

Trauma-Informed Compassionate Leader Behaviors:  
Showing Compassion in the Workplace to Those that have Suffered Trauma

by

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## **DEDICATION**

I would like to dedicate this work to the men and women globally who are victims of human trafficking, survivors of human trafficking, and/or working with those who have experienced human trafficking. Thank you for being willing to share your stories and your enthusiasm for this research. I am inspired by your desire to make the world a better place.

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## **ABSTRACT**

The present research study sought to develop a compassion scale – a measure of Trauma-informed Compassionate Leader Behaviors (TICLB) using a total sample size of 949 across three studies. In Study 1a, TICLB items were generated through interviews with trauma survivors using both an inductive and deductive approach. Interview questions and coding schema were informed by theories of compassion and trauma-informed approaches. Items were based on content from interviews. In Studies 1b and 1c, TICLB items were investigated for content validity, to ensure that items measured the focal construct TICLB. In Study 2, the TICLB measure was further refined, and the factor structure examined revealing a bifactor model with one general factor and two specific factors “tangible behaviors” and “intangible behaviors.” Additionally, Study 2 established convergent validity with extant measures of compassion as well as discriminability from conceptually similar constructs (e.g., perceived supervisor support). Study 3 revealed that TICLB predicted employee well-being, employee perceptions of the organization, and employee contributions to the organization. Additionally, Study 3 revealed that TICLB predicts these same outcomes above and beyond general compassion and compassionate leader behaviors. The theoretical and practical implications are discussed.

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## **Trauma-Informed Compassionate Leader Behaviors: Showing Compassion in the Workplace to Those that have Suffered Trauma**

The workplace is not safe from the impact of traumatic events. Many jobs are inherently traumatic (e.g., paramedics, social workers, ER staff, cops, military, etc.; e.g., Tsai et al., 2015). Even when workers are in jobs that do not expose them to exceptionally emotionally impactful events, the vast majority of people will experience some form of trauma during their working years (e.g., death of a family member, divorce, etc.). This is especially true following the COVID-19 pandemic (Duane et al., 2020). Experiencing trauma can negatively impact a person's ability to do their work and their feelings about work (Meyerson & Zuckerman, 2019) and positively influence employee turnover (Matthews & Chinnery, 2005), regardless of whether the traumatic event happened at work. Estimates suggest that employee suffering cost organizations more than \$75 billion annually (Zaslow, 2002).

To mitigate the effects of trauma on employee outcomes such as well-being, perceptions of workplace, and contributions to the workplace, supervisors may extend compassion to those who have suffered trauma. Indeed, experiencing compassion in the workplace following a hardship reduces anxiety (Lilius et al., 2008), increases attachment and commitment to the organization (Grant et al., 2008), and encourages physical and psychological healing (Bento, 1994; Doka, 1989). Conversely, indifference or lack of compassion toward trauma survivors may encourage employee turnover and provide grounds for a lawsuit over a hostile work environment (Lewis & Henderson, 1994). While compassion positively influences work outcomes for employees (Lilius et al., 2008), research has yet to identify *how* leaders can demonstrate compassion to their employees (Dutton et al., 2006; Frost et al., 2006; Way & Tracy, 2012).

Previous research has investigated compassion in the workplace and its positive relations with work outcomes (e.g., Lilius et al., 2008), but no studies have taken a trauma-informed

approach before. On the one hand, compassion research has not sufficiently investigated specific positive and negative behaviors supervisors could enact to help or hurt those that have experienced trauma in previous employment. On the other hand, the plethora of research on trauma-informed care (Wilson et al., 2013) has been typically directed toward how service providers interact with their traumatized *clients* – for instance, how a social worker interacts with a survivor of domestic abuse when providing counseling or helping this person to find safe housing. Thus, synthesizing the literature on compassion and trauma-informed care to identify the positive and negative behaviors *leaders* can enact when dealing with *employees*— specifically and especially following trauma – is a fundamental starting point to better understanding how supervisors may mitigate the disproportionate influence trauma has on employee outcomes. This integration of literature is necessary for the long-term performance and well-being of employees. A trauma-informed approach ensures that employees are not unnecessarily re-traumatized by their leaders (Middleton et al., 2015), but rather supported to heal and experience growth. Trauma-informed research has yet to investigate the ways in which a leader interacts with their followers at work to minimize chances of re-traumatization and ensure the affected individual's psychological and emotional safety in the workplace. Specifically, we focus on how a behaviorally compassionate response to trauma in the workplace may lead to 1) employee posttraumatic growth and self-compassion, 2) positive employee perceptions of the work environment, as measured by psychological well-being and psychological safety and 3) employee contributions to the work place such as employee job performance and organizational commitment for employees that have suffered trauma either inside or outside of work.

By delineating the compassionate behaviors in response to trauma, we extend the compassion at work literature by providing prescriptive information about what leaders should

actually do to provide compassion to those who have suffered trauma at work. Most prior research on compassion at work has been based on general measures of perceived compassion, as opposed to the identification of specific leader behaviors that demonstrate compassion toward those who have experienced trauma (McClelland, 2012). While several studies have qualitatively investigated compassion in the workplace, there has been little consensus as to which behaviors constitute compassion in the workplace (e.g., Dutton et al., 2006; Lilius et al., 2008). Similarly, little is known about the leader behaviors that inhibit psychological safety and well-being for those that have suffered severe trauma. Thus, this study aims to fill that gap by creating a valid measure of trauma-informed compassionate leader behaviors (TICLB) to inform leaders and organizations about compassionate behaviors they can perform.

A scale of TICLB would be of benefit because it would further our understanding of the influence compassion plays in the workplace for those that have experienced all manner of trauma and hardships. Specifically, measuring TICLB allows us to better understand how leaders support posttraumatic growth – sense-making, coping with distress, and acceptance – in employees following trauma or hardship (Maitlis, 2020). Indeed, little research has investigated the antecedents of posttraumatic growth at work. Furthermore, I expect that TICLB will predict self-compassion, psychological safety, and psychological well-being in employees, especially following work-related trauma, above and beyond general compassion or various forms of leadership. Coming to work after experiencing a work-related trauma may cause employees to experience anxiety and fear in a way that inhibits their ability to focus on work (Margolis & Molinsky, 2008). Leaders who take a trauma-informed compassionate approach to interacting with employees demonstrate an understanding of the effects trauma and hardships have on employees, and actively provide support to mitigate those effects. Conversely, leaders who

simply provide general compassion may work to relieve the effects of trauma but without an understanding of the effects of trauma, they may also re-traumatize employees in their efforts (Vivian & Hormann, 2015). Thus, this scale allows researchers to better understand the nuances of leading those who have experienced trauma or hardships.

The contribution will benefit theory as it will offer a measurement tool for further research in understanding the nomological network of compassion in response to trauma (i.e., antecedents, correlates, outcomes) that may be applicable to less severe emotional disruptions (e.g., hardships). The measure will also be of pragmatic benefit as well since most compassion intervention studies use proxy measures for leader compassion (e.g., Paakkanen et al., 2020). Furthermore, this research would also bring more focused attention on the oft ignored survivors of unusually extreme trauma like those who have endured human trafficking and military vets who continue to suffer from PTSD. By creating a reliable and valid measure of compassionate leader behaviors this study lays the foundation for future research on the impact of trauma-informed compassionate behaviors at work.

I further contribute to the compassion at work literature by demonstrating the relationship between compassionate supervisor behaviors and important employee outcomes such as psychological safety, well-being, and post-traumatic growth for employees. Little research has investigated the role of compassion, specifically from leaders, in driving these outcomes, especially for those who have experienced trauma. Compassion ensures that our more diverse workforce, including those that have experienced trauma in previous work experiences, receive the support they need for their circumstances (Dutton et al., 2014). Specifically, leaders who provide compassion support their followers as they navigate the effects of the traumatic experience and make sense of their experiences, which then enables follower well-being,

posttraumatic growth and psychological safety (Maitlis, 2020). However, previous research on compassion has failed to investigate how leaders enact compassion to ensure their followers are supported following traumatic experiences. Thus, our study investigates an additional avenue for organizations to increase employee health and well-being. Specifically, we contribute to understanding which leader behaviors facilitate employee well-being, perceptions of the work environment and subsequent attachment and contributions to the workplace following traumatic experiences. Consequently, we also contribute to the leadership literature by providing evidence of the efficacy of trauma-informed compassionate leader behaviors in promoting positive work outcomes for employees given that one of the main duties of a leader is to engender positive work outcomes of their direct reports (Neubert et al., 2013). Furthermore, we seek to demonstrate that compassionate leader behaviors predict these outcomes above and beyond social support, general supervisor support, transformational leadership, and perceived organizational support.

## **The Construct of Trauma-Informed Compassionate Leadership**

### ***Why Trauma-Informed***

Trauma is defined by many in the clinical literature as a terrible event or series of events that involve either real or perceived threats of death or serious injury, or actual injury to self or others, following which that person experiences overwhelming fear, hopelessness, helplessness, or horror (Wilson et al., 2013). A person's response to trauma is highly individualized and shaped by a wide range of factors (e.g., genetics, previous life experiences, or support systems). How others respond to the person who experienced the trauma also influences the long-term impact of traumatic events for the better, when delivered in a trauma-informed environment, or for the worse, if delivered in a trauma-insensitive manner (Wilson et al., 2013). Common

reactions to experienced trauma fall into four categories: emotional, physical, cognitive, and social (Alexander, 2005; Klein & Alexander, 2011). Examples of emotional reactions include helplessness, hopelessness, and anger directed toward others. Examples of physical responses include lack of energy, inability to relax, and hyperarousal (e.g., exaggerated startle response). Examples of cognitive responses include impaired memory and concentration, reduced self-esteem, and hypervigilance (exaggerated sense of risk). Finally, examples of social responses to trauma include withdrawal and lack of trust in others.

Traumatic experiences, both at work and in personal life, occur regularly (e.g., Chopko et al., 2018, 2019; Mark et al., 2018; Sattler et al., 2014). For instance, workers in the military, emergency services, medical, and social work professions consistently have experiences that can be considered traumatic such as vicariously experiencing death and/or injury, and as a result can exhibit any of the aforementioned symptoms as well as post-traumatic stress, major depression, and anxiety (Tehrani, 2010). Furthermore, organizations report frequent traumatic incidents such as serious accidents or deaths at work (Bureau of Labor Statistics, 2019). Additionally, researchers have recently begun to understand the impact of indirect exposure to traumatic events through supporting victims, reading or analyzing accounts of traumatic events, or viewing images of traumatic events (e.g., Burns et al., 2008; Steed & Bicknell, 2001; Vrlevski & Franklin, 2008). That is, people who have indirect exposure to traumatic events may in turn be traumatized themselves. That is to say nothing of the numerous traumatic events people experience in their personal lives such as the death of a loved one, illness, natural disasters, or pandemics. It is important to differentiate trauma from less severe suffering employees might experience in the workplace: Trauma tends to be acute in both severity of event and reaction (cognitively and emotionally); whereas chronic stressors (e.g., an annoying boss) tends to lead to

chronic stress and suffering of a lower intensity and require less support (Gottlieb, 1997).

Additionally, a negative work experience (e.g., a poor annual performance review) tends to result in a short term negative mood which might require short-term support (Zohar, 1999) but does not result in the same intense reactions as a traumatic event.

*Trauma-informed* refers to the basic understanding of how trauma affects the life of an individual as well as the vulnerabilities or triggers of trauma survivors so that future interactions are supportive and avoid re-traumatization (National Center for Trauma-Informed Care, 2012). A trauma-informed approach, or trauma-informed care, to interacting with those that have suffered from trauma should be guided by five principles: 1) Providing psychological and physical safety. Without a sense of safety, the anxiety and stress from the trauma may add new levels of trauma to their experience, amplify old trauma, and negatively impact work behaviors. It is important to consider both the actual safety of the workplace – is the person free from physical and psychological harm both from the work itself or coworkers? – as well as the perceived safety of the workplace. Does the person feel safe at work? 2) Building trust through clarity of expectations, consistency in behavior, and maintaining boundaries; 3) Giving the individual voice and choice by recognizing that every person’s experience is unique and requires an individualized approach; 4) Working in collaboration with the traumatized individual; and 5) Empowering the individual through recognizing and building upon strengths.

Trauma-informed care or approaches are often used in the medical and social services industries by service providers when interacting with clients or patients. This approach is taken to ensure that service providers do no additional harm to their clients but instead help guide them toward healing (National Center for Trauma-Informed Care, 2012). Because care providers can experience secondary trauma through interactions with those that have directly experienced



trauma, organizations recognize the need to ensure employees are not re-traumatized through interactions with colleagues and supervisors. Thus, many organizations within the medical and social service industries are taking a trauma-informed approach to organizational policy and practices (Esaki, 2020; Hales et al., 2019). Although research into the effectiveness of organizational trauma-informed care is nascent, initial evidence suggests that when organizations train and encourage leaders and employees to take a trauma-informed approach when interacting with one another, job satisfaction, organizational commitment and job performance increase while turnover decreases (Hales et al., 2017).

## **Compassion**

The workplace is an emotional arena in which human suffering is inevitable (Maitlis, 2020); however, compassion can mitigate the negative effect of this suffering and promote positive well-being for employees (Lilius et al., 2008). The idea of compassion has been around for many centuries, yet scholars still debate what constitutes compassion. The Buddhist tradition defines compassion as the deepest wish for others to be free of suffering as well as the causes of suffering (Gilbert, 2017; Ricard, 2015). Other scholars define compassion as a multifaceted process composed of noticing, empathizing, and (re)acting (Miller, 2007; Way & Tracy, 2012). Recently, Dutton et al. (2014) suggested a fourth subprocess of compassion: sense-making (Dutton et al., 2014; Kanov et al., 2017).

For the purpose of this paper compassion is defined as an “interpersonal process involving the noticing, feeling, sense making, and acting that alleviates the suffering of another person” (Dutton et al., 2014, pg. 277). It is important to note that these subprocesses sometimes happen simultaneously and distinctions between these processes are sometimes blurry (Miller, 2007; Way & Tracy, 2012). Additionally, compassion may require that the potential giver has

the ability to tolerate uncomfortable feelings aroused in response to the suffering person (e.g., distress, anger, fear) thereby remaining open to, and accepting of, the person suffering (Gilbert, 2017). To ensure we adequately define our new construct, each facet of compassion is described in depth below.

### ***Noticing.***

Noticing refers to a compassion-giver becoming aware of another person's pain or suffering (Kanov et al., 2004). Without noticing, the compassion process fails to begin. Becoming aware of another's suffering implies that compassion-giver recognizes both verbal and non-verbal cues as signs of suffering (Way & Tracy, 2012). In some situations, recognizing that another person is suffering may be easier because the person is displaying multiple cues. However, this may be difficult in a work setting when many organizations believe in the separation of work and personal life and that employees should their suffering at home. In these organizations, employees may not feel comfortable expressing obvious cues of suffering. Thus, noticing becomes difficult and a recurrent process (Frost, 2003). Therefore, noticing may involve intuition, active listening, and seeking out information to determine whether someone is suffering (Way & Tracey, 2012). Furthermore, noticing also includes attending to the situations and circumstances surrounding the sufferer (Miller, 2007). This information may provide additional information about the sufferer's experience. Additionally, some scholars argue that noticing also includes using appropriate emotional expressions to engage in an interaction with the sufferer (Miller, 2007; Way & Tracy, 2012). For the purpose of this paper, the subprocess of noticing is defined as both the 1) perceptual recognition of verbal and non-verbal cues a sufferer may exhibit as suffering along with the circumstances surrounding the sufferer and 2) the expression of recognition to the sufferer. Because I am investigating the experience of the

sufferer, it is important to include the expression of recognition otherwise a leader may internally recognize the suffering, but the sufferer would not be aware of this. It is important to note that sufferers may perceive the leader's expression of recognition as an act of compassion (discussed below) and may not distinguish between noticing and acting.

### ***Feeling Empathic Concern***

The second component of compassion is empathizing with the other person's suffering or putting yourself in their shoes and imagining what they might be feeling. This subprocess is also referred to as feeling empathic concern or relating empathically (Kanov et al., 2004; Miller, 2007; Way & Tracy, 2012). Empathic concern involves feelings of sympathy that are other-oriented and altruistic (Batson, 1994). This empathy motivates a person to respond to the suffering of another (Atkins & Parker, 2012). Way and Tracy (2012) refer to this subprocess as *relating* and suggest that the compassion giver may experience either affective feeling for the sufferer, cognitive connection to the sufferer's experience, or both. However, including both a cognitive and an affective component to this subprocess makes it difficult to ascertain where the empathetic concern develops from as well as the motivation behind a compassion giver's process (Wang, 2019). Thus, I abide by Dutton et al's (2014) definition of this subprocess as an emotional experience. This is consistent with dispositional empathy research findings which suggest that perspective taking (cognition) is empirically distinct from empathic concern (emotion) and that the former is an antecedent of the latter (Davis, 1983). More specifically, for the purpose of this study, I propose empathetic concern is the expression of feelings of sympathy that are altruistic in nature.

### ***Sensemaking***

Sense-making refers to interpretative work people do to explicitly comprehend a situation, to assign meaning to their experiences, and use this information to determine what to do next (Weick et al., 2005). Sense-making is a joint cognitive aspect of compassion where both the compassion-giver and the sufferer work to understand the sufferer's experiences. This is an important component of compassion that allows the compassion-giver to understand the other's suffering (Dutton et al., 2014). Drawing from cognitive appraisal theory (Lazarus, 1991), Atkins and Parker (2012) identify three appraisals that are important for the compassion-giver: the sufferer's deservingness of help, the self-relevance of the sufferer and their situation to the focal actor, and the focal actor's self-efficacy. These cognitive appraisals help a potential compassion-giver determine whether they should provide help, how they might provide help, and whether they are capable of providing the necessary help.

This subprocess is theorized to be ongoing throughout the compassion episode (Dutton et al., 2014). Once actors make sense of a situation and act in response, the actions and outcomes produced may require additional sense-making for both the compassion-giver and the sufferer. For the sufferer, sense-making includes making sense of the motivations behind others' compassionate behavior which in turn may influence how sufferer's interact with compassion-givers in the future (Crocker & Canevello, 2008). Furthermore, compassion-givers may help sufferers make sense of their own situation which enables sufferers to manage their own emotions and allows others to provide assistance needed to alleviate suffering (Lois, 2001).

### ***Acting (to alleviate suffering)***

And lastly, compassion does not exist without the actions of one person helping to alleviate the suffering of another person. Furthermore, compassion may be prevention based such that one evaluates and provides for needs in a way that prevents suffering (Gilbert, 2017). Dutton

et al. (2014) defined compassionate acts as any behaviors aimed at improving the sufferer's experience or alleviating their suffering. However, some argue that such a broad definition would inherently include noticing, feelings and sense-making as acts of compassion thereby confusing the subprocesses of compassion (Atkins & Parker, 2012). Conversely, based on their survey study Lilius et al. (2008) categorized three types of compassionate actions: emotional support, giving time and providing flexibility, and giving material goods. They argue that, in the workplace, the primary compassionate act is providing emotional support because there is little else coworkers can do to alleviate the situation at work. This assumes that the suffering is caused by something external to the workplace and fails to account for the possibility that the suffering is caused by experiences at work. This is an unfortunate oversight given that many jobs may be inherently traumatic (e.g., EMT, military service, police, sex work) or the large number of employees who face traumatic experiences at work such as abusive leadership or major accidents (see Maitlis, 2020). Thus, this project seeks to identify behaviors that are appropriate for the workplace, especially when the sufferer experienced trauma at work.

### **Defining Trauma-Informed Compassionate Leader Behaviors**

While compassion is meant to alleviate a person's suffering (Gilbert, 2017), the actions taken by another person may be unhelpful or at worst exacerbate the suffering. This is likely not the intention of the person providing compassion, but without properly evaluating the situation and the person's needs, compassion may not be perceived as compassionate by the receiver (Blum, 1980; Frost, 2003). Thus, it is important to take a trauma-informed approach to compassion in the workplace where the compassion giver understands the impact of trauma or hardship and adequately works to alleviate suffering. Grief and suffering already cost organizations millions of dollars annually (Zaslow, 2002), it would only exacerbate the issue if

leaders and supervisors within organizations are unable to provide effective compassion to their employees. Additionally, organizational leaders displaying compassion risk being perceived as inauthentic by their followers which may decrease the impact of the compassion and degrade trust between leader and followers (Michie, 2004; Michie & Gooty, 2005). Taking a trauma-informed approach means that the leader or supervisor needs to recognize that there has been a trauma and they need to empathize with their employee or put themselves in their employee's shoes. Thus, when interacting with the sufferer, leaders and supervisors must provide compassion in a way that (1) ensures the safety (psychological and physical) of their employee, (2) comes from a place of trustworthiness, (3) recognizes that this person's suffering is unique to them and requires individualized care and attention, (4) includes the employee in workplace decisions concerning them, and (5) empowers the employee to process their trauma and eventually heal (i.e., using a trauma-informed approach).

While compassion could come from multiple sources such as co-workers, friends, family and subordinates, I focus on leaders because of their unique position to influence employee outcomes (Eisenberger et al., 2002). Scores of research demonstrate that leaders influence their followers' well-being, job performance, self-efficacy/self-esteem, and myriad other outcomes (e.g., Dulebohn et al., 2012; Martin et al., 2016; Rockstuhl et al., 2012). Additionally, leaders have access to resources and influence that may aid sufferers that other people at work do not have. For instance, leaders and supervisors have discretion over employee schedules, the workload placed on employees, and performance appraisals (Lee et al., 2020; Purcell & Hutchinson, 2007). Thus, leaders have power that they can exert to help or hinder in ways that colleagues and subordinates cannot.

Based on the above definitions, trauma-informed compassionate leader behaviors are defined as those behaviors that encompass noticing, empathic concern, sensemaking, and acting that ensure the safety of the sufferer, comes from a place of trust, and centers the needs of the sufferer as the most important aspect of the compassion interaction. Compassion is a powerful relational tool with the ability to lower anxiety and increase healing following a traumatic event. However, both the medical field and social work field would argue that a trauma-informed approach makes compassion that much more helpful to sufferers (e.g., Hales et al., 2017). While many in the medical and social work fields are taught trauma-informed approaches to appropriately help patients and clients, business leaders typically do not receive the same training or development. Thus, this is the first project to bring trauma-informed approaches into businesses broadly and more specifically into the interactions between leaders and employees.

### **Distinguishing TICLB from Related Constructs**

#### ***General Compassion***

Currently, there are several measures of various aspects of compassion (Strauss, et al., 2016) but none take a trauma-informed approach. First, there are numerous scales that measure how compassionate a person is or how compassionate others perceive someone to be (e.g., the compassion scale; Martin et al., 2016). These scales tend to focus on the extent to which someone is generous, tolerant, and wants to help others (Strauss et al., 2016). Many of these scales lack items that measure the extent to which someone *acts* on their feelings of concern. Additionally, none of these scales measure the extent to which sense-making occurs in compassionate episodes. As this is a major component of compassion (Dutton et al., 2014; Kanov et al., 2016), the lack of items measuring sense-making suggests content deficiency.

Along these lines, the self-compassion scale (SCS; Neff, 2003) measures how compassionate one is to oneself. However, for the SCS the referent is the self and the six facets of self-compassion include self-kindness vs self-judgement, common humanity vs. isolation, and mindfulness vs over-identification. The facets of self-compassion do not fully align with those of compassion: noticing, feeling empathic concern, sense-making, and acting (Atkins & Parker, 2012; Dutton et al., 2014; Kanov et al., 2016). Self-kindness vs. self-judgement may be similar to someone feeling empathic concern for a sufferer. Indeed, this facet of self-compassion refers to how understanding and patient one is toward oneself (Neff, 2003). Mindfulness versus over-identification concerns a person's ability to regulate their emotions and their understanding of the situation. This facet of self-compassion is most similar to sense-making in compassion. However, common humanity refers to the understanding that failing is part of the human condition which is not reflected in any of the compassion facets. Furthermore, the self-compassion scale does not include any items about acting to lessen the suffering. Thus, self-compassion includes aspects that are not included in the definition of compassion and vice versa. Furthermore, compassion is viewed as a relational process happening between two people whereas self-compassion is viewed as an intrapersonal process one carries out alone.

The current measures of compassion at work focus on whether the sufferer perceives compassion broadly in the workplace from three sources; one's supervisor, one's coworkers, and the workplace broadly (Lilius et al., 2008). While perceptions of compassion are important (Lilius et al., 2008), it provides only a descriptive reaction (i.e., does the employee perceive they've received compassion) to some unknown actions within the organization. It does not capture the antecedents of this felt or perceived compassion. In other words, this gives us no indication of why employees may feel compassion within the workplace. Additionally, this



compassion at work scale includes leaders, co-workers and the organization as a whole as referents making it difficult to ascertain how specific people or entities at work influence an employee's perceptions of compassion. Additionally, the vagueness of the scale hinders our ability to more fully understand how compassion, and specifically trauma-informed compassion, is demonstrated to employees and how it influences numerous outcomes for both the sufferer, the team, and the organization.

Conversely, one attempt has been made to measure the specific behaviors that constitute compassion leader behaviors (Shuck et al., 2019). However, this scale did not utilize the contemporary definitions of compassion when creating the scale (i.e., noticing, feeling empathic concern, sensemaking, and acting). They argue that the operationalization of compassion as previously used has focused exclusively on suffering whereas their project focuses on compassion extended in everyday circumstances at work. Instead, Shuck et al. (2019) asked leaders, who were identified as compassionate, to discuss their leader behaviors. The authors then went out to classify six subcategories of compassion (integrity, empathy, accountability, authenticity, presence, and dignity) and create items based on those subcategories. Their scales contain no mention of noticing a person's suffering, or everyday struggle, nor does it include anything around sensemaking. While the intent of the scale was to focus on the behaviors leaders can enact to provide compassion to employees every day, the authors have essentially re-defined compassion. Thus, this scale also fails to measure compassionate leader behaviors based on recognized conceptualization of compassion.

Furthermore, taking a trauma-informed approach to compassion provides a nuanced view that may shift our previous understanding of compassion. More specifically, a trauma-informed centers the experiences of the sufferer, what kind of support they need following those

experiences, and how best to deliver support whereas compassion heretofore defined focuses primarily on the people providing compassion and how they perceive and respond to another's suffering. This focus on the compassion giver stunts our understanding of what's truly needed following traumatic experiences and how sufferers would like to receive compassion from another. While measures of compassionate behaviors are scarce, there are several constructs that may be related. Below, I describe those various constructs and detail how trauma-informed compassionate leader behaviors is a unique construct.

### ***Social Support.***

In the social support literature, four facets of support are commonly identified: emotional, instrumental, informational, and esteem support (House, 1981). Emotional support refers to actions that convey caring and empathic understanding while instrumental support refers to the provision of tangible goods and services. Esteem support provides feedback that is relevant to one's self-evaluation and informational support (typically subsumed under instrumental support in the workplace support) consists of providing information and advice.

While all four types of support mentioned above are important aspects of providing compassionate acts to a suffering employee, they are not sufficient. Specifically, there is a lack of awareness of employee suffering in the aforementioned support types. While emotional support provides the empathic understanding needed once a supervisor notices an employee's pain and instrumental support may include help to alleviate the added strains of work on top of suffering, we cannot be sure that the supervisor is doing these actions in response to employee suffering or simply to increase productivity and engagement at work. The purpose of compassion is to alleviate suffering and the cause of suffering; if the leader's goal is something other than

that, then they are not providing compassion. Thus, it is important to include noticing and acting with the intent to alleviate suffering in any compassion scale.

Additionally, while most measures of supervisor support include items that assess these four facets, items do not reflect specific behaviors supervisors enact to demonstrate support. For instance, “My supervisor really cares about my well-being” (Kottke & Sharafinski, 1988) or “How much can your supervisor be relied on when things get tough at work?” (Caplan et al., 1975). These items are too general to provide guidance about the specific behaviors that should be encouraged when demonstrating compassion to suffering employees.

### ***Supervisor Support***

Employees tend to make global perceptions concerning the degree to which supervisors value their contributions and care about their well-being (perceived supervisor support, or PSS; Eisenberger et al., 2002). This construct investigates the extent to which employees feel valued by their supervisors. It does not measure the specific behaviors that supervisors might engage in to make the employees feel valued, simply the employee’s overall evaluation of being valued. An example item from Kottke and Sharafinski’s (1988) scale includes: “My supervisor cares about my well-being, my supervisor values my contributions to the well-being of our department, and my supervisor takes pride in my accomplishments.” Another scale of perceived supervisor support includes items such as: “How much can your supervisor be relied on when things get tough at work” (Caplan et al., 1975). While some of these items do tap into whether the supervisor cares about the employee, it does not capture whether the supervisor takes action based on their care or concern. One of the core pillars of compassion is the action taken by the person providing compassion. A supervisor may notice a person’s suffering and care about that

person's well-being, but without taking action to help alleviate the person's suffering, there is no compassion.

Rooney and Gottlieb (2007) created a scale measuring supportive and unsupportive managerial behaviors. Unlike PSS, this scale does measure specific behaviors exhibited by supervisors. They took an inductive approach to create a list of supportive and unsupportive managerial behaviors in the workplace. They found 8 classes of supportive behavior and six classes of unsupportive behavior. Supportive behavior classes include: genuine concern, recognition, task guidance and assistance, trustworthiness, professional development, open communication, reasonableness, and encourages autonomy. While many of these classes are relevant to trauma-informed compassion, these items tap into the support employees receive directly related to accomplishing their work. For instance, items include: *My manager gives clear instructions, communicates in a direct manner, sympathizes with difficulties*. These behaviors are certainly supportive of an employee and enables work performance, however there is no mention of whether the manager notices the employee's suffering, empathizes with them (which is different than sympathizing), or takes action to alleviate the employee's suffering. Furthermore, these actions are those that a supervisor might provide regardless of an employee's experiences or needs, regardless of whether the employee needs or wants these behaviors. Conversely, compassion requires that the manager notice an employee's suffering, empathize with their experience, and act toward alleviating the employee's suffering. While some of the actions noted in this scale may alleviate an employee's suffering (e.g., *grants me time off when I need it*), the scale measures does not cover the full range of compassionate behaviors.

### ***Transformational Leadership***

Another related construct to trauma-informed compassionate leadership is transformational leadership. Transformational leadership (TL) is comprised of four components: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. The most relevant aspect of transformational leadership is individualized consideration (IC). This aspect of transformational leadership refers to leader behaviors that pay attention to the developmental needs of employees support and coach the development of their followers (Bass, 1999). While this aspect of TL demonstrates the individualized attention that a leader might bestow on an employee, the purpose is not to alleviate any suffering for the employee but rather for the leader to notice where the employee needs to develop and to provide the support and resources necessary to develop in those areas. Additionally, IC is traditionally more supererogatory rather than remedial with respect to employee's state of well-being. Thus, individualized consideration, like social support and general supervisor support, may be related to TICLB but due to its focus on work-related development, which may be part of TICL for those that have experienced trauma in previous employment experiences, does not cover the breadth or intention of TICLB.

### ***Perceived Organizational Support***

Perceived organizational support (POS) are global beliefs employees have about the extent to which their organization values their contributions at work and cares about their well-being (Eisenberger et al., 2002). POS is positively related to many important outcomes such as organizational commitment, psychological wellbeing, and performance (Kurtessis et al., 2017). However, this construct is different from TICLB in two important ways. First, TICLB is a measure of leader behavior as opposed to POS which measures a belief or perception. In fact, POS is a belief that employees develop based on treatment by organization members, the

relationship quality between the employee and the organization, and human resource practices and job conditions (Kurtessis et al., 2017), whereas TICLB measures the extent to which an employee's leader demonstrates specific behaviors. Second, the referent in POS is the organization as a whole and not one person within the organization. Again, POS is a global belief that an employee develops based on inputs from various aspects of the workplace. TICLB is concerned with the behavior of a specific person that the employee interacts with. Thus, the two constructs may be related, indeed TICLB may be an antecedent of POS, but ultimately are distinct from one another.

### ***Summary***

In conclusion, commonly studied and valuable organizational behaviors such as social support, general supervisor support, transformational leadership are not compassion unless they are accompanied by the noticing and feeling elements of the compassion process (Kanov et al., 2004). Additionally, perceived organizational support is a belief employees hold about the organization and does not contain most elements of compassion or trauma-informed approaches.

While general supervisor support is support provided to employees regardless of circumstances, TICLB is more targeted to provide needed support to those that have experienced trauma or hardships. Therefore, I expect TICLB to be distinct from these related constructs as well as predict employee well-being, perceptions of the work environment, and organizational contributions above and beyond general supervisor support. Furthermore, compassion broadly measures employee perceptions of compassion from various referents in the organizations, whereas TICLB is specifically from the supervisor. This is important because the supervisor can provide resources that coworkers cannot and can make work life easier or harder for employees in ways that coworkers or the organization itself cannot (Rockstuhl et al., 2012). Thus, I expect

that TICLB will predict employee well-being, perceptions of the work environment, and organizational affect and contributions above and beyond general compassion. Finally, I expect that TICLB will predict these outcomes above and beyond the Compassionate Leader Behavior Index because the TICLB measures all aspects of compassion in a trauma-informed approach which centers the employee's needs for the sake of relieving suffering whereas the CLBI measures aspects unrelated to compassion (Dutton et al., 2014) and does not center the employee experience. Qualitative research that is grounded in employees' experiences and perceptions of their leaders can provide insight into the ways in which trauma-informed compassion is expressed to employees who are suffering. This focus on the employee's experience will enable leaders to provide the care that followers need and help employees heal from their experiences.

### **TICLB and Outcomes**

Compassion at work research is still in its infancy and most studies take a qualitative approach to understand the process of compassion at work (e.g., Grant et al., 2008). This research has only scratched the surface of work outcomes associated with receiving compassion from another person at the workplace. Given (1) the recent focus on employee mental health and well-being following the collective trauma of COVID-19, gun violence, many other world events (DeLauro, 2022), (2) The Great Resignation as employees leave organizations where they don't feel safe nor appreciated (Sull et al., 2022) and (3) the importance of employee job performance to organizations' operations (Rotundo & Rotman, 2002), I investigate the influence of trauma-informed compassionate leader behavior on employee well-being (e.g., psychological well-being, posttraumatic growth, self-compassion, and health), perceptions of the work environment (e.g., psychological safety) and employee attachment and contributions to the organization (e.g., employee performance and organizational commitment).

## **Well-being**

### ***Psychological Well-being***

Psychological well-being reflects employees' perceptions and evaluations of the quality of emotional and social functioning both on and off the job (Kelloway et al., 2012). Furthermore, psychological well-being entails perceptions of engagement with existential challenges of life (Keyes et al., 2002). Psychological well-being is said to be either context-free or context-specific (Warr, 1992). For instance, studies have investigated psychological well-being at work as context-specific (e.g. Dagenais-Desmarais et al., 2012), while the majority of studies have measured psychological well-being as an overall state of being regardless of the context (e.g. Brown & Ryan, 2003). Because employees may experience trauma at work or outside of work (Maitlis, 2020) and receiving compassion may influence a person's life both at work and outside of work (Kirby, 2017), this project examines context-free psychological well-being.

Gillbreath & Benson (2004) found that positive supervisory behaviors (e.g., allowing more employee control, communicating and organizing well, considering employees and their well-being) made a statistically significant contribution to employee well-being over and above social support both at home and from co-workers. Van Dierendonck et al. (2004) found a similar relationship between leader behavior and increased employee well-being. Furthermore, Arnold et al. (2007) found that transformational leadership was significantly positively related to psychological well-being. Conversely, supervisors that fail to provide the support needed by employees is associated with reduced employee well-being (McIlroy et al., 2021). These findings suggest that supervisors and leaders have a significant influence on employee well-being. Indeed, when leaders exhibit behaviors that demonstrate care for their employees, employee well-being increases; and when they fail to exhibit caring behaviors, employee well-being decreases. This



suggests that for employees that are experiencing suffering, leader behaviors aimed at decreasing the suffering demonstrate care for employees and are likely to increase employee perceptions and evaluations of their quality of emotional and social functioning. Thus, I hypothesize:

*Hypothesis 1: Trauma-informed compassionate leader behaviors will be positively related to employee psychological well-being.*

### **General Health**

Employee health, both physical and mental, is important within organizations. Organizations lose up to \$168 billion due to employee health complications, time off due to health concerns, and medical costs (Goetzel et al., 2004; Hassard et al., 2018). Additionally, the effects of poor leadership influence physical outcomes such as increased blood pressure (Wager et al., 2003), as well as sickness, absenteeism, and presenteeism (Nyberg et al., 2008). Thus, it is important to understand how compassionate behavior from leaders can positively influence employee health following trauma.

Experienced trauma (psychological or physical) can manifest physically in numerous ways. For instance, those that have experienced trauma may suffer from sleep loss, they may lose or gain weight rapidly, or they may suffer from chronic pain among other symptoms (Schnurr & Green, 2004). Physical trauma may also leave a lasting mark through injuries and wounds or may be present in the form of permanent disabilities, both physical and mental. Because compassion may come the form of emotional support, schedule flexibility, or materials goods (Lilius et al., 2008), compassion may positively influence sufferers' health. More specifically, a trauma-informed approach to compassion ensures that leaders understand that trauma can negatively impact a person's physical and mental health. Additionally, a trauma-informed approach to compassion ensures that followers are empowered to seek the medical care or other

form of care they need. For instance, providing flexibility in someone's schedule may allow them to see a medical provider to receive medical attention. Similarly, providing work flexibility may mean that sufferers can come into work late allowing them to catch up on sleep missed.

Thus, I hypothesize:

*Hypothesis 2: Trauma-informed compassionate leader behaviors will be positively related to employee general health.*

### ***Self-compassion***

Ironically, people who experience negative events often treat themselves far more critically and unkindly than they would treat a loved one in similar circumstances (Terry & Leary, 2011). The definition of self-compassion is related to the definition of compassion from others. Self-compassion involves being kind and understanding towards oneself while being aware of the suffering, seeing one's fallibility as part of the human condition, and holding one's painful thoughts and feelings in a balanced perspective rather than over-identifying with them (Neff, 2003). The action in this case, compared with compassion received from others, is providing the self with love and grace cognitively and emotionally to allow oneself to process the (traumatic) events, make sense of it, and determine what needs to happen next (Neff, 2003). Self-kindness involves extending empathy, sensitivity, warmth, and patience to all aspects of one's self including one's actions, feelings, and thoughts (Gilbert & Irons, 2005). For someone who has experienced trauma in a previous work experience, it's possible the sufferer might blame themselves for the experience instead of correctly assigning the blame to the person or event that caused harm (Davis et al., 1996). Self-compassion in this instance would allow the sufferer to be empathetic to themselves and sensitive to how the traumatic event changed them or their behavior. Additionally, it allows the sufferer to be patient with themselves as they figure

out work in a different setting or environment. For instance, someone who has experienced trauma may have difficulty engaging in situations that are similar to the one that in which the event occurred. For someone who experienced trauma in a previous work experience, being at work and interacting with leaders and co-workers may be difficult. The sufferer may have difficulty getting to work, staying engaged once at work, or be short with others in the workplace (Meyerson & Zuckerman, 2019). Demonstrating self-compassion in that moment means forgiving oneself for those behaviors and the feelings and thoughts that accompany those behaviors. Furthermore, self-compassion is positively related to healing and future work engagement (Kotera et al., 2021; Neff, 2003).

Research has yet to investigate the link between receiving compassion from others and the self-compassion one demonstrates for self. However, research in self-efficacy and self-esteem suggest that when others provide positive feedback of one's abilities or when others react positively to one's work, then one's self-efficacy and self-esteem increase. Similarly, social learning theory (Bandura, 1997) suggests that people learn from watching others role model various behaviors. In this case, sufferers would experience and watch leaders role model compassion towards themselves (i.e., the sufferer). In turn, by watching and experiencing this compassionate behavior, sufferers may internalize what they see and begin to believe themselves worthy of compassion. In other words, receiving compassion from an important entity, such as a leader, may demonstrate that it's okay to show compassion to oneself. Additionally, sufferers would also learn *how* to show themselves compassion by holding their painful thoughts and feelings in a balanced perspective rather than over-identifying with them. So not only would they believe they deserve compassion, but they would also learn what behaviors they could exhibit towards themselves to demonstrate self-compassion. Furthermore, leaders who demonstrate

empathy as part of compassion may share a similar experience that they or someone they know has had. This information in turn may enable the sufferer to engage in self compassion through a connection to common humanity via a concrete example of others who have had similar experiences.

*Hypothesis 3: Trauma-informed compassionate leader behaviors will be positively related to employee self-compassion.*

### ***Posttraumatic Growth***

While exposure to traumatic experiences may result in poor psychological health (Winthrop, 2010), many people report unexpected positive outcomes and growth following traumatic events (Maitlis, 2020). Posttraumatic growth (PTG) is not only surviving traumatic events but also experiencing personal development that surpasses the level of functioning that was present prior to the negative event (Tedeschi & Calhoun, 2004). Common posttraumatic growth experiences include gaining wisdom from negative experiences, being more open to life experiences, and strengthening relationships with significant others (Calhoun & Tedeschi, 1999). While no research has investigated the relationship between compassion received from others and posttraumatic growth, research into self-compassion suggests a positive relationship between compassion and PTG. Indeed, Wong and Yeung (2017) found a positive relationship between self-compassion and PTG. While self-compassion pertains to the cognitive, behavioral, and/or emotional work one does to relieve one's own suffering (Neff, 2003), it stands to reason that receiving compassion from another person – actions, sense-making, and emotional support intended to reduce suffering – would also increase the likelihood that the sufferer will experience PTG following the traumatic event(s). Indeed, when employees feel high levels of compassion, they tend to generate positive emotions (Lilius et al., 2008), which can promote individual self-

improvement and psychological development (Frazier et al., 2009; Breines and Chen, 2012).

Thus, I expect that TCLB are positively related to posttraumatic growth.

*Hypothesis 4a: Trauma-informed compassionate leader behaviors will be positively related to employee posttraumatic growth.*

Additionally, because self-compassion is positively related to one's healing and growth following trauma (Winders et al., 2020), I expect the following:

*Hypothesis 4b. The relationship between TICLB and employee posttraumatic growth will be partially mediated by employee self-compassion.*

## **Perceptions of the Work Environment**

### ***Psychological Safety***

Psychological safety describes an employee's perceptions of the consequences of taking interpersonal risks at work (Edmondson & Lei, 2014). Employees who feel psychologically safe at work are more willing to express themselves cognitively and emotionally (Kahn, 1990) because they believe their expressions will be met with respect (Edmondson, 1999).

Psychological safety at work is extremely important for those that have experienced trauma to feel comfortable discussing their needs. Indeed, psychological safety is positively linked to voice – employee willingness to challenge the status quo and offer ideas to improve processes (Van Dyne & LePine, 1998). Those who do not feel psychologically safe at work will not feel comfortable voicing their concerns nor their needs to their leader (Sherf et al., 2021).

Trauma-informed compassionate leader behaviors are likely to increase employee's perceptions of psychological safety through attending to the needs (emotional, psychological, and physical) of the sufferer. This behavior communicates that the employee can share their thoughts and feelings and be met with respect and compassion. Indeed, TICLB creates an

expectation that employees will experience respectful and compassionate behavior in response to their interpersonal risk (i.e., sharing their needs, experiences, emotions) in future interactions. In a study of healthcare workers, Nembhard and Edmondson (2006) found that leader inclusiveness – words and deeds exhibited by leaders that invite and appreciate others’ contributions – was positively related to psychological safety. This suggests that when leaders provide compassionate behavior to sufferers, the sufferers will subsequently come to expect this type of behavior in response to future questions, needs, and ideas; thus, building the sufferer’s psychological safety. Furthermore, positive responses from leaders may also help sufferers overcome any sense of stigma they feel in regard to both their experiences and their own reactions to the experiences (Green-Shortridge et al., 2007).

*Hypothesis 5: Trauma-informed compassionate leader behaviors will be positively related to employee psychological safety.*

## **Attachment and Contributions to the Organization**

### ***Performance***

The job-demands resource model (Demerouti et al., 2001) as applied to the context of trauma suggests that compassion from leaders can be viewed as a resource to sufferers which in turn helps sufferers perform their job well. Experiencing trauma can drain mental, emotional, and cognitive resources an employee has to expend at work (Meyerson & Zuckerman, 2019; Sandberg & Grant, 2017). Compassion, in the form of emotional support, flexibility in scheduling, and material goods, is a resource that can help employees complete their work. Indeed, several studies have found a positive relationship between experienced compassion and job performance (e.g., Hur et al., 2016; Rhee et al., 2017). Similarly, social exchange theory (Blau, 1964) suggests that employees who receive help and resources from a leader will feel

obligated to repay those efforts. In turn, this felt obligation leads employees to exert additional effort at work thereby increasing their performance (Eisenberger et al., 2001; Wayne et al., 1997). Thus, I expect that receiving compassion from a leader will be a resource to help employees cope with the demands of the job and employees will feel obligated to repay their leader's effort through increased job performance.

*Hypothesis 6: Trauma-informed compassionate leader behaviors will be positively related to employee performance.*

### ***Organizational Commitment***

As we've seen recently following the COVID-19 pandemic, the way leaders respond to employee trauma can influence how employees feel about the organization (Lord & Maher, 1990). Indeed, leaders are often seen as a representative of the organization, and employees form global perceptions based on the actions of their leaders (Maskor et al., 2022). For those that have experienced trauma, leaders who fail to acknowledge that trauma and do what they can to help alleviate employee suffering can exacerbate the traumatic experience and subsequently lessen the commitment a sufferer is willing to expend toward their organization (MacDonald et al., 2003). However, receiving compassion from a leader may break the sufferer's cognitive connection between the workplace and trauma. By helping the sufferer make sense of previous trauma and healing from it, the compassionate leader makes it possible for the sufferer to commit to their organization. According to social exchange theory (Blau, 1964), receiving altruistic help or support from another leads to gratitude from the receiver who in turn desires to repay the giver. In this case, the sufferer may become more committed to both their leader and the organization. Indeed, Moon et al. (2016) found that receiving compassion from others at work was positively related to affective organizational commitment. Thus, we expect that experiencing trauma-

informed compassionate leader behaviors from their leader will positively influence a sufferer's organizational commitment above and beyond experienced compassion (Lilius et al., 2008).

*Hypothesis 7: Trauma-informed compassionate leader behaviors will be positively related to employee organizational commitment.*

## **Overview of Studies**

To test the hypotheses above, I conducted three studies to create and validate a measure of TICLB. The first study was conducted over three phases. In the first phase, I conducted interviews with those that have experienced extreme traumas to better understand the trauma-informed compassionate behaviors that their leaders exhibit at work or behaviors that these trauma survivors would like to see their leaders exhibit. These interviews also informed the items of the TICLB measure. The second phase of study 1 helped to establish content validity by asking graduate students to rate the extent to which the created items measured TICLB rather than related constructs. This study had a few issues and so the third phase sought to rectify some of those issues by inviting an SME panel to determine which items were essential to measure TICLB.

In study 2, I sought to provide evidence for the factor structure of the TICLB measure, as well as convergent and discriminant validity. In this study, participants recruited via Prolific were asked to provide substantive ratings for the TICLB measure as well as for measures of several related constructs. Lastly, in study 3, I collected data a second time from study 2 participants to provide additional evidence for the factor structure of the TICLB measure as well as predictive validity and incremental validity. Studies are discussed in detail below.

## **Study 1a Methods**

### **Study 1a: Item Generation**



The purpose of this first study is to gather narratives from those that have experienced trauma and their experiences with leaders in the workplace. These narratives, along with previous theory and research on both compassion and trauma-informed approaches, were used to create survey items for the TICLB scale. Taking this approach allowed me to gather rich information about the lived experiences of those who have experienced trauma and subsequently entered civilian and legal work, which enhanced my understanding of what they need from leaders. Additionally, drawing from previous theory and research guided the questions asked of participants and provide an initial framework for the scale being developed. More specifically, questions asked about behaviors and language that leaders use to convey they are noticing employee suffering, empathizing with that suffering, sense-making with employees and acting to relieve suffering (Dutton et al., 2014) in such a way that ensures the safety of the sufferer, comes from a place of trust, and centers the needs of the sufferer as the most important aspect of the compassion interaction. The responses to these questions then served as the basis for creating items that capture the behaviors mentioned by participants.

## **Participants**

Given the practical and ethical importance of accommodating trauma survivors in the workplace, it is critical that we gain insight into the experience of trauma and what constitutes trauma-supportive behaviors. Two samples in particular that seem well-suited given their extreme experiences of trauma are human trafficking survivors as well as military veterans who have been diagnosed with post-traumatic stress disorder (PTSD) who have transitioned into paid civilian work. Human trafficking, either sex or labor, is considered a traumatic event (Lugris, 2013). Similarly, those who have served in the military and have subsequently received a posttraumatic stress disorder (PTSD) diagnosis have experienced trauma. Following these

experiences in work-like conditions, these individuals typically then attempt to transition into civilian and legal work.

Participants included 22 people that identified as having experienced a significant trauma. The majority (n=15) were female, and the rest were male (n=7). While I had set out to recruit equal numbers of men and women, this sample aligns with data suggesting that men are less willing to discuss any aspect of their experienced trauma (Delle Donne et al., 2018). Half of participants were White (n= 11), with 32% Black (n=7), 10% Hispanic (n=2), and 5% identified as more than one race (n=1). Participants ranged in age from 23 to 62 (most declined to give their age). Additionally, time since most recent traumatic event ranged from 2 years to 30 years. It is important to note here that for several participants whose trauma happened 20-30 years ago, they had only recently realized they had suffered the trauma and had started therapy within the last 1-2 years to work through their trauma.

## **Procedure**

Participants were recruited in several ways. First, human trafficking survivors were recruited via a coalition comprised of organizations that provide direct client services. Coalition organizations were asked to post flyers for the study in their offices as well as send an email to clients, current and previous, describing the study. Both posters and emails contained information to sign up for the study as well as information concerning time commitment and compensation. Second, veterans with traumatic experiences were recruited using organizations that provide career services to veterans. Organizations distributed an email containing information about the study and a link to sign up to participant in the study, to current and previous clients. Additionally, study details were posted in both a Facebook group and LinkedIn group that cater to veterans. Participants were screened to ensure they met study criteria by

having them confirm they were over the age of 18, lived and worked at least 20 hours within the US, and had suffered a significant trauma. The majority of participants ( $n = 15$ ) were survivors of human trafficking, two suffered from PTSD following military combat, and the rest ( $n = 5$ ) suffered undisclosed traumas.

To get a well-rounded perspective of trauma-informed compassion, supervisors of those who have experienced human trafficking or veterans with PTSD were asked to participate. Supervisors were recruited through the anti-human trafficking coalition mentioned above. Three supervisors agreed to participate. All supervisors were women, two were White, and one was Hispanic. These women had all suffered significant traumas themselves (two experienced human trafficking and one experienced domestic abuse and sexual assault) and supervised those who had experienced similar traumas. Additionally, several of the participants were also supervisors, and they provided information about their interactions with subordinates, especially those known to have experienced trauma. For instance, one participant who experienced human trafficking was the supervisor for an employee who had recently experienced a significant trauma and the participant volunteered information about how they interacted with their employee.

In addition to supervisor testimony, two organizations shared training PowerPoints they use to train organizations on trauma-informed practices for leaders and organizations. As these trainings are proprietary, they are not included as an appendix but were used in the coding process.

Participants interviews lasted between 30 and 105 minutes with the average length being 59 minutes. See Appendices A and B for participant and supervisor interview questions. Twenty participants were interviewed via Zoom and two participants were interviewed over the phone; all three supervisors participated via Zoom. All interviews were recorded, after obtaining

consent, and then transcribed verbatim using Otter.ai. I reviewed all transcripts and audio recordings to ensure accuracy. Participants received \$30 via Amazon gift card for their time. Supervisors did not receive compensation for their time.

### **Analyses and Results**

Following all interviews, I conducted a content analysis of the data using an open-coding approach (Strauss & Corbin, 1998) to identify, categorize and describe both positive and negative trauma-informed compassionate leader behaviors using the ATLAS.ti 22 software. Transcripts were coded for behaviors that reflected at least one aspect of either compassion (noticing, empathetic concern, sense-making, or acting) or a trauma-informed approach (safety, empower/voice/choice, trustworthiness/transparency, or collaboration/mutuality). Attention was particularly paid to behaviors, actions, or discussions that demonstrated an aspect of both compassion and a trauma-informed approach. For instance, one participant who worked at a lingerie store was discussing safety at work and her leader's reaction when men called the store asking inappropriate questions:

“Um, one of my supervisors, like, if she heard, like, one of the employees or get like one of those [lewd]<sup>1</sup> calls, she would kinda step in, and, like, tell them in person on the phone, that it was inappropriate. And, like, so she would kind of like, step into that situation. And I think, if it was noticed that I was going on, that my supervisors there, they would step in to the situation.”

This was coded as both safety and acting because the leader's actions were taken to alleviate the stress of being triggered at work by lewd comments from male callers. Another example came

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<sup>1</sup> Word added by author for context

when a participant spoke about a conversation between her and her supervisor at work following some stressors in the participant's life:

“Yeah, I think it was just more to make sense of what like, what realistic expectations can she have? You know, so I think in that way, it was kind of good that she wouldn't put unrealistic expectations on me like, she's like, ‘Hey, I'm understanding of what's going on. And I just want to make sure that we're not overloading you, or giving you more than you can handle in this moment.’”

This was coded as both sense-making (compassion) and mutuality/collaboration (trauma-informed) as the leader and participant were jointly making sense of the participant's current capabilities and how both the participant and the leader could help each other be successful at work.

During the coding process, I took notes about observations and patterns in the text. After completing the first round of coding, I performed axial coding in which the initial codes were grouped in categories based on similarity. For instance, there were several times that participants mentioned accountability as an important behavior and initially I labelled these instances as accountability, but after further reflection and review of the text I realized that accountability was related to a leader's trustworthiness and so the accountability code was grouped into trustworthiness. After completing the two rounds of coding, a second graduate student unfamiliar with the scope of the study was given the codebook and one full transcript to code. Coding was then jointly reviewed. Coders agreed on 91% of codes, the rest were discussed until consensus was reached. Following this, I reviewed the other 21 participant transcripts, 3 supervisor transcripts, and 2 training PowerPoints to ensure coding was complete. After open-coding, categories, descriptions, and notes were used to create items to represent trauma-informed

compassionate behaviors. Following Hinkin's (1998) recommendation, items created were created to be simple to understand, consistent in terms of perspective, and not double-barreled. Items were created such that each item captured at least one aspect of compassion (i.e., noticing, empathic concern, sense-making, or acting) and at least one aspect of a trauma-informed approach (i.e., safety, empower/voice/choice, trustworthiness/transparency, or collaboration/mutuality); which created a matrix of 16 pairings. This procedure was done to ensure that items captured trauma-informed compassionate behaviors and not one or the other (i.e., compassion *or* a trauma-informed approach). When creating a scale, it is better to create a number of items that capture similar ideas (Clark & Watson, 2019), so for each pairing I created at least 3 items.

Following initial item creation, items were reviewed by subject matter experts (SMEs) for representativeness and redundancy. Subject matter experts included a social worker who leads community training and education on trauma-informed practices, a survivor of human trafficking who conducts research at a not-for-profit service organization, and an industrial/organizational psychologist who is trained in item writing. Any items that SMEs deemed redundant, non-representative, or difficult to understand were removed or re-written to better capture the construct. This was an iterative process until the SMEs and I had no further edits to the items. Ultimately, I created a total of 51 items, with each pairing between a compassion facet and a trauma-informed facet having at least three items and some having four items (see Table 1).

## **Discussion**

During the interviews and coding process a couple of interesting points came to light. The first regards participants' views on sense-making. In Dutton et al.'s (2014) conceptualization

of sense-making, they suggest that participants in the compassion episode will make sense of the sufferer's trauma or suffering. When asking participants of this study about sense-making or when coming across sense-making during the coding process, I realized that participants did not sense-make with their leaders about their trauma. While some participants did discuss their trauma with their leaders, they did not spend time reflecting on the trauma nor did the leader help the participant see their trauma in a different light (Dutton et al., 2014). Instead, participants discussed sense-making in terms of how their trauma or reactions to their trauma impacted their work and what that might mean for their work life. For instance, in the quote above, the participant and their leader made sense of the participant's current state of mind and mental space to determine what were feasible goals that the participant could accomplish. In another instance, a participant talked about an instance in which her leader was helping her make sense of her work strengths/weaknesses and abilities, and how those might (positively or negatively) impact her career.

Secondly, during the coding process and item writing, it was difficult to place specific items into just one pairing. For instance, the item "During our interactions, my supervisor speaks to me with respect and understanding," was ultimately placed in the sense-making and empower/voice/choice pairing because participants discussed this as being important during conversations in general and even more so during conversations involving sense-making to ensure participants felt they could use their voice. However, this item could have also fallen under the empathic concern and safety pairing because participants discussed the need for respect and understanding to help them feel safe during interactions with their leaders as well as to feel understood by their leader. Participants regularly spoke about behaviors or mannerisms that covered several aspects of both a trauma-informed approach and compassion. When creating

items to cover each pairing, I had to make decisions based on what the item best represented, however, items could be interpreted to cover different aspects than they initially intended. This could make it difficult for participants to accurately distinguish between different pairings or even between items that represent different aspects of either a trauma-informed approach or compassion. With this in mind, it is possible that TICLB will be a unidimensional construct with items covering various, and potentially overlapping, aspects of trauma-informed compassion.

### **Study 1b: Item Refinement**

This stage is used to provide evidence for content validity; specifically, definitional correspondence and definitional distinctiveness. Definitional correspondence refers to the degree to which a scale's items correspond to the construct's definition whereas definitional distinctiveness refers to the degree to which a scale's items correspond more to the focal construct's definition than to the definition of other related constructs (Colquitt et al., 2019). This stage provides justification for the removal of items that are not conceptually consistent with the construct definition (Hinkin, 1998). For this study, I followed the Hinken & Tracey (1999) approach.

## **Methods**

### **Participants**

Participants included doctoral and masters students. Doctoral and masters students were an appropriate sample for this type of task as they have the intellectual ability to assess the correspondence between items and conceptual definitions (Schriesheim et al., 1993) and they do not need to be experts in this domain (Anderson & Gerbing, 1991). Eighty-six people opened the survey, of those that opened the survey 43 consented to participate but did not participate in any other portion of the survey and 43 completed at least some portion of the survey. Of the 43 that



completed at least some portion of the survey, 21 had no missing data. Thus, the final sample included 21 doctoral and masters students for a 24% completion rate. This sample size is slightly smaller than recommendations for sorting tasks (i.e.,  $n = 30$ ; Hinkin & Tracey, 1999), as well as previous research (e.g., Ferris et al., 2008). This final sample was 48% ( $n = 10$ ) female, 43% male ( $n = 9$ ), 9% nonbinary ( $n = 2$ ); 57% Caucasian/White ( $n = 12$ ), 4% Black or African American ( $n = 1$ ), 29% Asian ( $n = 6$ ), 9% Hispanic ( $n = 2$ ). Age of participants ranged from 22 to 57 with an average age of 30. All participants spoke English, but six participants reported English was not their first language. Because students were all in graduate school in the U.S., it was safe to assume they had mastery over the English language and were retained in the analyses. Students were in various programs of study including psychology, management, information systems, and film.

## **Procedure**

Convenience sampling was used to recruit doctoral and master's students to participate based on the author's network. Students were contacted via email and social media with the title of the study and a short description of the sorting task. The email and social media posts also contained a link to the survey. Upon entering the survey, students were given a more detailed description of both the study and sorting task. They were then asked to provide their consent prior to proceeding to the sorting task. Students were given definitions of the following constructs: perceived supervisor support, perceived organizational support, supportive and unsupportive manager behaviors, compassion at work, compassionate leadership, trauma-informed compassionate leader behaviors, and transformational leadership. These definitions were then followed by 139 items in randomized order. The items included the items generated to assess trauma-informed compassionate leader behavior (51 items), supportive and unsupportive

manager behaviors (27 items; Rooney and Gottlieb, 2007), compassion at work (3 items: Lilius et al., 2008), the Compassionate Leader Behavior Index (24 items; Shuck et al., 2019) and perceived organizational support (8 items: Eisenberger et al., 2002), transformational leadership (20 items; Bass & Avolio, 1993), and perceived supervisor support (6 items; Eisenberger et al., 1986). Students were then asked to rate the extent to which each item measured each of the 7 constructs on a 0-6 scale (0=item does an extremely bad job of measuring concept above to 7=item does an extremely good job of measuring concept above; Hinken & Tracey, 1999). To control for any response bias caused by order effects, two surveys were created, wherein construct definitions were presented in different orders. Participants were randomly assigned to one of the two versions. Upon completing this task, students were asked to input their demographic information which included indicating whether they were currently enrolled in a master's or doctoral program and their program of study.

### Study 1b Analyses

First, for the 51 TICLB<sup>2</sup> items, ANOVAs were conducted to determine whether participants rated these items as significantly higher (i.e., does a better job of measuring the concept) on the target concept (i.e., TICLB) than the related concepts, significant ANOVAs were followed by Duncan's multiple comparison post-hoc test with a family-wise alpha correction (Hinken & Tracey, 1998). This information was used to identify items that should be re-examined or dropped from the set. Next, the item-level *Hinken Tracey correspondence* (HTC) was calculated using the formula  $\frac{c}{a}$  where  $c$  is the average definitional correspondence rating for an item and  $a$  is the number of anchors used (Colquitt et al., 2019). HTC values range from 0 to 1 with 0 indicating no correspondence between the item and the construct, whereas 1 indicates

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<sup>2</sup> Raw data were transformed from a 0-6 scale to a 1-7 scale to accurately calculate *HTC* and *HTD*

complete correspondence between item and construct. Again, this information was used to flag items that needed to be re-examined or dropped from the set. Due to lack of guidance in the literature on appropriate cutoff scores for item-level HTC, I choose a liberal cutoff of .5 which indicates that participants rated an item as measuring the target construct to some degree (Yang et al., 2019). Finally, I evaluated all items and evidence from previous analyses to winnow the list of items down to the 12 with the highest item-level HTC but that also covered the breadth of TICLB. Following this, I calculated the scale-level HTC using the formula  $htc = \frac{C_a}{a}$  where  $C_a$  is the average definitional correspondence rating and  $a$  = the number of anchors. This is an indicator of how well the items together correspond to the target construct. Finally, I examined the distinctiveness of the scale by calculating the *Hinken Tracey distinctiveness* using the formula  $htd = \frac{(C_i - C_o)}{a - 1}$  where  $C_i$  is the average correspondence rating on the intended construct and  $C_o$  is the correspondence rating on the orbiting construct. The difference is calculated between the target construct and each of the orbiting constructs, these calculated differences are then averaged, and finally divided by the number of anchors -1 (i.e., 6). The *htd* statistic ranges from 1 (when all items are rated as a 6 on the intended construct and 0 on the orbiting constructs) to -1 (when all items are rated as a 0 on the intended construct and 6 on the orbiting constructs). The *htd* statistic is an indicator of the definitional distinctiveness of the focal construct from other, related constructs.

### Study 1b Results and Discussion

All ANOVAs were significant at  $p < .01$ . Duncan's multiple comparison post-hoc tests revealed mixed results: 25 items were rated as measuring TICLB significantly higher than at least three out of the six orbiting constructs. Of those 25, ratings on 13 items were significantly higher on the target construct compared to at least four of the six orbiting constructs, and ratings

on four items were significantly higher than five of the six orbiting constructs. None of the 51 items were rated as measuring TICLB significantly higher than compassionate leadership and only four items were rated as measuring TICLB significantly higher than general compassion. Following these results, I calculated the item level HTC for the 13 items that were rated as measuring the target construct significantly more than four of the orbiting constructs (discussed below), all HTC values were above the cutoff of .5 (see Table 2); however, one item had a significantly lower item-level HTC than the other items and was subsequently dropped from the scale. Next, I calculated the scale-level HTC = .80. According to Colquitt et al. (2019) this indicated that taken together, the items demonstrated weak definitional correspondence when the orbiting scales are highly correlated to the target scale. While I am unable to determine the correlations between scales during this study of data collection, theoretically I assumed the constructs are highly correlated. Finally, I calculated scale level HTD using the ratings for the focal construct and the orbiting scales. Results (HTD = .25) provided very strong evidence for distinctiveness.

The finding that students rated TICLB items as measuring TICLB just as well as compassionate leadership behaviors and general compassion suggests two things. First, this suggests that students might have difficulty distinguishing between compassion and *trauma-informed* compassion. This is unsurprising given the fact that trauma-informed care has only recently been discussed more widely outside of the medical and client-based service industry (Manning, 2022). Furthermore, participants could believe that compassion should already incorporate aspects of a trauma-informed approach and thus have difficulty differentiating between concepts. Additionally, it is possible that students have difficulty identifying the nuances of a trauma-informed approach to compassion because they had not experienced major

traumatic experiences. In study 1a, I interviewed those that had experienced ‘extreme’ traumas like human trafficking and combat, which may have made those participants more sensitive to various aspects of their leaders’ behaviors compared to those that have not experienced such extreme traumas.

Second, after a review of the Hinkin & Tracey (1999) content validation method, guidelines for the procedure include not choosing orbiting constructs in which the focal construct could be nested (Colquitt et al., 2019). In this case, trauma-informed compassionate leader behaviors (TICLB) could be conceptualized as being nested within compassionate leader behaviors (CLB). In other words, TICLB is a more nuanced version of CLB. Subsequently, CLB could be conceptualized to be nested within general compassion. Taken together, I decided that performing a SME panel, with those that have experienced more extreme traumas, to identify items that measure TICLB and not simply compassion or compassionate leader behaviors would be beneficial to this study.

### **Study 1c: Further item refinement**

With results from the previous study suggesting that people had trouble distinguishing between compassionate leader behaviors and *trauma-informed* compassionate leader behaviors, I went back to the original items and edited the ones that performed the best in study 1b (were rated as measuring TICLB significantly better than at least three of the four orbiting scales not including general compassion or compassionate leadership and an HTC > .50) and added one new item for a total of 31 items. Following this, I conducted a SME panel (Wilson et al., 2012). As mentioned above, two potential reasons for graduate students’ inability to distinguish between compassionate leader behaviors and *trauma-informed* compassionate leader behaviors are 1) items were not written in such a way as to emphasize the nuances of a trauma-informed

approach to compassionate leader behaviors and/or 2) participants, on average, have not experienced extreme trauma which would make them sensitive to the differences. Thus, this study of scale creation was conducted to gather insight from those that specialized in trauma-informed approaches to ensure that those nuances were captured by the items.

## **Study 1c Methods**

### **Procedure**

Convenience sampling based on the author's network was used to recruit participants who specialize in trauma-informed practices. Participants were sent an email with a request for assistance as well as a short description of the task. Six people agreed to participate and were subsequently sent a link to a survey. The survey contained instructions for participating in an SME panel followed by the 31 edited or new items. Participants were provided with the definition of TICLB from study 1b as well as brief definitions of general compassion and compassionate leader behaviors. Participants were then asked to rate how essential each item was to measure TICLB on a three-point scale (essential, useful but not essential, and not necessary; Lawshe, 1975). Participants were instructed to rate an item as essential only if that item captured trauma-informed compassionate behaviors. They were instructed to rate items as not useful if they captured only some aspect of compassion or generally positive behaviors that leaders might exhibit. They were then provided with an example of the process followed by the task. After participants rated all items, they were presented with the list of 31 items and had the option to provide feedback on the wording of any item as well as whether they believed something wasn't covered by the current items.

### **Participants**

One participant left a comment that they completed the survey but were confused by the instructions; therefore, this participant's data were eliminated prior to analyses. Participants included five people well versed in trauma-informed approaches. See Table 3 for additional information about participants' backgrounds.

### **Study 1c Results and Discussion**

Based on proposed cutoff scores (Wilson et al., 2012), for an item to meet minimum cutoff scores with a one-tailed test with  $\alpha = .05$ , all participants would have to rate an item as essential. To provide some room for potential disagreements, I used the cutoff scores for a one-tailed test with  $\alpha = .10$ . This meant that at least four participants needed to rate an item as essential to meet minimum cutoff scores (Wilson et al., 2012). Of the 31 items rated by the SMEs, 17 were rated as essential to measuring TICLB by at least four of the participants (see Table 4) and were thus used for the TICLB measure.

In reviewing the items that participants rated as essential to capturing TICLB, items captured the various aspects of compassion equally (noticing = 4, empathic concern = 5, sense-making = 6, acting = 4). However, when investigating the aspects of trauma-informed, almost half of the items referred to the aspect of safety ( $n = 8$ ). When discussing with one of the SMEs afterwards, they explained that other aspects of trauma-informed could be considered generally positive leadership. For instance, we expect leaders to act with trustworthiness and transparency in the workplace and this was reflected in the results of the study, only two items meant to capture trustworthiness/transparency were rated as essential by at least four of the SMEs. The empower/voice/choice and collaboration/mutuality aspects of trauma-informed were equally represented with five and four items each, respectively. The large number of safety items that

were rated as essential points to the possibility that the biggest things leaders can contribute to those that have experienced trauma is a sense of (psychological and physical) safety.

### **Study 1 General Discussion**

Seventeen items made it through this first study of content validation. Based on the data above there are several important points to consider. First, two of the orbiting constructs used in study 1b were inappropriate. Orbiting constructs should not be constructs in which the new construct is nested, this violates the “not a part-whole relationship” criterion (Colquitt et al., 2019). For this reason, general compassion and compassionate leadership behaviors were inappropriate in this study. TICLB could be considered nested within compassionate leader behaviors, and both would be nested within general compassion. This would explain why students in study 1b had difficulty distinguishing between the three constructs. If items are measuring TICLB, then they are likely measuring some aspect of compassionate leadership behaviors as well as general compassion. However, the majority of items that students rated as measuring the target construct significantly higher than the other four orbiting constructs (Perceived Organizational Support, Transformational Leadership, Perceived Supervisor Support, and General Supervisor Support) were also rated as essential by the SMEs.

Second, it’s important to consider that a trauma-informed approach to compassionate leader behaviors is nuanced and may not be easily recognized by those that have not experienced a big “T” Traumatic event. While most people experience some sort of little “t” trauma in their life (e.g., sexual harassment, fender-bender, death of a loved one), not everyone experiences Trauma (e.g., combat, sexual assault, domestic violence; for explanation of the difference see Shapiro, 2001). Thus, the graduate students who participated may not have experienced such Trauma and did not recognize some of the nuanced differences. That is not to say that those who



have not experienced Trauma would not benefit from TICLB, just that they might have a hard time identifying it. Therefore, the SME panel helped determine which behaviors were essential when measuring TICLB.

Third, the point of study 1b was to provide evidence that the items written captured a unique construct as opposed to constructs that already have measurement tools (Hinken & Tracey, 1999). This is important for two reasons. First, to reduce construct redundancy. If two constructs are the same then creating the same construct under a different name leads to confusion within research (Gonzalez et al., 2021). Second, content validation helps to prevent lack of discriminability in future validation studies. In this case, I would argue that TICLB is in fact a different construct than both compassionate leader behaviors and general compassion, mainly due to the trauma-informed component of the construct (discussed above). Thus, while there may have been difficulty distinguishing between the three constructs conceptually, I expect that empirical data will demonstrate discriminability between general compassion, compassionate leader behaviors, and trauma-informed compassionate leader behaviors. Thus, in study two I collected data to investigate the convergent and discriminate validity of the TICLB measure.

## **Study 2: Development & Validation**

The purpose of this study is to assess the psychometric properties of the proposed scale by examining the scale's reliability, factor structure, convergent and discriminant validity. This includes the corrected item-total correlations as well as item descriptives and distribution characteristics.

## **Methods**

### **Procedure & Participants**

Participants were recruited via Prolific, an online participant pool platform. Only participants who were at least 18 years old, live and work in the US, and currently working at least part time were invited to participate in the survey (N=12,153). Participants who met the study criteria were invited to participate in this study. They were presented with a short study description and time required to complete the study. Those that chose to participate were presented with a link to the Qualtrics survey containing items from the scales below. Because this sample would be used for both the EFA and CFA analysis (split in half), I collected data from 1000 participants (Clark & Watson, 2019). Each participant received \$3.67 upon completion. I implemented several quality assurance measures, such as attention checks within the survey, removing those who spend too little or too much time on the survey, and ensuring that each participant responded only once (Curran, 2016). Participants also needed to provide a completion code to Prolific that they received on the last page of the survey to ensure it was completed. From the 1000 participants who provided completion codes indicating they had seen the entire survey, 99 were dropped from the final sample (for missed attention checks,  $n = 2$ , or significant missing data, i.e.,  $> 50\%$ ;  $n = 97$ ). See Table 5 for demographic information for the final sample of  $n = 901$ .

## **Measures**

### ***Focal Construct***

***Trauma-informed Compassionate Leader Behaviors*** was measured using the 17 items from study 1C. Items are rated on a 6-point scale (1= Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Somewhat Agree, 5 = Agree, 6 = Strongly Agree).

### ***Related Constructs***

**General Supervisor Support** was measured using Rooney and Gottlieb (2007) 27-item Inventory of Supportive and Unsupportive Managerial Behaviors (SUMB). Participants rated items on the following scale: “my supervisor does this... 1 = Almost never, 2 = Occasionally, 3 = Fairly often, 4 = Often, 5 = Always. This scale measures three aspects of managerial behaviors: Enabling Job Support, Personal Esteem Support, and Micro-Managing. Sample items include “explains the reasoning behind decisions that affect me,” and “shows interest in what’s going on in my life outside of work.” Previous research has demonstrated acceptable reliability for the subscales ( $\alpha = .93, .93, .91$ ; Rooney & Gottlieb, 2007). For the purpose of this study, only items for EJS and PES were used. The authors of the original study did not provide guidance on creating a global scale score (i.e., can a researcher reverse score micro-managing items and then sum across items). Furthermore, there is little theoretical understanding of what relationship TICLB might have with micromanaging behaviors.

General supervisor support was also measured using Eisenberger et al.’s (2002) 6-item perceived supervisor support (PSS) scale. These items are taken from the survey of perceived organizational support and use “my supervisor” as the referent. Items used are #1, 4, 9, 20, 23, and 27 from the original 36-item scale (Shannock & Eisenberger, 2006). Participants will rate items on a 5-point Likert type scale where 1 = Strongly Disagree and 5 = Strongly Agree. A sample item includes “My supervisor strongly considers my goals and values.” Previous studies demonstrate adequate internal reliability ( $\alpha = .87$ ; Shanock & Eisenberger, 2006).

**Perceived Organizational Support** was measured using Eisenberger et al.’s (1986) 8-item Perceived Organizational Support Scale. Participants rated items on a 5-point Likert type scale where 1 = Strongly Disagree and 5 = Strongly Agree. A sample item includes “The organization values my contribution to its well-being.” While the original scale had 36 items, a

shorter version with 8 items has been validated (Eisenberger & Stinglhamber, 2011). Previous studies provide evidence of acceptable internal reliability ( $\alpha=.90$ ; Eisenberger et al., 2014).

***Transformational Leadership*** was measured using the 20-item Multifactor Leadership Questionnaire (Bass & Avolio, 1993). The 20 items measure the four facets of transformational leadership: idealized influence, individualized consideration, intellectual stimulation, and inspirational motivation. For the purpose of this study, only items for individual consideration were used because this is the facet that is theoretically most similar to TICLB (as argued above). Individual consideration concerns caring about and for the follower; whereas the other three facets concern giving the follower a challenge (intellectual stimulation), how to influence the follower to do something (II), and motivating the follower to achieve goals (IM). A sample individual consideration item includes: “The person I am rating... Spends time teaching and coaching.” Participants responded on a 5-point Likert type scale where 0 = Not at all and 4 = Frequently, if not always. Previous research has demonstrated adequate internal reliability ( $\alpha=.94$ ; Frieder et al., 2018).

***Received Compassion*** was measured using Lilius et al. (2008) 3-item compassion scale. Items are rated on a 5-point scale with 1 = Never and 5 = Nearly all the time. Sample items include: “How frequently have you experienced compassion on the job?”, “How frequently have you experienced compassion from your supervisor?” and “How frequently have you experienced compassion from your coworkers?” Previous research has demonstrated acceptable reliability ( $\alpha = .89$ ; Moon et al., 2014).

***Compassionate Leadership*** was measured using Shuck et al.’s (2019) 24-item Compassionate Leadership Behavior Index. Items are rated on a 5-point scale with 1 = Strongly Disagree, 3 = Neutral, and 5 = Strongly Agree. Sample items include: empathy – “My leader

understands my perspective;” integrity – My leader can be trusted to be honest with me;” presence – “My leader makes time to really listen to me;” dignity – “My leader treats me with respect;” authenticity – “My leader expresses themselves in a genuine way;” and accountability – “My leader holds me accountable for my work.” Previous research demonstrates acceptable internal consistency ( $\alpha = .80$ ; Shuck et al., 2019).

### ***Unrelated Construct***

***Workplace Status*** refers to an employee’s relative standing in an organization, as characterized by the respect, prominence, and prestige he or she possesses in the eyes of other organizational members (Djurdjevic et al., 2017). Based on this definition, workplace status refers to how others perceive an employee in the workplace and should be unrelated to the compassionate behaviors a leader exhibits toward an employee who has experienced trauma. Workplace status will be measured using the 5-item Workplace Status Scale (WSS; Djurdjevic et al., 2017). Participants will respond on a 5-point Likert type scale where 1 = Strongly Disagree and 5 = Strongly Agree. A sample item is “I have a great deal of prestige in my organization.” Previous studies report adequate internal reliability ( $\alpha = .89 - .96$ ) and test-retest reliability ( $r = .78$ ).

## **Analyses**

### **Psychometric Evaluation**

The first step in this study is to examine individual items’ response distributions. Items with highly skewed and unbalanced distributions will be flagged for elimination. However, it is important to note that since the participants may not represent the full range of the scale’s target population, items with highly skewed and unbalanced distributions will be reviewed before elimination to determine whether the item is expected to perform differently across more diverse

samples. Next, I calculated the corrected item-total correlations to eliminate items that do not correlate highly with the proposed construct (Clark & Watson, 2019).

**EFA.** To examine the dimensionality of my trauma-informed compassionate leader behavior scale, I conducted an exploratory factor analysis using principal axis factor (PAF) analysis with a direct oblimin rotation using SPSS 28.0. The number of factors was determined by a combination of eigenvalue  $> 1.0$ , the scree test, and parallel analysis (Fabrigar et al., 1999). The scree test provides a visual representation of the eigenvalues of the correlation matrix and the number of factors is decided based on where the last significant drop in the magnitude of the eigenvalues (Cattell, 1966). Parallel analysis compares the eigenvalues obtained from the sample data to eigenvalues found in randomly generated data sets with the same number of cases and variables (Horn, 1965). Subsequently a model is specified with the same number of common factors as real eigenvalues that are greater than the eigenvalues generated from random data (Fabrigar et al., 1999).

Additionally, when reviewing the EFA results items a) with primary loadings below .35 to .40 and b) that have similar or stronger loading on other factors will be eliminated (Clark & Watson, 2019). After all initial item elimination, I conducted another EFA to determine whether the same number of factors appeared and if any items still had low primary loadings or cross load on other factors. I also calculated model fit indices to determine whether the number of factors extracted fit the data well ( $RMSEA \leq .05$ , 90% CI  $RMSEA UL \leq .06$ ,  $CFI > .95$ , and  $SRMR < .05$ ; Finch, 2020). I then followed the EFA with a confirmatory factor analysis.

**Factor Structure.** Factor structure of the TICLB was analyzed using confirmatory factor analysis in R using the Lavaan package (Rosseel, 2012). This analysis was conducted on the random half of the sample that was not included in the EFA analyses. A model which includes

the number of factors extracted from the EFA was analyzed for good fit indices (RMSEA < .08, CLI > .90, and SRMR < .08; Hu & Bentler, 1999; Kline, 2005). This model was compared to plausible rival models based on theory and empirical results to ensure it is the best fitting model using a Chi-square difference test.

***Convergent Validity.*** Regarding convergent validity, the focal construct should be empirically related to theoretically linked constructs such that it retains its uniqueness but reflects the underlying similarities with related constructs (Campbell & Fiske, 1959). In other words, convergent validity refers to the extent that a measure is significantly related to either different measurements of the same construct or measures of conceptually similar constructs (Campbell & Fiske, 1959; Clark & Watson, 2019). As previously discussed, trauma-informed compassionate leadership is theoretically related to general supervisor support (SUMB and PSS), POS, transformational leadership, received compassion, and compassionate leadership. Therefore, I expect measures of GSS, POS, PSS, transformational leadership, received compassion and compassionate leadership to correlate positively and significantly with the TICLB scale.

***Discriminant Validity.*** To demonstrate discriminant validity, I modeled the focal and related constructs in a series of one- and two-factor measurement models and used a chi-square ( $\chi^2$ ) difference test to determine whether one model has significantly better fit. This test examines whether the items from each measure share a common factor, or whether these item sets are empirically distinct (e.g., Kline, 2005). Another test of discriminant validity involves demonstrating that a focal construct is uncorrelated with a construct with which it should theoretically not relate. For this, I examine workplace status (Djurdjevic et al., 2017),

## **Study 2 Results**

Item response distributions were analyzed for normality. Results demonstrate item responses were normally distributed for all items (skewness < 2.0 and kurtosis < 7.0; Curran, West, & Finch, 1996). Thus, no items were dropped prior to conducting the EFA.

## **EFA**

The items were subjected to an EFA using principal axis factor (PAF) extraction method with an oblique rotation (Fabrigar et al., 1999). This resulted in two factors with eigenvalues > 1: the first, accounting for 64.4% of the variance, which included 11 items with factor loadings > .40, and the second, accounting for 7.1% of the variance, which included 9 items with factor loadings > .40 (see Table 6). The scree plot and a parallel analysis provided evidence for a similar factor structure. Three items cross-loaded on both factors with loadings > .40, thus, this three items were eliminated. The remaining 14 items were subjected to a second EFA using the PAF extraction method and an oblique rotation. This resulted in two factors with eigenvalues > 1: the first accounting for 63% of the variance which included 8 items with factor loadings > .40 and the second factor accounting for 8.4% of the variance which included 6 items with factor loadings > .40 (see Table 7). The scree plot and parallel analysis confirmed the two factor structure. However, when I calculated fit indices, they indicated that the two factor model did not fit the data well ( $\chi^2(77) = 973.77$ ,  $RMSEA = .16$ ,  $CFI = .83$ ,  $SRMR = .38$ ).

Results of the EFA suggest a general factor that accounts for additional variance the items beyond the two factors suggested by the parallel analysis and scree plot. Specifically, since a simple structure (in which all items load highly on a factor and do not cross load) was achieved using an oblique rotation strategy, it is recommended that a general factor be extracted (Gorsuch, 1983; Reise et al., 2007; Thompson, 2004). There are two options for this general factor, either a hierarchical model in which a higher order factor explains the variance in the two lower order



variables or a bifactor model in which the covariance among item responses is accounted for by a single general factor and the two specific factors that account for additional variance among groups of items (typically with similar content; Reise et al., 2007). Thus, I compared the two-factor model to 1) a hierarchical model with two lower order factors and one higher order factor and 2) a bifactor model with one general factor and two specific factors (see Figure 1). Results of the model comparison suggest that the bifactor model is the best fitting model ( $\chi^2(64) = 140.98, p < .05, RMSEA = .05, 90\% CI RMSEA [.04, .06], CFI = .99, TLI = .98, SRMR = .02, \frac{\chi^2}{df} = 2.2$ ; see Table 8). The models were not subjected to a chi square difference test, but rather compared using their fit indices (Finch, 2020). Next, I confirmed this factor structure in the other half of the data using a CFA.

## CFA

Using the half of the data that were not used for the EFA, I ran a CFA on the bifactor model in R with the Lavaan package (Revelle, 2012). I also compared this model to three other models: 1). a hierarchical model with a higher order factor; 2). a two-factor model based on the two factors found in the EFA; and 3) a one factor model in which all factors load on a single, unidimensional factor. Models were compared using the chi-square difference test which is appropriate in this situation because the hierarchical model is nested within the bifactor model and the two-factor model is nested within the hierarchical model (Mansolf & Reise, 2017). Results suggest that the bifactor model fit the data best (see Table 9 for model comparison and Table 10 for factor loadings).

In addition to confirming the factor structure, I examined the factor loadings for the general and specific factors to determine whether scale scores should be based on the general factor (i.e., averaging across all items) or on the specific factors (i.e., creating subscales by

averaging across items within each specific factor). Using the Omega SEM function in R, I examined a bifactor model with two specific factors to determine the amount of variance accounted for by the general factor ( $\omega_h$ ) as opposed to the specific factors ( $\omega_t - \omega_h$ ). Results suggest that the general factor accounts for 82% of the variance within item response ( $\omega_h = .82$ ) and the specific factors account for a total of 14% of the variance across both clusters of items ( $\omega_t = .96$ ). Because there are no specific guidelines within bifactor models for choosing to create a global scale score versus subscale scores, I examined the items within the two factors to determine if there was theoretical rationale for choosing two subscales over a global scale.

Items in the first factor relate to easily-identifiable, and tangible actions that a leader might exhibit. For instance, in the item “My leader and I discuss the things that make me feel unsafe at work,” there is a discussion between the leader and employee which is easy to identify as an event. Similarly, in the item “When I'm dealing with a hardship, my leader helps me determine feasible work goals based on my mental and physical state,” tangible goals are being set. Thus, I labeled this factor as “tangible.” Conversely, the second factor contains items in which the TICLB exhibited by the leader is less tangible or easily identifiable. These items focus on the idea that the leader is providing a safe space psychologically for the employee. For instance, in the item “My leader doesn't judge me when I share my personal experiences” it is difficult to pinpoint exactly what the leader is (not) doing to remain judgment-free, but rather they are (not) doing something less tangible that communicates a lack of judgment. Similarly, the item “My leader respects my personal and professional boundaries,” could be capturing any number of minor actions a leader takes to respect someone’s boundaries such as maintaining personal space, not emailing on the weekends, not discussing personal matters at work, etc. Thus, this factor is labeled “intangible.” While these two factors correspond to the idea that some

aspects of compassion are more tangible (i.e., sensemaking and acting) than others (i.e., noticing, and empathic concern), the two factors do not mirror these groupings (an item about empathic concern loaded on the tangible factor and an item about sensemaking loaded on the intangible factor). Furthermore, I could not find a rationale to support the idea that subfactors would differentially relate to outcomes. I would argue that it is both the tangible and intangible actions of a leader that influence the studied outcomes. Thus, based on this review of the items, along with the large amount of variance explained by the general factor, I choose to create a global scale score.

### **Reliability**

To test the internal reliability of the scale, I calculated Cronbach's alpha, Omega (Revelle & Condon, 2019), and corrected item-total correlations (Clark & Watson, 2019). Results provide evidence for good internal consistency:  $\alpha = .94$ ,  $\omega = .96$ . Corrected item-total correlations demonstrate that items are highly correlated: corrected item-total correlations ranged from  $r = .48$  to  $r = .86$ , with an average of correlation of  $.76$  and a median of  $.77$  (see Table 11).

### **Convergent Validity**

To test convergent validity, a measure should be related to similar constructs (Campbell & Fiske, 1959). Thus, TICLB should relate to, but be distinct from, measures of supervisor support, perceived organizational support, general compassion, compassionate leader behavior, and individual consideration. Bivariate correlations provide evidence for convergent validity (see Table 12). Results demonstrate all seven correlations were significant, with the smallest correlation between TICLB and perceived organizational support ( $r = .67, p < .05$ ) and the largest correlation between TICLB and perceived supervisor support ( $r = .86, p < .05$ ) and between TICLB and compassionate leader behaviors ( $r = .86, p < .05$ ), with the other

correlations as follows, between TICLB and: Personal/Esteem Support ( $r = .83, p < .05$ ), Enabling Job Support ( $r = .82, p < .05$ ), Individual Consideration ( $r = .79, p < .05$ ), and Compassion ( $r = .70, p < .05$ ).

### **Discriminant Validity**

For the chi-square difference tests, TICLB and each related construct (e.g., PSS, POS, general compassion, compassionate leader behaviors, supportive and unsupportive managerial behaviors, and transformational leadership) were separately modeled as one- and two-factor measure models (i.e., each pair of constructs was modeled separately). The results of all chi-square difference tests are shown in Table 13. As expected, for all construct pairs, the two-factor models (i.e., when TICLB and the related construct were modeled as two separate factors) were preferable to the one-factor models (i.e., when TICLB and the related construct were modeled as one omnibus factor).

Furthermore, TICLB was correlated with Workplace Status to provide additional evidence for discriminant validity because the two constructs should theoretically be unrelated. Results demonstrate that the two constructs were significantly, though moderately, correlated ( $r = .36$ ).

### **Study 2 Discussion**

Results from study 2 provide evidence that TICLB encompasses two subfactors, “tangible actions” and “intangible actions” but that the majority of variance in item ratings can be attributed to a general global factor. This factor structure demonstrated the best fit to the data in both the EFA and CFA. However, upon further inspection of the two factors and the item order presented to participants, it is possible that two factors emerged based on the fixed item order presentation of items. Within the study, participants were shown the TICLB items in a

fixed order, meaning that all participants saw the items in the same order. As shown in Table 7, items 4-10 all load on the first factor, while items 1-3, and 12-15 load on the second factor. Thus, the factor structure from the study may be due to study design rather than any actual underlying factors (Bandalos, 2021). Thus, further evidence is necessary to determine the factor structure of the TICLB measure. To verify the proposed factor structure from study 2, I will collect the TICLB items again but present them to participants in a randomized order to determine whether the two subfactors exist or were artificially induced in study 2 due to order effects.

Beyond the factor structure, study 2 provides evidence for convergent validity as the TICLB measure displays significant relations with measures of related constructs. The TICLB measure was significantly positively related to all of the proposed related constructs and correlations between measures was large. This suggests that the TICLB measure taps into the underlying similarities between TICLB and related constructs, as it should (Campbell & Fiske, 1959). While high correlations could be interpreted as the constructs having too much overlap (Gonzalez et al., 2021), there are no guidelines for what constitutes too high of a correlation between constructs before they are deemed the same (Clark & Watson, 2019). Furthermore, all constructs measured in study are conceptually very similar, thus it is understandable that the correlations are quite large.

Conversely, results support the discriminant validity of TICLB as CFA comparisons of one- versus two-factor models demonstrate the empirical distinctiveness of the TICLB measure from the related constructs. If the one-factor models had fit the data better, this would provide evidence that items tap into the same underlying construct as opposed to two different constructs. Because TICLB was highly correlated with the related constructs, the fact that the two factor models (suggesting two underlying constructs) consistently fit the data better than the one-factor

models (suggesting one omnibus construct), study 2 provides strong evidence for the distinctiveness of TICLB. Most importantly, the two factor model fit the data better than the one-factor model even for items measuring general compassion and compassionate leader behaviors. This suggests that while people may have difficulty conceptually differentiating between the three constructs (study 1b), study 2 provides empirical evidence that they are in fact distinct. Additionally, study 2 provides strong evidence for internal reliability.

### **Study 3: Predictive and Incremental Validity**

The purpose of this study is to provide evidence that the focal construct predicts employee outcomes (testing the hypotheses) and that TICLB predicts outcomes above and beyond existing measures of compassion. Finding predictive validity provides support of the utility of the TICLB measure in predicting the identified outcomes. Finding incremental validity provides further support of discriminability of TICLB. Additionally, incremental validity supports the practical utility of the TICLB measure in predicting the outcomes of this study beyond competing measures (Clark & Watson, 2019).

## **Methods**

### **Participants & Procedure**

Using Prolific, participants from study 2 were invited to respond to a second survey one week later that contained scales for the outcomes variables. For this study, a sample size of 500 was deemed sufficient, thus all participants from study 2 were eligible to participate but the first 500 to fill out the survey were accepted. After removing participants for failed attention checks ( $n=2$ ), I was able to match 442 to data from study 2; thus, data analysis for study 3 was conducted on these 442 participants. These 442 participants were 51% male ( $n = 222$ ), 48% female ( $n = 212$ ) and 1% nonbinary ( $n = 6$ ); 76% White or Caucasian ( $n = 334$ ), 5% Black ( $n =$

24), 6% Asian ( $n = 27$ ), 5% Hispanic ( $n = 21$ ), < 1% Native American ( $n = 2$ ), and 7% two or more races/ethnicities ( $n = 32$ ). The majority of participants (89%) had at least attended college while 74% of participants had at least a bachelor's degree. Participants had been in their current job for an average of 6.68 years. When compared to the participants in study 2 who did not participate in study, there were no significant differences in age, race/ethnicity, gender, job tenure, or level of education.

## **Measures**

### ***Focal Construct***

Trauma-informed Compassionate Leader Behaviors will be measured using the complete 17 item scale used in study 2. All 17 items from study 1 were included to ensure that the same 3 items should be dropped for cross loadings due to conceptual similarities and not due to order effects on the items (Bandalos, 2021). I collected this data again using a randomized order to provide additional evidence that order effects did not influence the results from study 2. Furthermore, this data was also used to investigate test-retest stability.

### ***Outcome Variables***

***Psychological Well-being*** was measured using the Diener et al., (2010) 8-item psychological well-being scale (also referred to as Flourishing). Participants responded on a 7-point Likert-type scale where 1 = Strongly Disagree, 4 = Neither agree nor Disagree, and 7 = Strongly agree. A sample item includes: "I lead a purposeful and meaningful life." Previous studies demonstrate adequate internal reliability for this scale ( $\alpha = .87$ ; Diener et al., 2010).

***Psychological Safety*** will be measured using the 7-item Psychological Safety survey (Edmondson, 1999). Participants will respond on a 5-point Likert type scale where 1 = Strongly Disagree and 5 = Strongly Agree. Sample item includes: "As an employee, I am able to bring up

problems and tough issues with my leader.” Previous studies demonstrate adequate internal reliability for this scale ( $\alpha = .83$ ; Markus & Frese, 2003).

***Subjective Health*** will be measured using a single item “How would you describe your current health?” Participants will rate this item using a 5-point scale where 1 = Very poor and 5 = Excellent. Such measures are common and perform well psychometrically (e.g., Piszczek & Pimputkar, 2020).

***Self-compassion*** will be measured using the 12-item Self-Compassion Scale-Short Form (Raes et al., 2011). Participants will rate the items using a 5-point Likert type scale where 1 = Almost Never and 5 = Almost Always. Sample item includes: “When I’m going through a very hard time, I give myself the caring and tenderness I need.” Previous studies provide evidence for adequate internal reliability ( $\alpha = .86$ ; Raes et al., 2011).

***Posttraumatic Growth*** will be measured using the 10-item Posttraumatic Growth Inventory – Short Form (Cann et al., 2010). Participants are asked to rate the degree to which this change occurred in your life following your crisis on a 6-point scale where 0 = “*I did not experience this change following my crisis*” and 5 = “*I experienced this change to a very great degree following my crisis.*” A sample item includes “I am able to do better things with my life.” Previous studies demonstrate adequate internal reliability ( $\alpha = .89$ ; Cann et al., 2010).

***Organizational Commitment*** will be measured using the 7-item Affective Commitment Scale (Allen & Meyer, 1990). Participants are asked to rate the items on a 5-point Likert-type scale where 1 = Strongly Disagree and 5 = Strongly Agree. A sample item includes: “I feel a strong sense of belonging to my organization.” Previous studies demonstrate adequate internal reliability ( $\alpha = .89$ ; Merritt, 2012).



***Performance.*** Employees' job performance will be self-reported using Williams and Anderson's (1991) seven-item in-role performance measure on a 5-point Likert scale where 1 = Strongly disagree and 5 = Strongly agree). A sample item includes "I perform tasks that are expected of me." Previous studies demonstrate adequate internal reliability ( $\alpha = .72$ ; Frieder et al., 2018).

### ***Demographic Variables***

In addition to the above measures, I also collected demographic information such as age, gender, and race/ethnicity. Participants were also asked to indicate their job title, their level of education, job tenure, and the number of trauma experiences they have encountered as defined by the DSM-V. I used gender as a control variable in study 3 analyses because women generally score higher on well-being measures than men (e.g., Ryff, 1995, Vishnevsky et al., 2010), whereas men tend to score higher on measures of performance (e.g., Roth et al., 2012). I controlled for age because older people tend to have higher ratings of well-being (Warr, 1992), they also have more work experience and therefore are likely to have better work performance, and may be more committed to their organization than younger employees (Ng & Feldman, 2008). I controlled for race because employees of racial and ethnic minorities still face racism and obstacles in the workplace that influence their well-being and job performance ratings (e.g., Bluestein, 2008; Stauffer & Buckley, 2005). I also controlled for number of trauma incidents because those that haven't experienced significant trauma may not respond to TICLB or may find it unnecessary in the workplace, whereas those who have experienced numerous traumatic experiences may have higher needs and expectations for TICLB in the workplace.

## **Study 3 Analyses**

### **CFA**

To ensure that the factor structure held in a second data collection where items were randomized, the TICLB items from this data collected were subjected to a CFA using the bifactor model found in study 2. This model was compared against a two-factor model with no general factor as well as a one-factor model. Models were compared using a chi square difference test.

### **Predictive Validity**

The next step of these analyses is to ensure that TICLB predicts outcomes as expected. I performed a multiple hierarchical linear regression analysis using SPSS 28.0 with demographic variables entered first followed by TICLB. The mediation analysis for hypothesis 4b was conducted using the Mediation package in R (Tingley et al., 2014). I used the scores on the measure of TICLB from study 2 to predict outcome scores measured in study 3, which were collected one week later.

### **Incremental Validity**

Incremental validity was investigated by calculating  $\Delta R^2$  using hierarchical linear regression analysis, again using SPSS 28.0. Specifically, I entered one of the orbiting constructs in step 1 and TICLB in step 2. Because results did not change when demographic variables were and were not included in previous analyses, they were not included in the incremental validity analyses. I did not include all orbiting constructs in one regression analysis due to the moderate to high correlations between orbiting constructs. Doing this prevents potential suppression from having so many related variables in one model.

## **Study 3 Results**

Means, standard deviations and bivariate correlations between all variables can be found in Table 14. Additionally, omega is reported for each scale on the diagonal of the table.

## Factor Structure

Results of the CFA for the bifactor model with a general factor and two specific factors confirm good model fit ( $\chi^2(63) = 193.2, p < .05, RMSEA = .07, CFI = .98, TLI = .98, SRMR = .02$ ). Additionally, this model was compared to 1) a hierarchical model in which a higher order factor explains the variance in two lower factors which in turn explain the variance in the item responses; 2) a two-factor model with no general factor; and 3) a one-factor model in which all items load on a single factor. Results of the chi square difference tests demonstrate that the bifactor model fit the data best (see Table 15).

## Predictive Validity

Results of the hierarchical regression analyses can be found in table 16. Hypothesis 1 stated that TICLB would predict psychological well-being. Results indicate that TICLB does predict psychological well-being after accounting for demographic variables ( $\beta = .44, p < .05, \Delta R^2 = .19, p < .05$ ). Thus, hypothesis 1 was supported.

Hypothesis 2 stated that TICLB would predict overall health. Results indicate that TICLB does predict overall health after accounting for demographic variables ( $\beta = .14, p < .05, \Delta R^2 = .02, p < .05$ ). Thus, hypothesis 2 was supported.

Hypothesis 3 stated that TICLB would predict self-compassion. Results indicate that TICLB does predict self-compassion after accounting for demographic variables ( $\beta = .21, p < .05, \Delta R^2 = .05, p < .05$ ). Thus, hypothesis 3 was supported.

Hypothesis 4a stated that TICLB would predict posttraumatic growth. Results indicate that TICLB does predict posttraumatic growth after accounting for demographic variables ( $\beta = .29, p < .05, \Delta R^2 = .08, p < .05$ ). Thus, hypothesis 4a was supported.

Hypothesis 4b stated that self-compassion would partially mediate the positive relationship between TICLB and posttraumatic growth. Results indicate that self-compassion does partially mediate the relationship between TICLB and posttraumatic growth. The indirect effect of TICLB on posttraumatic growth via self-compassion was  $b = .05$ ,  $p < .05$ , while the direct effect of TICLB on posttraumatic growth was  $b = .50$ ,  $p < .05$ . Because the direct effect of TICLB on posttraumatic growth was still significant after including the mediator, self-compassion partially mediates the relationship between TICLB and posttraumatic growth. Thus, hypothesis 4b was supported.

Hypothesis 5 stated that TICLB would predict psychological safety. Results indicate that TICLB does predict psychological safety after accounting for demographic variables ( $\beta = .62$ ,  $p < .05$ ,  $\Delta R^2 = .38$ ,  $p < .05$ ). Thus, hypothesis 5 was supported.

Hypothesis 6 stated that TICLB would predict employee performance. Results indicate that TICLB does predict employee performance after accounting for demographic variables ( $\beta = .24$ ,  $p < .05$ ,  $\Delta R^2 = .06$ ,  $p < .05$ ). Thus, hypothesis 6 was supported.

Finally, Hypothesis 7 stated that TICLB would affective commitment. Results indicate that TICLB does predict affective commitment after accounting for demographic variables ( $\beta = .49$ ,  $p < .05$ ,  $\Delta R^2 = .24$ ,  $p < .05$ ). Thus, hypothesis 7 was supported.

### **Incremental Validity**

I did not have specific hypotheses about whether TICLB would predict studied outcomes above and beyond existing measures. In general, I expected that TICLB would predict all studied outcomes above and beyond existing measures of compassion (i.e., general compassion and compassionate leader behavior inventory). As previously mentioned, TICLB is conceptually nested within compassionate leader behaviors and thus within general compassion, and could be

considered a facet of both broader measures of compassion. Previous research has shown that on average, facet level scales tend to better predict outcomes than broader level scales (Judge et al., 2013).

To test this idea, I ran several hierarchical linear regression models entering either general compassion or compassionate leader behaviors into the model first followed by TICLB. Specific results from these analyses can be found in Tables 17 and 18. Here I will cover an overview of the results. TICLB predicted psychological well-being, self-compassion, psychological safety, and affective commitment above and beyond both general compassion and compassionate leader behaviors. TICLB predicted posttraumatic growth above and beyond compassionate leader behaviors but not general compassion, whereas TICLB predicted performance above and beyond general compassion but not compassionate leader behaviors. Lastly, TICLB did not predict overall health above and beyond neither general compassion nor compassionate leader behaviors.

### **Study 3 Discussion**

Results from study 3 provide further support for the factor structure obtained in study 2. This suggests that while there are specific factors that account for variance in the item responses, the majority of variance is explained by a more general factor. This further suggests that item order did not influence factor structure in study 2 and that people may generally group together items that measure more tangible aspects of TICLB and those that measure less tangible aspects of TICLB. However, the large amount of variance accounted for by the general factor supports the use of a global scale score when measuring TICLB.

Results of study also provide evidence of predictive validity. TICLB positively predicted all employee outcomes above and beyond demographic variables such as sex, race/ethnicity, age,

and number of traumatic experiences. This evidence supports the utility of the created scale. Furthermore, study 3 provided evidence of the distinctiveness of TICLB from existing measures of compassion and its unique power in predicting employee well-being, employee perceptions of the workplace, and employee contributions to the workplace.

While TICLB did predict most outcomes above and beyond compassionate leader behavior and general compassion, it is worth noting that this pattern did not hold true for all outcomes. Specifically, TICLB predicted posttraumatic growth (PTG) above and beyond compassionate leader behavior but not general compassion. While trauma-informed compassion from a leader is more beneficial for employee PTG than compassion from a leader that is not trauma-informed, receiving compassion from multiple people (e.g., leaders *and* coworkers) might be enough to compensate for the lack of a trauma-informed approach from one person. Indeed, research shows that leader and coworker support play a unique role in employee outcomes such as well-being (e.g., Liu et al., 2011). Posttraumatic growth can be a large undertaking for the sufferer potentially entailing changes in life priorities, self-perceptions, and relationships with others (Cann et al., 2010). Having numerous people aid in this endeavor may be more beneficial than relying on one person for support.

Additionally, TICLB predicted performance above and beyond general compassion, but not compassionate leader behaviors. When investigating the items for the compassionate leader behavior scale, many items capture leader behaviors that directly impact employee performance. For instance, one item states, “My leader holds me accountable for my work” and another states “My leader provides helpful feedback about the quality of my work.” Because these items capture leader behaviors that would directly impact an employee’s work performance, it is

reasonable that TICLB does not provide additional predictive validity for employee performance after accounting for these compassionate leader behaviors.

Surprisingly, TICLB did not predict overall health above and beyond neither general compassion nor compassionate leader behavior. While I argued that experiencing TICLB would be beneficial to employee overall health because employees would be empowered to take care of themselves, results indicate other forms of compassion may be just as, if not more so, beneficial to employee overall health.

### **General Discussion**

Together, these studies highlight the importance of taking a trauma-informed approach to interacting with employees in the workplace. I conceptualize TICLB to refer to a trauma-informed approach to compassion that leaders can enact through their employee-directed behaviors. More specifically TICLB entails those behaviors that encompass noticing, empathic concern, sensemaking, and acting that ensure the safety of the sufferer, comes from a place of trust, and centers the needs of the sufferer as the most important aspect of the compassion interaction. Through three studies, I developed a scale measuring TICLB, established its content, convergent, discriminant, and incremental validity. Below, I elaborate on this study's implications for research on compassion in the workplace, specifically for leaders, as well as research on trauma-informed approaches in the workplace. I then discuss limitations of this study and avenues for future research based on the proposed concept of TICLB.

### **Theoretical Implications**

First, this research advances the compassion literature (c.f., Dutton et al., 2014; Frost et al., 2003; Lilius et al., 2008, 2011, 2012; Neff, 2004) by providing a more nuanced view of compassion. Specifically, compassion has traditionally been conceptualized as something others

choose to provide in a manner of their choosing. While the intention for the person providing compassion is to lessen the sufferers' suffering (Dutton et al., 2014), they do so without considering what the sufferer wants or needs. Results from this project suggest that when demonstrating compassion to employees, it is important to do so in a way that prioritizes the employee's safety, empowers the employee, collaborates with the employee, as well as trust and transparency from the compassion giver. This conclusion is empirically supported by the evidence of incremental validity of TICLB above and beyond compassion and compassionate leader behaviors.

In addition to suggesting a more nuanced view of compassion as whole, the findings of this study also suggest the need to revisit the conceptualization of compassion in the workplace. In their conceptualization of compassion, Dutton et al. (2014) define sense-making as the process of working through the sufferer's experience of their trauma to understand what it means and what the sufferer should do next. The focus in their definition is on the traumatic or problematic events. When interviewing participants in study 1a, no one mentioned discussing their trauma with their leader to make sense of the situation. In fact, many of the participants explicitly stated that they didn't want their leader to know they had experienced trauma, much less delve into a conversation about their experiences. Instead, participants talked about sense-making as it related to their ability to perform their jobs. For instance, participants talked about discussions they had with their leaders about what work goals were feasible based on their current mental and physical states. They also mentioned discussions with their leaders about the impact their trauma might have on their work, work goals, and career goals. This indicates that sense-making in the workplace is less about understanding the traumatic event itself, but rather sense-making about



the impact the traumatic events (and its consequences for the sufferer) might have on the sufferer's work and career.

Furthermore, this research indicated a global underlying factor that explains the majority of variance in the items even though items were meant to measure four aspects of compassion overlapping with four aspects of a trauma-informed approach. The final 14 items were equally distributed among the four components of compassion, but the factor structure did not indicate a four-factor structure. Traditionally, compassion is conceptualized as a more linear process with four (or three) distinct steps (e.g., Dutton et al., 2014; Frost, 2003; Lilius et al., 2008). However, the empirical results of studies 2 and 3 suggest that compassion is viewed as a combination of the four theoretical components. Participants did seem to distinguish between leader behaviors that were more easily identifiable or tangible (e.g., having a discussion, creating goals, learning about safety policies and practices) and those that are higher to identify or intangible (not judging, respecting boundaries, and not pressuring employees to share more than they would like). With a couple of exceptions, this differentiation seemed in line with grouping the more easily identifiable aspects of compassion (sense-making and acting) and the less easily identifiable aspects of compassion (noticing and empathic concern). These findings suggest a need for further exploration of the process of compassion at work (e.g., do the components of compassion happen simultaneously or linearly for employees; Dutton et al., 2014), how employees perceive compassion at work is happening (e.g., are some components of compassion invisible to employees), and whether the four components of compassion are distinct to employees.

Second, I advance the trauma-informed literature by demonstrating the positive effect that trauma-informed compassion has on employees. To date, research on trauma-informed

approaches has been directed toward how service providers should interact with their clients who have experienced trauma (Esaki, 2020; Hales et al., 2019). Conversely, research has yet to investigate how a trauma-informed approach might be useful when directed toward *employees* who have suffered trauma in or outside of work. Admittedly, there is a major difference between service providers caring for clients and leaders caring for employees. In the former, a service provider's sole focus is providing care to their clients and helping clients achieve their goals. Conversely, typically a leader's primary focus is reaching organizational goals and a secondary focus may be caring for employees (Bragger et al., 2021). Additionally, service providers are expected to care for clients' trauma whereas the workplace has traditionally been a place where discussions of trauma are frowned upon. However, both interviews with trauma survivors and quantitative assessment demonstrate that trauma-informed compassion belongs in the workplace. Results from study 3 demonstrate that a trauma-informed approach to compassion better predicts several employee well-being outcomes above and beyond compassion without a trauma-informed approach. Given the recent focus on employee mental health and well-being (e.g., DeLauro, 2022), it is imperative to understand the factors in the workplace, like a trauma-informed approach to compassion, that support employee health and well-being, especially for those who have experienced trauma. Thus, this research provides evidence of the efficacy of trauma-informed in a new setting.

Aside from a fundamental difference in context and focus, part of the reason for a lack of research in this area may be the lack of measurement tools available to researchers. Existing measures of trauma-informed care often contain items that ask about whether the person understands the impact of trauma, and more generally about a client's participation in their service decisions (e.g., Goodman et al., 2016). These scales are not easily adaptable to the

workplace environment. Thus, this study begins to rectify this limitation of the extant literature by creating a measurement tool for TICLB. This opens new avenues for investigating trauma-informed compassion in the workplace and how it might transform employees' experiences at work, especially those who have experienced traumatic events.

### **Practical Implications**

This research suggests several practical implications. First, results suggest that a TICLB is linked to important outcomes. Leaders who utilize trauma-informed compassionate behaviors can help increase employee well-being, which is a major concern of organizations especially following the pandemic (SHRM, 2022). Results from this study also suggest that leaders who utilize TICLB help the organization by positively influencing employee perceptions of the organization as well as their performance. Taken together, these results suggest that leaders should understand the impact that trauma has on employees and learn how to enact trauma-informed compassionate behaviors. In other words, leaders should learn how to provide support and care to employees in such a way that focuses on the needs and desires of the employee as opposed to focusing on what the leader thinks is best in the situation.

Furthermore, this work helps leaders and organizations understand which behaviors constitute trauma-informed compassion in the workplace. Guidance on trauma-informed practices has traditionally focuses on how providers should interact with clients seeking services as opposed to appropriate behaviors for leaders to exhibit during interactions with employees. This study highlights the need for leaders to provide employees with both physical and psychological safety in the workplace. Additionally, this study highlights the need for leaders to perform all aspects of compassion (i.e., noticing, empathic concern, sense-making, and acting to alleviate suffering) when interacting with employees. This measure could help leaders better

understand which areas of TICLB they fail to exhibit and which areas of TICLB they excel in to ensure they provide adequate support to employees who have faced trauma.

This work also opens avenues for organizations to have discussions around the influence trauma has on employee well-being and what organizations can do to not only mitigate the influence of trauma but also increase employee well-being. The posttraumatic growth literature suggests that those who have faced trauma may actually experience positive outcomes in terms of new skills, higher resiliency, and in some cases higher self-esteem (Maitlis, 2020). These findings suggest that one way in which organizational leaders can encourage posttraumatic growth for employees is through exhibiting TICLB in their interactions.

### **Limitations and Future Directions**

When interpreting the results of these studies a few limitations should be taken into consideration. First, the sample sizes for phases 1a and 1b were relatively small. Small samples are not uncommon when conducting research with vulnerable populations because these populations can be difficult to reach and difficult to recruit (Ellard-Gray, 2015). While data saturation (when no new ideas emerge from the data) is difficult to define, I set out with the intention of interviewing at least 20 participants, fewer if no new ideas emerged in 3 interviews – more until I conducted at least 3 interviews with no new ideas emerging (Francis et al., 2009). Fortunately, participants discussed similar ideas throughout the interviews, and I began to reach data saturation at interview 18. By interview 22, no new ideas had emerged in the previous three interviews; thus, I felt confident that no additional interviews needed to be conducted. Additionally, interviews with supervisors and the training materials I coded, supported the ideas found through the interviews, lending additional evidence that I had collected as many ideas related to the topic as I could. However, the majority of participants worked in office jobs; thus,

the possibility exists that I would have found other leader behaviors when interviewing those with blue collar jobs. Future research should investigate whether those who work in blue collar jobs identify similar leader behaviors as those who work in white collar jobs. Differences in behaviors may be due to contextual differences found in blue collar jobs that don't exist in office jobs such as scheduling constraints and lack of health care (retail and service industry),

Furthermore, the sample used to conduct the first content validation study was slightly smaller than recommended (Hinkin & Tracey, 1999). Indeed, in a review of articles that used the Hinkin & Tracey (1999) approach to content validation, sample sizes ranged from 47 to 782 (Colquitt et al., 2019). Thus, this small sample size may have made it difficult to detect significant differences in rating. However, I attempted to overcome the issues of small sample size by utilizing the expertise of a group of SMEs, though the sample of SMEs was also small. Conversely, while this panel has extensive knowledge of trauma-informed approaches, none of the SMEs are experts in the compassion literature. Thus, it is possible that the items included do not capture the full breadth of trauma-informed *compassionate* leader behaviors because these SMEs are less familiar with the compassion construct and more data should be collected to ensure that the TICLB measure captures the full breadth of the construct.

Furthermore, I used Prolific to collect data for studies 2 and 3. Although some recognize these internet-based survey pools as a valid data collection approach (e.g., Buhrmester et al., 2011), others question the quality of data collected in this manner (Curran, 2016; Ford, 2017). I addressed data quality issues by including attention checks throughout both surveys administered as well as removing anyone who had significant amounts of missing data or completed the surveys too quickly. At various points throughout the surveys, I also instructed participants to visualize their leaders and their leaders' behaviors at work (Study 2), as well as their own

behaviors and feelings at work (Study 3). Doing show has demonstrated a positive influence on participants recall (Naidoo et al., 2010). However, future research should collect data from members of an organization or from a targeted clinical sample.

Future research should also consider the role of time in processing traumatic events when investigating the relationships between TICLB and employee outcomes. Admittedly, this survey was distributed during what can be considered a traumatic period in the United States. Indeed, the country has only recently begun returning to pre-pandemic functioning, numerous companies are performing large layoffs, a number of mass shootings (especially of children) have taken place recently, and many women have been affected by the recent Dobbs supreme court ruling. These recent events have led to collective trauma country-wide and may have made participants especially sensitive to trauma-informed compassionate leader behaviors. Indeed, time since traumatic experiences may attenuate the relationship between TICLB and employee well-being and organizational perceptions/contributions (Wang et al., 2021). While I collected information about participants' history of traumatic events, I did not evaluate participants' current feelings of traumatization. Future research should investigate whether TICLB is more important directly following traumatic events or intense feelings of traumatization, or if it positively influences employee outcomes regardless of traumatization or time since traumatization.

Future research might also consider other outcomes that TICLB might influence and the underlying mechanisms through which TICLB influences outcomes. For instance, this project investigate the role TICLB played in predicting employee specific outcomes, and many of them related to employee well-being, but meso and macro-level outcomes should also be investigated. For example, TICLB is likely to influence both team and organizational culture. Performing these behaviors should indicate to employees that their leaders care about them and their well-

being thereby creating a culture characterized by respect and sensitivity. In fact, there is likely a spillover effect of TICLB such that the act of trauma-informed compassion, when enacted by leaders, encourages followers and other employees to act in a trauma-informed compassionate manner toward and with one another (Shuck et al., 2019).

Additionally, trauma comes in all forms and taking a trauma-informed compassionate approach in the workplace should positively influence the retention of people with diverse experiences. Specifically, those that have experienced trauma (e.g., micro-aggressions at work, COVID, combat) may be more likely to stay in organizations where leaders act with trauma-informed compassion. This is likely because recipients of TICLB know that their trauma and the consequences of their trauma will not be held against them and instead will be cared for. Thus, future research should investigate the influence of TICLB on team and organizational level outcomes as well as underlying mechanisms such as employee beliefs and perceptions.

Future research might also investigate the mechanisms, at both the personal and organizational level, that encourage or discourage TICLB at work. For instance, research might investigate the role of emotional intelligence or trait level compassion in a leader's ability to perform TICLB (Opengart & Bierema, 2015). More specifically, emotional intelligence may influence a leader's ability to notice that an employee is suffering or dealing with a hardship and express empathic concern in a trauma-informed manner. Similarly, a leader's trait level compassion may influence their ability and willingness to notice, feel empathic concern, sense-make with an employee and act to alleviate the employee's suffering. Investigating these antecedents can help organizations choose leaders who possess these skills and traits.

Additionally, organizational practices and policies may influence a leader's ability to demonstrate TICLB. Leaders who do not feel supported by their organization may not be able to

care for followers (Sun & Pan, 2008), thereby negatively impacting a leader's ability to demonstrate TICLB. Furthermore, organizations that fail to cultivate a culture that cares about employee well-being may dissuade leaders from enacting TICLB in the workplace either due to fear of acting outside of organizational norms or due to organizational signals that TICLB is inappropriate. Additionally, organizations with few policies and practices in place regarding employee safety (physical and/or psychological) are likely to leave leaders with few options to provide to their followers.

### **Conclusion**

Given the current state of the world it is imperative that organizations understand how to best interact with and support employees, especially when they are dealing with trauma. With the further integration of home and family life following the pandemic, any trauma that employees experience outside of the work environment is likely to influence their work life and leaders need to be prepared to lead those that are dealing with or have dealt with trauma. Thus, my proposed concept TICLB gives leaders an avenue to care and respond to employees dealing with trauma and positively influence employee well-being. By merging a well-known tactic used in clinical services (trauma-informed care) with a well-known concept in the business industry (compassion), this study enables conversations about the role organizations can play in supporting employees through trauma.



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**Table 1**  
*Initial items generated*

	<b>Noticing</b>	<b>Empathic Concern</b>	<b>Sense-Making</b>	<b>Acting</b>
<b>Safety</b>	<p>When my supervisor notices something is wrong, they ask me about it when no one else is around</p> <p>My supervisor checks in with me after difficult work situations to ensure my well-being</p> <p>When my supervisor notices something is wrong, they don't make a big deal out of it in front of other employees</p>	<p>My supervisor tries to understand me and my experiences without pressuring me to share more than I'm comfortable with</p> <p>My supervisor tries to understand me and my experiences without judgment</p> <p>My supervisor expresses concern in a way that is comfortable for me</p>	<p>My supervisor and I determine how to ensure I remain safe at work</p> <p>My supervisor and I create processes and practices at work that make me feel safe</p> <p>My supervisor and I discuss the things that make me feel unsafe at work</p>	<p>My supervisor ensures I have access to the accommodations and resources I need without making me feel guilty or ashamed</p> <p>My supervisor lets me know about processes or equipment that ensures my physical and psychological safety at work</p> <p>My supervisor steps in during (psychologically or physically) unsafe situations</p>
<b>Empower, Voice, &amp; Choice</b>	<p>When my supervisor notices something is wrong, they allow me to decide how much I want to share</p> <p>When my supervisor notices something is wrong, they let me share my feelings and experiences in my own time</p> <p>My supervisor doesn't make any assumptions when they notice something is going on with me</p>	<p>My supervisor acknowledges my suffering</p> <p>My supervisor validates my feelings and experiences</p> <p>My supervisor does not diminish my feelings or experiences</p>	<p>My supervisor and I determine strategies for me to accomplish my work</p> <p>My supervisor makes me feel that I am capable of doing my job</p> <p>During our interactions, my supervisor speaks to with respect and understanding</p> <p>My supervisor helps me determine feasible goals based on my mental and physical state</p>	<p>To help alleviate my suffering, my supervisor provides the help and support that I want</p> <p>My supervisor encourages self-care practices (e.g., stepping outside, going for a walk, getting counseling)</p> <p>My supervisor provides flexibility in my schedule so I can take time away from work for my well-being when necessary</p> <p>My leader respects my personal and professional boundaries</p>

**Table 1 con't**

	<b>Noticing</b>	<b>Empathic Concern</b>	<b>Sense-Making</b>	<b>Acting</b>
<b>Trustworthiness &amp; Transparency</b>	<p>When my supervisor asks how I'm doing, I know they want to hear how I'm actually doing</p> <p>My supervisor is intentional about regularly checking-in with me</p> <p>My supervisor doesn't hold it against me when they know I'm dealing with a personal matter</p>	<p>My supervisor demonstrates vulnerability by sharing their struggles with employees</p> <p>My supervisor keeps anything I share with them confidential</p> <p>My supervisor doesn't judge me when I share my personal experiences</p>	<p>My supervisor helps me understand my strengths and limitations at work</p> <p>My supervisor is transparent about what they can and cannot do to help me</p> <p>When trying to understand how my experiences impact my work, I know my supervisor has my interests in mind.</p>	<p>My supervisor follows through with providing the support and resources I need</p> <p>My supervisor remains calm when I'm struggling at work</p> <p>My supervisor informs me of organizational policies and practices that can help my well-being.</p>
<b>Collaboration &amp; Mutuality</b>	<p>My supervisor respects my boundaries when checking-in with me</p> <p>If my supervisor doesn't notice something is going on with me, I know that I can approach them to talk about it</p> <p>When my supervisor notices something is going with me, they ask how they can help me.</p>	<p>My supervisor understands that I know what is best for me</p> <p>My supervisor wants to understand how I am feeling</p> <p>My supervisor understands that we're both human beings who are more than just the work we do</p>	<p>My supervisor helps me understand how my how behavior impacts my work</p> <p>My leader helps me see the value I bring to the workplace and our goals</p> <p>My supervisor provides guidance about how to do my job in a way that encourages my autonomy</p> <p>My supervisor helps me understand how I can improve in my job, in a positive manner</p>	<p>To help alleviate my suffering, my supervisor asks what I need</p> <p>My supervisor considers my feedback and point of view when making decisions that affect me</p> <p>My supervisor really listens when I talk to them about my struggles or experiences</p>

*Note.* Facets of compassion are labeled along the top and facets of a trauma-informed approach are labeled on the left side of the table.

**Table 2***Item level HTC, mean, and standard deviation*

Item number and item	<i>htc</i>	<i>M</i>	<i>SD</i>
1. To help alleviate my suffering, my leader temporarily reduces my workload	0.80	5.57	1.69
2. When my leader notices something is going on with me, they allow me to decide how much I want to share	0.78	5.48	1.86
3. When my leader notices something is going on with me, they ask me about it when no one else is around	0.82	5.76	1.22
4. When my leader notices something is going on with me, they let me share my feelings and experiences in my own time	0.77	5.38	1.91
5. When my leader notices something is going on with me, they don't make a big deal out of it in front of other employees	0.77	5.38	1.72
6. When my leader notices something is going on with me, they ask how they can help me.	0.84	5.86	1.71
7. My leader doesn't judge me when I share my personal experiences	0.74	5.19	1.97
8. My leader and I create processes and practices at work that make me feel safe	0.78	5.43	2.11
9. To help alleviate my suffering, my leader provides the help and support that I want	0.88	6.19	1.40
10. My leader acknowledges my suffering	0.78	5.48	1.75
<b>11. My leader demonstrates vulnerability by sharing their struggles with employees</b>	<b>0.69</b>	<b>4.81</b>	1.97
12. My leader steps in during (psychologically or physically) unsafe situations	0.87	6.10	1.58
13. My leader and I discuss the things that make me feel unsafe at work	0.80	5.62	1.83

*Note.* *N* = 21.

These items were rated as measuring TICLB significantly higher than four of the orbiting constructs: perceived supervisor support, perceived organizational support, transformational leadership, and supportive and unsupportive managerial behaviors. Bolded item was dropped before calculating scale-level HTC.

**Table 3***Study 1c participant experience description*

Participant	Experience
P1	Trauma survivor and leadership researcher
P2	Clinician focused on trauma who works with organizations
P3	Former DOJ attorney in victims advocacy who provides consultation to organizations for trauma-informed practices
P4	Supervisor of trauma-survivor in non-profit organization serving trauma survivors
P5	Supervisor of trauma-survivor in non-profit organization serving trauma survivors
P6	Trauma survivor and employee at not-for-profit organization serving trauma survivors



**Table 4***SME Panel Content Validity Ratio*

Item	CVR
1. When my leader notices something is wrong, they ask me about it when no one else is around	0.33
2. When my leader notices something is wrong, they don't make a big deal out of it in front of other employees	0
<b>3. When my leader notices something is wrong, they allow me to decide how much I want to share</b>	<b>1</b>
<b>4. When my leader notices something is going on with me, they let me share my feelings and experiences in my own time</b>	<b>1</b>
5. My leader doesn't make any assumptions when they notice something is going on with me	-0.33
6. When my leader notices something is going on with me and asks about it, I trust that they genuinely want to know how I am doing.	0
<b>7. My leader respects my personal and professional boundaries</b>	<b>0.67</b>
8. When my leader notices something is going on with me, they ask how they can help me.	0.33
<b>9. My leader tries to understand me and my experiences without pressuring me to share more than I'm comfortable with</b>	<b>1</b>
10. My leader tries to understand me and my experiences without judgment	0.33
11. My leader acknowledges my suffering	0.33
<b>12. When sharing about my hardships or struggles, my leader validates my feelings and experiences</b>	<b>0.67</b>
13. My leader demonstrates vulnerability by sharing about their struggles with employees	-0.67
14. My leader doesn't judge me when I share my personal experiences	0.33
<b>15. My leader asks questions to understand how I am feeling</b>	<b>1</b>
<b>16. My leader and I determine how to ensure I remain (psychologically or physically) safe at work</b>	<b>0.67</b>
<b>17. My leader and I create processes and practices at work that make me feel safe</b>	<b>0.67</b>
<b>18. My leader and I discuss the things that make me feel unsafe at work</b>	<b>1</b>
19. When I'm dealing with a hardship, my leader and I determine strategies for me to accomplish my work	0.33
20. My leader makes me feel that I am capable of doing my job	-0.33
<b>21. When I'm dealing with a hardship, my leader helps me determine feasible work goals based on my mental and physical state</b>	<b>0.67</b>
22. My leader helps me understand my strengths and limitations at work	0.33
<b>23. My leader is transparent about what they can and cannot do to help me when I'm dealing with a hardship</b>	<b>0.67</b>
24. My leader provides guidance about how to do my job in a way that encourages my autonomy	-0.33
<b>25. My leader helps me see the value I bring to the workplace and our goals</b>	<b>0.67</b>
<b>26. My leader lets me know about processes or equipment that ensure my physical and psychological safety at work</b>	<b>0.67</b>
<b>27. My leader steps in during (psychologically or physically) unsafe situations</b>	<b>1</b>
28. To help alleviate my suffering, my leader provides the help and support that I want	-0.33
29. When I'm dealing with a hardship, my leader provides flexibility in my schedule so I can take time away from work for my well-being	-0.33
30. To help alleviate my suffering, my leader temporarily reduces my workload	-0.67
<b>31. My leader really listens when I talk to them about my struggles or hardships</b>	<b>0.67</b>

Note.  $N = 6$ .

Critical CVR value for a one-tailed test at  $\alpha = .10 = 0.6$ . Bolded items meet cutoff values

**Table 5***Study 2 Participant Demographics*

Demographic	Percentage (n)	
Gender		
Male	49%	(440)
Female	49%	(443)
Nonbinary	1.8%	(16)
Prefer not to disclose	<1%	(2)
Race		
White/Caucasian	77%	(690)
African American or Black	6%	(52)
Asian	5.5%	(50)
American Indian or Native American	< 1%	(2)
Hispanic/Latino	4%	(39)
Two or more	7%	(64)
Other	< 1%	(4)
Age	36	
Education		
Less than high school	< 1%	(3)
High school graduate	10 %	(88)
Some college, no degree	16.5%	(149)
Associate degree	10 %	(88)
Bachelor's Degree	43.5%	(392)
Ph.D.	2%	(19)
Graduate or professional degree	17%	(156)
Job Title		
Intern	2%	(18)
Entry Level	22%	(195)
Analyst/Associate	38%	(346)
Manager	26%	(231)
Senior Manager	4.5%	(41)
Director	4%	(33)
Vice President	< 1%	(7)
Senior Vice President	< 1%	(5)
C level executive	1%	(10)
President or CEO	< 1%	(1)
Owner	1.5%	(14)
Job Tenure	5.9 years	

*Note.* *N* = 901

**Table 6***Initial EFA results*

Item	F1	F2
1. When my leader notices something is going on with me, they allow me to decide how much I want to share	.09	<b>.88</b>
2. When my leader notices something is going on with me, they let me share my feelings and experiences in my own time or own way	.07	<b>.92</b>
3. My leader tries to understand me and my experiences without pressuring me to share more than I'm comfortable with	.06	<b>.83</b>
4. My leader asks questions to understand how I am feeling	<b>.57</b>	.27
5. My leader and I create processes and practices at work that help me feel safe	<b>.80</b>	.09
6. My leader and I discuss the things that make me feel unsafe at work	<b>.64</b>	.13
7. When I'm dealing with a hardship, my leader helps me determine feasible work goals based on my mental and physical state	<b>.64</b>	.24
8. My leader is transparent about what they can and cannot do to help me when I'm dealing with a hardship	<b>.48</b>	.35
9. My leader lets me know about processes or equipment that ensure my physical and psychological safety at work	<b>.81</b>	.05
10. My leader steps in during (psychologically or physically) unsafe situations	<b>.75</b>	.08
<i>11. My leader really listens when I talk to them about my struggles or hardships</i>	.48	.43
12. My leader respects my personal and professional boundaries	.18	<b>.67</b>
13. My leader tries to understand me and my experiences without judgment	.32	<b>.64</b>
<i>14. When sharing about my hardships or struggles, my leader validates my feelings and experiences</i>	.45	.48
15. My leader doesn't judge me when I share my personal experiences	.31	<b>.59</b>
16. Together, my leader and I determine how to ensure I remain (psychologically or physically) safe at work	<b>.80</b>	.09
<i>17. My leader helps me see the value I bring to the workplace and our goals</i>	.48	.40

*Note. N = 451*

Italics indicate items that cross-loaded on both factors and were eliminated from the scale

**Table 7***Final factor loadings*

Item	Tangible	Intangible
4. My leader asks questions to understand how I am feeling	.64	
5. My leader and I create processes and practices at work that help me feel safe	.83	
6. My leader and I discuss the things that make me feel unsafe at work	.68	
7. When I'm dealing with a hardship, my leader helps me determine feasible work goals based on my mental and physical state	.65	
8. My leader is transparent about what they can and cannot do to help me when I'm dealing with a hardship	.47	
9. My leader lets me know about processes or equipment that ensure my physical and psychological safety at work	.78	
10. My leader steps in during (psychologically or physically) unsafe situations	.75	
16. Together, my leader and I determine how to ensure I remain (psychologically or physically) safe at work	.80	
1. When my leader notices something is going on with me, they allow me to decide how much I want to share		.83
2. When my leader notices something is going on with me, they let me share my feelings and experiences in my own time or own way		.93
3. My leader tries to understand me and my experiences without pressuring me to share more than I'm comfortable with		.82
12. My leader respects my personal and professional boundaries		.60
13. My leader tries to understand me and my experiences without judgment		.55
15. My leader doesn't judge me when I share my personal experiences		.52

*Note.*  $N = 451$ . Results were obtained using a Principal Axis Factor extraction method and a direct oblimin rotation

**Table 8***EFA model comparison results for study 2*

Model	$\chi^2$	$df$	$\chi^2/df$	RMSEA	90%CI RMSEA	CFI	TLI	SRMR
Bifactor	140.98***	64	2.2	.05	[.04, .06]	.99	.98	.02
Hierarchical	491.54***	75	6.55	.11	[.10, .12]	.92	.91	.05
2-factor	973.77***	77	12.6	.16	[.15, .17]	.83	.80	.38
1-factor	819.82***	77	10.65	.15	[.14, .16]	.86	.84	.06

*Note.*  $N = 450$

\*  $p < .05$  \*\*  $p < .01$  \*\*\*  $p < .001$

Each model of the three comparison models were compared to the bifactor model in the chi square difference test

**Table 9***CFA model comparison results for study 2*

Model	$\chi^2$	df	RMSEA	CFI	TLI	SRMR	$\Delta\chi^2$	$\Delta df$
Bifactor	143.88***	64	.05	.98	.98	.02		
Hierarchical	479.00***	75	.11	.92	.90	.05	335.12***	1
2-factor	953.73***	77	.16	.83	.80	.37	809.85***	13
1-factor	780.51***	77	.14	.86	.84	.06	636.63***	13

*Note.*  $N = 450$ \*  $p < .05$  \*\*  $p < .01$  \*\*\*  $p < .001$ 

Each model of the three comparison models were compared to the bifactor model in the chi square difference test

**Table 10***Factor loadings for bifactor model*

Item	General Factor	F1	F2
4. My leader asks questions to understand how I am feeling	.74	.32	
5. My leader and I create processes and practices at work that help me feel safe	.73	.41	
6. My leader and I discuss the things that make me feel unsafe at work	.46	.36	
7. When I'm dealing with a hardship, my leader helps me determine feasible work goals based on my mental and physical state	.74	.32	
8. My leader is transparent about what they can and cannot do to help me when I'm dealing with a hardship	.67	.24	
9. My leader lets me know about processes or equipment that ensure my physical and psychological safety at work	.67	.40	
10. My leader steps in during (psychologically or physically) unsafe situations	.67	.39	
16. Together, my leader and I determine how to ensure I remain (psychologically or physically) safe at work	.75	.41	
1. When my leader notices something is going on with me, they allow me to decide how much I want to share	.67		.41
2. When my leader notices something is going on with me, they let me share my feelings and experiences in my own time or own way	.72		.46
3. My leader tries to understand me and my experiences without pressuring me to share more than I'm comfortable with	.78		.44
12. My leader respects my personal and professional boundaries	.73		.29
13. My leader tries to understand me and my experiences without judgment	.80		.30
15. My leader doesn't judge me when I share my personal experiences	.77		.29

**Table 11***Corrected item-total correlations*

Item	<i>r</i>
1. When my leader notices something is going on with me, they allow me to decide how much I want to share	.70
2. When my leader notices something is going on with me, they let me share my feelings and experiences in my own time or own way	.75
3. My leader tries to understand me and my experiences without pressuring me to share more than I'm comfortable with	.78
4. My leader asks questions to understand how I am feeling	.77
5. My leader and I create processes and practices at work that help me feel safe	.81
6. My leader and I discuss the things that make me feel unsafe at work	.48
7. When I'm dealing with a hardship, my leader helps me determine feasible work goals based on my mental and physical state	.80
8. My leader is transparent about what they can and cannot do to help me when I'm dealing with a hardship	.76
9. My leader lets me know about processes or equipment that ensure my physical and psychological safety at work	.71
10. My leader steps in during (psychologically or physically) unsafe situations	.77
12. My leader respects my personal and professional boundaries	.75
13. My leader tries to understand me and my experiences without judgment	.86
15. My leader doesn't judge me when I share my personal experiences	.80
16. Together, my leader and I determine how to ensure I remain (psychologically or physically) safe at work	.81

*Note.* *N* = 901

**Table 12***Study 2 means, standard deviations, correlations, and Omega*

	Mean	sd	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Sex	.55	.60														
2. Age	36.36	11.93	-.10													
3. Degree	4.64	1.52	-.03	.17												
4. Tenure	6.04	6.81	-.1	.49	.07											
5. Race	.77	.42	.06	.19	.03	.1										
6. TICLB	4.42	.96	-.05	.00	.03	.04	.03	(.96)								
7. POS	4.77	1.48	-.06	.08	.01	.09	.08	.67	(.96)							
8. PES	3.40	1.07	.01	.02	.07	.02	.06	.83	.67	(.96)						
9. EJS	3.69	.89	-.05	.09	.06	.05	.10	.82	.69	.86	(.94)					
10. IC	3.44	1.01	-.01	.02	.07	.00	.08	.79	.64	.86	.83	(.87)				
11. PSS	4.61	1.08	-.04	.05	.09	.05	.05	.86	.72	.88	.84	.81	(.95)			
12. CLB	3.96	.79	-.07	.03	.04	.03	.04	.86	.69	.84	.88	.83	.88	(.98)		
13. Comp	3.45	.88	.13	-.04	.03	-.02	.06	.70	.59	.76	.66	.68	.71	.66	(.88)	
14. WSS	3.75	1.60	-.17	.20	.15	.23	.08	.36	.55	.42	.40	.39	.42	.36	.33	(.91)

*Note.*  $N = 901$ All correlations above .10 are significant at  $p < .05$ .

Sex coded 0 = Male, 1 = Female. Race coded 0 = Non-Caucasian, 1 = Caucasian. Tenure is given in years. TICLB = Trauma-informed Compassionate Leader Behavior; POS = perceived organizational support; PES = Personal/Esteem Support factor from supportive and unsupportive managerial behaviors; EJS = Enabling Job Support factor from supportive and unsupportive managerial behaviors; IC = Individual Consideration factor from transformational leadership; PSS = Perceived Supervisor Support; CLB = Compassionate Leader behaviors; Comp = General Compassion; WSS = Workplace Status Scale

**Table 13***Model comparison results discriminant validity*

Model	$\chi^2$	df	RMSEA	CFI	SRMR	$\Delta\chi^2$	$\Delta df$
POS							
1-factor	5646.3	209	.16	.72	.09		
2-factor	2223.7	208	.10	.90	.05	3422.6***	1
PES							
1-factor	3579.01	230	.12	.84	.06		
2-factor	2302.93	229	.10	.90	.04	1275.08***	1
EJS							
1-factor	3840.18	299	.11	.83	.06		
2-factor	2614.57	298	.09	.89	.05	1225.61***	1
IC							
1-factor	2071.44	135	.12	.86	.06		
2-factor	1782.34	134	.11	.88	.05	289.1***	1
PSS							
1-factor	2317.43	170	.11	.88	.05		
2-factor	1864.36	169	.10	.90	.05	453.07***	1
Comp							
1-factor	2480.67	119	.14	.83	.07		
2-factor	1833.04	118	.12	.88	.06	647.63***	1
CLB							
1-factor	6491.79	665	.09	.84	.05		
2-factor	5094.82	664	.08	.88	.04	1396.97***	1

*Note.*  $N = 901$ \*  $p < .05$  \*\*  $p < .01$  \*\*\*  $p < .001$ 

POS = Perceived Organizational Support; PES = Personal/Esteem Support; EJS = Enabling Job Support; IC = Individual Consideration; PSS = Perceived Supervisor Support; Comp = General Compassion; CLB = Compassionate Leader Behaviors



**Table 14***Means, standard deviations, correlations and  $\omega$  for all scales*

	Mean	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Sex	0.52	0.58	-														
2. Age	38.16	12.27	-.04	-													
3. Degree	4.70	1.56	.00	.15	-												
4. Tenure	6.68	6.4	-.14	.53	.07	-											
5. Race	.76	.43	.06	.18	.05	.10	-										
6. TICLB T1	4.42	.99	-.05	.02	.01	-.01	.05	(.95)									
7. TICLB T2	4.34	1.10	-.07	.06	.04	.06	.07	.81	(.96)								
8. POS	4.85	1.49	-.07	.08	-.02	.11	.10	.69	.70	(.96)							
9. PES	3.40	1.09	.00	.05	.03	.04	.08	.84	.77	.69	(.96)						
10. EJS	3.71	0.9	-.03	.1	.03	.07	.13	.83	.79	.73	.87	(.94)					
11. IC	3.43	1.01	-.04	.05	.05	.02	.10	.79	.74	.66	.86	.83	(.87)				
12. PSS	4.63	1.09	-.06	.09	.06	.07	.10	.88	.82	.73	.88	.85	.8	(.95)			
13. CLB	3.96	0.8	-.05	.06	.00	.06	.07	.87	.79	.72	.83	.88	.81	.90	(.98)		
14. Comp	3.42	0.9	.10	.01	.00	-.02	.09	.71	.65	.61	.76	.67	.67	.70	.66	(.88)	
15. WSS	3.87	1.63	-.18	.18	.12	.29	.09	.39	.43	.57	.46	.44	.42	.45	.36	.39	(.91)
16. Health	3.72	0.81	-.13	.07	.18	.11	.04	.16	.26	.28	.24	.21	.21	.24	.18	.18	.31
17. PS	5.08	1.21	-.11	.14	.06	.14	.07	.62	.76	.73	.64	.68	.62	.70	.66	.57	.47
18. SC	3.15	0.83	-.17	.26	.08	.19	.02	.23	.27	.31	.24	.25	.23	.25	.19	.22	.34
19. PTG	3.02	1.26	.00	.08	.04	.08	-.08	.27	.27	.24	.30	.22	.27	.26	.20	.31	.23
20. AC	4.25	1.63	-.04	.18	.03	.24	.12	.49	.63	.71	.53	.54	.52	.56	.50	.49	.55
21. Perf	6.28	0.66	.02	.17	.11	.12	.14	.24	.30	.24	.27	.31	.25	.29	.28	.22	.20
22. PWB	5.21	1.32	-.12	.21	.06	.18	.10	.44	.55	.58	.48	.49	.48	.47	.42	.43	.47

*N* = 442. Note. All correlations above .10 significant at  $p < .05$

Sex coded 0 = Male, 1 = Female. TICLB T1 = trauma-informed compassionate leader behavior time 1; T2 = time 2; POS = perceived organizational support; PES = Personal/Esteem Support factor from supportive and unsupportive managerial behaviors; EJS = Enabling Job Support factor from supportive and unsupportive managerial behaviors; IC = Individual Consideration factor from transformational leadership; PSS = Perceived Supervisor Support; CLB = Compassionate Leader behaviors; Comp = General Compassion; WSS = Workplace Status Scale; PS = Psychological Safety; SC = Self-compassion; PTG = Posttraumatic Growth; AC = Affective Organizational Commitment; Perf = Performance; PWB = Psychological Wellbeing.

**Table 14 con't**

	16	17	18	19	20	22	21
16. Health	-						
17. PS	.33	(.93)					
18. SC	.41	.39	(.94)				
19. PTG	.15	.22	.23	(.94)			
20. AC	.24	.65	.30	.29	(.96)		
21. Perf	.16	.36	.24	.03	.27	(.93)	
22. PWB	.38	.60	.49	.34	.65	.34	(.93)

**Table 15***CFA model comparison results for study 3*

Model	$\chi^2$	df	RMSEA	CFI	TLI	SRMR	$\Delta\chi^2$	$\Delta df$
Bifactor	193.2***	63	.07	.98	.97	.02		
Hierarchical	368.92***	75	.10	.95	.94	.03	176.72***	12
2-factor	955.24***	77	.16	.86	.83	.44	762.04***	14
1-factor	646.88***	77	.13	.91	.89	.04	453.68***	14

*Note.*  $N = 442$ \*  $p < .05$  \*\*  $p < .01$  \*\*\*  $p < .001$ 

Each model of the three comparison models were compared to the bifactor model in the chi square difference test

**Table 16***Results of hierarchical regression analysis with controls*

Variable	Psychological Well-being				Health				Self-compassion				Posttraumatic Growth			
	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$
Step 1			.05	.07***			.07	.08***			.10	.11***			.01	.02
Constant	4.34(.28)***				3.33(.17)***				2.59(.17)***				2.75(.27)***			
Sex <sup>a</sup>	-.24(.11)*	-.11			-.12(.07)	-.08			-.18(.07)*	-.12			.03(.11)	.02		
Age	.02(.01)**	.16			.00(.00)	.01			.02(.00)***	.25			.01(.01)	.07		
Degree	.03(.04)	.03			.09(.02)***	.17			.02(.03)	.04			.02(.04)	.03		
Tenure <sup>b</sup>	.01(.01)	.07			.01(.01)	.08			.01(.01)	.05			.01(.01)	.06		
Race <sup>c</sup>	.21(.15)	.07			.08(.09)	.04			-.02(.09)	-.01			-.32(.14)*	-.11		
	-.01(.04)	-.01			-.07(.02)**	-.14			-.06(.02)	-.13			.02(.04)	.02		
Incidents																
Step 2			.24	.19***			.08	.02**			.14	.05***			.09	.08***
Constant	1.80(.35)***				2.83(.24)***				1.8(.23)***				1.16(.36)***			
Sex	-.21(.10)*	-.09			-.11(.07)	-.08			-.17(.07)*	-.11			.06(.10)	.03		
Age	.02(.01)**	.14			.00(.00)	.00			.02(.00)***	.24			.01(.01)	.06		
Degree	.03(.04)	.03			.09(.02)	.17			.02(.02)	.04			.02(.04)	.03		
Tenure	.02(.01)	.08			.01(.01)***	.09			.01(.01)	.05			.01(.01)	.07		
Race	.14(.13)	.05			.07(.09)	.04			-.04(.09)	-.02			-.36(.14)**	-.12		
	.01(.03)	.02			-.06(.02)**	-.13			-.05(.02)*	-.11			.03(.03)	.04		
Incidents																
TICLB <sup>d</sup>	.58(.06)***	.44			.11(.04)**	.14			.18(.04)***	.21			.37(.06)***	.29		

Note.  $N = 442$ .  $R^2$  reported is adjusted  $R^2$

<sup>a</sup>Sex coded as 0= Male, 1 = Female <sup>b</sup>Race coded as 1 = Caucasian, 0 = Non-Caucasian <sup>c</sup>Tenure refers to the numbers of year someone has worked in their current role <sup>d</sup>Analyses used the measure of TICLB from study 2 while outcome variables were measured in study 3

**Table 16 con't**

Variable	Psychological Safety				Performance				Affective Commitment			
	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$
Step 1			.04	.05**			.05	.06***			.06	.07***
Constant	4.60(.26)***				5.63(.14)***				3.44(.34)***			
Sex <sup>a</sup>	-.15(.10)	-.07			.02(.06)	.02			.00(.14)	.00		
Age	.01(.01)	.09			.01(.00)*	.12			.01(.01)	.06		
Degree	.03(.04)	.03			.04(.04)*	.10			.00(.05)	.00		
Tenure <sup>b</sup>	.01(.01)	.08			.00(.01)	.04			.05(.01)***	.20		
Race <sup>c</sup>	.16(.14)	.06			.16(.07)*	.10			.32(.18)	.08		
Incidents	-.07(.03)*	-.11			.02(.02)	.06			-.05(.04)	-.05		
Step 2			.43	.38***			.12	.06***			.31	.24***
Constant	1.29(.28)***				4.94(.19)***				-.10(.41)			
Sex	-.11(.08)	-.05			.03(.05)	.02			.04(.12)	.02		
Age	.01(.00)	.07			.01(.00)*	.11			.01(.01)	.04		
Degree	.03(.03)	.03			.04(.02)*	.10			.00(.04)	.00		
Tenure	.02(.01)*	.10			.00(.01)	.05			.06(.01)***	.22		
Race	.08(.11)	.03			.14(.07)*	.09			.23(.16)	.06		
Incidents	-.04(.03)	-.06			.03(.02)	.08			-.02(.04)	-.02		
TICLB <sup>d</sup>	.76(.05)***	.62			.16(.03)***	.24			.81(.07)***	.49		

**Table 17***Results of hierarchical regression analysis with general compassion*

Variable	Psychological Well-being				Health				Self-compassion				Posttraumatic Growth			
	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$
Step 1			.18	.18***			.034	.03***			.05	.05***			.10	.10***
Constant	3.06(.22)***				3.15(.15)***				2.45(.15)***				1.5(.22)***			
Compassion <sup>a</sup>	.63(.06)***	.43			.17(.04)***	.18			.20(.04)***	.23			.44(.06)***	.31		
Step 2			.22	.04***			.035	.001			.06	.01*			.10	.01
Constant	2.4(.26)***				3.07(.18)***				2.23(.18)***				1.29(.27)***			
Compassion	.34(.09)***	.23			.13(.06)*	.15			.10(.06)	.11			.34(.09)***	.24		
TICLB	.37(.08)***	.28			.05(.06)	.05			.13(.06)*	.16			.13(.08)	.10		

*Note.*  $N = 442$ <sup>a</sup> Analyses used the measure of TICLB and compassion from study 2 while outcome variables were measured in study 3**Table 17 con't**

Variable	Psychological Safety				Performance				Affective Commitment			
	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$
Step 1			.32	.32***			.05	.05***			.24	.24***
Constant	2.45(.19)***				5.73(.12)***				1.22(.27)***			
Compassion	.77(.05)***	.57			.16(.03)***	.22			.88(.08)***	.49		
Step 2			.42	.10***			.06	.02**			.28	.04***
Constant	1.48(.21)***				5.52(.14)***				.36(.31)			
Compassion	.34(.07)***	.25			.07(.05)	.10			.51(.10)***	.29		
TICLB	.55(.06)***	.45			.12(.04)**	.18			.49(.09)***	.30		

**Table 18***Results of hierarchical regression analysis with compassionate leader behaviors*

Variable	Psychological Well-being				Health				Self-compassion				Posttraumatic Growth			
	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$
Step 1			.18	.18***			.03	.03***			.04	.04***			.04	.04***
Constant	2.44(.29)***				2.99(.19)***				2.34(.20)***				1.75(.30)***			
CLB <sup>a</sup>	.70(.07)***	.43			.18(.05)***	.18			.20(.05)***	.20			.32(.07)***	.20		
Step 2			.20	.02***			.03	.00			.06	.02**			.08	.04***
Constant	2.36(.29)***				2.99(.19)***				2.30(.20)***				1.66(.29)***			
CLB	.28(.14)	.17			.18(.10)	.17			-.03(.10)	-			-.21(.15)	-.13		
TICLB	.40(.11)***	.30			.00(.08)	.00			.22(.08)**	.26			.50(.12)***	.39		

*Note.*  $N = 442$ <sup>a</sup> CLB = Compassionate Leader Behaviors. Analyses used the measure of TICLB and compassionate leader behaviors from study 2 while outcome variables were measured in study 3**Table 18 con't**

Variable	Psychological Safety				Performance				Affective Commitment			
	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$	b(SE)	$\beta$	$R^2$	$\Delta R^2$
Step 1			.43	.43***			.08	.08***			.25	.25***
Constant	1.23(.22)***				5.35(.15)***				.18(.34)			
CLB	1.00(.06)***	.66			.24(.04)***	.29			1.03(.08)***	.50		
Step 2			.44	.01***			.08	.00			.26	.01**
Constant	1.07(.22)***				5.35(.15)***				.11(.34)			
CLB	.70(.11)***	.46			.24(.08)***	.30			.63(.17)***	.31		
TICLB	.28(.09)***	.23			-.01(.06)	-.01			.37(.14)**	.23		

## Appendix A

### Interview Questions for survivors and veterans

1. Tell me about your experiences entering the legal (civilian) workforce.
2. What does compassion mean to you?
3. What are some ways your leader has shown you compassion in your time working for them?
4. What behaviors did (does) your leader exhibit that demonstrate compassion for you and your experiences? (Follow up questions below if not covered)
  - a. Tell me about a time when you felt your leader excelled at showing you compassion. What did they do? What did they say? How did that impact you and your work?
  - b. Tell me about a time when you felt your leader failed at showing you compassion. What did they do? What did they say? How did that impact you and your work?
  - c. How do you know when your leader has noticed you are dealing with something (or fail to)?
  - d. How does your leader demonstrate empathy for your experiences (or fail to)?
  - e. How does your leader help you make sense of your experiences (or fail to)?
  - f. How does your leader act to make things better for you (or fail to)? What actions, behaviors, or words does your leader utilize (or fail to)?
5. What behaviors do you wish your leader had done to demonstrate compassion?
6. What does it mean for your leader to take a trauma-informed or healing centered approach to demonstrating compassion? (Follow up questions below if not covered)
  - a. What behaviors demonstrate this approach?

- b. What behaviors fail to demonstrate this approach?
- c. How does your leader empower you (or fail to)?
- d. How does your leader build trust (or fail to)?
- e. How does your leader create a safe (physically, mentally & emotionally) environment (or fail to)?



## **Appendix B**

### Interview Questions for supervisors and leaders

1. Tell me what it was like for you as a leader to hire someone who has previously experienced work-related trauma?
2. What does compassion mean to you as a leader? (Follow up questions below if not covered)
  - a. What does it mean to show compassion to your employees?
  - b. Tell me about a time when you felt you excelled at showing your employees compassion. What did you do? What did you say? How did that impact them and their work?
  - c. Tell me about a time when you felt you failed at showing your employees compassion. What did you do? What did you say? How did that impact them and their work?
  - d. How do you demonstrate that you've noticed an employee is dealing with something?
  - e. How do you demonstrate empathy for your employees' experiences?
  - f. How do you help employees make sense of their experiences?
  - g. How do you make things better for employees? What actions, behaviors, or words do you utilize?
3. What behaviors do you wish you could exhibit to demonstrate compassion?
4. What does it mean for you to take a trauma-informed or healing centered approach to demonstrating compassion? (Follow up questions below if not covered)
  - a. What behaviors demonstrate this approach?

- b. What behaviors fail to demonstrate this approach?
- c. How do you empower your employees (or fail to)?
- d. How do you build trust with your employees (or fail to)?
- e. How do you create a safe (physically, mentally & emotionally) environment (or fail to) for your employees?