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# Reframing Silence as Purposeful: Emotions in Extreme Contexts

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ABSTRACT Individuals bear the weight of emotional distress when exposed to brutality and suffering in warzones. Yet, immersed in scenes of intense human tragedy, they must publicly mask their emotional turmoil. How then may such individuals cope with the emotional distress they suffer but mute? Through the analysis of 53 unsolicited, personal diaries, non-participant observations in conflict zones, and interviews with Médecins Sans Frontières personnel, we study medical professionals who work in extreme contexts. Employing Goffman's notions of frontstage and backstage behaviour, we reveal silence as an emotional defence mechanism. We argue that this silence is a result of individuals' deliberate choice rather than being muted by external forces. This choice enables individuals to maintain focus and perform critical, often life-saving duties under extreme pressure. We find that silence does not imply an absence of emotion nor diminish emotional distress. Instead, silence functions as a protective measure against potential emotional breakdowns. We illustrate how journaling serves as a private refuge for self-expression, enabling individuals to navigate their emotions and experiences away from scrutiny by others. We contribute to understanding emotional regulation in extreme contexts, and redefine silence as an essential aspect of coping and resilience.

**Keywords:** diaries, emotions, extreme context, silence

> What can be said at all can be said clearly, and what we cannot talk about we must pass over in silence. (Wittgenstein, 1921, in Tractatus)

## INTRODUCTION

Extreme contexts are characterized by violence, natural disasters, and wars (George et al., 2016; Hällgren et al., 2018). Studies have begun to illuminate the complex emotional landscapes navigated by workers on the frontline (e.g., Cornelissen et al., 2014;

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de Rond and Lok, 2016; Fraher et al., 2017). The medical and military professions, traditionally characterized by a stoic demeanour during crises, underscore the necessity of managing emotions under pressure (Green et al., 2010; Rauch and Ansari, 2022a). Yet, the apparent lack of emotional expression does not equate to an absence of emotional distress. This is highlighted by the rising mental health concerns among military personnel, evidenced by increased suicide rates and reported mental health issues among returning soldiers (Church, 2009; Kalkman, 2023).

Despite the growing interest in emotions within management studies (Voronov and Vince, 2012; Toubiana and Zietsma, 2017), the strategies individuals employ to handle emotional distress in extreme environments remain underexplored (Bacharach and Bamberger, 2007; de Rond and Lok, 2016). Emotions may not be 'worn on the sleeve' and emotional regulation often occurs behind a veil of professionalism (Jarvis et al., 2018, p. 4) as individuals adapt to the context and 'display emotions appropriately' (Voronov and Weber, 2016, p. 462). Difficult emotions may thus not be apparent in observable behaviours, especially in extreme contexts.

Our qualitative study delves into the experiences of medical professionals working with Médecins Sans Frontières in war zones, utilizing personal diaries, interviews, and observational data. We uncover a pervasive culture of silence: individuals tend to remain overtly silent based on an unwritten rule to maintain 'emotional control' (de Rond and Lok, 2016, p. 1983) and remain 'cool-headed and self-controlled' (Kalkman, 2023, p. 52). Emotional control is maintained not just at work (frontstage) but also privately among colleagues (backstage), despite organizational encouragement for emotional expression. Individuals cope with these feelings by expressing their innermost emotions in private diary entries that offer a personal sanctuary for unfiltered self-reflection away from the judgements and scrutiny of others.

This paper contributes to the literature in two ways. First, we expand on the understanding of emotion regulation in extreme contexts (Bacharach and Bamberger, 2007; Farny et al., 2019) by illustrating how individuals navigate the complex task of managing intense emotions, not only in professional settings but also in private. The need for workers to regulate their emotions at work is well established (e.g., Hochschild, 1979, 1983). They engage in creative activities (de Rond and Lok, 2016) or compartmentalize (Kalkman, 2023) – focus intensely on the present (Fraher et al., 2016). We extend this work by showing how some individuals cope with difficult emotions when they mask their emotions in public. In line with studies that have shown how individuals cope in stressful environments by creating a private safe space for self-preservation (McCarthy and Glozer, 2022), we show how diaries provide a safe, non-judgemental outlet for individuals to express their innermost thoughts and feelings to regain a sense of agency.

Secondly, we reframe the role of silence, not as a result of imposed censorship or emotional numbness, but as a voluntary emotional defence mechanism. Silence has often been cast in a negative light as a form of induced self-censorship or 'being silenced' (Fivush, 2010; Stouten et al., 2019) for fear of retribution or professional pressure to pay 'emotional dues' to a situation (Edmondson, 2003; Hochschild, 1983, p. 229; Morrison and Milliken, 2003), or being emotionally numbed by shock or trauma (de Rond and Lok, 2016). Our perspective aligns with views of silence as a form of agency (Anteby, 2013; McCarthy and Glozer, 2022, p. 386), serving as a protective

barrier against overwhelming emotions which could impair professional function in high-stakes environments. Our findings challenge the negative connotations often associated with silence, offering a nuanced understanding of its role as a strategic response to the emotional demands of working in extreme contexts.

## THEORETICAL BACKGROUND

Grand challenges, such as poverty, wars, and climate change are wicked problems (Rittel and Webber, 1973) that pose formidable challenges for humanity. While studies have proposed various approaches, such as robust action (Ferraro et al., 2015) and collaborative partnerships (Gray et al., 2023), fewer studies have focused on the grim realities faced by individual workers who are exposed to suffering in extreme contexts, such as warzones (de Rond and Lok, 2016; Rauch and Ansari, 2022a), refugee camps (de la Chaux et al., 2018) and natural disaster sites (Danner-Schroeder, 2018; Farny et al., 2019).

We adopt Hannah et al.'s (2009) definition of extreme contexts as environments 'where one or more extreme events are occurring or are likely to occur that may exceed the organization's capacity to prevent [it or them] and result in an extensive and intolerable magnitude of physical, psychological or material consequences to – or [to those] in close physical or psycho-social proximity to – organization members' (p. 898). This definition implies individuals can be traumatized by exposure to those physically present at the time of an extreme incident (Hällgren et al., 2018). Workers in extreme contexts often must cope with emotional distress when their hopes to alleviate suffering and create an impact on the ground are shattered (Fraher et al., 2017; Rauch and Ansari, 2022a). The brutal reality they face amid severe resource constraints generates feelings of 'senselessness, futility and surreality' and distorts their institutionalized sense of what is meaningful and worthy (de Rond and Lok, 2016).

Individuals experience emotions, but the way they experience or express these emotions is conditioned by social norms, values, and conventions (Barsade and O'Neill, 2014; Creed et al., 2014; Voronov and Vince, 2012). Turner and Stets (2005) note that emotional displays are subject to 'socially constructed definitions and constraints on what emotions should be experienced and expressed in a situation' (p. 9). In a study of flight attendants, Hochschild (1983) illustrates how individuals regulate their display of emotions or engage in 'emotional labor' to conform to the organizational demand to exhibit desirable emotive behaviours. Such emotional labour includes being told by superiors to 'smile like you really mean it' (Hochschild, 2012, p. ix) in order to 'maintain face' (Goffman, 1955, p. 213) and 'keep up appearances' (Goffman, 1959, p. 33). This line of research has primarily focused on the suppression of negative emotions at work (e.g., Grandey et al., 2015; Lindebaum, 2017). For example, in a study of call centres in Australia and the USA, Korczynski (2003) builds on Hochschild's idea of 'collective emotional labour' (1983, p. 114) by illustrating how abusive encounters with customers emotionally distress employees, but nevertheless, they need to mute their emotions and continue their duties.

Emotional displays are often decoupled from emotional experiences and conditioned by the norms and rules for appropriate expression in each situation (Hochschild, 1979; Jarvis, 2017; Martin et al., 1998). Emotions may even be deployed strategically to appeal to a target audience (Jarvis et al., 2018) or to foster ambiguity and obfuscate what is going on (Cappellaro et al., 2021). Jarvis (2017) stresses the importance of 'feigning behaviours' (p. 306) – masking emotional displays to comply with social expectations. Thus, people may choose to conceal their emotions while suffering internally.

Concealing or remaining silent about emotions may be caused 'by fear, by the desire to avoid conveying bad news or unwelcome ideas and also by normative and social pressures that exist in groups' (Morrison and Milliken, 2003, p. 1353). Silence may also arise from power inequalities, feelings of exclusion (e.g., Anteby, 2013; Brown and Coupland, 2005; Morrison and Milliken, 2000), and the formation of dominant opinions that quell dissenting views (e.g., Clemente and Roulet, 2015). Noelle-Neumann's (1974) idea of 'spirals of silence' suggests, to avoid isolation or penalization, employees are averse to voicing their opinions when they believe they hold a minority viewpoint. Employees may decide not to speak up about organizational issues (e.g., Edwards et al., 2009; Morrison, 2011), worrying how co-workers might react (Bowen and Blackmon, 2003).

Research conducted with medical and military workers in extreme contexts also reports that individuals remain silent about their emotions in public and 'emotions are treated as mere distractions that only get in the way of their attempts to decisively resolve a crisis' (Kalkman, 2023, p. 52). de Rond and Lok (2016) describe the 'emotional numbness' (p. 1983) experienced by staff at a military hospital in Afghanistan in a context characterized by a 'culture of silence' (p. 1979). Similarly, in a study of US Navy SEALs working in Afghanistan and Iraq, Fraher et al. (2017) note that 'the SEAL candidate is forced to compartmentalize [their] emotions – and not fixate on them – to provide [their] best effort in the moment and to not obsess over the "what-ifs"' (p. 252). Rauch and Ansari (2022a, p. 25) report how drone operators working for the US Air Force were trained to practice 'impassive emotional control' to 'ignore and overwrite' emotions. Such studies illustrate that trained professionals exercise strong emotional regulation in extreme contexts and emotional detachment is viewed as an expression of professionalism (Molendijk, 2021).

However, in non-military establishments, such as aid and non-governmental organizations (NGOs), that employ people to work in extreme contexts, workers are not trained to exercise emotional control. Rather, these organizations often prescribe that workers share their difficult emotions with peers and colleagues to alleviate their emotional burden and receive social support and comfort (e.g., Rimé, 2009). In their study of 9/11 and New York City firefighters, Bacharach and Bamberger (2007) report how post hoc supervisory support included creating a supportive environment for articulating and sharing emotions. By talking to others about difficult emotions, individuals can 'let off steam' and 'get it off their chest'. Indeed, studies often depict a negative side of remaining silent that can create stress, dissatisfaction, cynicism, disengagement, or even psychological disorders (e.g., Morrison, 2011).

At the same time, scholars have also discussed a more positive side of silence based on the saying 'speech is silver, silence is golden'. For example, Stouten et al. (2019) point out that 'silence can serve strategic functions' (p. 4) and help rather than hurt individuals.

Thus, individuals may choose to remain silent about their emotions even when their organizations encourage them to share their emotions. It is, therefore, worth exploring 'why are they keeping silent' (Sherf et al., 2021, p. 115) in their observable behaviours? How then may individuals cope with emotional distress in an extreme context in which they publicly mute their emotions?

## RESEARCH CONTEXT

To address this issue, we draw on an inductive, theory-building approach to emphasize how individuals in an organizational setting attempt to mitigate suffering and help people in despair in extreme contexts. Our primary data source draws on 53 personal diaries written by medical professionals working for MSF in extreme situations. These diaries contain intimate records of their lived experience and personal accounts during their deployment. We complemented these diaries with interviews, non-participant observations, and archival documents. This enabled us to shed light on 'thoughts, feelings, considerations, and reactions; the ability to capture these events as they happen to avoid the problems associated with retrospect' (Radcliffe, 2017, p. 190).

### Case Selection and Research Site: MSF

MSF is an international humanitarian medical NGO, most known for its projects in conflict zones and countries affected by endemic diseases. It was founded in 1971 by a small group of French doctors and journalists to extend independent, impartial medical care across national boundaries irrespective of race, religion, and political affiliation. The organization received the Nobel Peace Prize in 1999 for its members' continued efforts to provide medical care in acute crises. These volunteers usually join a specific project for three to six months before returning home to take up their regular jobs (if still available) from which they took a leave of absence (Médecins Sans Frontières, 2018). These workers seldom benefit from the intense training regime of professional soldiers. Volunteers working in these extreme contexts encounter brutal situations and may suffer emotional trauma, but the culture of silence in these contexts makes it difficult for them to reach out for help. Studying these workers provides a rare opportunity to understand how non-military personnel manage emotions in extreme contexts. Our access to their unsolicited, private diaries, alongside interviews and non-participation observations, provides a rare glimpse into their emotional worlds.

### Data Sources

Our principal data set comprises the personal diaries of individuals working for MSF in different assignments around the world. We also conducted interviews with the diarists to understand their experiences and ask follow-up questions about what they had written in their diaries. In addition, we studied internal documents and made non-participant field observations to gain an understanding of the contextual situation in which individuals wrote these diaries (see Table I for an overview). Our data collection builds on an

Table I. Overview of data sources

| *Data type* | *Details* |
|---|---|
| Interviews (58) | • 52 interviews with 52 diarists ranging from different occupations including medical professionals working as volunteers for MSF in the field; 5 interviews with non-diarists working for MSF as medical professionals in the field; and 1 interview with a high-level MSF executive.<br>• 54 interviews were audio-recorded and professionally transcribed verbatim; 4 interviewees preferred not to be recorded, so we took extensive notes of their interviews. One diarist was unavailable for interview due to illness. |
| Diaries (53) | • 53 unsolicited diaries written by medical professionals working for MSF, with various hierarchical and experience levels and different roles: nurses, general doctors, midwives, anaesthetists, and surgeons, including trauma surgeons.<br>• All handwritten diaries were transcribed electronically (31).<br>• Diaries were voluntarily written without the intention of becoming part of a research project or being handed over to anyone else (including MSF). They are personal diaries and thus address many private matters beyond the scope of diarists' work (e.g., about their family lives and other personal events). In preparatory meetings, MSF mentions diary keeping as one way of coping with emotional experiences.<br>• Diaries vary in their level of detail, style, and duration, the latter ranging from four weeks to five years.<br>• Note: In order to facilitate easier reading of the manuscript, we assigned interviews and diaries numbers from 1 to 53. Each participant was assigned one number, e.g., number 22, which was then used for both the interview and diary, e.g., Interview 22 and Diary 22. |
| Participant observations (1795 hours (h)) | • Observations of daily activities during various MSF missions in Afghanistan, Iraq, and Yemen, which were recorded in detailed field notes (1460 h).<br>• Observations of informal gatherings of group members outside work (e.g., friendly gatherings such as dinners or having drinks), which were recorded in detailed field notes (130 h).<br>• Observations of training, meetings, and other activities related to preparations to join missions (180 h).<br>• Observations of presentations and panel discussions at public events, which were recorded in detailed field notes (25 h). |
| Documents (542) | • Access to internal documentation, including reports, summaries, and interim reports on selected projects (312).<br>• PowerPoint presentations made by MSF to various governmental and non-governmental organizations, for example on post-traumatic stress disorder (PTSD) prevention (46).<br>• Training materials for new employees and training curricula for newly created job positions and training procedures (83).<br>• Publicly available coverage of MSF activities (101). |

ambitious multi-year data collection effort to engage with organizations, such as MSF and the United Nations, to uncover the dynamics of work in extreme contexts. We were fortunate to receive support from key players in these organizations, which opened many doors, including to extensive field access.

*Diaries*. Diaries, a form of personal document, were the primary data collection mechanism (Taylor and Bogdan, 1984). A key strength of unsolicited diaries is that they provide an insider's account of a situation (Rauch and Ansari, 2022b). Unsolicited diaries allow researchers to 'collect large amounts of real-time information… to capture reflections and perceptions either frequently or after unpredictably occurring events' (Balogun et al., 2003, p. 201), and provide 'an intimate view of organizations, relationships, and events, from the perspective of one who has experienced them' (Bogdan and Taylor, 1975, p. 7). This approach was valuable in light of our research question about understanding emotions and coping mechanisms in such circumstances (de Rond and Lok, 2016; Wright et al., 2023). The diarists voluntarily engaged in diary writing as opposed to writing solicited logs (Burgess, 1984), and their diaries were not written with the intention of being part of a research project. The diaries cover between four weeks and five years, including time spent at home between assignments in extreme contexts. Thus, many diaries also recount experiences during pre- and post-deployment and are personal in nature. We obtained consensual, voluntary access to diaries written by key actors. MSF does not advocate writing diaries, so the motivation to keep them was personal; some had written diaries since early childhood, while others began after reading about its benefits in the press.

We used a snowballing approach (Biernacki and Waldorf, 1981). We did not directly ask diarists to participate but relied on the unsolicited referral of individuals encouraging colleagues to share their diaries. We benefitted from the support of experienced individuals (mostly Doctors of Medicine (MDs)) and their familiarity with research, as well as our role as independent researchers (we do not have any links to MSF, consulting, or executive education). Given the sensitive nature of the diaries and maintaining them is not advocated by MSF, we do not know how many of the organization's volunteers keep journals. However, we informally heard that many volunteers regularly keep diaries, while others engage in different coping techniques. In an informal conversation during a field trip to Yemen, a trusted non-diarist informed us that he is more of a 'mandala type', referring to a Buddhist technique for focusing attention and establishing a sacred space for meditation. We took special care to uphold the trust placed in us as the diaries contained private reflections on topics beyond our research interest. We anonymized the data to protect the diarists' identities and those of the people they write about. The diaries vary in the degree of detail included and in writing style. All diaries were written in English by diarists who had English as their first language. All handwritten diaries were transcribed and imported into the qualitative text analysis software NVivo for further analysis.

*Interviews*. After reading the diaries several times which represent our main data source, we invited the 53 diarists for semi-formal, in-depth interviews to follow up on emerging issues. One diarist was unavailable due to illness. We used a semi-structured approach to allow respondents to talk about difficult events (e.g., de la Chaux et al., 2018). We designed the interview guidelines to reflect our research interest in their experiences of working in extreme contexts and their motivation to join MSF. Each interview lasted between 45 and 120 minutes. We used a critical incident method to ask the diarists about their individual experiences and significant

memorable events (Chell, 2004). Additionally, we conducted five interviews with non-diarists to hear about their experiences in the field and whether they had experienced a culture of silence or engaged in purposeful silencing. We also interviewed a senior executive to speak about mental health, working conditions, and humanitarian aid, more broadly. Overall, we conducted 58 interviews. Individuals were willing to engage with us in open conversations as they perceived us as not 'merely academics from the Ivory Tower' (Interview 11) but as people with a genuine interest in their work, which involved travelling with them to field sites in high-risk locations around the world, being with them 24/7 and sleeping and staying at the same facilities as them rather than opting for a fancy hotel with hot water and electricity. Having first-hand field experiences through this project and similar previous projects gave us legitimacy and helped us speak 'the same language'. Diarists felt comfortable engaging with us and talking about difficult emotions as they believed we could understand their experiences. Similarly, they often stressed that we had a deep understanding due to our first-hand experiences, stating, for example, 'You are one of us' (Interview 31) and 'You ask no naive questions like those [questions] of journalists' (Interview 10).

*Non-participant observations*. To understand the uniqueness of the war context, one author obtained consensual access to join different field trips (e.g., to Afghanistan, Iraq, and Yemen). One assignment comprised a delegation of official representatives from the United Nations, MSF, and other NGOs. The author attended several preparatory meetings and training sessions and recorded casual conversations with members of the delegation and other representatives to obtain their immediate reflections on activities and events; she recorded these as field notes within 24 hours. Other trips involved MSF alone, with the author observing their medical aid services in war-torn environments and earthquake-hit sites. Across these assignments, she spent more than four weeks observing workers in extreme contexts, such as during their day-to-day routines in regional MSF-run hospitals in Yemen, clinics dedicated to women and girls in Afghanistan, and makeshift tent cities in Iraq. Additionally, she visited regional MSF headquarters and took part in seminars in Europe and the USA attended by medical professionals who had worked in extreme contexts. In total, descriptions of events and experiences and the subjective commentary amounted to 410 pages of single-spaced field notes. These non-participant observations were conducted to witness first-hand and obtain a feel for the contextual peculiarities of working in extreme contexts.

Given our lack of medical training, we did not take any active roles in the field but remained in the background as non-participant observers. In rare cases, such as in Yemen, we gave basic assistance, such as holding a saline bag in an acute emergency and handing out blankets to family members who had to sleep on the floor. Witnessing atrocities and difficult situations first-hand gave us a 'seal of trust' and enabled us to develop a shared understanding with workers, including a belief in the sincerity of our research endeavours. Although our data collection process ended some years ago, we regularly receive invitations to field visits to engage in further non-participant observations and follow-up of MSF's activities.

*Documents*. We collected internal, archival documents. In winter 2018, we asked the diarists for documents that reflect the emotional side of their work. In total, we gained access to 542 internal documents, including annual reports, pre- and post-deployment information, country briefings, reports on post-traumatic stress disorder (PTSD) prevention, and training guides. We also gained access to MSF archival documents covering strategies, mission preparations, and operations.

## Data Analysis

We followed an inductive approach inspired by grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990). In keeping with other interpretive research, to analyse data, emerging themes, and existing theory over several phases, we followed a four-step iteration process (Locke, 2001): (1) a broad analysis of themes and developments in the context, (2) an elucidation of the challenges associated with working under extreme contexts, (3) an exploration of how participants coped with the challenges and (4) a developmental validation of how individuals cope with the emotions of a specific deployment situation.

We began our analysis by familiarizing ourselves with the specificities of working in extreme situations by delving into the literature on working under such circumstances, recent missions, and societal debates on the topic. We consulted news articles and press releases from institutions associated with working under extreme situations, including MSF, the Red Cross, and the United Nations. We read books, such as *M*A*S*H*, *Emergency Sex*, *War Doctor*, and *Doctors at War*, drawing on fictional and ethnographical observations of working in a combat zone and illustrating the surrealism of war that triggers emotional and psychological distress (de Rond and Lok, 2016). These works highlight a culture of silence and concealing emotions, which was a starting point for our analysis. We used NVivo to identify key themes and sub-themes.

Next, we elucidated the challenges of working under extreme conditions and the culture of silence. We created tables and timelines covering background information, key events, and assignment experiences (Van de Ven and Poole, 1990) for the various diarists. Developing chronologies revealed that individuals struggled with different feelings when reflecting on their work in extreme contexts amid severe resource constraints. We then examined the data, by division, for more detailed classifications and patterns (Taylor and Bogdan, 1984).

Following an interpretive approach, we started our analysis with open coding of the textual database. We explored common themes and engaged in a first round of in vivo coding by staying true to the terms and phrases used by our informants (Locke, 2001). In particular, the frequent, explicit use of the terms ‘surreal’, ‘horrific’ and ‘silence’ facilitated the selection of passages in texts. We then categorized the in vivo codes into an initial set of categories, which served as the basis for the subsequent comparative analysis (Glaser and Strauss, 1967). We also followed an iteration process with the literature supporting our coding scheme, such as Shaver et al.’s (1987) emotion prototypes and Bleich et al.’s (2003) coping strategies. Similarly, we drew upon recent papers studying the suppression of emotions (Jarvis et al., 2018; Rauch and Ansari, 2022a), emotional regulation (Kahn, 2019), and voice and silence (Creed, 2003) to further sensitize our

analysis. For example, we compared how participants described their emotions and experiences in their diaries in detailed, elaborate, gut-wrenching terms with our observations during which they appeared calm, composed and reticent about their feelings, even when prompted.

Next, we collapsed similar codes and created first-order categories, which enabled us to move from provisional to advanced categories (Locke, 2001). We observed recurring tensions between entrants' expectations about their daily work and their lived experience on the ground, as well as how they dealt with the emotions arising from their experience. This led us to further probe silence and voice in the field, as well as how actors experienced and coped with this silence. We then focused our analysis on how they dealt with the emotional side of work.

This was particularly valuable as, across various data sources (e.g., diaries, interviews and observations), we were able to identify how medical professionals coped with emotional distress in different ways. At this stage, we drew on Goffman's (1959) distinction between frontstage and backstage interactions and sought to uncover the underlying mechanisms (Mair and Hehenberger, 2014). Frontstage is 'that part of the individual's performance that functions regularly in a generic and fixed way in order to define the situation for those who observe the performance' (Goffman, 1959, p. 22). Meanwhile, backstage is 'a place, connected with a given performance, where the impressions aimed at by this performance are consciously contradicted in a natural manner' (p. 136) and in which 'the actor can relax, put aside [their] disguise, interrupt the performance and abandon the character that [they] play' (p. 135). While we did not perform a complete dramaturgical analysis (Goffman, 1959), focusing on different roles and scenes, we were able to organize different patterns, data sources, and further concepts by distinguishing between what happens in front of an audience and what occurs in their absence.

At this point, looking across different data sources (diaries, interviews, and observations), we recognized differences in how workers behaved in front of their patients and with their colleagues. We identified various patterns in how they expressed or suppressed demonstrations of emotion despite frequent interactions with their peers and colleagues. For example, individuals stated, 'This is no place for talking about feelings' (Interview 40) and 'Feelings are not welcome to be shown' (Interview 14) among peers. However, they engaged more openly with their patients despite their professional defence mechanisms. A study of participants' diaries revealed a contrast between their outward behaviours and their innermost thoughts. We observed how they created a private, safe, coping space in their minds by finding an interlocutor (real or imaginary) on whom to vent their emotions. Although there are other ways of coping (e.g., Bleich et al., 2003), we focused on the link between silencing emotions and resorting to private modes of coping. We identified and grouped various patterns, leading us to distinguish between the behaviours we observed and what we gleaned from reading the diaries. At this stage, we engaged in axial coding to discover the relationships among the categories (Strauss and Corbin, 1998). This process was iterative as we went back and forth between the data and the literature. Following common practice (e.g., Corbin and Strauss, 1990), we compared our respondents' reports to

discern differences across time and groups and generate theory-driven second-order categories. We then discussed alternative explanations for our findings.

Finally, we aimed to obtain an understanding of how individuals cope in extreme contexts. This process led to the final set of categories. We initially developed alternative explanations, which we tested by returning to the empirical data and subsequently synthesizing the aspects that most closely matched our observations. To test credibility and accuracy, we subjected our findings to member checks (Lincoln and Guba, 1985) by presenting them to and discussing them with various diarists and non-diarists on several occasions during and after data collection to revise and hone them. We provide quotations and representations of the diarists' personal accounts both in the text and in a table (see Tables II and III).

## PURPOSEFUL SILENCING IN EXTREME CONTEXTS

We now turn to how medical professionals experience their work in extreme contexts. In doing so, we draw on the distinctions between (1) frontstage, referring to when medical workers interact with their colleagues and key audiences (patients, caregivers and relatives); (2) backstage, referring to when these workers are off duty; and (3) a private, safe space – a personal sanctuary created by individuals to vent their emotions in solitude.

### Emotions on the Frontstage

Medical volunteers from the 'developed' world who join missions to provide medical assistance to vulnerable populations need to adjust their expectations of work in extreme contexts. Medical professionals, across rank, gender, and level of experience, described their work during their MSF assignments in the following terms: 'a rollercoaster of an

Table II. Coding scheme

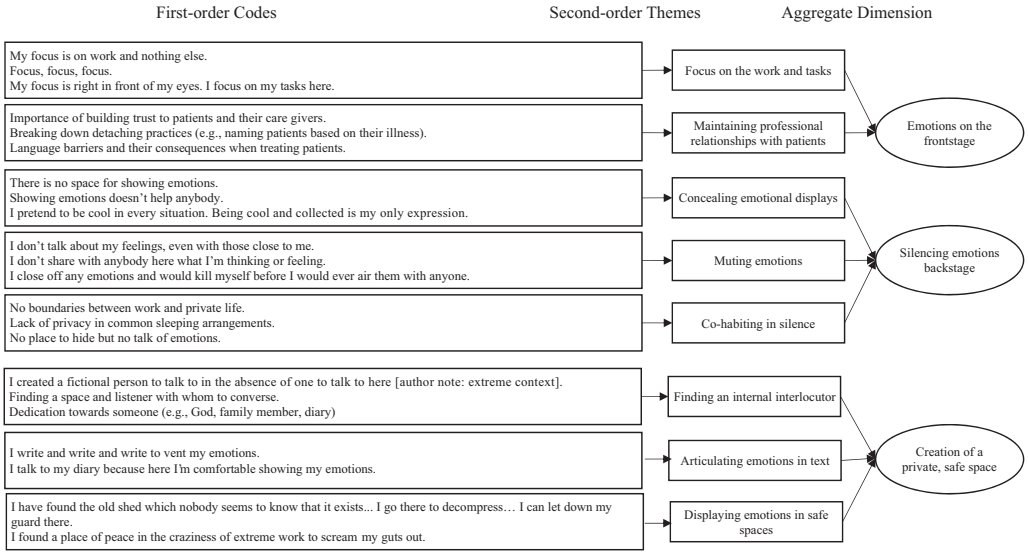

Table III. Representative supporting data

| *Theoretical category* | *Exemplars from the data* |
|---|---|
| Focusing on the work and tasks | 'We are here to get work done'. (Diary 10)<br>'Working for MSF is all about getting stuff done. MSF is not a charity or feel-good organization. They never say this but it's all about fucking getting the job done'. (Interview 22)<br>'Eye on the prize'. (Field notes 31)<br>'One can easily get distracted by so many things here [Yemen], but I just focus on the patients in front of me and the work'. (Diary 02) |
| Maintaining professional relationships with patients | 'I rarely can talk directly with my patient. They mostly don't know English and I don't speak the local languages. I always have to go [through] the local translator to ask questions or get answers. Just because of all this translation work, our rounds take much longer and I spend much more time in the bed than I would ever [do] in Canada'. (Field note 65) |
| Concealing emotional displays | 'Note to myself: Don't show any emotions to anyone'. (Diary 28)<br>'You can also call it a code of conduct; we are professionals in the field, and showing emotions is not a part of this'. (Interview 49)<br>'Just butchered a little girl. Fucking want to push Assad myself. Felt huge anger and rage inside myself. Locked myself inside the supply closet for some minutes. Needed a space to breathe'. (Diary 35) |
| Muting emotions | 'It is best to shut up'. (Diary 01)<br>'Will not help anybody if I share my feelings'. (Interview 31)<br>'Talking won't change the world. We need actions'. (Diary 08)<br>'The only way to survive is to swallow […] your emotions'. (Interview 41)<br>'I didn't realize for a long period that the solution to the problem was actually being silent'. (Interview 10) |
| Co-habiting in silence | 'You live in silence here. You eat and say nothing meaningful. Life is kind of on hold here. Your sole focus is on work. No room for emotions. You focus on surviving'. (Field note 78)<br>'MSF is like a commune or a bunch of hippies living in the '70s together. All happens in the same place. […] It's quiet and it's a strange way of living together. […] |
| Finding an internal interlocutor | 'Hey, you there. How are you doing?'. (Diary 01)<br>'Dear Diary, Thank you for listening to me day in, day out'. (Diary 14)<br>'Journalling and writing [a] diary – it's difficult to put in[to] words, but it's like […] creating a space for my thoughts and speaking but also having someone who is there for me'. (Interview 25) |

(Continues)

Table III. (Continued)

| *Theoretical category* | *Exemplars from the data* |
|---|---|
| Articulating emotions in text | 'My heart is dying here [author note: extreme context]. I'm mad, sad, tired. It's just fucked up'. (Diary 21)<br>'My safe space to cope, to vent, to fucking say what I think and feel and how miserable all of this is'. (Diary 41)<br>'Speaking about feelings with others is hard. Speaking with family is a hard thing to do because they didn't see what I have seen. My diary makes me feel calm. I can speak about my emotions without any fear of anything'. (Interview 19)<br>'I feel sad. I want to cry. I walked out of the diagnostic room before others could see my brokenness. The only place to show your emotions is this place [diary]'. (Diary 31) |
| Displaying emotions in safe spaces | 'Left the [MSF building] complex today illegally. I didn't go far but I needed to get out. [I] went to the river and just broke down [and cried]'. (Diary 11)<br>'Taking a piss and crying in the same location. Only possible here and sponsored by Assad [referring to the lack of humanitarian aid and the bad situation for civilians living in northeast Yemen]'. (Interview 20)<br>'I cry into my diary'. (Diary 22) |

emotional experience' (Interview 10); 'adrenaline rushing through my bloodstream' (Diary 21); and, 'Only here, [can you] feel pride, shame and guilt all within 60 seconds' (Diary 27). Such statements were provoked by the severe setting of the context, as illustrated by a physician describing MSF's involvement in Yemen, considered by international aid bodies as 'the biggest humanitarian crisis around the globe':

> We had no laboratory and no orthopaedic surgeons, and our patients were mainly having open fractures, wounded by explosives and gunshots, and burn injuries. There are just no resources. This absence of everything makes me so mad that at times I just want to scream to each and every one. […] I feel pride in our work, but I'm also mortified by so many things here. […] You have a malnutritioned baby in your hands [who] is lighter than your sons' PlayStation. […] This work is full of emotions even those you don't desire. (Interview 48)

This level of ambivalence in politically unstable MSF assignment regions, makes work very challenging. When prompted on how medical professionals cope with this experience, 'turmoil of emotions' (Interview 40) and the many stark contracts and hardships, many participants stressed how they 'manage[d] their emotions' (Interview 11). Individuals remind themselves of the unwritten professional rules they learned in medical and nursing school to 'man up' (Interview 10), 'show no weakness', (Informal conversation 30) 'leave your emotions at the door' (Interview 33), and 'don't be a burden to the team' (Diary 22). However, the severity of working in an extreme context makes it harder to follow these rules. We describe two prominent themes emerging from our

study regarding how individuals interact and cope in the field (1) focusing on work and (2) maintaining professional relationships with patients.

*Focusing on the work*. Medical professionals remarked that despite having received some preparatory training, they felt overwhelmed by their emotions. To manage their emotions, they resorted to focusing on the work and tasks in front of them, such as providing basic first aid, engaging in creative problem-solving, and preventing the spread of disease. Managing your emotions is an established unwritten rule in medical circles (Menzies, 1960). A doctor expressed this in an interview following his first mission to Afghanistan:

> First and foremost, we are professional medical professionals in service to civilians in need. […] It is absolutely silent in the field when it comes to personal feelings and emotions. Many things are going on and, at times, it's very hectic. We witness many tragedies involving children. Stuff is happening you wish you would have never witnessed and seen. At the same time, it's very quiet and not much sound. […] We focus on the work that is in front of us. (Interview 20)

Medical professionals often referred to their professional ethos and identity when working with patients and providing care 'as the ultimate goal' (Interview 41). After finishing a night shift during which they attended to scores of people, including young civilians, injured by a nearby detonation, a nurse in the field noted:

> Look, at the end of the day, I'm just a nurse here, like [the] nurse I was back home. I advocate for my patients and try to make sure they get the best care possible. It's about getting the job done. Treating patients, finding solutions [to] problems, and prioritizing work over anything else. (Field note 54)

Such descriptions were typical of medical professionals who frequently noted that they engage in humanitarian work to 'provid[e] first aid to those most in need' and '[to be] there for the ones that are forgotten by the world and humanity' (Interview 20). They often referred to their professionalism and teamwork that is required to provide care. A paediatric surgeon commented:

> I have to stay alert and be a good team player. I'm the only paediatric trauma surgeon in [an] area of 200 miles. Maybe even in the entire country. I need to perform to be of service to the team and patients. [There] is no room for anything else than work. The focus is work because I'm here for work. Work is paramount here to survive for all of us and the community. […] I cannot give in to my emotions. (Interview 30)

Overall, we observed a strong professional focus despite the dramatic change in environment.

*Maintaining professional relationships with patients*. While many medical professionals stressed the importance of maintaining the professional norms of their work in

the field – such as being used to long working hours and not getting too close to their patients – they also pointed to the differences in the nature of relationships with patients in this context and in their home countries. A nurse reflected on her experience in both contexts:

> Rule number 1 in nursing: don't get attached to your patients. We have various routines in place to make sure we [medical professionals] don't get too involved and too invested in the individual stories of each patient. This is simply a defence system built into our work. [At home], we frequently rotate the patients we take care of. We work on shifts for 3–4 days in a row and then are off for some more days; and by the time you are back at work, you have a new set of patients. […] But here we are a team of not even 10. We are only two nurses. I'm always needed even when I'm not scheduled to work. There are no rotations. […] You are with the patient from their intake to discharge. (Interview 09)

Some participants described distancing practices at home, such as referring to patients as 'hip in bed 9, kidney in bed 11' (Interview 20); however, they quickly pointed out that 'the usual' mechanisms to 'protect oneself from the families and the hugging mothers when one saved their baby' (Interview 11) did not apply in this situation. Some interviewees stressed how creating trust with patients and their families had a different and much more important role in this context. For example, an interviewee commented how medical professionals were 'much more emotionally involved than we used to [be]' (Interview 23):

> If a patient sees me at my clinic [in the US], my walls are plastered with [my] MD from Harvard, residency here and there, and all other certificates we like to pride [ourselves] with and collect along the way. Here, I'm just someone pretending to be good. I need to give them the feeling of providing because word of mouth here is much more important than any Yelp rating or fancy Harvard certificate. If I disrespect the village elder and […] word travels because I didn't talk long enough with them, all the other villagers won't come [to] us and Ebola spreads further. (Interview 08)

Typical detaching mechanisms used at home are less often deployed in extreme contexts. Medical professionals often become 'more entangled' than 'they would like' (Diary 22), which evokes strong feelings of empathy and sympathy 'beyond what [they] would ever feel at home' (Interview 07). A general surgeon reflected on this in a quiet moment during one of our field visits:

> We are the only clinic in 200 km or more. It takes patients often multiple days, sometimes even weeks, to make it to us. They travel with their families. You become invested one way or another. Some make it to us with their last breath. The patient is barely hanging in there. But, also, their relatives are in bad shape. They are malnourished, have small children or elderly [people] with them; all in, generally speaking, not [in] good shape. [They] have lost relatives and seen stuff that one cannot put in words. […] You feel for the patient no matter [whether] you want [to] or not. There is no different way. You become part of their story. This is why you are here. (Field note 58)

These professionals often work under extremely difficult circumstances, characterized by severe resource constraints and a lack of infrastructure such as running water and stable electricity. Yet, we observed that they never aired their grievances about the situation and the difficulty of their work with their patients. One experienced physician described this behaviour as an:

> […] ambivalent bag of feeling. I'm supposed to be warm and trusting, caring for my patients but distant and stoic when fixing the tiny human with my scalpel, and nothing can stop me from performing my work the best way possible. Everything is intense here. (Diary 19)

## Silencing Emotions Backstage

Given the emotionally taxing and difficult work, together with the unique setting with its resource scarcity and lack of infrastructure, medical professionals acknowledged that 'no possible training could prepare you for the severity' (Interview 22). Our analysis suggests new entrants to the field learn to suppress their emotions while working alongside more experienced professionals who had experienced dozens of field trips in highly disturbing contexts. However, in contrast to their experience of remaining silent in the field, MSF makes the following recommendation:

> Often far away from home, under the pressure of emergency work, and required to process the traumatic stories of the people they meet, they often also need a listening space where they can share their anguish and any other issues. (Internal document 151)

While the organization promotes talking freely and sharing as a coping strategy to avoid PTSD, provides 'listening spaces' and organizes activities – such as routine meetings to reflect on daily activities – and provides access to professional therapists, neither experienced nor first-time medical professionals in the field followed this advice. Instead, they described a strong preference to silence their emotions, even when with like-minded people. As one physician noted: 'Not talking about what happens in the field is a choice. Silence is my choice to survive' (Interview 19).

By drawing on a diverse set of data sources, we distinguish between how experienced individuals and new arrivals silence their emotions and illustrate the purposeful and voluntary nature of silencing through (1) Concealing emotional displays; (2) muting emotions and (3) co-habiting in silence alongside colleagues.

*Concealing emotional displays*. Members suppressed displays of emotion as an integral part of 'working and living in these circumstances' (Diary 17). New entrants to the field initially had to learn to deal with their emotions and, over time, to silence them. A nurse working for MSF on a rescue ship in the Mediterranean Sea during the refugee crisis in 2016 commented:

> Work on the vessel is more difficult than my previous assignments. There is no way of escaping. The stories are more brutal than what I was used to. […] Additional to what I now call normal pressure was the political pressure on our work and the increased

> attention [from the] media. And the stories from the refugees were very horrific. I knew I had to bottle [things] up and act as normal as possible. Show no emotion, no affection, besides, of course, empathy for my patients. But not to my peers. (Interview 50)

Concealing emotional displays was widely acknowledged and even seen to be a prerequisite for working in the field. For example, a newly assigned trauma surgeon acknowledged:

> It's all about pretending to be super chill and super cool. Nothing can touch you. […] Showing how miserable one is, is as likely as Assad be[ing] a humanitarian. (Diary 31)

However, medical professionals privately shared that they preferred to 'deal with their emotions in their own way' (Informal conversation 70). This is also demonstrated by a diary excerpt:

> I had to swallow […] my emotions. It was hard. It was the sixth death of the day. Inside, I was just empty, but I just couldn't show others. […] My aunt from Nebraska emailed writing she's happy I'm among colleagues who witness the same stuff as I do, and we can discuss the experiences. When I told her that we don't show emotions here, she didn't answer. She thought people are nasty here. Aunty fails to understand it's my own choice. She doesn't understand that not showing my emotions, to remain stoic, is my Superman cape, my armour. (Diary 18)

Experienced personnel rarely showed their emotions, with one describing this probability as '1 in 100 chance' (Interview 11).

However, new entrants were not familiar with this norm. An experienced surgeon described an encounter with a new colleague on his first MSF mission and how he had to ignore this colleague's display of emotions following a difficult surgery:

> A colleague just walked up to me and shared with me his take on how the last surgery went. I couldn't listen to him. I pretended I was listening, but I was in fact just blank. […] It wasn't so much what he said but how he looked. He was 6'4" – a hunk of a guy. He had tears in his eyes. It was obvious from his bloodshot eyes that it wasn't the first time [crying] today. I felt sorry for him but I really didn't want to deal with him. If I […] put my guard down, he will drown me with him. There is nothing to be said on the topic. I was also somewhat speechless. I could only mutter, 'You'll get the hang of it', which, I guess, made no sense [to] the person, and [I] continued walking. (Diary 39)

*Muting emotions*. Given the increasing awareness of the trauma caused by working in extreme contexts, MSF encourages their employees to 'actively cope by articulating their feelings and [the] distress they encounter' (Internal document 219). However, on the ground, it is extremely challenging to share emotions. A nurse illustrated her experience joining an aid mission to Congo, and how a foreign aid worker was taken hostage and later died:

> I started as a volunteer. […] The experience of Stephens'[1] hostage-taking shattered so much in me… I was so surprised [that] nobody talked or showed any emotion whatsoever. We kept on and went on, despite the one [who was] killed [being] one of our own [fellow professional]. I thought [that] we [would], at least this once, talk. (Interview 50)

Our analysis suggests that new entrants were surprised about the norm of concealing emotions and how hardly anyone attended meetings to promote the sharing of emotions. A surgeon who had just joined her first mission stated:

> We have this ritualistic meeting. I was very surprised about these meetings. […] We [have] been told there are these support groups where we can reflect and share our experiences beforehand, but nobody attends those meetings. And those meetings that are a must are kept short and only to the minimum. No room for anything personal. (Diary 21)

Individuals soon learn to silence emotions not just in the field but also backstage. In a series of diary entries, an experienced trauma surgeon describes the arrival of a new physician. He named her 'Miss Piggy' in his diary and describes how she learned, over the course of less than a week, to silence her emotions without being explicitly told to do so:

> Miss Piggy is new. First mission. I hate newbies. Newbie by the book. […] She takes everything so serious[ly] […] Either she breaks or I break her. If she fucking tells me one more time I need to come to the meeting, I speak to Tammie [person in charge] […] because, hey fuck, we all get it, she is new. She does not know the rules. […] Why the fuck [does] she need to talk so much? And why the fuck are we supposed to talk? Mind your own fucking business […] Those rookies really annoy me […] [I] don't give her more than a week and her fairytale will break. It is always the same. (Diary 35)

The surgeon continued to describe how newcomers threaten the existing 'order' of silence:

> Miss Piggy didn't last until Friday. She cried her lungs out. Five double [amputations] this week broke her. Feel bad for her. Remember my first. We have all been [t]here. It is not a place where we talk. Piggy [has] got this now. Asked myself in [a] brief second if [I] should say something to Piggy but, meh, what should I say? Been there done that? Will get better? That's a fucking bunch of horseshit. […] Finally, back to our routine. No more fucking talking about shit. Miss Piggy got it. (Diary 35)

A new physician described how purposeful silencing has benefits, such as not reliving horrific experiences by talking about them:

> With more time in the field, one starts to understand how to work here. Sure, we are encouraged to talk and share, but you learn that not talking might be a very attractive alternative […] It's like tell[ing] my daughter to finish her [dinner]; otherwise, it will rain tomorrow. She can also just not finish her [dinner] and it will rain tomorrow. It

> makes no difference. […] If you talk about it, you relive it another time. Why [would any]one in their right mind would want to do this to [them]self and [their] friend? (Interview 05)

About to return to Europe after a field trip, an experienced physician summarized:

> I don't speak because it's not helping anybody. It is scary but working here is about your own survival much more than about creating change or having an impact. (Informal conversation 49)

Across diarists, we observed differences in how different individuals muted their emotions in the field. For example, a doctor who was also an enthusiastic classical singer, shared in an informal conversation during a field visit, that every time he felt tempted to share emotions in the early days of his stint in the field, he started to hum in D Minor. This key is regarded as the saddest, darkest, and most melancholic key known in music (Field note 35). Other individuals resorted to different tactics to mute their emotions. Such tactics included the use of dark humour, banter, and sarcasm in conversation with colleagues.

*Co-habiting in silence*. Next to attending to patients in makeshift hospitals in trying circumstances, medical staff also had a life outside work despite long days and frequently working overtime. However, they did not return home after their shift, but lived in buildings adjacent to the hospitals, often in tents (Internal document 76). As a result of the volatile situation on the ground, they were seldom allowed to leave the compound due to security concerns, such as the potential kidnapping of foreign aid workers (Internal documents 69).

During a visit to a local MSF-run hospital in Sanaa, Yemen, a physician, who had already spent four months working for the MSF clinic in the country, showed us around the small facility. He started the tour by greeting, 'Welcome to the place where we work, sleep, and shit at the same time' (Field note 312). He was referring to the absence of a clear distinction between private and professional lives, which is often typical in such situations. Similarly, a surgeon commented:

> I mean, it is not only the butchering of people, but you need to have in mind [that] we are also living together […]. Essentially, we sleep in rooms [crammed] together: 5 to 10 people with zero privacy. One can hear if [an]other is having a digestion problem because of local food [or] vomits because [they] couldn't handle the pressure of the day. It is not only the work that is beyond impossible, but it is also the circumstances in which we live. And I put 'live' in quotation marks because this is *not* living. (Interview 49)

Given the lack of options in terms of bars and cinemas, medical staff often resort to spending time together after dinner or the end of the shift. Typical dinner conversations included the retelling of daily events (e.g., severe cases), world politics, and sports (Field notes 354). On a particularly difficult day, during which three children under the age of 3 and a local nurse who worked and translated for MSF had died, there were no

conversations at dinner. Some may have muttered requests to pass the salt and cutlery, but everyone seemed immersed in their own thoughts (Field note 180). A new entrant to an MSF-led mission in Syria reflected in her diary:

> My first day was horrible. I have never seen so much misery as today. I want to cry and scream. […] I went with big hopes to the round of beers to chat with others, share my sorrows, cool off. But they all seemed like machines. Nobody talks about anything meaningful. They talk about the weather, football, recent news, but hardly any discussion on what just happened in the operating theatre. They take it as the normal. It seems like they [don't] give a damn that [they] just butchered three children. (Diary 24)

Although workers mute their emotions both in the field and when off duty, their personal diaries demonstrate how their emotional turmoil despite appearing and 'pretending all to be cool. Nothing can get to me and I'm the master of the disaster' (Diary 02). Individuals did not share their emotional distress, even in meetings held for this purpose. An experienced nurse acknowledged the contradictions she had experienced:

> If I am really honest with myself and you, I feel discomfort with the arrival of new colleagues. They are great human beings. But they make me very uncomfortable. They have an illusion about the reality, about the work we are doing here. It is not only about doing our work in the field. Foremost, and [this] is not known to most of them, you need to secure how to survive. You need to find a story to tell you[rself] to go to bed every night. We are told by the organizations [that] we need to talk about the experience. Of course, they tell this to us because they want to avoid any damage [to] their reputation and all the shit that is going on with PTSD and cases of suicide. But have you actually had a look at the paperwork we have to sign before going to the field? It's blatantly insane. It's absurd. (Informal conversation 82)

## Creation of a Private, Safe Space

Workers had to wrestle with the issue of coping with brutal realities in the field. This included asking themselves, 'How will I survive this hell?' and 'What is the story I am going to tell myself every night before going to bed?' (Diary 15). When asked about their way of coping, several respondents confirmed that 'each [of us] has to find [our] mode of working' (Interview 21) through 'how to deal with the bullshit you encounter daily' (Interview 08). One surgeon commented 'With writing diaries, I can create a room for myself. A room of silence and peace despite all the noise surrounding me' (Interview 44). Another general physician noted, 'Writing is my place. My mind place. My freedom' (Diary 3). From our analysis, we identified three prominent themes around the creation of a private, safe space: (1) finding an internal interlocutor, (2) articulating emotions in text and (3) displaying emotions in safe spaces.

*Finding an internal interlocutor*. Many respondents shared that they are not typically a 'diary person' but that writing diaries is their 'only safe haven' and 'own space' (Interview 12)

in their usually very busy, turmoil-filled environment which offers little privacy. Their motivations to keep a diary are personal. Some described it as a technique they had used since early childhood or a self-improvement method they had heard about. However, MSF does not promote keeping a diary. A doctor acknowledged the value of writing diaries:

> Our head is our space. We don't talk about the inevitable we cannot change. We know the reality. We live the reality every day. Nothing will change if I speak about it. […] Writing helps to clear my head. Dumb my thoughts inside. (Interview 38)

We observed a special relationship with the internal interlocutor among diarists. Some started their diary entries with 'Dear Diary', 'Hi, Diary' or 'Hi, there. It's me again'; others wrote to fictional friends, such as 'Travis from Memphis'. Some viewed writing their journal as having a conversation with God. For example, 'God, I know you are watching me, but you don't see how cold the [touch] of a scalpel is here' (Diary 11). Others found comfort in writing to themselves:

> Writing to myself is liberating. It is a way to consciously think out loud and look at what my brain and heart produces, only to then reflect and ponder on it again. (Diary 13)

In his field assignment, a doctor dedicated his journal to his children:

> I have decided that, from now on, I am writing this diary to my children. As a memory for them. Dear Christian and Cathy. This is for you. You are my inspiration and [are] keeping me sane on this trip. I hope one day the children here [East Africa] have the same chances as you do. (Diary 34)

Thus, workers conversed with a range of internal interlocutors: real people (e.g., relatives), fictional people, faith-related figures, and themselves. A visceral surgeon reflected, 'It [Diary name] has remained unspecified. […] Writing diaries is my therapist' (Interview 17).

*Articulating emotions in text.* Medical professionals agreed that writing a diary gives them a forum for describing their innermost thoughts and feelings, which they describe as 'something liberating, writing inside this book. I can [aside] down my inner fear, my thoughts, my sorrows and my desires' (Diary 06) and free from judgement. A doctor reflected:

> It is really comforting writing [on] this blank page of MS Word. It has a sense of purity. And then I come with my thoughts. [It] feels like Word is not judging me. Is not reacting to what I am saying and thinking out loud. Well, OK, it does react to my bad grammar and spelling. Hahahahhahahaha. (Diary 45)

Diarists felt the need to find their individual way of coping, especially in light of the emotional distress of 'feeling powerless because you […] cannot change the world' (Interview 42). Writing diaries allows them to voice their despair about how unjust the situation seemed compared to their 'normal' life at home:

> I mean, fucking shit, there are still people dying of TB [tuberculosis] here. HELLOOOOOO?????? And we are concerned in the fucking US that Obama plays a lot of golf. I mean go to hell, US. Really? Why can't we just take the stuff that we already have back home to whatever places? Why do they need to suffer for no reason if we have the solutions already? I'm so frustrated and so mad and pissed off. Nobody seems to care about these children here. (Diary 29)

A surgeon noted the 'soul-crushing' contrast between the dire situation on the ground and their desire to 'mak[e] the world a better place':

> We had nine civilians wounded by air strikes again, including seven children and two women. A seven-year-old girl will most likely lose her eyesight owing to her injuries. I just wanted to cry. She lost her eyes in the midst of war. I have this girl in front of me. […] I couldn't do anything for her. […] Everything is just fucked up. [I] am just broken beyond repair today. I didn't say shit today at dinner. I pretend to be cool and all mighty fine but, fuck, this world is made by motherfuckers. (Diary 37)

While their behaviour on the field may appear impassive on the surface, trauma surgeons expressed their emotional distress in their diaries:

> Diary, this smell of blood, metal, and fluids after a double amputation is worse than other smells [s]. It stinks. It kicks [me] in the guts. (Diary 01)

*Displaying emotions in safe spaces*. Professionals not only expressed their emotions in words but also in visuals. A general physician drew pictures in his diaries, including one of a young patient who was eventually discharged after being treated for an infected amputation wound. This picture is a sketch of the patient with a caption that reads 'Me and Tasha, 11 years old; both smiling and happy after meds [medicine] kicked in. Happy moment for both of us. Much needed!' (Diary 3). Other diarists also engaged in drawing self-portraits – in one picture, the diarist portrayed himself crying while performing surgery. Later in his diary, he referred to the self-portrait, stating:

> I know I'm not allowed to cry in public, but I can't shake the feeling of guilt. It's burnt onto my skin how the uncle of the boy said it's OK when the boy dies because they don't have food to feed him, let alone money to buy medicine. […] We operated on him, he survived, but the only thing I wanted to do [was] cry while operating because we just made it harder on that uncle and his family. (Diary 3)

One of the handwritten diaries was visibly damaged by water, and we initially suspected adverse weather conditions. However, while meeting the diarist for a follow-up interview in the USA, during which we returned the transcribed, handwritten diary to him, he volunteered, 'They are not drops of rain. I cry when I write. I cry a lot when I write' (Interview 10).

Individuals not only used diaries to display their emotions but also looked for hideouts and unfrequented places, such as next to an old energy generator to avoid being observed and heard when 'puking my guts out because I cried too much after my system failed me'

(Field note 85), or leaving the premises despite not being allowed to do so 'to vent my emotions' (Interview 36). A trauma surgeon noted how he sought places where he could find a moment of privacy:

> I press 280 lbs [reference to bodybuilding] but cry. More often than not. Never in public. Only when I'm alone. […] I go for [a] number 2 [toilet] without doing it, close the [door] behind me. […] Sit on the [toilet] rim and cry. (Diary 35)

These professionals found creative ways to display their emotions. One physician into classical music revealed how he turned to composing music to express his emotions:

> I started to write a symphony as a way of working through my emotions in the field. I called it Johan Sebastian Bach's Come, Sweet Death [regarded as one of the saddest symphonies of all times] meets humanitarian aid work. Like Bach, I'm asking for death to come quickly and peacefully to deliver the patients to heaven, where they can see the face of Jesus. I also added allegro con brio [fast tempo], and the famous four chords of Beethoven's 'da da da duuum' [5$^{th}$ symphony in C Minor]. Beethoven must have said that fate is knocking at the door with the short short-short-long motif. […] Sometimes I walk around and sing da da da duuum when nobody is around. (Field note 43)

Individuals found different ways to cope both on the frontstage, backstage, and in their private safe spaces. However, we also observed patterns in how diarists express and record their emotional distress and to engage with the various facets and 'shades of silence in the field' (Interview 33).

## DISCUSSION

Our study shows that silence may be 'golden' when it comes to maintaining the composure that is required for carrying out work in extreme contexts. Silence serves as a collective pact that communicates without expressing or articulating how one feels about a brutal situation. Rosenblatt (1998) described the silent nature of friendship between two poets.

> Wordsworth goes to visit Coleridge at his cottage, walks in, sits down, and does not utter a word for three hours. Neither does Coleridge. Wordsworth then rises and, as he leaves, thanks his friend for a perfect evening.

Our findings suggest that diaries serve as an outlet for unfiltered, cathartic self-expression of difficult emotions without reservation or external interference. Our findings enable us to offer two interrelated contributions.

### Contribution to the Literature on Emotions in Extreme Contexts

Prior research has highlighted the taboo surrounding emotions within organizations like the military, where individuals are often left to manage their emotional turmoil independently (Rauch and Ansari, 2022a). By applying Goffman's concept of frontstage and

backstage behaviours, we extend this conversation, revealing that emotional concealment occurs not only in public (frontstage) but also in private interactions among colleagues (backstage), despite organizational prescriptions and encouragements towards emotional sharing. Instead, people engage with and process their emotions privately through journaling.

We illustrate how workers in extreme contexts, perceived as stoic and emotionally undemonstrative agents (Fraher et al., 2017), actually grapple with feelings of futility and a diminished sense of agency. While the external facade may suggest emotional composure, individuals experience psychological pain and emotional trauma. Thus, putting on a 'Superman cape' on the frontstage does not necessarily indicate an absence of emotional trauma or psychological pain.

Contrary to the collective coping strategies of sharing emotions in communities of coping (Korczynski, 2003), or well-established coping strategies (e.g., avoidance, denial, and behavioural or mental disengagement) (de Rond and Lok, 2016; Fraher et al., 2017; Rauch and Ansari, 2022a), our study uncovers a distinct approach to emotional management: the creation of private sanctuaries for emotional expression, shielded from social judgement. These are spaces where the individual lives 'without a sense of watchers' (Hochschild, 1983, p. 226). This method of coping, as described by Hochschild (1979), involves intimate self-disclosure in diaries or letters. In this form of coping, individuals direct their emotional experiences towards themselves or symbolic interlocutors, away from the gaze of others. As Hochschild (1979) described: At home with her diary, she felt free of her obligation to please her suitor by trying to like him. There, she felt another obligation – to be honest to her diary (p. 45). We thus shed light on a unique type of 'social sharing' of emotions in one's private sanctuary.

Our findings also speak to the broader discussion on the significance of 'free spaces' for emotional expression in various settings, as explored by Zhang et al. (2023). These spaces, free from the scrutiny of normative expectations, allow individuals to authentically express their thoughts and feelings (Kellogg, 2009, p. 659; Ross, 2007). While safe spaces allow individuals to 'take off the mask' in front of trusted ones (Goffman, 1957), they can also exist in an individual's own thoughts. McCarthy and Glozer (2022), in their study of an online feminist movement, reported how individuals take recourse to a 'sensory retreat that provides a purposive focus on self-preservation through withdrawing from the online platform to replenish emotional energy' (p. 386) and take 'solace through the self' (p. 388).

We extend this discussion by focusing on how individuals articulate and record their emotions in private, discursive sanctuaries: keeping a journal. We show how individuals create a private, safe space, which is inaccessible to others, to express and process their innermost thoughts, and explore their fears, hopes, and dreams without the fear of social scrutiny.

Journaling allows individuals to keep a written record of their thoughts and emotions that they can revisit to find succour. Other forms of creating a private, safe space that respondents told us about, such as how they cried in the shower or next to a noisy generator to express their emotions, do not provide a lasting written record or a safe haven. Our research thus underscores the role of journaling as a potent tool for creating such discursive sanctuaries, enabling individuals to explore their emotions and aspirations in

a judgement-free environment. This practice not only aids in emotional processing but also in reclaiming a sense of agency in extreme contexts.

### Contribution to the Literature on Silence in Extreme Contexts

Our study also offers a fresh perspective on silence within extreme contexts. Moving beyond the conventional view of silence as a negative (Creed et al., 2014; Edmondson, 2003) or 'passive act' that is induced by fear or intimidation (Cappellaro et al., 2021, p. 36), we demonstrate how silence can serve as a purposeful strategy for maintaining emotional equilibrium and focusing on critical tasks in high-stress situations. Talking about terrible experiences visible to everyone is akin to 'reliving these experiences again' in the words of a respondent. This conceptualization of silence as a form of 'conscious withholding' aligns with previous research by Morrison (2011, p. 377) and others that cast silence in a more positive light. For example, in business school education, Anteby (2013, p. 128) argues that 'under certain conditions, silence can perhaps prove generative'. Similarly, McCarthy and Glozer (2022) depict silence as an 'agentic choice' (p. 389), where online MeToo activists purposefully used silence for self-care. We thus reframe silence not as a sign of acquiescence but as an active choice for emotional preservation.

Drawing parallels with studies on protective silence in various domains, we argue that purposeful silence in extreme contexts is not imposed but chosen, acting as a shield against emotional overload. This perspective challenges the negative connotations often associated with silence, presenting it as a strategic response to the demands of working in extreme environments.

Our findings have practical implications for organizations operating in extreme contexts. While traditional training may emphasize emotional detachment and the sharing of feelings in structured settings, our study highlights the limitations of these approaches. The reality of working in extreme conditions, especially for volunteers from different backgrounds, necessitates a more nuanced understanding of emotional coping strategies. Organizations need to reconsider their approaches to emotional support, recognizing the value of private, discursive spaces and the strategic use of silence as a legitimate and effective means of managing emotional distress. This calls for a shift in organizational policies and training programmes to accommodate the diverse emotional needs of individuals in extreme situations, ultimately fostering a more supportive and understanding work environment.

## LIMITATIONS AND FUTURE RESEARCH AVENUES

This study has several limitations that also provide avenues for future research. First, while we draw upon diaries written during various assignments in extreme contexts of war, such as in Afghanistan, Iraq, and Yemen, personal experiences can change over time. For instance, while workers need to adjust to the situation in the field, they might have different reactions to the situation at different points in time. Paying greater attention to temporal dynamics, such as the mundane practices of work and experience of

boredom (e.g., while waiting for incoming patients) with intense emotions during action-filled times, may generate fresh insights.

The exploration of diary entries presents a compelling frontier in narrative research, meriting a deeper integration with the broader discourse on narrative studies (Vaara et al., 2016). Through the practice of regular journaling, diarists undertake a reflective process of reconstructing past, present, and future events, and craft versions of themselves and their experiences in solitude. These personal narratives, inherently private and unshared, offer a unique lens through which to examine identity construction, potentially unveiling distinct patterns not observable in narratives intended for public consumption. Consequently, diary-based personal narratives warrant a more pronounced focus within narrative research, from both theoretical and methodological standpoints.

We began this manuscript with a quote by Wittgenstein pointing out the difficulty of expressing a range of emotions that one might experience and the potential lack of vocabulary. This issue warrants future research into how individuals translate and narrate their experiences from a warzone and may result in important insights for professional training and media reporting.

Although we had access to diarists' lives outside their missions, we did not assess how they coped with emotional distress once they returned home. Future studies can shed light on the coping strategies of people returning to their regular jobs, as different psychological disorders may surface when people are back in their regular environment. Similarly, while we focused on difficult emotions, future research can examine the types of emotions experienced and regulated at different times. We must stress here that we are not suggesting that keeping a journal as a coping mechanism is a preferable course of treatment for emotional trauma or war-related psychological problems. This is beyond the scope of both the data and our own professional expertise. As such, a comparison of different coping strategies would be an intriguing follow-up to our study; this could include diarists and non-diarists in varying levels of extreme situations and in organizations with different degrees of psychological safety. It is worth exploring if our findings hold for non-diarists and how they deal with difficult experiences inside and outside the field.

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## NOTE

[1] Anonymized (including all other subsequently used names).

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