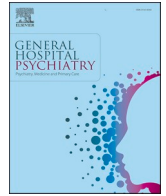




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## Resilience coaching for healthcare workers: Experiences of receiving collegial support during the COVID-19 pandemic

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### ABSTRACT

**Objective:** To explore experiences of receiving collegial support from the department of psychiatry at an acute care hospital during the COVID-19 pandemic.

**Method:** The Resilience Coaching program launched in April 2020, with the aim of offering a timely response to supporting psychosocial needs of healthcare workers (HCWs), leveraging collegial relationships and mental health training to offer support. Twenty-four HCWs were interviewed about their experiences receiving support from resilience coaches.

**Results:** Participants reported that Resilience Coaching offered hospital staff opportunities for connection, encouragement to attend to personal wellness, and avenues to learn practical skills to assist with coping. Coaching also assisted HCWs in accessing clinical mental health support when that was requested by staff.

**Conclusions:** Resilience Coaching is a model for supporting colleagues in an acute care hospital during a pandemic. It is generally regarded positively by participants. Further study is warranted to determine how best to engage some occupational subcultures within the hospital, and whether the model is feasible for other healthcare contexts.

## 1. Introduction

The COVID-19 pandemic triggered unprecedented levels of workplace stress for healthcare workers (HCWs) globally. Workplace support for HCWs is considered vital to their well-being and to the stability of the healthcare system [1–4].

The Department of Psychiatry at Sinai Health in Toronto, Canada, led an effort to support HCWs through a program called Resilience Coaching [5]. The program was developed using evidence-based principles, drawing from lessons learned from previous outbreaks of infectious disease when possible. The program design was also informed by first-hand local experience supporting HCWs during the 2003 outbreak of SARS [5–10]. The model is fundamentally based on leveraging collegial relationships and mental health training to offer timely support.

A qualitative approach has been utilized to understand the experiences of providing and receiving Resilience Coaching in an acute care hospital setting from April 2020–May 2021.

### 1.1. Principles of supporting HCW psychological needs during a pandemic

HCW distress may persist for years after the acute phase of an infectious outbreak [6]. Providing consistent psychosocial support, delivering clear information to staff, conducting regular reviews of work conditions and care commitments, and emphasizing the altruism of health care are recommended strategies to support wellness [7,11–13]. Support should be responsive to individuals and local environments, and ideally, mental health professionals should be involved in program design and delivery [13–15]. Using mental health professionals to provide psychoeducation ensures concepts are correctly conveyed, and their therapeutic training provides them with skills help frontline HCWs manage stressors. When mental health professionals are embedded within the clinical context, the likelihood of staff accessing additional support when needed is increased [11].

HCWs vary in demographics, professional training, and life circumstances. Exploring these differences can help to focus support. For

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example, stress impacts from working during the COVID-19 pandemic may be greater in HCWs who self-identify as women, those who have elders or children to care for, or those who work with acutely ill COVID-19 patients [11–13]. HCWs with more work experience, and those who received training and support in managing stress (including attending to basic self-care) may show greater resilience [16–18].

### 1.2. Conceptualizing resilience and burnout

Resilience can be defined in different ways; a core component is a person's ability to cope with adversity and carry on with facets of their lives [19]. The most effective interventions to support resilience tend to focus on bolstering a sense of personal control, coping skills, and access to psychosocial resources [20]. Folkman and Greer [21] describe a sequential approach to coping: Problem-focused, emotion-focused and meaning-focused coping. An important aspect of resilience may also be fostering a supportive workplace environment [22].

In occupational settings, burnout - a response to occupational chronic stress, characterized by emotional exhaustion, depersonalization and diminished professional achievement - is a threat to resilience [23,24]. One framework for understanding burnout highlights three facets that protect workers from burnout: Control, Competence and Connection – the 3 Cs [25]. *Control* considers one's autonomy (the ability to self-govern) - to control schedules and do work in a way that makes sense for the individual. *Competence* is a sense of being skilled or well-trained, and proficient at work. *Connectedness* is a feeling of belonging and relating to other people at work, as well as the larger aim of the organization.

### 1.3. Examples of staff support programs

Many support programs for HCWs have been described. Though they differ and may not be universally transferrable, some commonalities exist [4]: the involvement of mental health professionals and having flexible support mechanisms. A modular program developed by consultation-liaison psychiatrists in France featured a telephone hotline, onsite relaxation rooms, and a mobile team to visit staff experiencing difficulties [26]. "Battle Buddies," a program implemented in Minnesota, highlights the value of pairing staff to provide immediate, on-the-ground support. In addition to the peer support, areas of the hospital strongly affected by COVID-19 were also assigned a mental health consultant, who attended meetings, helped staff plan responses to change, and assisted in obtaining clinical assistance when needed [27]. A program called "CREATE," developed at an academic cancer hospital in Toronto, paired psychosocial coaches with unit managers to deliver adaptive support. In this model, coaches with interdisciplinary backgrounds work to address emotional needs of the team, promote calming, provide resources and assistance to advocacy where appropriate, and facilitate working through the Folkman and Greer model of coping [28]. Other examples of support programs include mobile applications with guided resources, online courses, and the creation of a dedicated research center that offers ongoing, multifaceted support [29–32].

## 2. Methods

### 2.1. Setting

Sinai Health is a multi-site facility in Toronto, Canada, comprising Mount Sinai Hospital, and Hennick Bridgepoint Hospital, as well as the Lunenfeld-Tanenbaum Research Institute, and community clinics. Resilience Coaching was developed and offered to groups of staff at Mount Sinai Hospital and Hennick Bridgepoint Hospital.

### 2.2. Resilience coaching description

This Resilience Coaching model draws from principles of

consultation-liaison (C/L) psychiatry, including the importance of working closely with medical and surgical teams in providing patient care to complex patients. In contrast to C/L psychiatry, the focus of support is the team, rather than the patient or family.

Although coaches are mental health clinicians, Resilience Coaching is distinct from clinical care. Coaches apply skills and training in psychotherapy to provide support to colleagues [5]. While most coaches are psychiatrists, the group here also includes a bioethicist, mental health nurses, and a social worker. In general, coaches try to provide support to a team with whom they had a pre-existing relationship when possible. Where no prior relationship existed, coaches work to rapidly establish a relationship by providing a consistent and supportive presence. Coaches provide dynamic support and are responsive to the group's needs (i.e. leading a mindfulness activity or discussing a challenge faced by the unit). Coaches lead unstructured sessions where staff explore feelings and provide mutual support; this promotes group cohesiveness. Coaches also facilitate access to clinical care for staff when appropriate; for privacy reasons, data is not kept about these facilitations. Coaches were oriented to the key model and principles of Resilience Coaching, and the program was launched and refined iteratively based on this model. Although there is no formal training program or manual, Resilience Coaches meet regularly to support one another, share best practices and identify priorities or areas of need.

### 2.3. Resilience coaching locations

Resilience Coaching began at Sinai Health in April 2020 and remains ongoing. Initially, the intervention focused mostly on clinical staff in frontline areas, including: Emergency Department, ICU, NICU, Labor and Delivery, Palliative Care, Anesthesia, Family Health, Infection Prevention and Control, and General Internal Medicine Units. As the pandemic evolved, coaches expanded support to non-clinical teams, such as security and program administrators. Coaching was both offered directly and available on request. Requests corresponded with community infection rates, and other stressors such as government-mandated restrictions or school closures.

### 2.4. Qualitative inquiry

In October 2020, a qualitative inquiry was undertaken to explore the experience of receiving Resilience Coaching. Qualitative interviews were conducted with 24 staff who had access to the intervention. There was no standard exposure for this study. A control group was not used in this study; in the face of limited time and human resources for research, the team chose to focus on collecting narratives about Resilience Coaching itself. The study was approved by the Mount Sinai Hospital Research Ethics Board.

Participants were recruited via email invitation, from a range of disciplines and units across the hospital that had an affiliated coach. Interview participants were identified to achieve a maximum variation of participants across the units being coached. Hour-long, semi-structured interviews were recorded using the hospital's virtual meeting software. The interviewer asked questions about demographics and work history, work life before and during the COVID-19 pandemic, experiences with coaching, home-life during the COVID-19 pandemic, and whether and how Resilience Coaching should continue or should be promoted. The interviewer was responsive and allowed for organic discussions. Interviews were professionally transcribed, edited for clarity, and analyzed for themes by the team.

### 2.5. Data collection and analysis

Data collection and thematic analysis were conducted concurrently [33,34]. The research team comprised a mixture of coaches and researchers with expertise in health services (LJ) and education (HR). (HR) conducted all interviews. After each interview, (HR) identified

themes and noted questions to discuss with the larger group. (HR) reported weekly to the research team, and adjusted topics in accordance with emerging themes in coaching discussions, and the evolving pandemic. Interview collection was completed when saturation of themes had been reached. A group of researchers (BR MP LJ HR) coded a subgroup of transcripts to establish a working codebook. (HR) coded the remaining transcripts. To reduce coding bias, emergent themes were regularly discussed among the following researchers (BR MP LJ RM DC RG) [33,34].

### 3. Results

#### 3.1. Participant description

Study participants included 4 physicians (17%), 10 nurses (42%), 8 allied health professionals (33%) and 2 other staff (8%). There were 4 participants who identified as male (17%) and 20 who identified as female (83%). The majority of participants (8 [38%]) were between the ages of 30–39; the full age span of participants ranged from 20–29 to 60–69 years old.

In the following sections, quotes from participants are labelled based on their occupation category: “N” are nurses, “MD” are physicians, “AH” are allied health professionals (other clinical staff, such as social workers and pharmacists), “OS” are other staff (includes non-clinical hospital staff, such as entry screeners and research staff). Numbers that follow the label refer to the order in which a participant’s quotation appears in the paper.

#### 3.2. Interview themes

Participant interviews revealed information about their experiences with Resilience Coaching. Four main themes were identified:

- A) Resilience Coaching fosters connection
  - B) Resilience Coaching encourages attending to wellness during the workday
  - C) Resilience Coaching facilitates workplace learning about maintaining wellbeing
  - D) Resilience Coaching can help HCWs access additional mental health support
- A) Resilience Coaching fosters connection

Numerous participants reflected on challenges talking to family and friends about their experiences of working during the COVID-19 pandemic. One participant noted friends could not “hear those kinds of conversations,” and the participant instead felt they needed to discuss “non-nursing, lighthearted things” with friends (N1). Another noted avoiding conversations with a loved one because, “I don’t want her to worry that I’m not in a good emotional space, but I also don’t want to tell her what I’m seeing...” (AH1). Another shared social isolation from usual supports made them appreciate Resilience Coaching: “...for me personally, my husband or my friends don’t get it in the same way that the people that I work with every day get it. So, it’s nice to speak to people who are in the same boat as you...” (AH2). Resilience Coaching was often described as a place where staff found it was helpful to talk about shared experience. This helped foster trust and connection with colleagues and the coach.

Participants also reflected on how certain work relationships strengthened during the pandemic. One participant, who volunteered for redeployment to another clinical setting, commented: “We have to be like-minded people to decide to go into the fire willingly.... So...we’re bonding in that way, and it feels good to have that support group...” (N1). Another reflected, “I feel like in the hospital, [there is] a lot of unity, and people dropping everything...just, ‘I’m here to help.’... as sad as it is, you know, everybody is really trying.” (OS1).

- B) Resilience Coaching encourages attending to wellness during the workday

During the interviews, participants described various threats to their wellness, including: access to and quality of personal protective equipment, fear of transmitting infection to family, anticipation of waves of infection, and uncertainty about the future of their home and work lives. One participant described fear exposure to COVID-19 at work and shifted their role as a result: “...I was very, very nervous...I definitely took the next opportunity to get off that unit...I was terrified for my own health” (AH3). More than half of participants predicted after the acute phase of the pandemic, either themselves or their colleagues would experience a decline in mental health. One described being in “flight or fight” and that they expected “a crashing phase” would be coming (N1). Another described colleagues as “hanging on by a thread,” and that they were “going to explode” (N2).

Participants consistently described Resilience Coaching as a forum to process these issues. Coaching offered a safe space where participants could acknowledge emotions, decompress, or brainstorm: “That space with the Resiliency Coach in my experience actually became a space to problem solve and feel that sense of agency for how you can effect change...” (AH4). Participants appreciated coaches’ ability to create a safe space: “The Resilience Coach...brings a very calm energy to the space, it feels extremely safe, it really does feel like you could say anything and that you wouldn’t have to be worried” (AH5). Another described how Resilience Coaching influenced their mood, and made them feel more able to hold work-life balance: “it can...help you to recognize that there’s more to life than just work, that there’s other things that we need to focus on” (N3).

Even though Resilience Coaching emerged from the Department of Psychiatry rather than from hospital leadership per se, coaches were often perceived as agents of the hospital in a positive way. One participant noted that Resilience Coaching felt: “...like an acknowledgement” from the organization, “that this has been very difficult for us and it’s been valuable to be able to share our experiences...” (AH2). This translated to feeling cared for by the organization. This participant described feeling relief when coaching began: “...the fact that he came made me realize that the hospital is going to support us through this...I personally had a sigh of relief...because I wouldn’t have to be the only one trying to help my team...” (AH1).

Many Resilience Coaches, given their clinical connection to the units where they work, were largely able to maintain a presence in affected units during outbreaks of COVID-19. One participant reflected on sessions during a COVID-19 outbreak, describing that, “it is really meaningful... being cared for in a time where we as healthcare workers...are so focused on caring for others...” (AH4).

- C) Resilience Coaching facilitates workplace learning about maintaining wellbeing

Several participants appreciated opportunities to learn about coping; learning ranged from acquisition of mindfulness and other stress-reduction skills to learning about their teams and the hospital. For some, learning practical coping skills was most valued, such as this participant who described a breathing exercise important to them: “I find myself really using that a lot...when I notice I’m, like, I can feel kind of my heartrate going and I feel periods of stress...that has been very useful.” (N1). Another recalled a lanyard card with relaxation tips that was made by their coach: “[my coach] made these cards available, and the uptake of that card was immediate, which to me was a sign that people...[are] trying to find ways to do even better” (OS1).

For others, learning about expected reactions to psychological stress was useful. One participant noted coaching support provided after a crisis was beneficial, “...that first meeting was really helpful because [the coach] talked about...everybody is going to feel differently...you might be in shock right now...you might not sleep well tonight...I didn’t

sleep that night and I was like...OK, at least I know this is normal” (OS2).

Another participant expressed that for them, Resilience Coaching was helpful because it provided “transparency with respect to information...questions that could be asked and information that was available” (N2). Another noted they learned ways to frame issues “in a way that could be beneficial to bring to management” from their coach, which made the staff team “feel advocated for” (AH5). Finally, one participant, who holds a senior position, noted sessions were a place to learn about their team: “I didn’t realize...how much personal stress people were in, away from work...I was very glad to hear how supported they feel at work. And I didn’t realize what some of them were going through in their personal lives” (MD1).

D) Resilience Coaching can help HCWs access additional mental health support.

Several participants noted the presence of coaches helped facilitate access to clinical mental health support when needed. This participant commented they would not have sought clinical support without their coach: “having that – the face and the name and knowing that door is open, and sometimes you need to hear several times...‘my email’ on the board, reach out if you guys need anything, if you want to talk one on one,...So, yeah, just their presence was helpful for me to reach out” (N4). This participant, noted “it makes a huge difference to know that...we can have a general conversation, but if something is really hurting you hard, you can reach out...” (N1).

Several participants described appreciating that support took place directly on the unit where they worked, from a coach they knew well: “...with our coaches it’s almost like peer support...for me personally...I could be myself more and not have to watch what I say” (AH2). Another participant also described that they preferred support in the unit because there was “an added layer of... relationship and trust” (AH3).

## 4. Discussion

### 4.1. General discussion

The Resilience Coaching model was developed in response to the urgent need to support HCW wellbeing. It was informed by research, departmental values and our team’s experience supporting colleagues during previous outbreaks of infectious disease [5–10]. Overall, participants indicated they were receptive to and appreciate of offerings of collegial support from the Resilience Coaches.

The results from this inquiry indicate the Resilience Coaching model aligns with principles described in literature about factors that promote resilience. With respect to Folkman and Greer’s model of coping [21], staff reported greatest benefits in emotion and meaning-based coping. Participants described sessions as a safe place to regulate emotions, which resulted in feeling less alone; additionally, participants acknowledged emotional shifts towards being able to maintain work-life balance. Participants also described coaching as a safe, supportive environment, which is known to facilitate resilience [22].

Themes emerged about how coaching fostered connectedness and solidarity. The 3C’s of burnout demonstrates the importance of this in the *Connection* facet [25]. The interview data showed that shared experience of working in healthcare during the pandemic helped to facilitate connection between participants and coaches. This sense of *Connection* was bolstered by the perception that hospital leadership cared about their wellness and resilience. Research has shown leadership support is a key factor in avoiding burnout [35]. This project also illustrates how familiarity and consistency between coaches and HCWs can contribute to a well-received support program. Study participants acknowledged that Resilience Coaching facilitated access to mental health resources that might otherwise not have been sought.

While Resilience Coaching was well-received overall, it is important to note that Resilience Coaching cannot overcome systemic and societal

stressors (i.e. staffing shortages, or governmental response to pandemic management). Ideally staff resilience support occurs alongside material and operational support. Hospital leadership at our institution have championed Resilience Coaching as part of a comprehensive staff support approach, though it continues to be run by the Psychiatry Department. It is also worth noting that this intervention took place at a particular hospital in Toronto, Canada, where the Department of Psychiatry had experience providing collegial support during the SARS and H1N1 epidemics. This likely lent credibility to coaches when they offered support. Given that the Resilience Coaching model leveraged both relationships and mental health training, we cannot decouple these to know the relative contributions of credible colleagues vs key resilience principles. Therefore, future research could explore if this model is translatable to other contexts, like rural hospitals, long-term care facilities, or non-healthcare sectors, such as education. It would be especially important to explore what minimum mental health background would suffice to support Resilience Coaching.

### 4.2. Limitations – Research sample and analysis

The information in this study represents participant experience from year one of the COVID-19 pandemic in this region. The interviews were completed by the middle of May 2021. It remains unknown how subsequent waves of the pandemic influenced participants’ perception of Resilience Coaching. Due to ongoing demand, coaching efforts are ongoing. An important question for future studies may be how to determine whether and when the intervention reaches an acceptable endpoint.

Additionally, there was less participation from staff who identify as male, and as physicians (compared to nurses and allied health). Further research is needed to explore whether these factors are of significance. Further cross-sectional analysis of our data will reveal the degree to which Resilience Coaching was helpful for specific subpopulations of HCWs who are more or less prone to resilience. Another possible avenue for research would be comparative analyses between the experiences of staff who participated in Resilience Coaching and staff who chose not to access the intervention.

Lastly, the majority of the research team are practicing coaches (except for LJ and HR). While there may be possibilities of bias, we believe the embedded status of the researchers enriches it through increased understanding of context and process. It is also methodologically harmonious with the goals of Resilience Coaching, which prioritizes connection. The presence of non-coaches (LJ) (health services) and (HR) (education) on the team adds an objective perspective, as discussions regularly required clarification of concepts.

### 4.3. Significance of research

Resilience Coaching is not unique in its provision of support for HCWs during this time. Worldwide, there are programs reported that range from peer-support to the development of smart phone apps [11,14,26–32]. These services answered global calls to action, issued at the start of the pandemic [2,3], where the immense challenge and risk of HCWs’ burnout being amplified by the COVID-19 pandemic was highlighted.

Where this paper adds to ongoing discussions is in highlighting voices of participants who experienced the intervention. This paper sits within a growing body of qualitative literature on working during the COVID-19 pandemic [12,13,15] that emphasizes the lived experiences of HCWs in their own words. A theme from our research is some HCWs find it difficult to communicate realities of their lives, creating barriers to accessing support, and potentially development of successful interventions [36]. Therefore, we believe a key element of research in this area is to highlight voices of HCWs’ to facilitate understanding, and better support.

## 5. Conclusions

Resilience Coaching is a support program that has been well-received by staff during the COVID-19 pandemic. Analysis is ongoing with a focus on how to understand and support staff who did not readily access available coaching and how to translate Resilience Coaching to other contexts.

## CRedit authorship contribution statement

**Benjamin Rosen:** Conceptualization, Formal analysis, Writing – review & editing, Supervision, Project administration, Funding acquisition. **Mary Preisman:** Conceptualization, Formal analysis, Writing – review & editing, Supervision, Funding acquisition. **Heather Read:** Methodology, Formal analysis, Investigation, Data curation, Writing – original draft, Writing – review & editing, Project administration. **Deanna Chaukos:** Formal analysis, Writing – review & editing. **Rebecca A. Greenberg:** Formal analysis, Writing – review & editing. **Lianne Jeffs:** Conceptualization, Methodology, Writing – review & editing, Supervision, Funding acquisition. **Robert Maunder:** Conceptualization, Methodology, Writing – review & editing, Supervision, Funding acquisition. **Lesley Wiesenfeld:** Conceptualization, Writing – review & editing, Supervision, Funding acquisition.

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