Promoting our Colleagues' Wellbeing: Group Work during the Covid Pandemic[1]

Promover el bienestar de nuestros colegas: Trabajo en grupo durante la pandemia

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As a Canadian, I want to make special note and express appreciation today that right now in Canada, Pope Francis is on a mission of reconciliation and repair with the Canadian indigenous communities, who have been harmed and traumatized by the Canadian residential school system. His visit is the opportunity for great healing.

LEARNING OBJECTIVES

What I will be talking about with you today relates to work that has been important to me going back to SARS and that has accelerated in its importance over the last two and a half years. I gave an early version of this talk at an IAGP meeting in Thessaloniki about three years ago, just before the pandemic. It was based upon past experience and theory. I am going to be talking with you now about the actual experience, at micro and macro levels of interventions providing frontline care workers with support in the face of COVID. I will also discuss my work in leading *Leading for Wellness* communities of practice (COP) for senior healthcare leaders across the province of Ontario.
Our learning objectives are to talk about the Covid pandemic as a traumatic stressor; describe principles of support from the group perspective for our colleagues and trainees experiencing stress and trauma; detail learnings from *Leading for Wellness* group for health care leaders. We are going to talk about PPE - not personal protective equipment but personal psychological protective equipment and how group therapy plays an important role in supporting wellbeing. Finally, I will address how we can help implement interventions that bolster organizational culture, workplace safety and reduce colleagues' burnout. We, in mental health, have an enormous opportunity now to play a role both in the treatment and management of the stress and hopefully the prevention of future distress. I will outline for you why this has never been more important.

Let me share with you an email sent to me by a woman colleague. She is the director of education in a training program at University of Toronto. University of Toronto Faculty of Medicine is one of the largest in the world. This woman is in charge of the training of hundreds of residents annually, and she wrote to me, "The leadership, community of practice has been incredibly helpful. It's not an interpersonal therapy group per se, but the universalization of experience is powerful: the sense that you are not alone in struggling with difficult issues while being expected to master them. As for so many things we cannot change and we must learn to accept, having someone validate and bear witness to our distress or suffering is a powerful medication for the grief, anxiety and upset that is an inherent part of the human condition and accentuated during Covid." Those concepts and principles resonated throughout the work I will detail.[2] Let me go into greater detail.

COVID CRISIS

The Covid crisis has really overwhelmed us. But I suggest that it is both a danger and opportunity. We are embedded in the larger social context and the political aspects of Covid also influence the psychological dimensions of people's experiences (Marmarosh

1 I am very glad to be at this IAGP conference in Italy. I appreciate the invitation by my friend and colleague Richard Beck and the efforts of Prof. Kaoru Nishimura in bringing my presentation to publication.

2 By way of disclosures, I receive book royalties from Norton books and Hachette books for publications).

et al, 2020). It is safe to say that there has never been a time when nurses, physicians, health care workers (HCWs), and hospital service workers have experienced so much significant and enduring psychological distress. Distress is exacerbated by soaring levels of moral distress and moral injury as the pandemic has forced people to violate the normal professional behavioral and ethical codes of conduct as HCWs, because of the systemic obstruction to desired actions and emotions (Williamson et al., 2020). People are experiencing high levels of acute risk from patients literally dying in the ICU saying "Don't tell me I have Covid"; overwhelming demands of health care, stigma and guilt. The kind of losses that healthcare workers have witnessed first-hand is unprecedented: many nurses and doctors I have spoken with said they have lost more patients under their care in two months than in twenty years (Maunder et al., 2003; Lai et al., 2020; Wu et al., 2020; Leszcz et al., 2020; Honarmand et al., 2022).

The good news is that mental health awareness has never been more prominent, and we have an opportunity regarding how we can identify principles to help implementation with the aim of preventing and reducing excess distress generated by the pandemic.

HUMAN CAPITAL

The first principle is the importance of human capital. It is a chief resource in health care and it has been neglected and untended to for too long. The Institute of Health Care and Innovation has identified HCW wellness as its fourth aim. The three health care aims that we have all identified with before are lower cost, better outcomes, and, better patient experience. Now added to that, is the concept of better provider experiences (Bodenheimer & Sinsky, 2014). We need to build and maintain social connections with our staff, ideally in advance of crises, and seize the opportunity now to consolidate these kinds of connections. In my hospital, since SARS, we have had mental health embedded in every program, in the emergency room, in the ICU, in obstetrics, in surgery, in medicine, even pharmacy, with the result that when there is a crisis, like Covid, we have a preexisting relationship that we can fall back on for support of our colleagues with coaching and resilience training. We need this kind of deliberate focus on our staff. Although some health care workers are stigmatized by their need for mental health care, simple interventions can help reduce their anxiety and apprehension. For example, a video about stigma, mental health, stress and Covid changed nurses' reactions dramatically and increased their willingness to participate in these resilience building interventions (Amsalem et al 2021).

CONNECTION

At the heart of what we do and part of what I am going to outline are all the areas in which we, through our psychological knowledge and expertise, can make a difference. In the same way, if this was a talk about group therapy for patients with breast cancer, I would encourage you to learn much about breast cancer, and its treatment, and psychological adaptations and dealing with existential crisis. Dealing with Covid and its impact on health care workers requires the same level of attention to detail, as noted earlier.

The second important principle relates to the concept of connection. Connection offsets the social isolation that Covid has generated. We know the value of social integration. Group therapists know this better than anyone. Many hospitals have had good success with establishing formal and informal peer support groups using drop-in opportunities where people could come and get food, meet with peer counselors, someone just to talk to, ventilate and debrief. Group support is incredibly valuable (Gerada, 2018; Southwick et al., 2020; Albott et al., 2020).

You are familiar, with Judith Herman's quote: "The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience" (Herman, 1997). Building strong group connections is essential. Related to this is the essential value of *Socialized Leadership*, a term from Mikulnicer and Shaver - leadership that is intended to create for the members of that unit, team, military unit, or organization, a sense of a secure base, a safe haven with predictable responsiveness and validation (Mikulnicer & Shaver, 2017; Mahon & Leszcz, 2017; Leszcz, 2017; Park et al., 2020). That's the kind of leaders we need, and I think we can help cultivate this through development of these kinds of COPs. I use the term COP and I should probably explain. When I was asked to create an intervention to help health care leaders, largely vice presidents of hospitals, chief executive officers, and chairs of university departments, I was advised that if I called it a "group", people would not come to it because of stigma around the idea of group therapy. But if we called our work, a community of practice, that would be a way around that potential barrier. Though it would function as a group, we would emphasize that we are all colleagues, working together, pointing in a similar direction to make things better for our staff, our trainees and our colleagues.

CONFIDENCE AND TRUST

A related important principle is the development and maintenance of HCWS' confidence and trust in their organization (Costa 2003). There are three elements associated with trust and organizations: Are my leaders competent? Are they benevolent? Do they operate with integrity? You should filter all your decisions through that lens (CMA, 2020). These things come into play when we are dealing with issues such as vaccine access equity and distribution, redeployment equity, or the role of race, gender and power dynamics. We know that some people in our systems get advantaged and others get disadvantaged. Race and gender play a huge role. We want to create a safe environment for difficult dialogues around these tension points. That requires the attention to cultural humility, cultural opportunity and cultural comfort. We welcome the opportunity to learn more about unique experiences people have in the face of adversity that we are all facing and in the adversity they may be facing that are related to discrimination around race and gender (Sue et al, 2019; Adler & Bhattacharya, 2021).

COMMUNICATION

We spent a lot of time in the communities of practice talking about the role of communication. Clarity, consistency, transparency, timeliness, relevance, recognizing that every communication you send out as CEO, as VP or chair or team leader, is of value to your members and will also be absorbed by their families. It's been a kind of mythology that leaders need to be opaque and show that they are strong and invulnerable. What Covid has shown us is that leader opacity invites regression and projection and that the more transparent we can be around the rationale of our decision making, the more effective we will be. Our communication needs to be mentalization-informed. We need to understand not only our intention, but our impact (Yalom & Leszcz, 2020). And the great value in helping people understand what traumatic stress feels like, what it looks like, what the symptoms of it are.

Two examples from the communities of practice of health care leaders: A colleague who recently became the CEO of her hospital shared in her community of practice an experience that she had with her first public address to her hospital. It was a town hall meeting. Some people were present in person and some by zoom. Early on in the talk, she began to talk about how grateful she was for the many sacrifices health care workers in her hospital made to provide care during Covid. She became quite emotional and started to tear up. She felt embarrassed. She talked in the community of practice how she quickly wanted to shift away from that level of emotionality only to find out afterwards that her colleagues told her that that was the most powerful part of her talk. It is important for the frontline staff to know that what they do matters to leadership - that it is seen, recognized and acknowledged. Another CEO, claimed that she had trouble understanding what traumatic symptomatology felt like. She had heard about it from the nurses and doctors working in her hospital. But then she had the experience of being robbed when she was in a parking lot. Somebody grabbed her purse and threw her down to the ground. She said now I understand what trauma is, and the importance of understanding traumatic stress and symptomatology. It increased her empathic attunement dramatically.

CONFLICT

We have to expect in this environment that conflicts are going to be more prominent because systems, units, teams and individuals are going to regress. It has been being incredibly instructive to teach about interpersonal communication in the COPs. We talked a lot that under stress there will be a loss of reflective function and staff are going to respond with heightened reactivity. Things are going to be looked at in a more polarized fashion; and fault lines that are historical are going to explode because of the regression. We talked about aiming for assertive and affiliative interpersonal communication rather than joining in an interpersonal maladaptive loop, responding to a hostile attack, either with another hostile attack, or by submission (Yalom & Leszcz, 2020). Finding a third path that allows one to affiliate and assert is essential.

We focused on recognizing the value of the dissonant voice and not excluding the person who is giving you the hardest time in your team, because that person may be expressing an important truth shared by many others. An expression that I use a lot in dealing with conflicts, is helping people fight fire with water and not to fight fire with fire. The importance of recognizing that as a leader everyone is going to watch what you say and watch what you do. For example, when the head of the department of surgery is attacked by a member of his team in front of the rest of the team and residents, saying "You are not fair. You haven't given me back my operating time. My patients are dying and need care," the attacked leader must find a way of responding that validates and does not attack the person who is attacking. These are common principles in mental health work, but they are less common for people who do not have a mental health background and they are more important than ever in the midst of the Covid pandemic.

CARING AND CREATIVE RESPONSIVENESS

We need to create a caring and creative response to all of our staff. Steven Shanafelt wrote a beautiful article early on in the pandemic that "health care workers in the frontline have five needs: Hear me, protect me, prepare me with resources and equipment, support me and care for me" (Shanafelt et al., 2020). If you were asked to get these answers correct on a multiple-choice exam, everyone would get these answers right. But the issue is how do you implement that responsiveness. How do you use this to operationalize your care and responses. That brings us into the concept of wellness-centered leadership (Shanafelt et al., 2021). Everything that you do must go through these filters: "hear me, protect me, prepare me, support me, care for me". Destigmatize vulnerability and provide access to support (Galbraith et al., 2021). Recognize that nurses are particularly at risk. A recent study showed that 2/3 of nurses in North America, I doubt that it is different in Europe, South America or Middle East, want to leave their field. Twenty-five percent of nurses have reported being assaulted at work in the last couple of years (Maunder, 2021). It's not sustainable. You cannot run a hospital without staff.

GROUP LEADERSHIP

The *Leading for Wellness* COP groups are guided by core group therapy principles and I think it's been very, very helpful that I am a group therapist by training. That training helps to promote a cohesive, safe and brave space where we manage conflict.

I am able to judiciously use the here and now to illuminate the value of engagement and transparency about vulnerability. It used to be that heads of the hospitals or the heads of the programs would say, "I am working 75 hours a week" or a head of the department of psychiatry might say, "I was working on a paper last night until 2 am and I am in the clinic this morning at 7 am," as though our capacity to not have limits was a strength. We are recognizing now that leadership that cultivates that kind of expectation is destructive and that our staff value, humanity and vulnerability. Leaders won't always have the answers but should always signal their commitment to trying collaboratively to find the best answers to difficult problems with our colleagues.

GROUP INTERVENTIONS

Building cohesive and supportive staff groups, that normalize vulnerability and depathologize anxiety and psychological distress is essential (Gerada, 2016). Group and peer support promote an organizational response that reduces isolation and that reduces shame. It helps people make sense of collective trauma and injuries to their professionalism and promotes both reflection and a sense of agency (Resnick and Fins, 2021).

I've been talking about the COP, but I want to also talk about front line group interventions that also have enormous value. Over many years, I have been asked to intervene in my hospital, in different departments because of a range of Covid-related issues and before Covid, other trauma-related issues. I find Steven Hobfoll's five-factor model to be very useful (Hobfoll et al 2007). In the same way that a good psychoanalyst does excellent supportive psychotherapy by using their analytical skills to know what to go after and what not to go after, a group therapist can provide support to a traumatized team or a traumatized unit by paying attention to these principles. 1. Focus on **Safety**: It is important to restore a sense of safety in the context of a crisis. Limit harm, accept reality, recognize the ongoing threat, do not pathologize people's anxiety. 2. Find a way to introduce some **Calming** maneuvers, calming interventions -listen, validate, attune, calming exercises, mindfulness, deep breathing. A book that I have recommended many times in the last year is a book by James Nestor called "Breath". It's a terrific book that looks at how breathing puts a kind of brake on the negative intensity we can be feeling in other circumstances. 3. **Restore a Sense of Self/Team Efficacy**: Address cohesion and team integrity, build on the strength on the unit, find ways to repair regression that may have occurred, talk about coping strategies as a way of helping arm staff with resources. 4. **Promote Connection**: Foster connection, replenish old ties and employ principles of socialized leadership as mentioned earlier; make it safe to engage. 5. **Promote Hope**: not in some kind of naive or unrealistic fashion, but in a way that re-moralizes for the moment, and helps people move forward.

It is important to actualize people's willingness to change and willingness to manage as a way to feel that they can regain some power. This is not critical incident debriefing, which is emotionally activating and may be retraumatizing. A couple of months ago I was approached by a psychologist in Toronto, whose son is a member of the American Group Psychotherapy Association and who knows me. She called me and asked me if I would be willing to meet with her patient who was a pediatric dentist. In this dentist's office, 17 staff suffered a traumatic event in the office. A 7-year-old girl bled to death after a tooth extraction. They were, as you can understand, traumatized with all of the classic symptoms of intrusiveness, avoidance, reexperiencing, hypervigilance, dysregulation. They couldn't work. I actually arranged to meet with them the next day because

it is important to intervene urgently when you are invited to intervene. We began a process of meeting twice over about three hours to help restore a sense of safety; help restore a sense of some calming, remind them of the good work that they do; restore a connection because part of the traumatic response was no one wanted have anything to do with anybody else - no one even wanted to go into that part of the dental office; restore a sense of hope and help them with their grieving process and help them to help the family who lost the child with the grieving process.

CONFIDENTIALITY

In all of the group work I do with the health care workers within a hospital setting, I operate with the principle of protecting individual confidentiality, but always securing consent to utilize themes so that I can maximize my impact as an advocate within the organization (Leszcz, 2020).

COPING STRATEGIES

We spent time in these frontline groups talking about coping strategies and employing a model that people who work in the medical field will be familiar with. First developed by Folkman & Greer (2000). It is a tri-partite model of coping that emphasizes emotion-based, problem-based, and meaning-based coping, it is an accessible model and making something that is implicit more explicit gives people more reliable access to it so that they can employ it constructively. With the COP groups, we employ these principles, and also, I provided a set of curated reading about leadership.

What are the three coping strategies (Leszcz & Goodwin, 1998; Folkman and Greer, 2000; Yalom & Leszcz, 2020)? "Emotion-focused coping", which focuses on the value of social support: Not being alone, reducing isolation which has been so powerful during Covid. Ventilation, the importance of talking; expressing emotions; accepting and normalizing vulnerability rather than denying emotional impact; addressing hazards of tentative communication which can paralyze a team, a unit, an organization.
The second set of principles relates to "Problem-focused coping." Here, we address issues around self-care, regulating overwork, the value of exercise and diet, avoiding substance use, relaxation, mindfulness and sleep. Sleep is the best protector against traumatic stress in health care workers and it is the most vulnerable because of the way in which we run hospitals with 12-hour shifts. I recently treated a nurse who was referred to me because of burnout who worked a 12-hour shift. She never finished in 12 hours and it took her an extra hour to finish at the end of the day. It meant being in the ICU from 7:30 in the morning until 8:30 at night. She didn't have a car. She had to use public transit which added 2 hours of travel in the morning and 2 hours of travel in the evening. It was no wonder that she broke down.
We have to redefine professionalism as recognizing limits and the need to ask for additional resources. Hospitals have to do something about shifts. They have to shorten the shifts and simplify tasks. It is very helpful to provide education about moral injury, moral distress and trauma (Sheather & Fidler 2021). A nurse reported to me that she thought that she was losing her mind because she had a dream about intubating her best friend, a colleague at work. This was her working through the experience of how closely identified she and her colleagues are to their patients. Covid has eliminated that boundary because anybody could be a Covid patient tomorrow. Allied problem -focused coping include advocacy both in the hospital and in the public as noted before; and helping people with interpersonal communication strategies to avoid avoidable injuries and abuse. Mindfulness and meditation have never been more important.
The third form of coping that is useful relates to finding meaning. The purpose-base of our work: "Meaning-focused coping." Why do we do the work? Nietzsche (1968) noted that if we understand the "why," we will find out the "how." It is important to always honor the integrity and dignity of the work we do, as we marshal resources while maintaining self-care, recognizing that post-traumatic growth is possible as well for many people.

CULTURE

Honoring, validation and attunement are essential. This shifts us now to talk about culture. We want to have hospital cultures that are congruent, that respect for the patients is shaped by the respect for the staff and it runs up and down the organization, from top to bottom. There is some nice research that shows the healthiest organizations are ones where there is an alignment between the values of frontline staff and the values of administration (Shanafelt, Wang et al 2021). When Covid first broke out, and I was facilitating groups with American health care workers, I often had experiences of nurses saying they did not want to let me know where they were working. They were afraid that if their boss found out they were participating in a group like this and protesting the work conditions, they would be fired. What misalignment of values and principles!! Culture is critically important. Organizational psychologists have this great phrase which I love, which is "culture eats strategy for breakfast daily."

We need cultures that model transparency to reduce projections and normalize vulnerability and reduce

feelings of shame. As I mentioned, socialized leadership is such a critical concept. As mental health professionals, we know this and we need to help our non-mental health colleagues understand the values of attunement and emotional validation, as serving a neurobiological regulatory function (Siegel 2012). We all know the toxic impact of not being seen.

WORKPLACE PSYCHOLOGICAL SAFETY

Psychological safety, and our commitment to psychological safety, means that we make every practical effort to avoid reasonably foreseeable injury to the mental health of our colleagues and employees (Shain 2010).

We can think of psychological safety as the result of an equation. On the left side of the equation, we have the individual's sense of control, and how that person is being rewarded. And on the right side of the equation, we have what is the demand that is being placed upon this person and what is the effort that person has to put out. If you want to create a psychologically unsafe environment, reduce people's control, diminish their reward, increase the demand and increase the effort. You have the recipe for burnout and a recipe for people to abandon the field. This is important for many reasons. It is ethical. In Canada, we have a legislative imperative to provide a psychologically safe environment. There is a clinical imperative and an economic imperative as well. A psychologically safe environment is one in which your opinion is welcomed, constructive conflict is okay without shame or attack, and it is an environment that leaders help create by doing three things (Edmonson, 2019).

1. **Set the stage**: we share the expectations of safety, justice, underscoring the purpose of our work. When my colleague teared up, expressing gratitude to her staff in her first public address, she had set the stage for a psychologically safe environment.
2. **Invite participation**: Acknowledging the fact that you don't have all the answers and need others to be successful. Employ situational humility, noting your limitations, - "I don't know the answer to this. Maybe you do, maybe you could help me."
3) **Respond productively** without shame. Shame is a killer in this kind of environment. Credit effort, share recognition and reward.

In my hospital, we have made a big commitment to enhancing workplace psychological safety with a focus on reducing stigma related to race, mental illness, gender, and diversity. Every individual can be a champion of a healthier process. We have had a robust campaign which we call the ALLY campaign. All our staff are encouraged to be champions of a healthier process related to mental health issues, race, ethnocultural diversity, and LGBTQ status.

ORGANIZATIONAL CULTURE & CLINICAL OUTCOMES

Organizational culture has a huge impact on clinical outcomes (Falkenstrom et al., 2016; 2018). This is the part of the clinical and economical imperative I was referencing before. The culture of the organization influences what happens to frontline staff and for patients and may be contributing as much as 6% of the variance. To put that in perspective, therapists contribute 8% to the variance of good outcome in psychotherapy (Leszcz et al 2015). We are talking about a large impact on the variance of outcomes. Organizational culture relates to the shared norms, beliefs and expectations, shaped by the structure, by the leadership support, transparency and respect shown by our leaders. Organizational climate refers to the sense of psychological safety and security members of the organization experience. Recognize always the concept of isomorphy. What happens at one level of the organization gains an expression at every level of the organization. In other words, if you seek good patient care, create an environment where staff are looked after and feel validated and recognized. Better staff engagement improves the quality of clinical care significantly. In an environment where the quality of engagement by staff is low, high-quality care is reached only 20% of the time. When staff engagement is high, high-quality care is provided 67% of the time, a compelling finding published in HealthCare Quarterly (Lowe et al 2010).

COMPASSION FATIGUE AND BURNOUT

We must talk about compassion fatigue and burnout because these are big drivers of the stress that cause people to abandon our field. Burnout has three elements: exhaustion, a sense of futility, and a sense of distance or depersonalization which is not a psychoanalytic term but is a sense of "I just don't care." It is manifested in physical, emotional, cognitive elements (Maslach and Leiter 2016) Although it is experienced by individuals, it is a systemic and an organizational issue that amplifies and builds upon individuals' tendency to be perfectionistic, feeling of doubt, guilt and responsibility. Nearly 50% of physicians before Covid reported burnout (Hartzband & Groopman, 2020; Stapleton & Opipari, 2021). The figures now are all off the charts. Although it is true that prior mental illness or early life trauma are factors that contribute vulnerability to burnout, it is essential to not blame the victim. Burnout is an organizational malady. Burnout emerges when a health care worker lacks a sense of connection, lacks a sense of competence and lacks a sense of control (Hartzband & Groopman, 2020). Covid has generated that in an enormous quantity.

Redeployment has been a powerful contributor to burnout. Moving health care workers from one area where they know their colleagues, know their patients, and know what to do to another area where they do not have expertise, is a turbo charger for burnout. We need to be aware of these factors.

I would add that psychiatrists and mental health providers are particularly vulnerable to burnout because of the affective intensity of our work, the ongoing exposure to trauma, the limits of our skills and effectiveness, and the impact of patient suicides (Maslach & Leiter, 2016).

Burnout impacts individuals and our systems at three levels at least. At the personal level: it impacts by damaging relationships and by frank psychological distress. At the patient care level: it impacts with regard to less empathy, less patient satisfaction, poor communication. At the systemic level: it impacts by people leaving the workforce prematurely, high rates of attrition, early retirement, and absenteeism. It is much better to prevent burnout than to treat it. Again, we see the value of social connection, even the value of workplace civility. As I mentioned earlier, the more aligned the values of leadership is with frontline staff, the healthier the organization is going to be. Leadership matters: it needs to be cultivated and supported because it plays an essential role in HCWs' wellness (Stapleton & Opipari, 2021; Shanafelt, Trockel et al 2021).

HCWS AND INTERVENTIONS

There are a number of programs that have been employed. Every hospital teaches its staff how to manage hazardous material. I have never touched any hazardous material in decades as a psychiatrist. But what was more relevant to our staff is that they have training in psychological first aid (PFA) and how they could help and support one another without judgment, reduce isolation and provide some practical assistance. A whole host of programs launched just in the last couple of years, have been intended to help staff manage stress and enhance resilience. They involve elements we have been talking about this morning: peer support, validation, connection, mindfulness, resilience training, and ideally these are offered with a low barrier to access and broadly accessible (Rosen et al 2022; Robins et al 2022)

LEADING FOR WELLNESS COPS

I have some feedback from the *Leading for Wellness* COPs. I am now in my third COP and this will grow to 8 within the year. At this moment I have been involved with probably 35 people and this is feedback from the first two COPS. These were all experienced health care leaders, more than 70% of them have been in leadership for 11 years.

They reported the following:

- The COP was safe, supportive, engaging and promoted space for reflection and learning about coping and leadership skills (90%).
- There is an enormous value in sharing and learning from one another (90%).

Nearly two-thirds took away the following findings:

- They felt authorized now to advocate for wellness. These were legitimate with evidence informed approaches.
- They gained wellness and mental health literacy, language and skills to help promote wellbeing, and how to address "bad behavior" within the organization. In the feedback that I received, the phrase "Fighting fire with water, not fire" came up repeatedly.
- The final point is wellness initiatives promote and do not compete with the clinical and academic mission of the hospital. They enhance the academic and clinical mission of the hospital and university.

100% of the participants say that they would do this again.

CRISIS AND OPPORTUNITY

I am going to conclude with a few final thoughts:

- Don't waste this crisis: We should all aim to be better after. We need to move beyond resilience, which gets us back to where we were before. Let's promote post-traumatic growth in face of these existential confrontations (Taleb, 2012; Park et al., 2020; Brooks et al., 2020).
- There is good evidence that we can be better. A recent paper by Geertz et al. (2021) in JAMA [Journal of American Medical Association] talked about evidence-based consensus guidelines of planning for the future.
- Being better after: means greater mental health awareness, destigmatizing mental illness and personal vulnerability, committing to work-life balance, and enhancing interprofessionalism.
- And, creating an environment where social justice is the norm with regard to diversity, equity, and inclusion.
- We are gifted now with a unique opportunity to train the next generation of professionals.

In conclusion, what Covid has also taught us is that we are interconnected across the universe in every way and our emotional and physical health depend on trust and collaboration. We need to invest in our social capital to prepare for the future.

REFERENCES

Adler, S., & Bhattacharyya, S. (2021). Beyond the nurses and doctors: Structural racism and the unseen frontline service workers during the COVID-19 pandemic. *Psychiatric Services 72*, 594-596.

Albott, C. S., Wozniak, J. R., McGlinch, B. P., Wall, M. H., Gold, B. S., & Vinogradov, S. (2020). Battle buddies: Rapid deployment of a psychological resilience intervention for health care workers during the COVID-19 pandemic. *Anesth Analg, 131*(1), 43-54.

Amsalem, D., Lazarov, A., Markowitz, J. C., Naiman, A., Smith, T. E., Dixon, L. B., & Veria, Y. (2021). Psychiatric symptoms and moral injury among US healthcare workers in the COVID-19 era. *BMC Psychiatry, 21*, 546. https://doi.org/10.1186/s12888-021-03565-9

Brooks, S., Amlôt, R, Rubin, G. J., & Greenberg, N. (2020). Psychological resilience and post-traumatic growth in disaster-exposed organizations: Overview of the literature. *BMJ Military, 166*, 52-56.

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med, 12*(6), 573-576.

Canadian Medical Association. (2020). Framework for ethical decision making during the coronavirus pandemic. CMAS Policy Base, retrieved from, https://policybase.cma.ca/en/permalink/policy14133

Costa, A. C. (2003). Work team trust and effectiveness. *Personnel Review, 32*(5), 605-622.

Edmondson, A. (2019). *The fearless organization: Creating psychological safety in the workplace for learning, innovation, and growth*. New Jersey: John Wiley & Sons.

Falkenström, F., Grant, J., & Holmqvist, R., (2018). Review of organizational effects on the outcome of mental health treatments. *Psychotherapy Research, 28*(1), 76-90.

Falkenström, F., Ekeblad, A., & Holmqvist, R. (2016). Improvement of the working alliance in one treatment sesion predicts improvement of depressive symptoms by the next session. *Journal of Consulting and Clinical Psychology, 84*(8), 738-751.

Folkman, S., & Greer, S. (2000). Promoting psychological well-being in the face of serious illness: when theory, research and practice inform each other. *Psychooncology, 9*(1), 11-19.

Geerts, J. M., Kinnair, D., Taheri, P., et al. (2021). Guidance for health care leaders during the recovery stage of the COVID-19 pandemic: A consensus statement. *JAMA Network Open, 4*(7), e2120295. https://doi:10.1001/jamanetworkopen.2021.20295

Galbraith, N., Boyda, D., McFeeters, D., & Hassan, T. (2021). The mental health of doctors during the COVID-19 pandemic. *BJPsych* Bull, *45*(2), 93-97.

Gerada, C. (2018). Doctors, suicide and mental illness. *BJPsych Bulletin, 42*, 165-168.

Gerada, C. (2016). Healing doctors through groups: Creating time to reflect together. *British Journal of General Practice, 66*(651), e776-e778.

Hartzband, P., & Groopman, J. (2020). Physician burnout, interrupted. *NEJM, 382*(6), 2485-2487.

Herman, J. (1997). *Trauma and recovery*. New York: Basic Books.

Hobfoll, S. E., Watson, P. J., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry, 70*(4), 283-315.

Honarmand, K., Yarnell, C., Young-Ritchie, C., et al. (2022). Personal, professional, and psychological impact of the COVID-19 pandemic on hospital workers: A cross-sectional survey. *PLoS ONE, 17*(2), e0263438. https://doi.org/10.1371/journal. pone.0263438

Lai, J., Ma, S., Wang, Y, et al. (2020). Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA Network Open, 3*(3), e203976.

Leszcz, M., Maunder, R., & Hunter, J. (2020). Psychological support for health care workers during the COVID-19 pandemic. *CMAJ*, 192(24), e660. DOI: https://doi.org/10.1503/cmaj.75864

Leszcz, M. (2017). How understanding attachment enhances group therapist effectiveness. *International Journal of Group Psychotherapy*, 67, 280-287.

Leszcz, M., et al. (2015). *Psychotherapy essentials to go - achieving and sustaining psychotherapy effectiveness*. Maunder, R., Ravitz, P., editor(s). New York, NY: W.W. Norton & Company, Inc. 208 p

Leszcz, M., & Goodwin, P.J. (1998). The rationale and foundations of group psychotherapy for women with metastatic breast cancer. *International Journal of Group Psychotherapy, 48*(2), 245-273.

Lowe, G. (2012). How employee engagement matters for hospital performance. *Healthcare Quarterly, 15*(2), 29-39.

Mahon, L., & Leszcz, M. (2017). The interpersonal model of group psychotherapy. *International Journal of Group Psychotherapy, 67*(Supp1), S121–130. https://doi.org/10.1080/00207284.2016.1218286

Marmarosh, C. L., Forsyth, D. R., Strauss, B., & Burlingame, G. M. (2020). The psychology of the COVID-19 pandemic: A group-level perspective. *Group Dynamics: Theory, Research, and Practice, 24*(3), 122-138. https://doi.org/10.1037/gdn0000142

Maslach, C. & Leiter, M. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry, 15*(2), 103-111.

Maunder, R., Heeney, N., Kiss, A., et al. (2021). Psychological impact of the COVID-19 pandemic on hospital workers over time: Relationship to occupational role, living with children and elders, and modifiable factors. *Gen Hosp Psychiatry, 71*, 88-94. https://doi:10.1016/j.genhosppsych.2021.04.012

Maunder, R., Hunter, J., Vincent, L., et al. (2003). The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *CMAJ, 168*(10), 1245-1251.

Mikulincer, M., & Shaver, P. R. (2017). Augmenting the sense of attachment security in group contexts: The effects pf a responsive leader and a cohesive group. *International Journal of Group Psychotherapy, 67*, 161-175.

Nietzsche, F. (1968). *The Will to Power*, trans. Walter Kaufmann and R. J. Hollingdale. New York: Vintage Books.

Park, B., Steckler, N., Sydney, E., Wiser, A. L., & DeVoe, J. (2020). Co-creating a thriving human-centered health system in the post-COVID-19 era. *NEJM Catalyst*, Available at, https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0247

Resnick, K., & Fins, J. J. (2021). Professionalism and resilience after COVID-19. *Acad Psychiatry,45*(5), 552-556. https://doi:10.1007/s40596-021-01416-z

Robins-Browne, K., Lewis, M., Burchill, L. J., et al. (2022). Interventions to support the mental health and well-being of front-line healthcare workers in hospitals during pandemics: An evidence review and synthesis. *BMJ Open*, *12*, e061317. https://doi:10.1136/bmjopen-2022-061317

Rosen, B., Preisman, M., Read, H., Chaukos, D., Greenberg, R. A., Jeffs, L., Maunder, R., & Wiesenfeld, L. (2022). Resilience coaching for healthcare workers: Experiences receiving collegial support during the COVID-19 pandemic. *General Hospital Psychiatry, 75*, 83-87.

Shain, M. (2010). *The Shain reports on psychological safety in the workplace – a summary.* Report prepared for the Mental Health Commission of Canada (www.mentalhealthcommission.ca).

Shanafelt, T., Trockel, M., Rodriguez, A., & Logan, D. (2021). Wellness-centered leadership: Equipping health care leaders to cultivate physician well-being and professional fulfillment. *Academic Medicine, 96*(5), 641-651.

Shanafelt, T. D., Wang, H., Leonard, M., Hawn, M., McKenna, Q., Majzun, R., Minor, L., & Trockel, M. (2021). Assessment of the association of leadership behaviors of supervising physicians with personal-organizational values alignment among staff physicians. *JAMA Network Open, 4*(2), e2035622. https://doi:10.1001/jamanetworkopen.2020.35622

Shanafelt, T., Ripp, J., & Trockel, M. (2020). Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic. *JAMA,* 323, 2133-2134.

Shanafelt, T., Ripp, J., Brown, M., et al. (2020). Caring for health workers during crisis: Creating a resilient organization. *American Medical Association*. https://www.ama-assn.org/system/files/2020-05/caring-for-health-care-workers-covid-19.

Sheather, J., & Fidler, H. (2021). Covid-19 has amplified moral distress in medicine. *BMJ, 372*, n28. https://doi:10.1136/bmj.n28

Siegel, D. (2012). *The developing mind, second edition: How relationships and the brain interact to shape who we are.* New York, NY: Guilford Press.

Southwick, S. M., & Southwick, F. S. (2020). The loss of social connectedness as a major contributor to physician burnout: Applying organizational and teamwork principles for prevention and recovery. *JAMA Psychiatry, 77*(5), 449-450.

Stapleton, F. B., & Opipari, V. P. (2020). The current health care crisis – Inspirational leadership (or lack thereof) is contagious. *JAMA Network Open, 3*(6), e208024. https://doi:10.1001/jamanetworkopen.2020.8024

Sue, D. W., Alsaidi, S., Awad, M. N., et al. (2019). Disarming racial microaggressions: Microintervention strategies for targets, white allies, and bystanders. American Psychological Association, 24(1), 128-142. http://dx.doi.org/10.1037/amp0000296.

Taleb, N. (2012). *Antifragile: Things that gain from disorder.* New York, NY: Random House.

Williamson, V., Murphy, D., & Greenberg, N. (2020). COVID-19 experiences of moral injury in front-line key workers. *Occupational Medicine*, *70*(5), 317-319. https://doi.org/10.1093/occmed/kqaa052

Wu, P. E., Styra, R., & Gold, W. L. (2020). Mitigating the psychological effects of COVID-19 on health care workers. *CMAJ*, *192*, e459-e60.

Yalom, I., and Leszcz, M. (2020). *The theory and practice of group psychotherapy, 6th edition.* New York, NY: Basic Books.