thoughts and feelings (Buzzanell, 2010). By redirecting attention to actions that can be taken, individuals are able to resituate stressful events to become positive and manageable. Rather than ruminating on the negative feelings that may arise following a triggering event, individuals using this process can work discuss options that promote growth and forward movement. In recent CTR literature, productive action has been observed as conducting research on cochlear implants (Scharp et al., 2023), redirecting attention to social-distancing-friendly activities during the COVID-19 pandemic (Turner et al., 2022), and

spending time with non-estranged children (Scharp et al., 2020). Within the context of trauma work, trauma workers might focus their attention on patient care or services that need to be provided rather than dwelling on the emotional weight of the situation at hand. By prioritizing the needs of the patient, trauma workers may be able to temporarily distract themselves from any negative emotions that arise on the job and instead respond to emergent situations while on the job.

Affirming Identity Anchors. In addition to crafting normalcy and foregrounding productive action while backgrounding negative feelings, individuals also construct resilience by affirming identity anchors. Through this communication process, individuals connect to key components of their identity that have persisted through the triggering event. For example, some individuals choose to focus on their religious identity or their identity as a parent in order to reinforce their sense of self as a constant through triggering events such as child illness and global pandemics (Lillie et al., 2018). Trauma workers may have a variety of identity anchors that they connect to, however, the most prevalent within the context of trauma work would likely be their identity as a trauma worker. By reminding themselves of their role as someone who works with others through potentially traumatic events, trauma workers can alleviate some of the stress associated with their job and reassure themselves that they are capable of managing the stressful event in front of them.

Maintaining and Using Communication Networks. A fourth way in which individuals construct resilience is through the use and maintenance of communication networks. Similar to the proposition of TRRL wherein close relationships serve as a source of resilience, this process highlights the need for community and close interpersonal relationships in order to enact resilience through stressful events (Buzzanell, 2018). Specifically, this process involves

connecting with others who have experienced similar situations (Buzzanell, 2010). By connecting to others with shared experiences, individuals can feel less alone while also taking advantage of communal resources. In trauma work, the communication networks most likely to be utilized are the ones with fellow trauma workers. As military literature highlights, it is important for individuals to have support from those with similar backgrounds and experiences in order for the support to feel genuine, understanding, and authentic (Clark-Hitt et al., 2012; Peck & Sahlstein Parcell, 2021; Wilson et al., 2014). For this reason, it is most likely that trauma workers would turn to each other in moments of stress both to take advantage of the similarity in experiences and also to limit the need to for explanation of the situation. Because other trauma workers, particularly those within the same field, are likely to know and understand the more common moments of stress, there is less burden assumed when seeking support and connection with others within the field.

Putting Alternative Logics to Use. The final communication process in CTR is putting alternative logics to use. This process refers to how "resilient systems incorporate seemingly contradictory ways of doing organizational work through development of alternative logics or though reframing the entire situation" (Buzzanell, 2010, p. 6). Through this process, individuals engage in methods of coping that may at first appear counterintuitive. Existing CTR literature has explored the enactment of this communicative process in the form of storytelling to reconnect with family following a disruption (Pangborn, 2019), mantras and cliché sayings used to reframe a situation (Fanari et al., 2023), and humor as a way of reframing disruptions (Lillie et al., 2018). For example, following grief, some choose to use humor as a coping mechanism. This process also involves shifting perspectives of the situation to find positivity. For trauma workers, alternative logics may include reframing negative patient outcomes as learning opportunities for

future cases. In the case of organ donation, patient death may be reframed as continued life for organ recipients.

Anticipatory Resilience. While the above processes were originally presented as being used to construct resilience following a triggering event, more recent literature has speculated on the use of these processes to construct resilience in anticipation of triggering events (Betts et al., 2022). As was mentioned previously, some triggering or disruptive events can be anticipated before they take effect. In these instances, individuals have the opportunity to construct resilience in anticipation of the disruptive event. Though this proposition is new to CTR framework, having the foresight to prepare for disruptive events allows individuals the time and space to preemptively process the impending changes to their daily lives. In contrast to CTR where resilience is conceptualized surrounding a disruptive event, a second communication theory, TRRL (Afifi et al., 2016; Afifi et al., 2019b), approaches resilience through a relational stress tolerance perspective.

The Theory of Resilience and Relational Load (TRRL)

The theory of resilience and relational load (TRRL) is rooted in the idea that relational maintenance behaviors contribute over time to create emotional reserves through which future stressors can be (re-)evaluated as more manageable (Afifi et al., 2016). Similar to Buzzanell's (2018) CTR, TRRL is centered on the ways in which resilience can be built through relational processes. TRRL hypothesizes that an individual's capacity for buffering stress depends upon the emotional reserves developed through relational maintenance behaviors and mutual investment in the relationship (Afifi et al., 2016). According to the TRRL model (Appendix A), individuals who have accumulated more emotional reserves through prolonged investments in their

relationships (i.e., those who have strong and secure relationships with others) are better situated to encounter stressful situations and remain resilient.

Emotional reserves, however, remain an abstract concept within the model. For this reason, additional research is needed to qualitatively investigate the presence and use of emotional reserves within supportive relationships. Because existing TRRL research is primarily quantitative, research that approaches the model from a qualitative method might explore the nuances involved in the enactment of relationships as a source of resilience. Through this study, three components of the TRRL model will serve as foundational elements upon which trauma co-worker relationships can be explored: communal orientation, relational maintenance, and relational load.

Communal Orientation. As a primary aspect of the model, TRRL positions communal approaches to stress as integral to individual thriving (Afifi et al., 2016; Afifi et al., 2019b; Guntzviller & Wang, 2019; Haas & Lannutti, 2022). Positive engagement in relationships is crucial to individual perceptions of stress and capacities to thrive. Taking this idea further, TRRL argues that relational partners who approach stressors from a communal orientation are more likely to perceive a stressor as manageable and maintain a sense of thriving and mental, emotional, cognitive, and relational well-being (Guntzviller & Wang, 2019; Haas & Lannutti, 2022). Framed as 'unified couples,' relational partners who approach stress and conflict communally, as opposed to individually, are more likely to minimize the negative effects of stress and emerge with minimal harm (Afifi et al., 2016; Afifi et al., 2020a).

Though some literature exists on occupational applications of resilience (Dutta, 2019; Kim, 2020; 2021; Wieland, 2020), the ways trauma workers build resilience in anticipation of occupational trauma exposure has not been a focus. Across both CTR and TRRL, there is a

consistent theoretical focus on communal orientations to resilience. CTR, for example, places emphasis on the ways in which individuals communicate with others (e.g., co-workers, family members) to maintain resilience following (Buzzanell, 2018) or in anticipation of (Betts et al., 2022) a triggering event, while TRRL is focused entirely on relational characteristics that work to build resilience prior to stressful events (Afifi et al., 2016; Afifi et al., 2019b). From these two theories, it is suggested that resilience is best built with others rather than individually.

Trauma workers not only regularly face traumatic events, but they do so with their co-workers. Because each traumatic event is uniquely experienced, and therefore difficult for others to fully empathize with, fellow trauma workers are often best suited to support each another and remain resilient in the face of occupational trauma exposure (Sawicki, 2019; Wilson et al., 2019). Through common experiences and knowing what each other has seen and been through, trauma workers have unique bonds that allow them to understand and support each another. As is evident in military communication research, service members who experience traumatic events while on duty often report that support is best received from credible sources (i.e., those who have verifiably been through similar experiences in military service; Clark-Hitt et al., 2012; Peck & Sahlstein Parcell, 2022; Wilson et al., 2019). Military service, especially in combat zones, is often perceived as an experience unlike any other. For this reason, service members report that support from family, friends, and spouses, though well intentioned, are not sufficient sources of support due to their lack of shared experiences (Clark-Hitt et al., 2012; Peck & Sahlstein Parcell, 2021; Wilson et al., 2015; 2019). Though not all trauma work has strict boundaries around in- and out-groupers like military service, these findings can be applied to other forms of trauma work given their unique experiences of regular job-related trauma exposure. Therefore, it can be theorized that trauma workers are best situated to support each another through regular

occupational trauma exposure as they share these unique experiences and can presumably understand and empathize with each other. To better understand the role of co-worker relationships within trauma work, the following research question is posed:

RQ1: How do trauma workers conceptualize co-worker relationships within the demands of their profession?

Relational Maintenance. Relationship maintenance within TRRL is conceptualized as positive behaviors that contribute to relational support, such as uplifting and supporting each other, showing appreciation and admiration, and sharing tasks and workload (Guntzviller & Wang, 2019; Haas & Lannutti, 2022). Examples of relational maintenance behaviors can vary across relationships, but most often include small interactions such as expressions of gratitude and affection (e.g., saying "I love you," hugging, kissing), spending quality time together, sharing meals, giving compliments, and asking about each other's day (Afifi et al., 2019b). Through such behaviors, individuals are able to build emotional reserves that help to mitigate stress from a variety of sources (Afifi et al., 2016; Afifi et al., 2019b; Guntzviller & Wang, 2019; Haas & Lannutti, 2022). The accumulation of emotional reserves, which are built following continued and repeated engagement in positive relational maintenance behaviors, then encourage individuals to re-evaluate stressful situations from a larger perspective (e.g., minimizing the stressor and its effects) and use more uplifting communication with partners as they navigate stress, as opposed to releasing stress through bursts of anger and irritability (Afifi et al., 2016; Afifi et al., 2019b). One way in which individuals may engage in relational maintenance is through enactments of social support.

Social Support. Social support literature demonstrates that social relationships are significantly beneficial to the well-being of those receiving support (Goldsmith, 2004;

Vangelisti, 2009). For this reason, it is expected that supportive relationships among trauma workers would be beneficial to trauma worker well-being. Existing literature suggests that nurses use peer support to ward against work-related burnout (Sawicki, 2019). However, the type of support and how it functions as a relational maintenance tool in these relationships has yet to be explored. Relational maintenance behaviors in current TRRL literature includes a range of behaviors such as physical touch (e.g., hugging, kissing), expressions of appreciation (e.g., saying "I love you" or "thank you"), and participation in shared activities among others (Afifi et al., 2021). While these forms of relational maintenance have been repeatedly tested and verified within the context of romantic and family relationships, little research exists on the forms of relational maintenance used within co-worker relationships (Waldron, 2003), particularly within trauma work. To better explore the enactments of relational maintenance within trauma worker relationships, the following research question was posed:

RQ2: What relational maintenance behaviors do trauma workers enact with their co-workers?

Relational Load. In addition to relational maintenance behaviors and emotional reserves, the model of TRRL includes relational load, or depletion of cognitive, emotional, and relational resources (Afifi et al., 2021; LaFreniere, 2022). In contrast to emotional reserves, relational load aggravates stress and leads to more pessimistic evaluations (Afifi et al., 2016; 2019b; 2021). When relational partners experience heightened relational stress, such as conflict, and/or exhibit a tendency towards appraising situations negatively or as threatening, they contribute to relational load (Afifi et al., 2021; Guntzviller & Wang, 2019; LaFreniere, 2022). Relational load, as opposed to emotional reserves, makes individuals feel "weighed down" by their relationships, rather than "lifted up," and further aggravates stress, rather than using the relationship to lessen

the burden of stress (Afifi et al., 2016; 2019b; 2021). Additionally, the presence of relational load has been connected to difficulties in executive functioning which further aggravates an individual's ability to manage stress (Afifi et al., 2021). Two primary factors that might contribute to relational load within trauma work are work-related stress and conflict among co-workers.

Work-Related Stress. Stress from work-related experiences can negatively impact a person's ability to navigate other stressors (Riforgiate et al., 2021; Rivera & Tracy, 2016). Though present in all careers, stress is a significant factor within trauma work (Rivera & Tracy, 2016; Tracy, 2004; Way & Tracy, 2012). Due to regular exposure to actual or threatened death, serious injury, and sexual violence, trauma workers must constantly navigate work-related stress (Briere & Scott, 2015; Sawicki, 2019). Within the TRRL framework, stressors are found to be a contributing factor to a person's resilience (Afifi et al., 2016; 2021). Like conflict, the presence of stress itself is not inherently detrimental. Rather, the ways stress is managed is a more significant predictor of outcomes (Afifi et al., 2021). When individuals are experiencing stress frequently and failing to manage their stress effectively, perceptions of additional stressors might become more pessimistic (Afifi et al., 2016; 2019b; 2021). Afifi et al. (2016) argues that the effects of stressors can be mitigated through conversations with relational partners. Specifically, when relational partners are present and supportive, individuals are more likely to appraise stressful situations optimistically (Afifi et al., 2021). In this sense, conversations about salient stressors with co-workers likely are vital for trauma worker well-being. To further explore how trauma workers talk about their work-related stressors with each other, the following research question was posed:

RQ3a: How do trauma workers talk to each other about work-related stress?

Conflict. A subject not unique to trauma work, conflict can become a source of stress in any relationship. Though not inherently unhealthy, frequent conflict between relational partners has the potential to become destructive (Fowler & Dillow, 2011; Gottman & Gottman, 2008). Relating specifically to TRRL, mismanaged conflict can serve as a stressor and deplete emotional reserves (Afifi et al., 2016; 2021). Sources of conflict can range widely from work-related disputes to personal disagreements. Despite the source, conflict can be deeply detrimental to individual stress thresholds and lead to more pessimistic evaluations of stressful events (Afifi et al., 2021). Conflict among co-workers, particularly in healthcare settings, can be equally detrimental. Due to the need for quick decisions to be made that can be the difference between life and death, hospitals and other medical settings have strict rules regarding the flow of communication (Shin, 2009). For example, doctors may freely communicate their thoughts, questions, and criticisms to nurses, but nurses cannot question doctors. As a result, research has shown that the most common type of reported conflict among healthcare workers was professional conflict, or friction between doctors and nurses (Shin, 2009). Whereas conflict between two people of equal positions might allow for a more open exchange between the involved parties, conflict between two people of different positions or status can be difficult to resolve. Additionally, Moreland et al. (2015) found that nurses often adopt a sense of learned helplessness when managing conflict in the workplace. In this study, nurses reported feeling as though they were unable to make an impact if they did address the conflict at hand, which led these nurses to adopt more avoidant conflict management behaviors. If resolved efficiently, typically through collaborative efforts that include all parties involved, the harmful effects of conflict can be minimized (Afifi et al., 2021; Fowler & Dillow, 2011; Gottman & Gottman, 2008). However, when conflict is left unresolved, or is resolved in ways that are perceived to be

unfair, stress levels are likely to heighten (Afifi et al., 2021), making management of stress increasingly more difficult. To explore the presence and management of conflict within trauma worker relationships, the following research question was posed:

RQ3b: How do trauma workers experience and manage conflict with co-workers?

In sum, TRRL has been applied to a variety of contexts including families with type I diabetes (Afifi et al., 2019b), stress management in dual career families (Afifi et al., 2020b), and feelings of unity in romantic relationships (Afifi et al., 2021). Across each of these contexts, stress management has been studied as a result of relational maintenance behaviors that contribute to an increased capacity for stress and greater chance to thrive throughout hardship (Afifi et al., 2016). TRRL, like CTR, is primarily applied to romantic and family relationships (Afifi et al., 2019b; Scharp et al., 2020), thus leaving applications of co-worker relationships and anticipatory resilience understudied. Therefore, the present study aims to further expand upon organizational applications of CTR and TRRL, as well as applications of resilience work to trauma work specifically, while also exploring potential overlaps between the resiliency models of CTR and TRRL.

Chapter Two: Methods

This dissertation aims to explore trauma co-worker relationships and resilience. Relating to the present study, TRRL and CTR provide valuable lenses through which trauma co-worker relationships can be explored as a source of resilience. Through communal approaches and relational maintenance behaviors, some trauma workers are likely able to combat the stress of the job and thrive despite frequent exposure to violence, injury, and death. To explore co-worker relationships within trauma work, the present study interviewed trauma workers including firefighter paramedics, nurses, and hospital staff. Through interviews, lived experiences of trauma workers and their relationships with co-workers were explored to further expand upon the individual experiences of relationships as a source of resilience and bridge existing resiliency theories. This project included interviews with trauma workers to generate a comprehensive understanding of resilience practices and communication strategies used within co-worker relationships to build resilience.

Qualitative Rationale

Because this study takes an exploratory approach to applications of the TRRL model to trauma work and possible overlaps between CTR and TRRL, a qualitative approach was well suited (Tracy, 2020). Since TRRL literature has not yet expanded to co-worker relationships as a form of resilience, this study aims to explore the applicability of the TRRL model to co-workers, particularly in the field of trauma work. By using a qualitative approach, participants can freely report their lived experiences with their co-workers. In qualitative research, lived experiences include the ways in which individuals think and feel about their situations (Ganong & Coleman, 2014). By using a qualitative approach, particularly an approach that uses interviews as the primary method, participants are enabled to report and explain their lived experiences using their

own words and meaning. Because TRRL research has not yet looked at co-worker relationships as a type of relationship through which resilience can be built, a qualitative approach where participants openly share will help to further explore possible applicability of the model and enactments of relational maintenance within to co-worker relationships.

Recruitment

To recruit for this study, qualifying workplaces across the Milwaukee area, such as hospitals, fire-stations, funeral homes, hospice centers, victim advocacy centers, and women's shelters, were contacted through human resources departments (Appendix B). Upon contacting these workplaces, the recruitment flyers (Appendix C) for the study were distributed to employees. The flyer instructed participants to contact the primary researcher via email to express interest and confirm eligibility through a screening survey (Appendix D). Individuals who were interested in participating were asked questions about their line of work, how long they've worked in their current position, and how frequently they encounter trauma directly and indirectly. Frequency of trauma exposure was organized by daily encounters, weekly encounters, monthly encounters, annual or rare encounters in order to ensure that enrolled participants are working in positions that expose them to direct or indirect trauma at least monthly and was therefore a regular and expected component of their work. To further recruit, snowball sampling (Tracy, 2020) was used wherein participants were asked to share the project flyer with anyone they know who may be eligible and interested in participating.

To be considered eligible to participate in this study, individuals had to currently work in a position that includes regular (i.e., at least monthly) and expected exposure to violence and/or death and have been in their position for at least one year. Exposure could be direct (i.e., witnessing or being intimately involved in violence and death) or indirect (i.e., working with

detailed accounts of violence and death). Participants who experience direct exposure to trauma were considered as primary trauma workers while those who experience indirect exposure to trauma were considered as secondary trauma workers. Individuals who work in qualifying workplaces (e.g., fire-stations or hospitals) but do not work in a position involving trauma exposure (e.g., administrative work) were not eligible to participate. Due to rates of turnover in related professions, such as child welfare social workers (Middleton & Potter, 2015), the requirement that participants have worked in their position for a minimum of one year served to ensure that participants have experiences with co-workers that they can discuss. Though possible in these professions, diagnoses and presence of PTSD symptoms were not included in eligibility criteria. Due to a multitude of barriers to diagnoses, including cost and time restraints, availability of mental health professionals, and social stigma, inquiring about diagnoses might not accurately reflect the presence of these disorders within trauma work professions. Additionally, because enactments of resilience may include a range of presentations, findings could potentially be limited if adverse experiences are screened out. Eligible participants were scheduled for virtual interviews that took place via Microsoft Teams. Recruitment continued until interview data reached saturation (Tracy, 2020), which occurred after 15 interviews.

Participants

Seventeen trauma workers (three men and 14 women) participated in semi-structured interviews. Participants reported an average age of 37.13 years (*SD* = 9.79, *range*: 24–65 years) and have worked an average of 8.31 years in their current careers (*SD* = 5.89, *range*: 2–19 years). Participants were primarily healthcare workers (*n* = 14) along with two firefighter paramedics and one protective placements attorney. Of the 14 healthcare workers, most work as nurses (*n* = 13). Healthcare workers ranged in specialty from intensive care units (ICU; *n* = 6),

hospice care (n = 4), and emergency departments (ER; n = 3) with one participant working as an organ procurement coordinator.

Procedure

Interviews were conducted virtually through Microsoft Teams to accommodate participant availability and schedules and were audio and video recorded. Prior to each interview, participants were provided with the informed consent form (Appendix E) which was verbally discussed before the start of the interview. Interviews followed a semi-structured format using an interview guide developed by the researcher to explore components of the TRRL model (Appendix F). Topics included framings of co-worker relationships as necessary to trauma work (e.g., "How do you rely on co-workers as you prepare for [especially stressful calls/cases/jobs]?"), relational maintenance behaviors used with co-workers (e.g., "Who is someone at work that you've relied on in moments of stress?"; "What are some examples of ways that you bond and build your relationship with X?"), work-related stress conversations with co-workers (e.g., "How do you rely on co-workers as you decompress from [especially stressful calls/cases/jobs]?"), and conflict management in the workplace (e.g., "What is it like when there is conflict with your co-workers?"; "How is conflict with your co-workers typically resolved?"). Each section of the interview began with a generative question (e.g., "How would you describe your relationship with your co-workers?"; "What comes to mind when you think about conflict with your co-workers?") to orient the participant to the subject and allow the participant to lead the direction of conversation (Tracy, 2020). Due to the potentially distressing nature of these topics, resources were made available to participants following the interview (Appendix G). Interviews averaged 58 minutes, totaling 16.46 hours, and generated approximately 294 single-spaced pages of transcription.

Compensation

As compensation for their involvement in the study, participants received a $40 Target e-gift card upon completion of their interview. Incentives were chosen for this study to encourage participation. Due to trauma workers' varying schedules and job demands, scheduling a one- to two-hour interview was anticipated to be challenging. By offering a $40 incentive, participants were motivated to find time to participate in the study (e.g., on days or hours off of work, or during breaks). Additionally, due to the potentially distressing nature of the study's subject matter, a higher incentive was deemed to be appropriate. Funding for this project included $850 in grant money provided by the University of Wisconsin-Milwaukee Department of Communication.

Thematic Analysis

Analysis for this project was conducted using Braun and Clarke's (2006) thematic analysis, of which there are six phases: familiarizing yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun & Clarke, 2006). To become familiar with the data, each interview was immediately transcribed using the Microsoft Teams transcription feature. Following transcription, de-identified audio files and auto-generated transcriptions were reviewed and edited by a research team of five graduate students. Following the interview stage, transcripts were read thoroughly and repeatedly to immerse myself in the data. Transcripts were printed and color coded based on research questions being addressed (e.g., a purple tab to indicate discussions of relationships, a blue tab to indicate discussions of relational maintenance, a green tab to indicate discussions of work-related stress, and a yellow tab to indicate discussions of conflict). Portions of each transcript were read repeatedly for several weeks after the interview

process had finished. Following processes of familiarization, existing data underwent first-round holistic coding. At this stage, initial codes were generated based on salience, frequency, and relevance to the research questions (Braun & Clarke, 2006). Initial codes were handwritten in the margins of transcripts and later entered into an excel spreadsheet where codes were separated by research question (e.g., one tab each for relational framing, relational maintenance, work-related stress, and conflict). Following this stage, initial codes were collapsed into relevant and encompassing categories to create themes representative of the data (Braun & Clarke, 2006). Once themes were established, analysis continued using the posed research questions and sensitizing concepts of CTR and TRRL to recognize patterns, refine themes, and create clear labels that accurately describe the theme in response to the originally posed questions (Braun & Clarke, 2006). After clarifying and finalizing themes, representative examples of each theme were selected from the data to present in the final report.

Trustworthiness of Data

To ensure trustworthiness of the data analysis, memo writing and peer debriefing were used. Memo writing was used throughout the process of this research to create an audit trail (Lincoln & Guba, 1985). Memos were written weekly in a dedicated notebook about collecting, analyzing, and writing the data as well as the data itself. Written memos were typed weekly for organizational purposes. In addition to memo-writing, transcriptions were repeatedly read to familiarize myself with the participants' reports and generate new ideas and reflections of note (Tracy, 2020). Additionally, fellow researchers in the department joined in informal discussions and data conferencing to review data and discuss findings. Through these conversations, thoughts were teased out and expanded.

Chapter Three: Findings

In this chapter I present the findings answering my research questions: **RQ1)** How do trauma workers conceptualize co-worker relationships within the demands of their profession? **RQ2)** What relational maintenance behaviors do trauma workers enact with their co-workers? **RQ3a)** How do trauma workers talk to each other about work-related stress? and **RQ3b)** How do trauma workers experience and manage conflict with co-workers?

Framing Relationships (RQ1)

The findings in this section include common responses to how trauma workers frame and conceptualize their relationships with their co-workers (RQ1). Two categories emerged as prevalent: in the trenches together and building community outside of the trenches.

In the Trenches Together

One way in which trauma workers conceptualized their relationships with their co-workers is by situating them as being "in the trenches" with one another. They reported that shared experiences on the job was crucial to their development of trust and support systems. Due to the intense nature of their work, trauma workers prefer communicating about their work with others who have similar experiences, which narrows their support network to those within their career. These shared experiences can help trauma workers to support each other as well as understand the difficult situations they often face. ICU nurse Nicky reflected on the importance of having someone with similar experiences when making difficult decisions around a patient's end of life pain management: "You can say those things and somebody who's been a nurse for like about 10 years will get that like, 'Oh yeah, I know what you mean. I got you.'" When discussing something as difficult as how to keep a dying patient comfortable, Nicky pointed out that those outside of her career field are less likely to understand the situation. Instead, turning to

someone who has been ‘in the trenches’ allows for clearer understanding of the situation and more productive discussion of next steps. ICU nurse Dakota echoed the need for strong relationships with those within the medical field who ‘get it’:

> It’s good to have somebody who gets it because I can talk to other people, but when you're not…in the medical world, sometimes that nuance of what being at the bedside is like is really hard to grasp.

Similarly to Nicky, Dakota highlighted the need for shared experience to reach shared understanding of difficult situations. Though support networks exist outside of the workplace, trauma workers prefer talking to those within the same field as they are more likely to understand the nuances of their work.

While being in the same career field can provide pathways for understanding the situations trauma workers are put in, being ‘in the trenches,’ or working the same job, is oftentimes more important because career fields, such as the medical field, can have jobs that vary significantly. While some work at the bedside of severely injured and dying patients, others do not interact with patients as much as other employees. ICU nurse Andy discussed the differences in connecting with management versus those who work the same job:

> Management tries to come across as very open and, you know, supportive and they are, but it’s really the people that are, like we say, “in the trenches” with you. They just relate to everything you’re experiencing the most.

As Andy points out, despite best efforts, those outside of the trenches cannot fully relate to the experiences trauma workers face. Despite being in the same career field, those in other positions, such as management, do not go through the same experiences as trauma workers, thus limiting their ability to empathize and support trauma workers. Hospice nurse Griffin confirmed these

sentiments by expressing the importance of being ‘in the trenches’ together to empathize with each others’ experiences: “The feeling of empathy and the validation coming from someone who's in the trench with me is exceptionally healing and just cathartic.” As Griffin explains, being ‘in the trenches’ with each other creates a sense of validation that makes the workplace experience more “healing,” which is particularly important with trauma work. ICU nurse Jamie expanded on these thoughts by explaining that being ‘in the trenches’ with someone means seeing the same things as them. As Jamie puts it, “They will see what you see. And just being able to have somebody who you connect with just be there in the room with you is really much more meaningful than I think anybody really acknowledges.” For Jamie, being ‘in the trenches’ together means being in the same room seeing the same things. Through this conceptualization, trauma workers share a unique bond based in shared experiences through which they can best understand and relate to one another. When asked about her favorite moments with her co-workers, hospice nurse Griffin says, “It’s all the hard moments that you go through together.” Through these shared experiences, trauma workers are able to develop relationships with one another that can then be used to provide support.

Building Community Outside of the Trenches

In addition to using shared experiences within the workplace to bond and develop relationships, trauma workers also reported actively engaging in shared activities and events outside of work to build community. Trauma workers commonly talked about bonding over shared interests, celebrating big life moments, and supporting one another through personal struggles. Through each of these engagements, trauma workers can strengthen the bonds that have been established ‘in the trenches.’ By connecting on a personal level, rather than solely connecting on a professional level, trauma workers are able to create a sense of community that

encourages support and comfortability. ICU nurse Val described a few shared interests among her co-workers and how those interests have been implemented into the workplace:

> We have like a little nook in our workroom where we have like some plants and we made a little library and we like, we'll talk. There's like a little checkout section, it's adorable, where we'll like check out books and then you know whose book you got so you can talk about it. We're all like friends on Goodreads, so you can, like, see who's reading what.

Through their workroom library, Val and her co-workers can connect over stories they enjoyed and favorite authors. By having the library as well as connections on the reader's social media platform Goodreads, the nurses in Val's unit have more opportunities for establishing and prolonging relationships through discussions of books. In addition to the library and comforting nook at work, Val also mentioned a common interest in knitting among her co-workers that is often used to foster conversation. By bringing their interests into the workplace, trauma workers are able to create stronger connections with one another to make the workplace more comfortable rather than emotionally distressing.

In addition to sharing interests, other trauma workers discussed engaging in regular social events outside of work to allow for time to bond and connect without the surrounding context of work and patient care. ER nurse Charlie discussed regular get-togethers with her co-workers that allow everyone to bond and enjoy each other's company outside of the workplace: "We usually do a potluck like every weekend, and so that's pretty enjoyable, people get into that and some of them that are really well organized have themes, and I think people think that is fun." Charlie emphasizes the need for fun with co-workers outside of work through regular events like these. Similarly, hospice nurse Kerry highlights the need for non-work-based socialization with co-workers in order to truly connect and bond:

> I would rather just go out and do something where we're creating something versus just go out and like vent…Sometimes I think when we don't have that, we can get almost too sucked into work talk, and I don't think it is always the most therapeutic. So I find if we have something that's structured, we're healthier and more boundaried when we're together.

Kerry points out the need for fun and conversations that do not concern work to truly escape the intensity of their work and set healthy boundaries. By planning more structured events, such as knitting circles or painting nights, trauma workers have a specific focus that does not relate to their work, which provides for a welcomed distraction that continues to promote communal bonding and relationship development among co-workers.

In addition to bonding over shared interests and participating in regular social events outside of work, trauma workers also reported bonding over personal life events outside of work. Whether it be having a child, getting married, or losing a loved one, the bonds created in the workplace often extend outside of work. By connecting over life's stressful and celebratory events, trauma workers strengthen the communal bonds that are established 'in the trenches.' Hospice nurse Layne says that she and her co-workers are "usually rooting for each other and supporting each other, especially in difficult times or celebratory times." Similarly, EMT Sam talks about celebrating and supporting co-workers in their personal lives, which also extends to holidays:

> My shift's on Christmas Eve. We'll do something Christmas Eve. We're going to make kind of more of an elaborate meal…We do try to support each other and do stuff like that as well, like I said, like if this guy needs to move his house or he needs some help with

> something, we usually can kind of help him out on one of our off days. We just had a retired member who his mom passed away and we went to her memorial yesterday.

By taking time out of their days off of work to continue to support one another, trauma workers like Sam create a sense of community that extends beyond their shared work experiences. While trauma workers often help one another on the job, being able to do so outside of work creates a deeper connection and strong relationship where trauma workers become a community rather than work friends. ICU nurse Dakota further supports the importance of personal connections among co-workers in trauma work:

> There's only 12 of us in the whole group…so I see everybody really frequently…We have different like texting chains and hangout groups and that kind of thing. We all know about each other's like family…we're pretty close as a group and…now that I've been there for a while and I've seen them interview new people, I realize that they're like, really, really, really picky with who they bring in because they really want to protect that group dynamic, which I'm really appreciative of.

By focusing hiring practices on cohesion among co-workers as well as ability to perform the job, management contributes to the fostering of community that occurs within trauma work. This recognition of the need for community among trauma workers supports the idea that strong co-worker relationships are essential for trauma worker well-being. Hospice nurse Bailey pointed to the significance of having a strong network among co-workers while working in an emotionally distressing field:

> I would rather take a lower paying job and love my co-workers than with very good hours and shitty co-workers. There's something about really being in this job and being a nurse and being a hospice nurse, you need to have good co-workers. You just do.

Because trauma work, such as hospice work, can be emotionally intense, the need for strong relationships with co-workers becomes crucial. Bailey points out that the co-workers around her are what makes the work do-able. Without good co-workers, there is no pay or shift that is sufficient enough to get her through her line of work. A strong community with supportive co-workers is a priority for trauma workers in order to successfully manage their own well-being and thrive.

Relational Maintenance (RQ2)

This section reviews the various forms of relational maintenance and social support that is enacted among trauma workers (RQ2). In addition to developing strong relationships with co-workers, it is also important that trauma workers maintain these relationships to continue receiving the benefits of a strong community. When examining the relational maintenance behaviors trauma workers use with their co-workers, four categories emerged as prevalent: sharing responsibilities, emotional support, verbal appreciation, and gift giving.

Sharing Responsibilities

One way trauma workers reported supporting one another was through shared responsibilities. Because trauma work can be very hectic and demanding, teamwork is necessary to provide the best service possible. Sharing responsibilities in trauma work primarily involves assisting one another with patients, duties, and tasks. Examples of shared responsibilities include getting water for a co-worker's patient, monitoring a co-worker's patients when they need to step away, and helping a co-worker to chart or complete paperwork. To help each other, trauma workers often ask each other how they can help. ICU nurse Jamie discusses how she directly asks co-workers about their needs:

> I try to just support them by asking them frequently, "Do you need anything for me? Is there anything else I can be doing for you?" I try to help them at bedside…I feel like a little bit goes a long way. If the patient wants to drink water or something, I can get them a drink of water [instead of my co-worker]…Some people are really busy and do need you to help. And I'm certainly willing to help and happy to, you know, make [my co-workers'] lives a little bit easier if I can.

Jamie supports her co-workers by assisting them in their work and helping with the little things they may not have time to take care of themselves. As she points out, trauma workers can get very busy, so by lessening their workload even a little bit, co-workers can help to alleviate some of the burden of their work. This assistance allows trauma workers to focus on the bigger demands of their work without worrying that they are neglecting patients or other tasks. By sharing tasks and responsibilities, trauma workers are able to strengthen the trust they have in their co-workers by knowing that they have help available when it is needed.

Similar to Jamie, behavioral health access coordinator Frankie offers support to her co-workers directly. Additionally, she reported how her co-workers are perceptive to each other's needs and offer support before it is asked for:

> Just literally kind of picking up on the things that they know that I'm going to need or they know that the patient's going to need. So, you know, even if they're not in the room, they can kind of hear outside the room. So if they hear me inside saying, "Hey, can I get you a blanket? Hey, can I get you a Pepsi? Hey, can I get you something?" By the time I come out of the room, they've already got it there waiting for me.

By paying attention to each other and anticipating one another's needs, Frankie's co-workers are able to expedite the service being provided to patients. Additionally, by listening for the things

that may be needed, Frankie's co-workers can help to lessen the burden of each other's work before it becomes burdensome. By anticipating each other's needs, these trauma workers create a sense of teamwork in the workplace where each person can help pitch in anywhere possible. ICU nurse Nicky makes a similar point about the need for team support in trauma work:

> I can see that this is hard for everybody, and we're all a team and I can help, like if I'm free, I will help. That's one of the things that I like to show new nurses. It's like you might be done doing your things. That doesn't mean that everybody else is.

By training new nurses to help each other whenever possible, Nicky contributes to the expectations of teamwork and shared responsibilities in the workplace. By implementing this mindset from the very start, Nicky ensures that her work environment is one built on support for one another. Rather than leaving each person to their own responsibilities, each of these trauma workers supports one another to ensure all work gets done, not just their own. Through this sense of shared responsibility, trauma workers are able to see each other as a collective team, rather than individual co-workers.

Emotional Support

In addition to providing support through shared tasks, trauma workers also reported supporting each other through emotional support and validation of emotions. Because trauma work can be emotionally strenuous, talking about the heavy emotions associated with their work becomes necessary. Through these conversations, trauma workers are able to recognize and validate each other's feelings. Hospice nurse Griffin discusses these emotionally supportive conversations with her co-workers: "I appreciate having conversations with my co-workers and feeling validated and supporting one another and just someone who can relate and empathize with me." In this statement, Griffin points to the need for relation in those to whom she vents.

While trauma workers could potentially turn to anyone to talk through the emotional difficulties of their work, trauma workers choose to turn to other trauma workers who understand and can relate to their experiences. Hospice nurse Layne contributed to this sentiment by highlighting the need for support from people who understand her situation: “A lot of times it’s just validating my feelings. And also it’s coming from someone who gets it, who does the work with me. So when they say, ‘I hear you,’ they truly hear me.” Rather than trying to provide solutions to her situation, Layne reports appreciating the co-workers who understand and validate her emotional distress. Unlike non-trauma workers who may not understand the nuances of their work, trauma workers are best able to support one another emotionally and empathize with each other’s experiences. ER nurse Charlie expressed similar thoughts in the need for someone to listen to her emotional frustrations:

> Just validating, validating your feelings and, you know, letting me express how I'm feeling or my frustration or whatever. And just either agreeing, “Oh yeah, that sounds horrible.” Or, you know, just kind of letting me talk through everything and not necessarily giving me their opinion.

Charlie, like Griffin and Layne, reported needing co-workers who can listen and validate her heavier feelings at work. Charlie also adds that this emotional support needs to be judgement and opinion free so that she can be free to vent and express her frustrations and feel validated in the process. Because trauma workers endure similar experiences, they are able to provide this judgement free support without burdening the support receiver with questions. Non-trauma workers, while well intentioned, might not understand these situations well enough to withhold questions or uninformed opinions.

In addition to providing space for one another to share their feelings and be validated, other trauma workers highlighted the importance of having alternative perspectives presented to help them process their experience. Protective placements attorney Rowan discussed their appreciation for the different perspectives that their co-workers provide:

> They all are really great at validating my feelings and…providing different ways to look at things or maybe try different things that they have done. And it's the same as I was describing before, where I do that back for them too.

Rowan reports wanting co-workers who not only listen and validate her emotions, but also help her to process them. By providing alternative perspectives on the situation at hand, Rowan's co-workers help her to reappraise the situation and gain further insight. Other trauma workers reported similar types of support that expands beyond validation. Hospice nurse Kerry reported supporting a co-worker by providing esteem support: "I think she was feeling like she was failing. And I just had to reassure her that she wasn't failing and that the most experienced nurse with like the greatest time management is still going to fall behind sometimes." Because trauma work often includes having to make difficult decisions and not being able to help everyone, the emotional burden that trauma workers face can be accompanied by face threats. Kerry provided her co-worker with esteem support by reminding them of the difficulty of the job they are doing and the impossibilities they often face. Through this support, Kerry was able to alleviate some of the face threats her co-worker was experiencing and instead reassure her that she is doing a good job and is not failing at an impossible job.

While most of these examples stem from healthcare settings that tend to be more nurturing of one another, trauma workers in other career fields, such as fire rescue, echoed the need for emotional support. EMT Peyton discussed the highly masculine and individualistic

environment that is the fire station, but mentioned that this culture is evolving to be more emotionally supportive:

> I think the mentality of the fire department, at least, is shifting a bit where I think there's more of an understanding that if a guy is struggling with something or needs to talk about something that we can and that it's less of a, "You just need to keep that to yourself…" Now, technically, we can, we can take mental health days if we wanted to, but still nobody has. But yeah, I think the mentality of the department is a little different.

Peyton reported a shifting mentality in the fire department towards a more supportive one where mental health days are encouraged and support groups are available. However, Peyton also points out that those these resources are available and there is talk of more support, many of his co-workers have not yet taken advantage of these opportunities. Because fire departments have a long history of highly masculine cultures (Richardson & James, 2017), changes to these environments might be slower to catch on. Despite the slower pace of change, the fact that mentalities are shifting and resources are becoming available shows a willingness to change towards more emotionally supportive environments.

Verbal Appreciation

Along with shared responsibilities and emotional support and validation, trauma workers also maintain and strengthen their relationships through verbal acknowledgements of appreciation. Most trauma workers in this study reported directly saying 'thank you' to their co-workers or telling them how much they are appreciated. As was noted above, trauma workers regularly help each other with their work through shared tasks. Following these moments of assistance, trauma workers verbally thank one another for their help and directly communicate their appreciation for the support they have received. "We just tell each other how much we

appreciate each other. That goes a long way" (Frankie, behavioral health access coordinator). Frankie and her co-workers choose to acknowledge each other directly in order to clearly communicate their appreciation for each other. Rather than expecting one another to intuitively know that their support is appreciated, trauma workers like Frankie make it clear by being direct with their co-workers.

In addition to direct exchanges of verbal appreciation, trauma workers also reported systems in place for recognizing a co-worker. These systems go by a variety of names (e.g., "kudos" or "high-fives"), but are essentially the same in practice: employees who would like to thank or recognize a co-worker can submit a "kudos" which is then sent to management to formally recognize the employee. What happens after management receives them varies by workplace. Some workplaces have contests where each kudos an employee receives counts as an entry into a drawing for a grand prize. Other workplaces simply record the acknowledgement in the employee's record. Hospice nurse Kerry explains her experiences giving kudos to co-workers:

> You can write up a kudos for somebody at work and explain why they went above and beyond, but they're always going above and beyond. So that's how we recognize them, and I also make sure not only to share that with our manager, but I tell the person directly and I say, "Why should I keep this to myself? I think you're fantastic."

Kerry explains that her co-workers are "always going above and beyond" making the kudos process more regular. By showing regular appreciation for her co-workers through the kudos system, Kerry is acknowledging her co-workers in ways that management can recognize and document. In addition to using the kudos system, Kerry also chooses to directly thank her co-workers so that they are equally as aware as management of her appreciation for their work and

support. In addition to recognizing co-workers through management systems already in place, other trauma workers like to recognize co-workers in front of management during shift meetings. Hospice nurse Bailey describes a moment when a co-worker recognized her during one of these meetings:

> I think it was Monday, this week I had one of the worst shifts of my nursing career. It was just all-around terrible, and she could tell how hard of a day I was having, and we do a safety huddle meeting like with the previous shift and the oncoming shift and the management. And during that meeting, she made sure to mention to us, like "Bailey had a really rough night Monday, and she did a really good job." She said, "I just wanted to recognize that she really was a good asset to the team," and…I wish management hadn't put me in the position they had and they could have fixed it. But having recognition from people who just tried to help me did feel, it made me feel a little better about the night before.

Despite an awful shift that left her feeling terrible, Bailey's co-worker chose to express appreciation for her in front of management and the entire shift during a meeting to acknowledge the struggles she faced and commend her on her work. Bailey also notes that management fell short on the support they could have provided during the bad shift she experienced, but the verbal acknowledgment she received from her co-worker helped to make the situation feel lighter.

The examples of verbal appreciation above each demonstrate recognition of a co-worker of equal power. However, other trauma workers discussed receiving words of appreciation from superiors and those in higher power. ER nurse Hayden discussed the regular acknowledgements she received from her supervisor:

> For like two months at the end of each day, he would come up to pretty much everyone, including myself. I would be in triage a lot and he would walk out of his way to come over and say, “Thank you for your work today. I appreciate how hard you work today.” So, you know that was, I don't know. That was always nice.

Hayden mentioned that her supervisor would intentionally go out of his way in order to express his appreciation for her at the end of the shift. This display of gratitude was not limited to Hayden; her supervisor would do this for anyone he supervised on a shift. Through these interactions, Hayden’s supervisor shows his appreciation for his employees through both his words and his actions as he took the time and effort out of his day to go up to each individual and thank them for their work. In turn, Hayden has adopted this practice by thanking the technicians she delegates tasks to on a regular basis:

> I always tell [the techs] that I appreciate them and I try and remind them of that every single day because to me, techs are so important in an emergency room, and I just want them to know that I appreciate them. Even if no one else is telling you that they appreciate you, they do. We're so grateful that you're here.

In this show of gratitude, Hayden carries on the practice started by her supervisor to ensure that those in lower status positions are receiving the thanks that they deserve. Rather than letting the technicians go overlooked, as they often do, Hayden extends the words of appreciation to everyone around her, regardless of status or power level.

Gift Giving

In addition to assisting with responsibilities, emotional support, and verbal expressions of appreciation, trauma workers also reported exchanging gifts as a common way in which they bond with their co-workers. While some gifts are part of more structured events (e.g., Secret

Santa, potlucks), others are more spontaneous. ICU nurse Dakota discussed how a structured event provided more opportunity for spontaneous gift giving for her co-workers:

> We did a Secret Santa this year and we…filled out a sheet that said like everything that we like to give our Secret Santa hints. And so I just screenshot all of them. So now I… use that as like little gifts that they did something nice for me. Or if I want to, you know, bring in their favorite snack because they did something great for me yesterday or whatever in general.

Due to the organization of the department's Secret Santa gift exchange, Dakota was able to access information on each of her co-worker's likes to give her ideas for more spontaneous gifts throughout the year. Through this list, Dakota was also able to learn more about her co-workers to grow closer to them. Since obtaining this information, Dakota is able to provide gifts for co-workers to thank them for their help.

Other trauma workers, like hospice nurse Griffin, echoed the sentiment of spontaneous gift giving as a form of bonding with co-workers:

> I might pick up something for them, like something silly or like a gag gift or something and leave it on there. You know, like one of our social workers likes Ruth Bader Ginsburg, and I got her a sticker and left it on her desk.

While Dakota primarily uses spontaneous gift giving as a way to thank her co-workers, Griffin uses spontaneous gift giving to show appreciation for her co-workers. Through these gifts, Griffin is able to demonstrate to her co-workers how well she knows them while also showing appreciation for their companionship. Similarly, ICU nurse Andy gives small gifts to her co-workers to thank them for their support: "I like to buy tiny little gifts or send somebody a Starbucks card and just like little birthday or Christmas presents and just be like, 'Hey, thanks for

always being there.'" Though the gifts trauma workers provide for each other are often smaller and more spontaneous, they hold significant meaning. Through these gifts, trauma workers are able to symbolize their appreciation for each other while also acknowledging and connecting with each other's likes and interests.

In addition to small spontaneous gifts, several trauma workers mentioned providing food and caffeine for each other as a form of support. Due to their traditionally longer shifts, trauma workers, primarily healthcare workers, use food as a way of supporting and appreciating one another. Some trauma workers, like ICU nurse Taylor, talked about food as being a central component of their line of work: "Nursing is so food oriented…On our weekends, we bring in food for each other and sometimes, you know, bring in like coffees and stuff." Taylor also discussed bringing in snacks for the shift to bring a little light to everyone's day. By bringing in food, snacks, and coffee for one another, trauma workers are able to support each other tangibly by keeping each other fed and caffeinated. While food and coffee can be more of a spontaneous gift for co-workers or a small gesture for the shift, there are also moments where these gifts are more meticulously planned as an event. Hospice nurse Griffin reported fully planned meals that the staff will have together:

> Sometimes we bring in food and we like eat together. Dr. Jones is Indian and so she'll sometimes have Indian food catered and we'll eat together, which we always appreciate that or she'll make, like Indian dishes from home and bring it in for us to try, which I always like that experience. So that's some ways that we try to do things and bond and enjoy time with each other.

Rather than simply bringing in food and snacks for the shift, larger meals, like the one described by Griffin, provide more opportunity for trauma workers to bond and spend quality time

together. Through these meals, trauma workers can satisfy more tangible needs, like feeding each other, while also developing their relationships.

Work-Related Stress Talk (RQ3a)

This section also overviews the ways in which trauma workers experience and navigate relational load through discussions of work-related stress (RQ3a). Due to the arduous nature of their jobs, trauma workers often encounter significant stressors throughout their workday. Participants reported using several different ways of managing these stressors by talking with their co-workers. Their approaches are reflected in the four categories: debriefing, foregrounding patient humanity, using humor, and providing time alone.

Debriefing

One way that trauma workers reported engaging in conversation about the stressful moments of their work was through debriefing. Debriefing involves talking through traumatic events (e.g., multi-patient deaths, losing a family member of the staff) with other co-workers who were involved. During these debriefings, trauma workers revisit the details to discuss what went well and what went wrong while collectively processing the shared experience. As ER nurse Hayden explains,

> [D]ebriefing is…basically just a time where we all sit back, we discuss if there was something else that we could have done for the patient, if anything went poorly, or if anything went really great. Let's shout people out for that as well. And then it's just a time to talk and reflect on the situation.

As Hayden describes, debriefings involve recognition of both the good and bad of the situation. While it is important for healthcare workers to reflect on ways to improve their patient care moving forward, it is equally important to praise one another for the good work they have done.

By reflecting on both the positive and the negative actions taken in the situation, trauma workers are able to balance their emotional reflection of the situation while also foregrounding productive action for future patients.

In addition to acknowledging what went well and areas for improvement, trauma workers also reported using debriefings to collectively process the more emotional moments of their work. Due to the nature of their work, trauma workers must find ways to cope with stressful and potentially traumatic events on a regular basis. By talking through the more stressful moments, trauma workers are able to collectively "heal." ICU nurse Nicky discussed the collective nature of their work by saying, "[I]t's a shared experience and it's traumatic, and to be able to talk about it is something that's actually healing for the staff." As Nicky highlighted, it is most important to discuss these events with the people who were also present during the event. Because these events are shared experiences, co-workers are best suited to support and reflect each other. While Nicky highlights the importance of shared experience in debriefings, others made this point by discussing those who are not helpful to share debriefings with. ER nurse Charlie pointed out that management and grief counselors, while well-intentioned, are not best equipped to navigate potentially traumatic events that have happened at work because they were not present for the event:

> [M]anagement will arrange for us [to debrief] after a particularly bad trauma, like the death of a child or a multi person death or something that…one of our staff that worked upstairs died during COVID in our ICU and so they arranged something for that. Those I feel like are not as universally well taken as defusings are. Sometimes there's been feelings of anger because they bring in a grief counselor to talk to you and then people feel like, "Well, you weren't there, you didn't do that." But they talk to you about it. So I

> feel like, for some people, they're really helpful and then for other people, just talking to each other about it is more helpful.

As Charlie mentioned, some of the most helpful debriefings occur outside of the formal debriefings arranged by management. Talking with others who were present in the moment is more helpful than having a trained professional step in to navigate the emotional processing trauma workers go through. These informal debriefings are particularly salient to Charlie and her colleagues considering they have a different name they give to these sessions (i.e., defusings) to differentiate them from formal debriefings. According to Charlie, what is most important to a debriefing is being able to process the event with someone who shared the experience. "[Defusings help] you acknowledge your feelings in the moment because usually it's done by somebody that just had that experience with you." As Charlie points out it is important that trauma workers have strong relationships with those who are 'in the trenches' with them so that they are able to fully heal and process the stressful events they experience through both formal debriefings and informal defusings.

While the potentially traumatic events that lead to debriefings are stressful, they often are related to patients with whom trauma workers do not have a personal relationship. However, the stress of these jobs can become exponentially more stressful when the patients in question are those whom the trauma workers know personally. Participants reported experiencing moments where staff members or staff members' family members pass away in their workplace. In these moments, debriefings are particularly important. Behavioral health access coordinator Frankie recalled a recent event involving a co-worker's family member:

> There most recently was a distressing incident where one of my co-workers, her mother-in-law, came in and she coded in the emergency room and she ended up passing away.

> And it was pretty tough on all of the providers and the nursing staff. And so I immediately had a bit of a debriefing after, you know, the family went in. And so we kind of sat around and we talked about what had just happened and how we're feeling about it and what we could do to support each other.

Because trauma workers create such strong community bonds, the death of one trauma worker's family member can impact the rest of the department, especially when the family member passes away in that particular workplace. As Frankie put it, the debriefing that followed this family member's death was more about processing the heavy emotions that followed rather than the steps that should or should not have been taken. By focusing primarily on the feelings involved, these trauma workers were able to direct the conversation towards ways to support one another.

While the bonding done in trauma work can lead to heavier emotions following potentially traumatic events, sharing the experience of potentially traumatic events can also operate as a form of bonding among trauma workers. As ER nurse Charlie described,

> We do a lot of bonding through trauma, like through traumatic events. We have a fair amount of death and dying in our department, but some things are always worse than other things. One of our codes that stands out a lot to me is a child that died in a car accident, and we called her resuscitation before her parents were there, so she was just like a little Jane Doe, and that was really traumatic for a lot of our staff. And so what we did for that, and there was a formal debriefing, but what was more helpful was we did a defusing. The ER doc took us all in the break room and we talked and said the serenity prayer, and then we had to turn around and go back to work because there was, of course, the shift was not over. And so that, I think, was a really powerful bonding experience for the team.

Similarly to her prior discussion of formal debriefings versus informal defusings, Charlie highlighted the need for more informal connections with her co-workers that worked on this particular case with her rather than relying on the formal debriefing provided by management. Charlie also noted that going through these shared experiences together, regardless of how upsetting they are, is part of what bonds trauma workers together. Being able to not only bear witness to potentially traumatic events together, but also processing those events together creates a strong sense of community, understanding, and support for trauma workers that is unlikely to be found outside of their workplace.

Foregrounding Patient Humanity

While debriefing and talking through the situation was reported as a strategy for talking with co-workers about work-related stress, trauma workers also reported foregrounding patient humanity as a strategy for navigating the dismal situations they regularly experience. Because a large majority of participants for this study were healthcare workers (e.g., ER workers, ICU nurses, hospice nurses), a lot of reports concerned patients and patient care. In the medical field, some healthcare workers opt to decentralize patient humanity to maintain their composure and focus instead on the medical puzzle in front of them. However, several trauma workers discussed the importance of foregrounding patient humanity to emotionally cope with the vicarious stress of their patients' conditions. Though many trauma workers foreground patient humanity, their reasons for doing so varies. For ICU nurse Andy, foregrounding patient humanity is how she keeps herself from getting too emotionally detached.

> Just trying to…process it, know that I did everything that I can and just respect that they're human and not just, you know, part of my job and honoring that is important to me. That's how I stay grounded and not get, you know, kind of frozen over.

By engaging in self-talk and reminding herself of her patients' humanity, Andy is able to ground herself through the rough emotions that come with her work while also respecting her patients. Instead of framing her patients as another part of her job, Andy reminds herself that they are human and not just a thing to take care of. By doing this, Andy is also able to reflect on her own humanity and process her actions in the patient's care. Like Andy, ICU nurse Val respects her patients' humanity to stay grounded and provide the best care possible: "If I start crying or getting emotional like, then I can't do what I'm, I need to do and I can't do what she needs me to do." By maintaining focus on the patient and their needs, Val, like Andy, is able to ground and sideline emotional outbursts to foreground patient care. As she explains, if she were to openly cry with each patient, then she would not be able to perform her job and provide the best possible care for the patient. By reminding herself that the patient is human and needs her care, Val can put aside her outward emotional expressions until a more appropriate time when her patients do not need her immediate attention. Sometimes, the moment to outwardly express her emotions over patients comes when talking with patient families. As Val continues:

> I often cry with the family and when I sit with them and talk about how incredibly hard this is and being able to connect with them on that level, I think helps to see that like, so they see that I'm human too, and I can see their sorrow.

As Val explains, there are moments in her work when respecting the patient means concealing her emotions, while there are other moments when respecting the patient means expressing her emotions. By crying with the families of her patients, Val can emotionally process the hard moments with the family while also allowing the family to recognize her own humanity.

While foregrounding patient humanity sometimes involves crying to connect with the family or concealing emotions to focus on patient care, for other trauma workers, foregrounding

patient care involves connecting to the patient personally and creating an environment that is tailored to them. Hospice nurse Kerry describes a moment while giving a bath to an unresponsive patient along with a co-worker:

> [S]he looked up in the patient's chart when they were born, how old they were and figured out [when] they were, when they were in their 20s and 30s, took her personal phone, put on Spotify with music from that era and played that music while she gave a bath.

Even though this patient was unresponsive and unable to communicate their preferences, Kerry's co-worker took the initiative to look up the years in which the patient was a young adult to play music that may be more familiar for them. By taking this step, Kerry's co-worker is able to connect with the patient in a way that is more human while also lessens the emotional burden of their work. Though separate from the patient's medical needs, providing a familiar and comforting space for the patient allowed Kerry's co-worker to care for the patient as a human.

For hospice nurse Bailey, foregrounding patient humanity involves memorializing each patient she helps to pass peacefully. Specifically, Bailey has a jar she has labelled her "death jar" that she uses to memorialize her patients. As she described,

> Labor and delivery nurses do it a lot, they have like a bead jar. They put a bead for every baby they deliver. I have a bead that I put for every patient that I've pronounced…I just kind of put it in the jar and I'm just like, "Thank you for letting me be a part of your journey, rest easy," and just kind of a way to memorialize.

Bailey connects her memorializing of the end of patient life to the ways in which labor and delivery nurses celebrate the start of new patient life. By maintaining a physical container with a bead for every patient she pronounces, Bailey is able to highlight and honor the lives of her

patients rather than completely letting them go. While her “death jar” is a very symbolic visual for the lives she’s touched, Bailey also light-heartedly recognizes the dark humor involved in keeping this remembrance: “I guess it’s kind of disturbing when I like shake it like it’s a maraca, that’s a little more morbid” (Bailey, hospice nurse). Despite the heavy nature of her work, Bailey is able to spotlight the humanity of her patients while also keeping things light through dark humor.

Using Humor

In addition to formal and informal debriefings, as well as foregrounding patient humanity, trauma workers also reported using humor to manage work-related stress. Several trauma workers discussed the importance of humor to counterbalance the brevity of their work. As hospice nurse Layne puts it, “You got to make it fun sometimes, like on a dark job like this, you have to have humor.” Layne highlights the importance of bringing fun into a job that is otherwise emotionally laden. In order to manage the emotions that come with trauma work, humor and fun are needed to make the job less burdensome. ICU nurse Andy expands on these thoughts by explaining how humor is used to break tension and relieve stress:

> I mean, she knows that I appreciate humor and breaking the ice when I’m really stressed and or just respecting when I need my space. If I’m feeling overwhelmed about situations, we always jokingly but also seriously, just say like, “You're doing great sweetie,” from the doorway yelling into each other's room.

Andy emphasizes the importance of both validation and humor to bring light to the heaviness of their work. In this situation, Andy reports humor as being able to “break the ice” or relieve tension while on the job. Additionally, the use of a joking yet sincere compliments from co-workers help relieve work-related stress.

In addition to using humor to relieve tension, other trauma workers reported using humor to decompress. ICU nurse Taylor discussed how humor is used in his unit to lighten the environment:

> I typically use dark humor. I think that that's something that's very big on our unit. We're all pretty calloused. I think that I kind of just make fun of myself with some self-deprecating humor and the situation at hand, even though a majority of the times, it's really serious and traumatizing to not only myself, to patients or family, but it's just more so trying to make it a little bit lighter because it's just really hard to take in. So I think a lot of the decompressing time is just basically trying to get a laugh or just kind of like, you know, my co-workers making fun of me and trying to get me to chuckle and stuff like that. So I think, I think it's typically laughter.

As Taylor points out, trauma work can be "really serious and traumatizing," thus making need for ways to lighten the mood or decompress. In his unit, laughter and humor are two ways that this decompression happens. Whether the humor is a small joke about the situation or making light-hearted jokes about each other, laughter is needed to lessen the weight of the seriousness in the ICU. By getting each other to laugh, trauma workers are able to balance the heaviness of their work and find some joy with one another. However, because environments like an ICU or ER are so emotionally laden, humor and laughter can feel inappropriate at times as ER nurse Charlie points out: "I think that sometimes that how we blow off stress is by being goofy or being loud, sometimes maybe being inappropriate." In environments where people are managing serious illness and injury, laughter and silliness are not the first emotions typically thought of. Management, in particular, might be especially protective of the ways in which trauma workers present themselves around patients and families. However, as others mentioned, laughter and

light-heartedness are needed every so often in these environments to manage emotions. Organ procurement coordinator Quinn highlights the importance of shared perspectives to understand the need for humor:

> I think having some humor too, right, when you can and working in this line of work, you know, I mean, ICU, critical care, [organ] donation, death, dying, right? You have sometimes a warped sense of humor it seems, right? And so if you're not in this line of work, it might not come across the right way. But you got, you got to laugh things off.

Like the other trauma workers reported, Quinn says humor is needed to "laugh things off" so that the intense emotions associated with their work does not weigh them down too much. Quinn, however, also points out how humor in these situations might not be understood by those who are not in the same line of work, or those who are not 'in the trenches.' Without seeing the same degree of death and dying that trauma workers see, others may not understand the need for or the type of humor in this work.

Providing Time Alone

In addition to debriefings, foregrounding patient humanity, and moments of humor, trauma workers also reported needing to take time alone when their work becomes too overwhelming. Due to the emotionally intense nature of their work, trauma workers sometimes need to step away and have co-workers cover their responsibilities so that they can have time alone to process and gather themselves. Although the work never stops, trauma workers occasionally need breaks in order to do their job to their best ability. Hospice nurse Bailey mentioned a co-worker who gets very emotionally attached to each patient she interacts with, which leads that co-worker to needing time alone to cry and process:

> I think we're all doing it the best we can in that moment because we, you know, we just have our own ways of doing it. And like the aide that I work with, she's one that loves every patient like it was her grandma. So like, she'll have to step away and cry, and, you know, back in the day when we first got together, I'd be going with her and rubbing her back, but now I'm like, “Give her a few minutes. She’ll be fine.”

While Bailey’s initial response was to follow her co-worker and support her, overtime Bailey has realized that her co-worker just needs some space to process the passing of a patient. By explaining to others in the unit that the aide needs a few moments to herself, Bailey is able to provide time alone for her co-worker to work through her emotions before returning to her job. Like Bailey, behavioral health access coordinator Frankie also ensures that the others in her workspace have the space and ability to step away when needed:

> I make sure they have the ability to decompress if they need to take a walk or let them go and take a lap or whatever it is they need to do and then they help by just making sure if the patient is stable that they’re there for the patient if the patient needs anything, thus giving me the time to be able to walk away and do my little bit of quiet.

As Frankie explains, providing time alone involves more than just letting a co-worker step away; it also includes covering each other’s responsibilities while the co-worker is recovering themselves. Therefore, in order to provide co-workers with time alone, trauma workers must check in with each other to ensure the work continues and patient care is not neglected.

While each trauma worker has a different approach to the time they take when they step away, taking that time alone is important to each trauma worker’s well-being. For some, a quick walk is needed. Other trauma workers need time and space to cry. For others still, a quiet, private

space with a co-worker is all that is needed. Hospice nurse Griffin describes an unofficial private space used by the nurses to step away and vent:

> We have a med room, it's a locked room that you need a badge access to get into, only nurses can get in. And so something that I'll say to my co-worker, a nurse is, "can you waste in med with me?" because we have to waste narcotics that we don't use and that's usually a cue I need to vent… And that's usually a safe place for us to have a conversation, I would say that happens very frequently, it happens every shift that's just kind of our place to be together and support each other in privacy.

As Griffin points out, stepping away sometimes includes bringing a co-worker along. In these instances, stepping away is more about privacy and getting away from the intensity of more public areas. By having a private space that is accessible only to staff, Griffin and her co-workers are able to maintain a safe haven that allows for support, venting, and quiet as it is needed.

Conflict in Trauma Work (RQ3b)

This section also overviews the ways in which trauma workers experience and navigate conflict with co-workers (RQ3b). While work-related stress is a significant cause of tension in trauma work, workplace conflict can also create stress in an already stressful environment. When asked about conflict in the workplace, trauma workers consistently discussed two different phenomena represented by the following categories: hierarchy as silencing and backgrounding petty disputes.

Hierarchy as Silencing

A majority of trauma work, such as that which takes place in the medical field, operates using strict hierarchies for communication and orders. Doctors give orders to nurses, who give orders to technicians. Due to the emergent nature of medical work, these hierarchies are used to

lessen confusion and facilitate efficiency in the chain of command. Rather than having several voices offering different opinions, one person makes the call and others follow. While this system works to a patient's benefit, it can also create difficulties communicating around interpersonal conflict. ICU nurse Jamie discussed how conflict in the workplace is different depending on the status difference of those involved:

> Conflict between…equals is a lot different than with the residents like doctors and things like that because they are your superior. So at the end of the day, you have to listen to what they say and if you don't agree with it, it can be very frustrating.

As Jamie expresses, when conflict arises with a superior, there is very little that can be done. For this reason, nurses often feel silenced and do not express their frustrations or different opinions with their superiors. Because the chain of command is so strict, nurses like Jamie do not engage in conflict when disagreements arise. By knowing that their concerns will not be heard, trauma workers like Jamie are effectively silenced by the hierarchical structure in place. ER nurse Hayden echoed this silencing in situations of conflict with superiors:

> I don't always address things with the doctors because I just view them as kind of my superior and then it becomes this awkward, unbalanced [thing where] I really need to come to some resolution with this, but [they] don't seem willing to talk about it.

Hayden points out that the status difference makes addressing conflict with superiors "awkward." In addition to this awkwardness, Hayden acknowledges that her superiors are not willing to engage in conflict, thus limiting her options for how to manage the conflict at hand. Instead of engaging with conflict, those in lower status positions have no choice but to comply with their superior's orders.

Hierarchies in trauma work are not limited to differences in position. Other trauma workers mentioned the factors of age and experience affecting who is deemed superior. ICU nurse Dakota reported moments of conflict with someone in a lower status position who is her superior in age and experience:

> There's a CNA who's worked in [the ICU] longer than I've been alive. She's approaching retirement, she knows a ton, she could basically be a nurse, but she never went and got the degree. Sometimes she can be a little rough with patients, or she's annoyed because she doesn't want to do something, and I'll be like "No, it's alright." I don't want to stir the pot. I'll just go and do it… just to prevent further conflict from happening.

Dakota's experiences with her co-worker indicate how status differences are not limited to differences in position. Despite her co-worker being of a lower status position, Dakota accommodates her instead of engaging in conflict. This example demonstrates the prevalence of status in trauma work, particularly in the medical field. Whether status comes from position, age, or experience, conflict between superiors and their subordinates becomes silenced. This silencing also occurs when disputes and concerns are brought to management. ICU nurse Nicky discussed talking to management about issues she was having with her superiors, only to have the behavior continue.

> I don't even know how many times we would talk to our manager about like the unprofessional, rude behavior of the physicians and the nurse practitioners. And it's like, that's how they're making money, the hospital's making money. And so why would they, why would they do anything about it? I mean, it's like, this should be unacceptable. But here we are, like allowing this behavior to continue.

Despite talking to management on several occasions, the hierarchical structure that supports physicians proved too strong to be disrupted. Even when the behavior in question is rude or unprofessional, the position of the physicians protects them from management intervention. Due to this rigid hierarchy, any conflict between trauma workers of different status is silenced in favor of the individual of higher status, whether that status come from position, age, or experience.

Backgrounding Petty Disputes

In addition to workplace conflict going unaddressed due to hierarchical structures, trauma workers also reported avoiding conflict when the conflict is petty, passive aggressive, or not worth the fight. While some conflicts can have larger repercussions, others can be relatively minor, such as clashing attitudes, name-calling, and cliques. When asked about conflict with co-workers, ICU nurse Taylor said "I think those are a lot more passive aggressive and just unaddressed. And I just don't really want, I don't really want to give that attention because I just don't believe in it." Taylor thought mostly of passive aggressive conflict with co-workers and moments that have little impact on patient care or the work being done. Because these moments of conflict are minor, petty, or unrelated to the job, Taylor opts to let the conflict go unaddressed to avoid creating more trouble than the situation is worth. By ignoring these smaller conflicts, Taylor is able to background petty disputes to focus instead on patient care and more significant issues.

While Taylor situates petty disputes as being passive aggressive or not worth his time, hospice nurse Layne looks at petty disputes as outside of her "sphere of control." When asked how she addresses conflict with co-workers, Layne said "It's like, what's in your sphere of control? And some things that are outside of it that I, you know, I don't have a lot of influence

over." When conflicts arise that Layne has little control over, she chooses to let them go. Instead of wasting her time with issues that she cannot change, Layne chooses to maintain focus on the problems that she can influence. By shifting her perspective this way, Layne is able to reframe the work around her to focus on patient care and things in her control, while backgrounding the petty disputes of which she has no influence.

While Taylor and Layne situate petty disputes as being passive aggressive and outside of their sphere of control, ICU nurse Nicky frames petty disputes as being a waste of time in comparison to patient care. Nicky discussed conflict between doctors and nurses, primarily the rude and unprofessional behavior exhibited by physicians. In this discussion, Nicky also mentioned how these conflicts are a distraction from the work that needs to be done. Upon reflection, Nicky said, "Why am I wasting so much of my own time and energy when like, this isn't where my focus should be. I'm spending too much energy here." By reframing the situation to ignore the petty disputes and small conflicts, Nicky is able to instead focus her time and energy on her work and patients.

Across each of these findings, trauma workers reported on the importance of shared experiences with their colleagues in order to build and maintain resilience against the stressors associated with trauma work. Participants reported framing their relationships with their co-workers as connecting with those who are "in the trenches" with them while also building community outside of the "trenches" or in the moments surrounding the stressors of their work. Participants reported a range of ways in which they maintain these relationships with their co-workers such as sharing responsibilities on the job, emotional support and validation, direct verbal expressions of appreciation, and gift giving. In addition to maintaining these relationships, trauma workers also reported using several strategies for mitigating work-induced stress such as

debriefing stressful events and moments with co-workers, foregrounding patient humanity in self-talk, talk with co-workers, and interactions with patients, using humor with co-workers, and providing space for co-workers to step away and take time alone. While trauma worker relationships with their co-workers have shown to be important to trauma worker well-being, moments of conflict can create divides within this community. Participants in this study mainly reported avoidant tactics for managing conflict in favor of focusing on the job at hand and prioritizing patient care. Despite these moments of conflict, co-worker relationships have shown to be a key source or resilience for trauma workers.

Chapter Four: Discussion

This dissertation sought to explore the relationships trauma workers have with their co-workers and, particularly, their potential as a source of resilience against potentially traumatic work environments. Particularly, relational maintenance and relational load were examined within the context of trauma work. Following 17 semi-structured interviews with trauma workers in a range of occupations (e.g., hospice nurses, first responders, organ procurement coordinators), several patterns were identified in response to the following research questions: **RQ1)** How do trauma workers conceptualize co-worker relationships within the demands of their profession? **RQ2)** What relational maintenance behaviors do trauma workers enact with their co-workers? **RQ3a)** How do trauma workers talk to each other about work-related stress? and **RQ3b)** How do trauma workers experience and manage conflict with co-workers? Commonalities across findings and expansions to current literature are discussed in this section.

Trauma Worker Relationships (RQ1)

Participants reported conceptualizing their relationships with their co-workers as (a) being in the trenches together and (b) building community outside of the trenches. When framing their co-worker relationships as being 'in the trenches together,' participants primarily talked about the importance of shared work experiences as a unique factor that allows them to connect with one another in ways that non-trauma workers cannot. Through these shared experiences, trauma workers develop trust and support systems with one another. This finding is consistent with literature on military support systems where military service members reported having the most confidence in turning to other service members for support relating to their experience in the military (Clark-Hitt et al., 2012; Peck & Sahlstein Parcell, 2021; Wilson et al., 2014). Due to the unique nature of military service, service members often operate under the assumption that

those outside of the military, including spouses and family members, would not understand the stressors they experience, and therefore cannot adequately provide support (Clark-Hitt et al., 2012; Peck & Sahlstein Parcell, 2021; Wilson et al., 2014). Similarly to this research, participants in the present study reported beliefs that those outside of the 'trenches,' or those who do not work in similar fields, do not have the experience needed to provide adequate support. For this reason, trauma workers discussed their relationships with their co-workers as being 'in the trenches' together, meaning they have shared experiences upon which they can connect and support one another where others cannot. Additionally, trauma workers reported that these shared experiences create a shared understanding of the difficult decisions inherent to the job, such as how best to manage pain medication in end-of-life care, that others may not understand. Because non-trauma workers do not see and experience the same situations, it can be challenging for trauma workers to receive support from those not in their field. Military service members reported similar mentalities when considering who to turn to for support (Clark-Hitt et al., 2012; Wilson et al., 2014). Trauma workers also reported that the conceptualization of the trenches is more specifically narrowed to those who work the same or similar jobs within the field, as opposed to management who may try to understand the situations trauma workers are in but cannot fully empathize or "get it." Similarly, service members have reported needing to turn to other service members rather than spouses or families (Clark-Hitt et al., 2012; Wilson et al., 2014). Though spouses and families of service members have some experience of military life, their experiences are distinct from service members themselves, similar to how management within trauma work experiences the work differently than the trauma workers themselves. For these reasons, the relationships trauma workers develop with their co-workers becomes important for empathy and support for work-related stressors.

Though much of trauma worker relationship building happens on the job or 'in the trenches,' participants also reported developing their co-worker relationships and a sense of community outside of work responsibilities and hours. Some of the ways that participants reported building community with each other included sharing their life experiences (e.g., moving, having children, losing a loved one) and interests (e.g., books, knitting) to expand the shared topics they have between each other. Some participants reported having dedicated spaces at work, such as a 'book nook,' where they can connect over non-work subjects. Additionally, participants reported engaging in social events (e.g., potlucks) and structured activities (e.g., candle making) outside of work to further build a sense of community. This finding is consistent with the CTR communication process of maintaining and using communication networks (Buzzanell, 2010; 2018). Through this communication process, individuals turn to others who have similar experiences for support while also nurturing their relationships. Individuals who employ the communication process of maintaining and using communication networks are able to construct resilience by creating a sense of community in order to feel less alone in their moments of hardship (Buzzanell, 2010; 2018; Dutta, 2019). Through these social events and activities, trauma workers are able to avoid 'shoptalk' and instead focus on spending quality time with one another and maintaining their communication networks. Trauma workers also reported bonding over shared meals, holidays spent on the clock, and helping one another move. Dutta (2019) had similar findings where women in notoriously male dominated STEM careers bonded with one another in order to combat feelings of being a "black sheep." This sense of community helps trauma workers to strengthen their support systems with one another by expanding upon their shared work experiences, which has also been found to be a protective factor against the development of posttraumatic stress for healthcare workers (Laurent et al., 2021; Madsen &

Abell, 2010). This sense of community is also recognized by management as important for trauma worker well-being as some participants reported adaptations to the hiring process in order to protect the supportive environment among trauma workers.

Workplace Relational Maintenance and Social Support (RQ2)

Participant reports of relational maintenance fell into four categories: (a) sharing responsibilities, (b) emotional support, (c) verbal appreciation, and (d) gift giving. One of the biggest ways that trauma workers reported supporting and showing their appreciation for each other was through sharing responsibilities. Shared responsibilities varied, but mostly included helping with each other's patients, helping to chart or file paperwork, and covering each other's patients when their co-worker is overworked or needs to step away. This finding is consistent with social support research, particularly tangible or instrumental support (Cutrona & Russel, 1990) which also appears in relational maintenance literature (Dainton & Myers, 2020; Stafford, 2011). Sharing tasks is one of the commonly reported relational maintenance strategies across relationship types (Dainton & Myers, 2020), but is particularly relevant in organizational contexts (Madlock & Booth-Butterfield, 2012). Trauma workers reported both asking their co-workers what they need help with and anticipating their co-workers needs by listening to what their patients ask of them. Through both direct asking and anticipating co-workers' needs, trauma workers are able to communicate to each other that they are available to help and that no one is working alone. Some trauma workers reported sharing this sentiment when training new hires in order to set a precedent in the workplace that everyone helps each other where they are able.

In addition to sharing responsibilities, trauma workers also reported engaging in emotional support with their co-workers. Emotional support among trauma workers is primarily

enacted through expressions of emotion validation. Several trauma workers reported the importance of emotional support specifically from co-workers, or others who work similar jobs due to their understanding of the stressors at hand and the ease at which they can relate. This finding is also supported by social support literature that highlights the importance of esteem support in order to provide the support seeker with an increased sense of self-worth (Afifi et al., 2016; Cutrona & Russel, 1990; Goldsmith, 2004; Lafreniere & Shannon, 2021). In work such as trauma work, the emotional distress that can accompany occupational trauma exposure can lead trauma workers to devalue themselves (Laurent et al., 2021), thus increasing the need for emotional support and validation. Because trauma worker emotional support comes from someone else who understands the demands and difficulties of the job (e.g., someone who is 'in the trenches' with them), trauma workers reported a greater sense of validation. Additionally, trauma workers reported that emotional support with their co-workers is particularly helpful when they are able to vent without receiving opinions from their co-workers as well as when they can receive reassurance that the work is difficult no matter how hard they work or how many people they help. Through these validations that the work itself is difficult, trauma workers are constructing resilience through the communication process of crafting normalcy (Buzzanell, 2010; 2018). By situating the work as difficult for everyone, regardless of performance or ability, trauma workers are creating a narrative that the norm for trauma work is challenging. Some trauma workers also reported emotional support being helpful when their co-workers provide alternative perspectives on the situation at hand such as different ways to understand the situation or different approaches to try. These findings are also consistent with social support literature, particularly that which highlights the importance of reframing and reassurance within emotional support (Rains & High, 2021). Similarly, these findings line up with the CTR communication

process of providing alternative logics wherein stressful situations are reframed to become more manageable (Buzzanell, 2010; 2018). By helping one another to re-evaluate a stressful situation, trauma workers are able to help each other to reframe the situation at hand to become one that is more emotionally manageable. It is through these conversations that trauma workers are able to actively construct resilience by regaining a sense of worth and establishing new ways of perceiving their surrounding environments. Though a majority of participants in this study come from the field of healthcare, participants who work in fire stations shared that their environment is also shifting to become more open to discussing and supporting one another through emotional hardships, rather than feeling the need to keep emotional distress to themselves as has traditionally been the case in more masculine workplaces such as fire stations.

Another way in which trauma workers maintain their relationships with their co-workers is through verbal appreciation. Many trauma workers reported directly and verbally expressing their gratitude to their co-workers, either by saying ‘thank you’ after receiving help or simply saying that they appreciate their co-worker. Trauma workers reported two different approaches to these verbal expressions: talking to the person directly and using systems already in place to recognize one another. Such systems have a range of different names (e.g., kudos, high-fives), but are essentially the same. Through these systems, employees can identify and report a co-worker for doing a good job. Those reports are then sent to management. What happens following a ‘kudos’ varies from workplace to workplace. In some workplaces, each ‘kudos’ a person receives equates to an entry in a raffle. In other workplaces, management simply makes note of the kudos in the employee’s file. Some trauma workers reported that they prefer to both use the ‘kudos’ system and tell their co-worker directly when they are appreciated. Other trauma workers reported taking time to recognize co-workers when they are going through particularly

challenging times (e.g., an emotionally draining and demanding shift). These findings are consistent with literature that highlights the importance of positivity as a relational maintenance strategy (Dainton & Myers, 2020; Stafford, 2011). By verbally expressing appreciation for one another, trauma workers are able to shift their often stressful work environment to become more positive and supportive. These trauma workers also mentioned recognizing their co-workers in front of others (e.g., other co-workers and management) to especially highlight the praise they are providing. In addition to recognizing one another, few trauma workers reported also receiving expressions of gratitude from management, particularly when management goes out of their way to show their appreciation (e.g., finding everyone individually at the end of the day to say thank you). These trauma workers then also reported following the example set by management and taking the time to express thanks to the employees who report to them (e.g., ER nurses thanking technicians).

Lastly, trauma workers reported using gifts to show appreciation for one another and strengthen their relationships with co-workers. As is common in a multitude of workplaces, some trauma workers reported participating in formal gift exchanges at work (e.g., "Secret Santa") wherein participating employees list the things they enjoy. One participant in this study reported using these lists to make note of the things their co-workers like so that they can give gifts throughout the year, rather than just during the holiday season. Other trauma workers reported giving spontaneous gifts when they see something a co-worker might like (e.g., stickers, mugs, Ruth Bader Ginsburg bobbleheads). Occasionally, these gifts are accompanied by a verbal "thank you for being there" to highlight the gift giving act as one of appreciation. Aside from small gifts given throughout the year, trauma workers, particularly nurses, frequently talked about providing food and caffeine for one another as a way of bonding and appreciating one

another. Such acts resemble both positivity as a relational maintenance strategy (Dainton & Myers, 2020) and tangible support via providing nourishment through long workdays (Goldsmith, 2004). As one participant put it, “nursing is so food oriented” (Taylor, ICU nurse). Providing food for one another ranged from bringing in a co-worker’s favorite snacks, to bringing coffee in for everyone on the shift, to hosting full home-cooked meals to be enjoyed together.

Work-Related Stress Management (RQ3a)

Participants reported four specific strategies for talking about and supporting one another through work-related stress: (a) debriefing, (b) foregrounding patient humanity, (c) using humor, and (d) providing time alone. Trauma workers frequently discussed debriefings as a useful strategy for navigating more stressful situations at work (e.g., multi-patient deaths, losing a family member of the staff, child jane doe deaths). Debriefings can be formal (i.e., arranged by management and scheduled) or informal (i.e., casual discussions with co-workers) but consistently include reflections on the situation and discussions of what was done well and what could use improvement. One trauma worker mentioned a different name they use for informal debriefings, or “defusings” (Charlie, ER nurse) to highlight the distinction between formal and informal debriefings. This finding is consistent with existing literature on debriefing as a learning strategy within healthcare contexts (Dalton et al., 2022; Dismukes et al., 2006; Sawyer et al., 2016). In this literature, debriefing acts as more than a helpful tool for reflection; it also serves as a strategy for effective learning. By thoroughly reviewing the positive and negative actions of a recent event, trauma workers can collectively process and learn from their actions (Dalton et al., 2022; Dismukes et al., 2006; Sawyer et al., 2016). Trauma workers talked about debriefings as being useful to facilitate healing, particularly when the debriefing exclusively includes co-

workers who were part of the stressful situation at hand. Some trauma workers talked about formal debriefings as being unhelpful when management brought in grief counselors or external others who were not present for the stressor. This external support was often talked about as being unfavorable due to the lack of shared experience and possibility for empathy. Instead, by debriefing with co-workers who directly encountered the same situation, trauma workers are able to connect with one another and collectively heal through the event. This finding is similar to literature that highlights the importance of in-grouper support, such as support between military service members (Clark-Hitt et al., 2012; Peck & Sahlstein Parcell, 2021; Wilson et al., 2014). Though well-intentioned, support received from others who are external to the stressful event at hand is often viewed as inadequate (Clark-Hitt et al., 2012; Wilson et al., 2014). For this reason, trauma workers feel most comfortable debriefing with their co-workers who were at their side during the event itself, rather than mental health professionals who may make speculations about experiences shared among the trauma workers. Some trauma workers also discussed debriefings as being a moment of bonding between trauma workers as everyone can share their feelings and insecurities relating to the event, thus creating more trust and potential for support among co-workers. Debriefings typically take place soon after the stressful event but are sometimes delayed due to the constant demand of trauma work.

Trauma workers also reported reframing their mindsets while working to foreground patient humanity as a way to combat work-related stress. Through this reframe, trauma workers actively perceive their patients as people rather than a component of their work. This strategy appeared mostly among healthcare workers. By recognizing the humanity of the patient, trauma workers are able to empathize with the patient and provide the best care possible as they see the patient as someone in need of help, rather than a task that needs to be completed. By re-orienting

themselves to view patients as people, trauma workers are able to ease some of the stress associated with their work and reassure themselves that they have done everything they can to make the patient comfortable. This finding is consistent with CTR communication process of foregrounding productive action (Buzzanell, 2010; 2018). Rather than dwelling on the emotional stress associated with occupational trauma exposure, trauma workers construct resilience by actively choosing to foreground the work that they can do to help their patients. This reframing tactic is also consistent with rumination literature. Rumination has been reported to be detrimental to well-being and posttraumatic growth (Carr, 2019) as it leads the individual to hyper-fixate on their stressors rather than the actions they can take (Roeder et al., 2020). As demonstrated in the findings of this study, trauma workers are able to construct and maintain their resilience by avoiding rumination and instead foregrounding their responsibilities to their patients. Some trauma workers also discussed selective expressions of emotion as a way in which they can recognize and care for the patient. One trauma worker talked about waiting to cry until they are no longer working with the patient to prevent their emotions from impeding the care they provide. This same trauma worker then went on to discuss how they display their own humanity and connect with patients' families by crying with them. When talking about ways to highlight the importance of working with human lives, each trauma worker reported different approaches which included expressions of emotions, relating to moments in older patients' young adult lives, and attending funerals as a way to honor and memorialize their patients. One hospice nurse specifically talked about a "death jar" she keeps with each bead representing a patient she helped to pass peacefully. These forms of emotional engagement and honoring patients' humanity are consistent with literature on hospice worker emotion management (Way & Tracy, 2012). By connecting, feeling, and expressing the emotions experienced surrounding a

patient, healthcare workers, such as hospice workers, are better able to process their emotions in ways that promote healing, rather than continued stress (Way & Tracy, 2012).

In addition to debriefings and reframing to foreground patient humanity, trauma workers also reported using humor to manage work-related stress. Uses of humor varied in form but often included small jokes, quick wit, and occasional pranks. Participants talked about using humor as a way to lighten otherwise emotionally heavy work. Many trauma workers reported humor as being necessary for the job in order to make work less burdensome. The necessity of humor in trauma work was reported as important for different reasons. Some trauma workers talked about humor as a strategy for blowing off steam or relieving stress. Others discussed using dark humor specifically in order to process emotionally laden situations and relieve tension. Uses of humor, particularly dark humor, have been discussed in resilience literature as useful for coping by reframing traumatic and stressful events to be less burdensome (Bischetti, 2021; Buzzanell, 2019; Kennison, 2022). CTR research positions humor within the communication process of providing alternative logics, wherein individuals can creatively reshape stressful events to be lighter or more amusing (Buzzanell, 2010; 2018), such as using humor as a coping method after a family member develops a serious illness (Buzzanell, 2019). Dark humor in particular was talked about by participants as sometimes being inappropriate if heard by others but maintained that dark humor was important to lighten the seriousness of certain situations. Because dark humor could be mistaken as inappropriate by those outside of trauma work, participants reported the importance of engaging in humor, particularly dark humor, with co-workers or others 'in the trenches' who best understand the intentions of and need for this type of humor within these contexts.

The final strategy participants reported using to help each other manage work-related stress was providing time alone. Because trauma work can be very emotionally heavy, some trauma workers need to step away occasionally to process their emotions and regroup before returning to work. Taking time alone can take a few different forms, including taking a brief walk and going to a private, secured space where they would not be intruded upon. Because this is a common need recognized by trauma workers, participants reported providing time for their co-workers to step away without letting their responsibilities go unfulfilled. By providing this time alone for their co-workers, trauma workers are enacting the CTR communication process of maintaining and using communication networks (Buzzanell, 2010; 2018). While this communication process often involves time spent together, it can also include addressing the needs of those within one's network, such as the need for time alone. By providing ample time and space to process either individually or with another person, trauma workers are able to communicate solidarity with and support for one another. The ways in which trauma workers provide time alone for their co-workers include covering each other's patients and responsibilities, explaining to others where their co-worker is and why and they had to step away, and going somewhere private with their co-workers. Some trauma workers reported having designated spaces for time alone as well as codes to communicate to co-workers when they need time alone versus when they need privacy with someone to whom they can vent.

Conflict in Trauma Work (RQ3b)

Two commonalities emerged in participant experiences of workplace conflict: (a) hierarchy as silencing and (b) backgrounding petty disputes. When discussing conflict in the workplace, trauma workers mostly talked about moments where they either cannot fully engage in conflict or when they chose not to engage in conflict. Some of the most common moments of

conflict that trauma workers reported involved tensions between people of different power levels, such as doctors and nurses. Because hospitals run on a strict hierarchy in order to act quickly in emergent situations and provide efficient care (Shin, 2009), it is routine that workers follow the orders they are given without question or discussion. However, this hierarchy also creates an environment where subordinates cannot voice their perspectives in moments of conflict. This finding is consistent with literature on conflict among healthcare workers. Shin (2009) conducted a meta-analysis of healthcare conflict research ranging from 1970 to 2006 and found that the most common type of reported conflict was professional conflict, or friction between doctors and nurses. As opposed to conflict between equals, conflict with someone of higher power typically means that the person with less power will have to listen to and accommodate the person with more power. Moreland et al. (2015) found that despite identity perceptions nurses were likely to adopt a sense of learned helplessness in response to conflict in the workplace. Rather than engage in conflict, nurses felt they could not have any effect on their environment, thus leaving conflict unresolved. Reported hierarchies affecting trauma worker conflict management in this study were not limited to the position a person holds. Some trauma workers reported experiencing a similar silencing effect, or learned helplessness (Moreland et al., 2015), with co-workers who are either older than them or have more experience in the field. In each of these instances, trauma workers feel the need to accommodate the person in power in order to keep the peace.

Similarly, trauma workers also talked about managing smaller disputes by ignoring them or letting them go. Some of the petty disputes that trauma workers reported experiencing include name calling, clashing attitudes, passive aggression, and the formation of cliques. In moments where trauma workers encounter a petty conflict trigger such as these, participants reported

focusing instead on what is in their "sphere of control" (Layne, hospice nurse) or what they have control over rather than devoting attention to the smaller disputes they encounter. This finding is also supported by existing nurse conflict literature. Due to sensations of learned helplessness, nurses actively choose to avoid confronting conflict and instead focus on situations within their environment that they can control, such as patient care (Moreland et al., 2015; Moreland & Apker, 2016). By focusing their attention on patient care instead of these petty disputes, trauma workers reported being able to remind themselves of where their focus should be and what is important. Doing so also reframes situations of conflict in ways that are consistent with learned helplessness psychology (i.e., nurses support their mindset that they cannot resolve conflict by actively avoiding it). By intentionally letting these petty conflicts go unaddressed, trauma workers are able to keep the peace in their workplace and maintain operations via patient care. This finding is also consistent with CTR research, specifically surrounding the communication process of backgrounding negative feelings (Buzzanell, 2010; 2018). By backgrounding negative feelings, such as those that arise within petty disputes, trauma workers are better able to foreground productive action (e.g., patient care).

Theoretical Contributions

The most prominent theoretical contribution of this study is the application of TRRL (Afifi et al., 2020a) to co-worker relationships. Rather than limit the use of relationships as a source of resilience to romantic and familial relationships, future literature should, as this study did, consider the importance of co-worker relationships as a means of enacting resilience. While research exists on the uses and benefits of workplace friendships (Raile et al., 2008; Sias et al., 2012; 2020), scholars have not yet considered workplace friendships as a source of resilience. In the present study, TRRL was considered within the context of co-worker relationships in trauma

work. Being a career field that includes high exposure to potentially traumatic events, trauma work has great demand for strong co-worker relationships and resilience as part of the job. Due to the regular trauma exposure trauma workers face, it is crucial that these workers have systems in place to construct and enact resilience to avoid burnout and maladaptive trauma responses. Literature in other highly stressful career fields, such as the military, suggests that support for work-related stressors is best received when it comes from others within the same career field (Clark-Hitt et al., 2012). This need for shared experience implies that those who are not trauma workers, such as the families and partners of trauma workers, might not be able to empathize with and support trauma workers. While romantic and familial relationships might help an individual to build resilience, this study suggests an additional need for relationships with those who are 'in the trenches' (i.e., co-workers). Social support literature suggests that perceived availability of support supersedes enactments of support (Cutrona & Russell, 1990; Goldsmith, 2004; Vangelisti, 2009). Because trauma workers, like service members, do not expect their partners and families to understand what they experience, they perceive a lack of available support from these sources. Instead, co-worker relationships and the emotional capital they reap appear to be important to the management of work-related stress and the support that follows.

Bridging Resilience Models

The present study makes a second theoretical contribution by proposing an overlap in the resiliency theories CTR and TRRL. Though these theories are distinct in their conceptualization of enactments of resilience as well as the construction of resilience (i.e., CTR views resilience as constructed through dialogue whereas TRRL views resilience as resulting from emotional capital and well-maintained relationships), similarities connect the two theories. Firstly and most notably, the CTR communication process of using and maintaining communication networks

shares clear connections with the theoretical model of TRRL. In CTR, communication networks serve as a means of constructing resilience via strong relationships and shared experiences. In TRRL, strong relationships serve as the foundation on which resilience is built. In the present study, communication networks of co-workers served as a specialized community through which trauma workers could seek support and understanding. Participants reported turning to co-workers to vent and seek support while also taking steps to ensure strong connections to co-workers through activities such as shared meals, group outings, and shared hobbies and interests.

Additionally, there was also observed overlap between the communication process of foregrounding productive action while backgrounding negative feelings and the TRRL components of relational maintenance (e.g., positivity and assurances) and relational load (e.g., conflict with co-workers). In this study, participants reported foregrounding patient humanity and care (i.e., productive action) while backgrounding petty disputes (i.e., negative feelings). In these reports, particularly in discussions of petty disputes, trauma workers highlighted the use of avoidant conflict management strategies in order to maintain a peaceful working environment. In doing so, trauma workers are limiting their engagement with relational load while also backgrounding negative feelings in favor of more peaceful relationships with co-workers. In addition to the mitigation of relational load via conflict avoidance, participants in this study also discussed engagement with co-workers in moments of humor to alleviate the stress of their work. Some participants described humor as being necessary to the work in order to prevent burnout. Uses of humor with co-workers also serves to alleviate tension brought about by conflict (i.e., petty disputes), thus theoretically lessening the relational load associated with such conflicts. Connection of these theoretical models should continue to be investigated in additional contexts to assess the potential overlaps between conceptualizations and enactments of resilience in

scholarship. Such exploration may uncover ways in which resilience within relationships can be further strengthened (e.g., constructing resilience within resilient relationships).

Practical Implications

This study has practical implications that can be used to improve the relationships between co-workers, particularly in trauma work fields. First, his study highlights the importance of support networks in trauma work. As was reported by participants in this study, support for trauma work is best received when coming from those who share similar experiences. For this reason, workplaces that employ trauma workers would benefit from encouraging relational development among co-workers. Secondly, some trauma workers in this study reported having a close community with their co-workers that is fostered through events outside of work as well as discussions of shared interests and hobbies. By promoting relational development through subjects that do not include trauma work, trauma workers are able to build strong bonds with one another that lead to increased trust and support through the difficult moments of their work. Due to the importance of co-worker relationships and support in trauma work, workplaces that employ trauma workers should consider devoting resources (e.g., time, dedicated spaces, and financial support for events) to the promotion of bonding among co-workers. By doing so, workplaces can communicate to their employees that these types of relationships are important to their work and well-being. Thirdly, findings from this study may also apply to occupations outside of trauma work. While trauma work has its own unique stressors, other types of occupations may benefit from having close relationships with co-workers. Such relationships would facilitate reciprocal support over work-related stressors that others outside of their field may not understand well enough to provide support.

Fourth, this study also found that trauma workers are more likely to prioritize their work and care for patients over workplace conflict. Though conflict is a natural occurrence in most every relationship type, trauma workers reported regularly silencing themselves due to power differences and perceptions that the conflict at hand is not important enough to detract from their work. While it may be difficult to navigate opening discourse between employees of different power levels due to the hierarchical structure of healthcare and other forms of trauma work, workplaces should consider implementing tools for conflict management and resolution that allow all perspectives to be heard regardless of power. Lastly, conflict resources should also be dedicated towards the management of smaller or petty disputes in the workplace. Though they are smaller in nature and deemed less important than the work itself, continued workplace conflict that goes unresolved can become draining to employees and diminish their ability to be resilient against workplace stressors. Overall, this study highlights the importance of relationships among co-workers as a useful tool for building resilience. Despite the type of work being done, strong relationships among co-workers can serve as the foundation for greater resilience in stressful work environments while also potentially enhancing employee satisfaction and well-being.

Limitations

As with any study, the findings presented above are limited in various ways. First, this study almost exclusively recruited primary trauma workers instead of evenly recruiting primary and secondary trauma workers. Though both types of trauma workers engage in regular exposure to potentially traumatic work environments, any possible distinctions between direct and indirect exposure to traumatic events could not be examined. Secondary trauma workers, such as victim advocacy workers and therapists, may have similar experiences and perspectives on co-worker

relationships as primary trauma workers, however, such similarities would need to be examined more closely in further research. Second, a vast majority of participants in this study were healthcare workers. While healthcare is a prominent form of trauma work, other forms of trauma work, such as fire and rescue response teams, deserve attention in order to determine similarities and differences across the spectrum of trauma work. Because participants in this study were mostly healthcare workers, findings for this study cannot reliably be applied to trauma workers external to the healthcare industry. Other limiting demographic features include the majority of participants being White women in the Midwest. Due to differences in gendered and regional socialization towards emotional expression and communication, findings from this study cannot be expanded to people of color, men, or those outside of the Midwest without further study (Afifi & Cornejo, 2020).

Future Directions

This study provides several opportunities for continued research. First, future research should continue to expand on the theoretical model of TRRL through exploration of the applicability of the model to co-worker relationships. By expanding the TRRL model to include co-worker relationships, future research can establish the importance of these types of relationships within organizational contexts. Though the model appears to apply to co-worker relationships in trauma work, other occupations should be studied to explore the extent to which co-worker relationships can serve as a source of resilience. To expand on this, future research could continue to use qualitative methods to explore other career fields (e.g., hospitality, academia, and entertainment) and the types of relational maintenance used within co-worker relationships in order to look for commonalities across co-worker relationships, which would help to further expand and apply the TRRL model to co-worker relationships.

Second, future research should continue to explore the overlaps between CTR and TRRL. While some communication processes of CTR were found to be similar to components of TRRL (e.g., maintaining and using communication networks), other processes and propositions of CTR should be investigated. By exploring the overlaps and connections between resilience theories, future research may be able to establish stronger potential forms of resilience via communicative processes within resilient relationships. One such direction future research could explore would be the communication process of affirming identity anchors as a means of affirming relational identities. In other words, future research should explore the ways in which individuals view their positionality within a relationship (i.e., as a relational partner) as an identity anchor they connect to in particularly distressing moments. Similarly to communal coping research (Afifi et al., 2016; 2020a; Guntzviller & Wang, 2019; Haas & Lannutti, 2022; Rice & Jahn, 2020; Richardson & James, 2017), such research could apply to any relationship type (e.g., romantic, platonic, co-worker, family) and would be useful to unpack the ways in which individuals reflect on and discuss their role in their relationships as a form of reassurance and resilience (Afifi et al., 2016; 2020a; Haas & Lannutti, 2022). Such investigation has the potential to further solidify the importance of social relationships as a source of resilience as has been proposed by TRRL (Afifi et al., 2019a; 2019b; 2020b) and communal coping scholarship (Afifi et al., 2016; 2020a; Rice & Jahn, 2020; Richardson & James, 2017).

Third, future research should examine co-worker relationships as a source of resilience through quantitative methods. Because the present study used a qualitative approach, correlations and effects could not be measured to confirm the influence of strong co-worker relationships on trauma worker resilience. As a qualitative study, this dissertation prioritized exploration of co-worker relationships within trauma work in order to investigate the possible expansion of TRRL

to organizational contexts. This exploration demonstrated possible applicability of co-worker relationships within the TRRL model, thus suggesting need for future research to continue to test and investigate the applicability of the TRRL model to other relationship types besides romantic and familial.

Fourth, future research should study the socialization of newly hired trauma workers into the communities built by other trauma workers, as well as the ways in which they assimilate into potentially traumatic work environments. Such research would build off organizational socialization research (Bauer & Green, 1994; Cepale et al., 2021; Choi, 2018; Scott & Meyers, 2005) to expand specifically to practices and effects of emotion socialization in organizations, particularly trauma work. Within this line of research, scholars have the opportunity to investigate factors that distinguish trauma workers that thrive from those who struggle through or prematurely end their careers in trauma work. Such research could benefit from a longitudinal method wherein newly hired trauma workers report their connections with their co-workers and strategies for emotion management across timepoints ranging from orientation to several years on the job. By conducting this type of research, insight can be gained as to the usefulness of particular communication strategies and assimilation tactics used to adjust to stressful work environments, such as that found in trauma work.

Future research should also explore the extent to which workplace conflict affects an individual's threshold for stress. TRRL hypothesizes that conflict with a relational partner creates relational load which ultimately lowers their threshold for stress (Afifi et al., 2019b; 2020b; 2021), meaning the more unresolved conflict relational partners experience, the more of a toll it takes on their well-being and ability to thrive in stressful situations Therefore, it can be theorized that workplace conflict has a similar effect within the context of workplace

relationships (i.e., trauma workers are less able to thrive when they experience continuous unresolved conflict with one another). However, further research is needed to confirm the applicability and extent of this effect.

Conclusion

This study aimed to explore the relationships between trauma workers as a potential source of resilience. Trauma workers were conceptualized as individuals who regularly (i.e., at least monthly) work either directly or indirectly with violence, serious injury, or death. Due to the potentially distressing nature of this work, it was expected that trauma workers have established strategies of resilience to combat the emotional stress inherent to their work. Using TRRL and CTR as sensitizing concepts, research questions for this study were developed to include exploring relationship conceptualization among co-workers in the field of trauma work, workplace relational maintenance among co-workers, work-related stress management talk and tactics, and conflict among trauma workers. Qualifying workplaces (e.g., hospitals, emergency rooms, fire stations) were contacted directly to seek participants. Interested individuals were directed to complete a screening survey to confirm their eligibility as a trauma worker, after which semi-structured interviews were scheduled. Seventeen trauma workers participated in interviews to discuss their experiences working as a trauma worker, particularly their experiences and relationships with their co-workers. Interviews were recorded and transcribed generating 294 single-spaced pages of transcriptions. After a thematic analysis was conducted, commonalities across trauma worker responses were recorded. Participants reported conceptualizing their relationships with their co-workers as being those who are 'in the trenches' with them while also building a sense of community outside of work hours and activities. Reported relational maintenance strategies included sharing responsibilities, emotional support, expressions of verbal appreciation, and gift giving. Trauma workers reported managing work-related stress with their co-workers through debriefings and defusings, foregrounding patient humanity, using humor, and providing time alone as needed. Experiences of conflict

demonstrated minimal engagement with conflict triggers. Motivations for avoiding conflict included power differences acting as a silencer and perceptions of petty disputes as being unimportant within the context of their work. This study expanded upon CTR and TRRL research to explore potential overlaps in enactments of resilience within trauma work. In doing so, justification was found for further support of co-worker relationships within the field of trauma work to strengthen co-worker relationships and provide additional opportunities for resilience through belonging and community. Future scholarship should explore the applicability of the TRRL model to alternative types of relationships (i.e., non-romantic and non-family relationships) and co-worker relationships in other career fields. Additionally research should continue to examine the connections and overlaps between resilience theories in order to investigate the potential of resilient communication to well-being.

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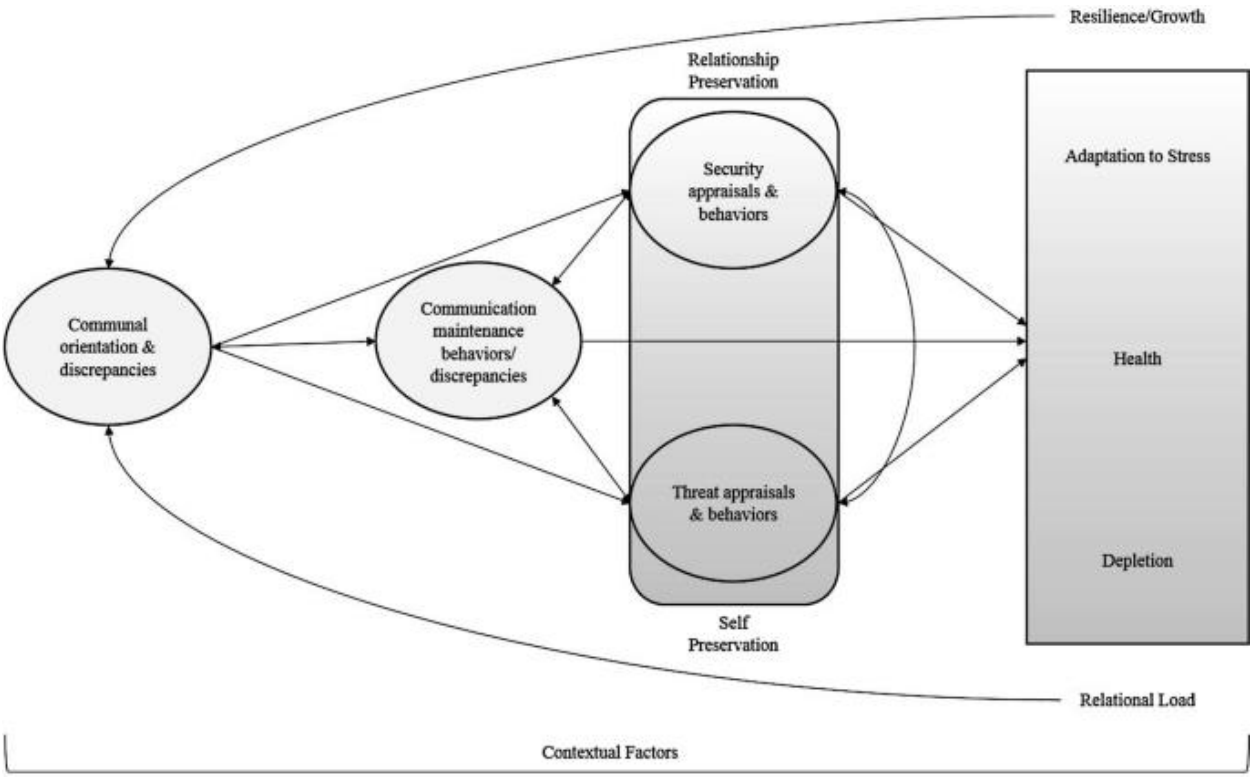
Appendix A: TRRL Model



(Afifi et al., 2016)

Appendix B: Recruitment Email Template

[*Subject Line*]: Interview Study on Trauma Worker Relationships
Hello,

I am a doctoral candidate at the University of Wisconsin-Milwaukee and am conducting a study on Co-worker Relationships, Trauma, and Resilience ("Building Resilience in Trauma Work," UWM IRB# 23.076), and I am hoping employees in your organization might participate. Would you help to get the word out about this study?

To conduct this study, I am looking to recruit trauma workers who are interested in participating in 60–90-minute virtual interviews. To be eligible for the study, interested persons must meet the following criteria:

- Live and work in the United States
- Speak English
- Be 18 years or older
- Currently work in a position that directly or indirectly encounters violence, serious injury, or actual or threatened death as a regular and expected part of your job
- Have worked in your current position for at least one year

Participants will be compensated with a $40 Target e-gift card as a thank you for their involvement in the project.

If you are willing to help spread the word, I would greatly appreciate your time and efforts. I have attached the flyer for this study [*see below*]. If you are unable to assist me with this, would you mind sharing the contact information for those who might be interested? I can contact them directly or you could share this email with them.

Thank you so much for your time, and I look forward to hearing from you.

Jacki Willenborg, M.A.
Doctoral Candidate & Teaching Assistant
Department of Communication
The University of Wisconsin - Milwaukee
Office: 332 Johnston Hall
Pronouns: She/Her/Hers

Appendix C: Recruitment Flyer

Trauma Workers Wanted

If you regularly work with actual or threatened death, serious injury, or violence, you may be eligible to participate in a research study.

Co-Worker Relationships, Trauma, and Resiliency

We are studying the role of co-worker relationships in managing traumatic work environments, such as those that expose workers to violence and death. We are hopeful that findings will provide useful information on how trauma workers navigate work-related trauma, which can then be extended to other demographics.

Participants will receive:

- $40 Target e-gift card

Location

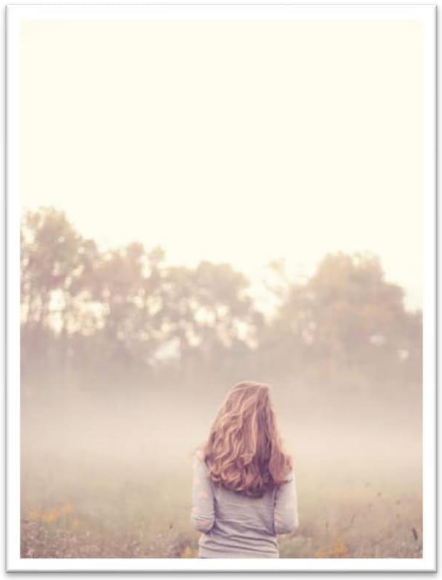
- Virtual interviews over Microsoft Teams for approximately 60-90 minutes
- Interviews will be audio and video recorded

Are you eligible?

- Live and work in the United States
- Speak English
- 18 years or older
- Currently work in a position that directly or indirectly encounter violence, serious injury, or actual or threatened death as a regular and expected part of your job
- Have worked in your current position for at least one year

Examples of jobs that qualify

- First Responders
- Hospice Workers
- Hospital Staff
- Social Workers
- Forensic Investigators
- Violence Prevention Teams



If you're interested in participating or have questions about this study, please email:

Jacki Willenborg (MA)
Doctoral Candidate & Primary Researcher
willenb2@uwm.edu

IRB Approval #: 23.076
IRB Approval Date: 11/16/2022

UNIVERSITY of WISCONSIN UWMILWAUKEE

University of Wisconsin-Milwaukee, Department of Communication

Appendix D: Qualtrics Screening Survey

Thank you for your interest in participating in Building Resilience in Trauma Work (IRB Approval #: 23.076). To confirm your eligibility, please answer the following questions:

1. How old are you? _____ [*Qualify if older than 18 years*]
2. What is your email address? _____
3. Do you currently live in the United States?
    a. Yes [*Qualify*]
    b. No [*Disqualify*]
4. Do you currently work in the United States?
    a. Yes [*Qualify*]
    b. No [*Disqualify*]
5. Which of the following best describes your line of work?
    a. First responder
    b. Hospital staff
    c. Hospice work
    d. Disaster response
    e. Social work
    f. Forensic investigator / crime scene worker
    g. Mortuary/morgue worker
    h. Other: _____
6. What is your job title? _____
7. How long have you worked in your current position? _____ [*Qualify if one year or greater*]
8. How often do you directly encounter actual or threatened death, serious injury, and/or violence at your job? [*Qualify if monthly or more frequent*]

a. Every day

b. Every week

c. A few times a month

d. A few times a year

e. Rarely, if ever

9. How often do you encounter details of actual or threatened death, serious injury, and/or violence at your job? [*Qualify if monthly or more frequent*]

    a. Every day

    b. Every week

    c. A few times a month

    d. A few times a year

    e. Rarely, if ever

Thank you for your responses. Someone will be in touch within the next couple of days to discuss your eligibility and potentially schedule an interview. If you have any questions, please contact Jacki Willenborg at willenb2@uwm.edu. If you know anyone else who may be eligible and interested in participating, please have them contact Jacki Willenborg at willenb2@uwm.edu.

Appendix E: Informed Consent Form

Study title	Building Resilience in Trauma Work: An Application of the Theory of Resilience and Relational Load to Occupational Trauma Exposure
Researchers	Jacki Willenborg, doctoral candidate; and Dr. Erin Sahlstein Parcell, Professor, Department of Communication

We are inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later.

What is the purpose of this study?

We would like to investigate the ways that trauma workers navigate traumatic environments, particularly how co-worker relationships serve as a protective factor against regular exposure to trauma. We are hopeful that findings will provide useful information on ways that trauma workers navigate trauma, which can then be extended to other groups of people.

Who can participate in this study?

In order to participate in this study, you must:

1) Live and work in the United States,
2) Speak English,
3) Be 18 years or older,
4) Currently work in a position that either directly or indirectly encounters violence or death as a regular and expected part of the job,
5) Have worked in your current position for a minimum of one year.

Compensation

Participation in an interview for this study will be compensated with a $40 Target e-gift card.

What will I do?

I am asking you to sit for an audio and video recorded interview that will last 60 – 90 minutes. In the interview I will ask questions regarding your relationships with your co-workers, how you maintain these relationships, how you talk about work-related stress with your co-workers, and experiences of conflict with co-workers. I will also ask you about your demographics— gender, age, race, and area of work.

Risks

Possible risks	**How we are minimizing these risks**
Some questions may be emotionally upsetting.	You can skip any questions you do not want to answer. You may also ask to take a break or stop the interview at any time.
Breach of confidentiality (your data being seen by someone who should not have access to it)	• We will store all identifiable information in electronic data on a password-protected, encrypted computer.

There may be risks we do not know about yet. Throughout the study, we will tell you if we learn anything that might affect your decision to participate.

Other Study Information

Estimated number of participants	30
How long will it take?	60 – 90 minutes

Costs	None
Compensation	$40 Target e-gift card for participating in an interview
Future research	De-identified (all identifying information removed)
Recordings	We will be audio and video recording using Microsoft Teams and transcribing all interviews for this study. Recording your interview is necessary to this research. If you do not want to be recorded, you should not be in this study.

Confidentiality and Data Security

We will collect the following identifying information for the research: your name and email address/phone number. This information is necessary for potential follow-up questions on the interview.

Where will data be stored?	On a password protected computer with restricted access
How long will it be kept?	Up to 5 years (until 2028)

Who can see my data?	**Why?**	**Type of data**
The researchers	To conduct the study and analyze the data	De-identified (no names, birthdate, address, etc. attached to the data that is reported)
The IRB (Institutional Review Board) at UWM The Office for Human Research Protections (OHRP) or other federal agencies	To ensure we are following laws and ethical guidelines	De-identified (no names, birthdate, address, etc. attached to the data that is reported)
Anyone (public)	If we share our findings in publications or presentations	De-identified (no names, birthdate, address, etc.) • If we quote you, we will use a pseudonym (fake name)

Contact information:

For questions about the research	Jacki Willenborg, Dr. Erin Parcell	willenb2@uwm.edu eparcell@uwm.edu
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	414-662-3544 / irbinfo@uwm.edu
IRB Approval	#: 23.076	Date: 11/16/2022
For complaints or problems	Jacki Willenborg, Dr. Erin Sahlstein Parcell	Willenb2@uwm.edu eparcell@uwm.edu
	IRB	414-662-3544 / irbinfo@uwm.edu

Verbal Agreement of Consent

Remember, your participation is completely voluntary, and you're free to withdraw from the study at any time. Do you have any questions about the study? Do you agree to participate?

Appendix F: Interview Guide

Interview Guide

[*Opening Script*] Thank you for meeting with me! My name is Jacki, and I am a doctoral candidate at UWM. I am conducting a study about co-worker relationships and how they create resilience in an otherwise stressful work environment. For this interview, I will be asking questions about how you maintain relationships with co-workers, how you talk about work-related stress with them, and experiences of conflict with co-workers. [*Review consent form and obtain verbal consent*].

I should emphasize that this is completely voluntary. You do not have to answer any of my questions, and we can stop at any time. Some of the topics we will be discussing may be emotionally distressing, so feel free to ask for a break, or to skip a question, at any point in time. I will not share your information with others without camouflaging your identity so others cannot figure out who said what. I will be recording the interview to make sure that I do not miss anything you say or take it down incorrectly. Do you have any questions? [*Answer participant questions*]. Are you ready to begin? [*Once the participant is ready, start recording and begin the interview*].

Topic Sections

1. Where do you work?
    a. How long have you worked there?
    b. What is your current job title?
    c. What led you to this line of work?
    d. Describe a typical day in your job.

2. The focus of this study is about the co-worker relationships of trauma workers, particularly in times of stress. Who, at work, are the people most significant to your day?
    a. *[note for interviewer: list each person mentioned then proceed through the following questions (3-6) focusing on one person at a time]*
3. How long have you known them?
4. How would you describe your relationship with _____?
5. Could you describe a situation where you turned to _____ for support?
    a. *[potential follow-up questions & topics]*
        i. *[What did they do/say that you found especially helpful?]*
        ii. *[Can you think of any situations where you have supported them at work? If so, please describe the situation and what you did/said]*
    b. *[note for interviewer: take note of moments of support and incorporate into questions 8 & 9 as relevant]*
6. What is an example of how you bond or build your relationship with ____?
    a. *[potential follow-up questions & topics]*
        i. *[What is an example of things you and _____ do that you enjoy?]*
        ii. *[In what ways do you and _____ show appreciation for each other?]*
        iii. *[What is a favorite memory you have with _____?]*
7. Is there anyone else at work that you would say is significant to you or your day?
    a. *[If yes, repeat questions 3-6]*
    b. *[once interviewee feels they have run out of people close to them, continue with the following]:*

8. Now I'd like to talk a bit about your job and how you encounter stressful situations. Think of the last time you were assigned an especially stressful [call/case/job]. How did you prepare yourself emotionally?
    a. How do you rely on co-workers as you prepare for this [call/case/job]?
    b. *[potential follow-up questions & topics]*
        i. *[How do you and your co-workers talk about the (call/case/job) as you prepare?]*
        ii. *[Who would you say is most important in helping you prepare to enter the scene?]*
            1. *[How do they help you prepare?]*
        iii. *[Who would you say is most supportive as you prepare to enter the scene?]*
            1. *[What do they do to support you?]*
9. Think back to when you finished this [call/case/job]. How did you decompress?
    a. How do you rely on co-workers as you decompress from this [call/case/job]?
    b. *[potential follow-up questions & topics]*
        i. *[How do you and your co-workers talk about the (call/case/job) afterwards?]*
        ii. *[Who would you say is most important in helping you decompress?]*
            1. *[How do they help you?]*
        iii. *[Who would you say is most supportive?]*
            1. *[What do they do to support you?]*

10. Now that we've talked a bit about how your co-workers help and support you, I'd like to shift gears and talk about moments of conflict with your co-workers. When thinking about conflict with your co-workers, what comes to mind?
11. When was the last time you had conflict with your co-workers?
    a. What happened in this situation?
    b. How was this situation resolved?
    c. How does this situation compare to other moments of conflict between co-workers at your place of work?
    d. Are there other moments of conflict you've experienced with co-workers that come to mind?
        i. *[If yes, repeat questions 11a-11c]*
        ii. *[If no, continue to question 12]*
12. Before we wrap things up, is there anything about your co-worker relationships that you think have had an impact on your resilience that we have not yet had a chance to discuss?

[*Closing Script*] Thank you so much for speaking with me. As I continue with the project, I would like to include participants in the analysis process. Specifically, I would like to send my preliminary findings to participants to ensure that what I am finding is representative of your experience as a trauma worker. Would you like to be contacted later on to review these findings and offer feedback? [*Make note of response and respond accordingly*]. I will now stop the recording [*end the recording*]. Because we talked about some potentially distressing information, I shared with you via email resources. If you have any further questions about the study or would like to share anything else, please feel free to reach out to me via email.

Appendix G: Participant Resources

Talk and Text Hotlines

Copline: 24-hour hotline for law enforcement only answered by retired officers trained to be peer listeners and provide support for law enforcement officers and their families at 800-267-5463.
Crisis Text Line: 24/7 counseling support for first responders who are struggling with a mental health crisis and who text "BADGE" to 741741.
Frontline Helpline: staff of former first responders who offer support for first responders and their family members affected by their traumatic experiences at 866-676-7500.
National Suicide Prevention Lifeline: network of local crisis centers that provides emotional support to anyone in suicidal crisis or emotional distress 24/7 at 800-273-8255.
SAMHSA Disaster Distress Helpline: those experiencing emotional distress related to natural or human-caused disasters can call or text the 24/7, 365-day-a-year support line at 800-985-5990.

Factsheets, Guides and Toolkits

Emergency Responders: Tips for Taking Care of Yourself, Centers for Disease Control and Prevention (CDC): strategies for coping before, during and after working during crisis situations.
First Responder Mental Health and Wellness, KaiserPermanente.org: advice for employers on how to address mental health and first responders.
First Responders: Behavioral Health Concerns, Emergency Response, and Trauma, SAMHSA (PDF, 269 KB): report on the behavioral health risks and intervention needs of police and firefighters.
First Responders Trauma and Suicide, Centre for Suicide Prevention: ways to recognize, prevent and address PTSD with a specific example of peer support in action.
Mental Health Fact Sheet – First Responders, Veterans Affairs (PDF, 1 MB): list of places that support first responders with meals, yoga therapy, comfort dogs and other needs.
Suicide Prevention for Healthcare Professionals, American Foundation for Suicide Prevention: hub for information on an online interactive screening program, including crisis help and support after a suicide loss.
The Vicarious Trauma Toolkit, Office of Justice Programs, Department of Justice: Tools and resources for first responders, those in the fields of victim services and other allied professionals.

Organizations and Websites

911 Buddy Check Project: peer support and coaching services for police, firefighters, EMS, and emergency dispatchers.
Behavioral Health – First Responder Center for Excellence: curated videos, articles, and presentations to help improve the physical and psychological health of first responders.
The Code Green Campaign: organization that works to educate first responders on self-care, peer care and advocate for systemic change in how mental health issues are addressed by their agencies.
Crisis Support Resources for Emergency Responders, Disaster Responder Assets Network (DRAN): one-stop shop listing organizations and crisis lines for first responders and health care workers.
Firefighter Behavioral Health Alliance: organization that offers behavioral health workshops to fire departments, EMS, and dispatch organizations, focusing on behavioral health awareness with a strong emphasis on suicide prevention.

First Responder Support Network: collaboration of emergency service peers and family members, mental health clinicians, and chaplains who volunteer to offer intensive retreats and ongoing support.
Frontline Professionals, National Alliance on Mental Illness (NAMI): hub for information on professional support, peer support, techniques to build resilience and how to help family members.
Mental Health First Aid for Fire and EMS, National Council for Mental Wellbeing: program focuses on the unique experiences and needs of firefighters and EMS personnel.
Project Healing Heroes: resiliency training and advice to help individuals and their families heal from the invisible wounds of trauma.
ResponderStrong: curated information on responder-informed crisis and clinical services, educational content and tools for responders, families, leaders, and the clinicians who work with them.
Share the Load Program: effort to make available resources for first responders who need help managing and overcoming personal and work-related problems, including behavioral health issues.
Survive First: organization that helps first responders and their families navigate mental health challenges and reduce first responder suicide.

Warning Signs of Suicide

If someone you know is showing one or more of the following behaviors, they may be thinking about suicide. Don't ignore these warning signs. Get help immediately.

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

Get Help

If you or someone you know needs help, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). Trained crisis workers are available to talk 24-hours a day, 7 days a week.

If you think someone is in immediate danger, do not leave them alone – stay there and call 911.