We deserve that care and attention we are trying to nurture within other people: Exploring the Experiences of Co-Active Life Coaches on Self-Care and Professional Practice during the COVID-19 Pandemic

A Thesis Presented to the

School of Kinesiology

Lakehead University

In Partial Fulfillment of the Requirements

For the Degree of Master of Science in Kinesiology

By Kayla Waddington

2021

Acknowledgments

I would like to express my sincere appreciation to my supervisor, Dr. Erin Pearson, for her continued support and guidance throughout my entire academic journey. Without you, I would not have developed the passion I have for health promotion nor have been introduced to the countless opportunities where I was able to practice my newly acquired research skills. We have developed a close relationship throughout the years, and I am so grateful for the hours you spent mentoring me all while acknowledging my strengths, guiding me through areas of improvement, and trusting my abilities to facilitate this research project. You helped me see my potential, even when I didn't see it myself, and brought out initiative and leadership skills in me that I will be forever grateful for. Words cannot describe how fortunate I am to have been supervised by such a compassionate, dedicated, and strong supervisor that I am proud to call my mentor and will continue to look up to.

I would also like to acknowledge my committee members, Dr. Kathryn Sinden, Dr. Jennifer Irwin, and Dr. Aislin Mushquash for taking the time to provide insightful and valuable feedback to my research project. Your expertise, attention to detail, and diverse knowledgebase has been vital to the completion of this research project. Thank you as well to Dr. Rebecca Fried for contributing her time and knowledge as the external reviewer for this thesis.

I would also like to thank Ms. Caileigh Leach for her eager volunteerism during the progression of this project. Her dedication, flexibility with scheduling, and communication during the data collection and transcription process was timely and incredibly generous, especially with the constraints of COVID-19 and her personal academic responsibilities.

Lastly, I would like to acknowledge my friends, from within the Master's program and beyond, for always checking in, lending a helping hand, and simply being there to listen as I

moved from stage-to-stage during this process. I would also like to thank my family for their ongoing support of my research, willingness to listen, and always being there during the highs and lows of my educational journey. They truly went through this voyage with me. Thank you for the consistent encouragement, believing in me, and always being there to guide me. I couldn't have done it without all of you.

Abstract

Self-care is broadly defined as a chosen, *proactive* initiated practice, with the goal of promoting well-being. Self-care provides many social, emotional, and psychological benefits, and it is important to understand its role among those who are responsible for helping others. *Helping professionals* such psychologists, social workers, and nurses are tasked with promoting self-care and nurturing individual growth amongst their patients and clients. Working in these industries can lead to excess stress, burnout, and professional impairment, all of which can negatively impact clinical work and personal health. Ironically, these helpers' personal self-care is not always an immediate priority. In light of these challenges, it would seem that enhanced self-care may provide an avenue to reduce negative outcomes seen in the personal and professional lives of helpers. Beyond exploring self-care and health among helping professionals, it is also important to understand how self-care relates to professional practice during COVID-19, an era fraught with government restrictions mandating lockdowns and the use of telecommunications. Certified Professional Co-Active life coaches (CPCC), helping professionals who provide highly personalized support endorsing self-care for their clients and are trained in using virtual tools, have yet to be examined in this context and are poised to provide unique insights.

The primary *purpose* of this descriptive qualitative study was to explore CPCCs' experiences related to: (a) coaching during the COVID-19 pandemic; and (b) their own self-care during the COVID-19 pandemic. The secondary purpose was to collect insights from CPCCs about the utility of telecommunications for service provision. Certified Professional Co-Active coaches residing in North America were eligible to participate. Individual semi-structured interviews explored experiences related to COVD-19, self-care, and the use of

telecommunications for their coaching services. Interviews were transcribed verbatim and analyzed manually using deductive and inductive content analysis. To validate the findings further, the software program NViVo 12 was used in the coding process to compare and contrast multiple transcripts. Twelve CPCCs from across North America completed the study (10 female and 2 male) with a mean age of 54.5 years. In line with the primary purpose, four main themes and eight related subthemes emerged related to coaching experiences during a pandemic and self-care: (a) a shift in practice (accommodating remote working; adjusting approaches to coaching); (b) changes in clients (heightened need for support; enhanced adaptability); (c) personal self-care practices (self-care is more intentional; fill your bucket first); (d) professional self-care practices as a Co-Active life coach ("taking our own advice"; and more emotional boundaries). Regarding purpose two and the utility of telecommunications in practice, two main themes with four accompanying subthemes were observed: (a) modality specific benefits (video: cues and connection; telephone: listening and focus); and (b) video specific challenges (technology failure; screen inadequacies). Overall, and in line with the literature, study findings emphasized the importance of intentional self-care for helping professionals, especially during a worldwide pandemic. Not only is this vital for the helpers themselves, but resultantly, the self-care of coaches likely has a direct effect on clients and the quality of care they receive. Given that remote working is predicted to continue in the future, remaining flexible with clients and focusing on the human condition will be valuable for practice. The link between therapeutic empathy and setting appropriate emotional boundaries in service of self-care was also identified as important during times of crisis and should be considered by helpers. Inadequacies associated with video technology and Wi-Fi led participants to recommend traditional methods for service delivery such as the telephone, suggesting that a *back to the basics* approach may be worthy of

further investigation. Future studies should seek to include a larger sample for thematic saturation purposes. Having a smaller geographical range of participants to keep pandemic-related restrictions consistent, and exploring both client and coach views, could be useful for further uncovering best practices for therapeutic effectiveness in this context.

Table of Contents

We deserve that care and attention we are trying to nurture within other people:

Exploring the Experiences of Co-Active Life Coaches on Self-Care and Professional Practice during the COVID-19 Pandemic

Overview

Self-care is a well-known term used in many health-oriented and professional settings (Mills, Wand, & Fraser, 2018). Broadly defined as a chosen, initiated practice, with the goal of promoting health and well-being (Sherman, 2004), self-care involves purposefully addressing multiple dimensions of wellness (e.g., physical, emotional; Myers et al., 2012). In contrast to coping, which deals with life changes perceived to be stressful *after* the event has passed (Cleveland Clinic, 2020; Mills et al., 2018), self-care is a more *proactive* and personalized approach to health promotion that incorporates various cognitive behavioural strategies (Mills et al., 2018). For example, self-care embodies having a kind attitude towards oneself; that is, engaging in both self-reflection and action in order to foster well-being (Poslums & Gall, 2020).

Helping professionals such as psychologists, nurses, and social workers are tasked with promoting self-care and nurturing individual growth among their patients/clients to enhance health and/or wellness (Engel, 2017). Often working in industries where a one-way caring philosophy is endorsed, these professionals are expected to continually demonstrate empathy, patience, and compassion for others which can feel overwhelming, demanding, and tiring (Killian, 2008; Posluns & Gall, 2020). Repeatedly, research has emerged regarding the need for self-care – and lack thereof – among helping professionals, many of whom counsel their clients about the application and benefits, yet don't seem to engage in self-care themselves (Friedman, 2017; Posluns & Gall, 2020). For example, Greenstone and Leviton (1982), Figley (2002), and Bruns and colleagues (2014) found that when helping professionals continually neglected their

own health, nutrition, and safety needs, their clinical effectiveness was greatly reduced. These studies demonstrate a long-term issue of self-care neglect amongst helpers spanning decades, highlighting the need for more research, and accompanying strategies. More recent data also indicate that while helping professionals find self-care important, it is not typically taught or spoken about within their occupations (Posluns & Gall, 2020). Indeed, Mills and colleagues (2018) noted the value of self-care stating that it "is not a selfish luxury, but is instead essential to clinicians' therapeutic relationship with patients" (p. 8).

Given that 26-44% of Canadian adults suffer from at least one chronic condition requiring ongoing management (e.g., obesity, diabetes, hypertension; Government of Canada, 2019; Twells, Janssen, & Kuk, 2020), and nearly one in five experience a mental health problem in any given year (Canadian Mental Health Association [CMHA], 2021), the need for and value of helping professionals cannot be overstated, especially during times of crisis where health-related issues and symptoms are often amplified (Engel, 2017; Norcross & Phillips, 2020). On March 11, 2020, the World Health Organization (WHO; 2020) declared the Coronavirus (COVID-19) a worldwide pandemic (Infection Prevention and Control Canada [IPAC], 2020). This viral outbreak has caused drastic global measures to be put in place, including recurrent lockdowns and quarantine measures for many countries and travellers (Cascella et al., 2020). The resulting social isolation has had a severe impact on people's well-being, with heightened experiences of anxiety, depression, and stress being reported frequently, in addition to other adverse psychosocial outcomes (Fetzer et al., 2020; Pfefferbaum & North, 2020; Xiao, 2020). Concomitantly, there has been increased concern about pandemic-related stress levels and angst being experienced among some helping professionals (Unadkat & Farquhar, 2020). Thus, it has been recommended that the self-care orientated tools and strategies being shared with clients also

be used by the helpers themselves (Phillips, 2020). Yet, while extensive research verifying the efficacy of helping professions exists (Posluns & Gall, 2020; Newnham-Kanas, Irwin, & Morrow, 2011), little is known about the degree to which helping professionals are equipped to provide services from self-care and professional practice standpoints, especially during times of crisis such as the COVID-19 pandemic (Unadkat & Farquar, 2020).

According to the WHO (2019), past emergencies, such as natural disasters, have highlighted the need to strengthen mental health initiatives, such as telephone hotlines, for psychological and self-care counselling. In the era of COVID-19 where physical distancing and telemedicine are becoming the new normal (and in place for the foreseeable future; Centers for Disease Control and Prevention, 2020), understanding self-care as it relates to professional practice is vital. To date, several studies have been conducted examining self-care among helping professionals such as nurses, physicians, psychologists, and counsellors (e.g., Friedman, 2017; Mills et al., 2017; Rupert & Dorociak, 2019) and provided valuable insights. However, the study contexts have generally been clinical in nature, involved face-to-face delivery models, and applied predominantly quantitative methodologies (Miller et al., 2018; Mills et al., 2017; Rupert & Dorociak, 2019). As the pandemic ensues and the demand for telehealth-oriented services increases, understanding self-care practices from the perspectives of those who have traditionally used telecommunication methods for service delivery is essential. Moreover, because most helping professions are clinical in nature, they may not be appropriate for individuals seeking self-improvement or addressing non-clinical issues, such as lifestyle change or motivation.

Co-Active Life Coaching (referred to herein as CALC; Newnham-Kanas, Morrow, & Irwin, 2010; Kimsey-House, Kimsey-House, Sandahl, & Whitworth, 2018) is a non-clinical, theoretically-grounded, cognitive behavioural technique that has been used effectively to

enhance wellness and promote positive behaviour change in various populations (e.g., Fried & Irwin, 2016; Goddard & Morrow, 2015; Irwin & Morrow, 2005; Mantler et al., 2013; Pearson et al., 2012). Certified Professional Co-Active Coaches (CPCCs) are equipped with tools and strategies to help clients attain personally meaningful goals and fulfillment (Co-Active Training Institute [CTI], 2020). The CTI was founded in 1992 and trains coaches to deliver their services over the telephone – a modality that provides substantial geographic reach in an accessible manner (Pearson et al., 2012). The use of telecommunications (e.g., telephone, Skype, Zoom) has slowly started to evolve within the areas of chronic disease management and mental health, but many studies have noted the need for insightful guidance on using such delivery modes in order to identify how different professions might utilize such technology (Bokolo, 2020; Molfenter et al., 2015). Because CALC is founded on promoting self-care for others, typically over the telephone, it is important to understand how coaches achieve this for themselves, especially during times of crisis (Miller et al., 2018). Further, in light of the societal movement towards telecommunication models for helping professionals and the lack of information in this context, it stands to reason that CPCCs, in particular, may offer unique insights given their historical use of the telephone in practice. Thus, the primary *purpose* of this qualitative study was to explore CPCCs' experiences and views related to: (a) coaching during the COVID-19 pandemic; and (b) their own self-care during the COVID-19 pandemic. The *secondary purpose* of this study was to collect insights from CPCCs about the utility of telecommunication for service provision.

As this universal situation continues, uncovering the viewpoints of CPCCs is important and timely. Findings may be transferable to other helping professionals contemplating or transitioning to remote service delivery, while providing enhanced understanding of self-care

during times of global/national crises. Moreover, exploring these phenomena will be valuable, not only to the coaches themselves, but to helping professional training bodies, and the clients who participate in the sessions (Newnham-Kanas, Irwin, & Morrow, 2012).

Background

Practice-Related Challenges for Helping Professionals

A *helping profession* is any career that assists in nurturing an individual's growth while addressing problems associated with physical, psychological, intellectual, emotional, or spiritual well-being (Engel, 2017). Examples of helping professions include medicine, nursing, clinical and counselling psychology, social work, and life coaching (Engel, 2017; Kimsey-House et al., 2011; Westergaard, 2013). Helping can be explained as the process through which the helper interacts with another individual to facilitate movement toward a specific outcome or goal (Parsons, 2001). These exchanges are given to only one member, the client, as it is their needs and goals that are the focus (Parsons, 2001). These encounters can be very intense and intimate, as clients often disclose personal details about themselves and their lives, leaving them vulnerable to the helper's actions. This process also recognizes the helper as ethically responsible for the relationship (Parsons, 2001; Posluns & Gall, 2020). Due to the highly emotive encounters, the helper must remain emotionally objective throughout the sessions, which can be difficult to maintain as the relationship gets stronger or the circumstances become more severe (Parsons, 2001; Posluns & Gall, 2020). Often working in industries where one-way care provision occurs, these individuals are typically expected to demonstrate empathy, patience, and compassion, often leading to feelings of being overwhelmed and fatigued (Killian, 2008; Parsons, 2001; Posluns & Gall, 2020). Due to the nature of this work, helping professionals are

at risk for developing stress, burnout, and professional impairment that can negatively impact their performance (Posluns & Gall, 2020; Richards et al., 2010).

Workplace burnout, described as emotional exhaustion and diminished self-efficacy (Friedman, 2017; Killian, 2008; Posluns & Gall, 2020), can be associated with many factors including the inability to influence decisions that affect one's career (e.g., increased workload, lack of social support, work-life imbalance), as well as more personal factors (e.g., struggling to achieve unattainable goals, feelings of isolation and distance, and having a hard time being alone; Ericson-Lidman & Strandberg, 2007). These issues can relate to increased stress, fatigue, anger and irritability, high blood pressure, and heart disease (Fountoulakis, Kaprinis, & Kaprinis, 2002; Mayo Clinic, 2020). Experiences of vicarious trauma can also emerge within a professional as professionals empathetically engage with a client (Killian, 2008). Not to be confused with burnout which happens overtime, vicarious trauma, or compassion fatigue, describes the phenomena associated with the "cost of caring" (American Counseling Association [ACA], 2020; Figley, 2002). It is a state of tension and preoccupation with stories from clients, and can be considered emotional residue from the exposure that helpers have when working with clients in an intense, emotive environment (ACA, 2020). This can lead to helpers experiencing: (a) emotional avoidance where the helper is almost numb to the trauma experienced by these clients; (b) difficulty talking about their feelings; (c) diminished joy and satisfaction; (d) losing sleep over clients; and (e) hopeless feelings about their work or clients (ACA, 2020).

The cumulative effects of work-related stress and burnout can be associated with different behaviours towards clients, such as depersonalization (Killian, 2008; Posluns & Gall, 2020): a process whereby the helping professional distances themself from the client, which in extreme cases, can result in diminished compassion and overlooking unique qualities that make

humans human (Goodman & Schorling, 2012). It is considered harmful in a helping context as it reduces empathy given to the person coming for guidance (Harpham, 2011). Other negative outcomes associated with stress and burnout include provider-client relationship issues (Friedman, 2017). For example, a helper suffering from compassion fatigue may make more mistakes with their clients (e.g., clinical errors, misjudgements; Figley, 2002), thereby decreasing the effectiveness of practice for the client. Indeed, as noted by Bratton (2018), increased fatigue in nurses had an increased risk of errors, a decline in memory, impaired communication skills, and reduced ability to learn new tasks. Moreover, any increased stress and anxiety experienced can negatively impact the helper's self-efficacy to effect change (Fulton & Cashwell, 2015).

In summary, burnout can negatively affect helping professionals' physical and emotional well-being, resulting in a lack of empathy, negative attitudes towards oneself and clients, and poor job performance (Keim et al., 2008; Kumar 2011). Self-care, which is aimed to assist individuals in a proactive fashion, may be a useful strategy in combating stress and improving personal well-being. Ironically, helping professionals who are tasked with assisting patients/clients with enhancing well-being often neglect their own needs, as engaging in personal self-care is not always a priority (Friedman, 2017; Posluns & Gall, 2020). In light of the challenges discussed, it would seem that self-care practices amongst helping professionals are crucial and should be further explored as their absence can have a significant impact on clients (Harpham, 2017), as well as professional and therapeutic effectiveness (Friedman, 2017; Richards et al., 2010).

Self-Care and Helping Professionals in Health Promoting Contexts

The importance of and benefits associated with practicing self-care among helping professionals has been noted extensively in the literature (e.g., Clarke, 2019; Friedman, 2017; Killian, 2008; Posluns & Gall, 2020). Goncher and colleagues (2013) claimed that self-care should be ongoing, and includes self-awareness, the use of helpful self-care strategies, and active self-assessment. Some strategies include valuing oneself, refocussing on the rewards of practice, recognising the early signs of workplace hazards such as overscheduling, and cultivating nurturing and supporting relationships (Goncher et al., 2013). This list demonstrates that self-care is not just about healthy eating, exercising, or getting enough sleep, but actively engaging in a way of being that can be considered an antidote to burnout (Barnett et al., 2007; Empowerment Counselling Associates, 2020). The benefits of partaking in this practice not only assists in keeping burnout and compassion fatigue at bay, but also helps to create a healthier version of the self; the healthier the care provider, the more effective the help can be (Empowerment Counselling Associates, 2020).

According to Posluns and Gall (2020), self-care is most commonly studied in relation to the well-being of practitioner trainees such as graduate students in clinical psychology programs. While this population actively provides mental health services, the results may not be generalizable as graduate students are known to experience higher levels of stress due to various demands associated with being a student and providing services to others (Myers et al. 2012; Posluns & Gall, 2020). Beyond this trainee-oriented body of research, some studies have examined the concept of self-care among helping professionals practicing in conventional (e.g., physicians) and allied health (e.g., nurses, psychologists) occupations (Engel, 2017), and are worthy of review. Conventional health professionals are involved in the treatment of symptoms

and disease using pharmaceuticals, radiation, or surgery (National Cancer Institute, 2020). Allied health professionals are a group who aim to apply their expertise to prevent disease, diagnose, treat, or rehabilitate populations of all ages and specialities: psychologists, counsellors, and occupational therapists, for example (Hakkennes & Dodd, 2007). To better understand the history of self-care practice within these helping professions, a literature review summarizing related studies has been provided below.

Self-Care Views and Related Outcomes Among Helping Professionals

Alkema and colleagues (2008) investigated the relationships between self-care, compassion fatigue, burnout, and compassion satisfaction amongst hospice workers, the majority of whom were nurses. They used a cross-sectional study design involving a self-care assessment form and Quality of Life Survey. The sample included 37 home hospice workers (n = 17 nurses; n = 5 home health aids; n = 4 social workers; n = 1 volunteer coordinator; n = 3 bereavement professional; n = 2 chaplains; n = 1 administrative assistant; n = 2 medical director; and n = 2 others). One major finding was that as compassion fatigue increased, the number of self-care activities that healthcare professionals reported decreased. This inverse relationship was the same for burnout and self-care. It was also noted that healthcare professionals who take care of themselves in one area are more likely to care for themselves in other areas as well. Those who had been in the profession for a longer duration seemed to take better care of themselves than those new to the workforce. In summary, these results highlighted noteworthy relationships between self-care, compassion fatigue, and burnout suggesting that paying attention to self-care is important for emotional health and enabling helping professionals to help others. Alkema and colleagues (2008) recommended that future research be conducted to investigate ways in which helping professionals can effectively engage in self-care strategies.

In a similar vein, Mills and colleagues (2017) examined self-care among palliative care nursing and medical professionals using a cross-sectional survey which asked about the perceived importance of self-care, self-care education and planning, and self-care strategies most utilized. A total of 372 participants (67% worked as palliative care nurses; 33% worked as palliative care doctors) completed the survey. Results revealed that even though self-care was regarded as important, few actually practiced and engaged in effective strategies, such that only 6% reported they used a self-care plan; however, 70% indicated they would use one if they had proper training. The authors suggested that further qualitative inquiry into the personal or professional contexts of infrequent self-care practice and planning could assist educators in promoting effective self-care practice. It was also recommended that future research focus on the development and evaluation of innovative self-care education programs in terms of strategies used for professional practice (Mills et al., 2017).

To further the research in this context, Rupert and Dorociak (2019) investigated how self-care may function to help reduce the risk of burnout and increase job satisfaction amongst practicing psychologists. The cross-sectional study included 422 survey responses; results revealed that a key mechanism of self-care is reducing stress, which was associated with less burnout and higher job satisfaction. Additionally, the authors found that self-care is more effective if used proactively rather than as an after-thought once the damaging events (e.g., traumatic experience, stressful session) have already occurred. Rupert and Dorociak (2019) concluded that future research is still needed, emphasizing the importance of self-care, and the need for it to be proactive and ongoing among helping professionals.

Beyond understanding the views and actions of helping professionals in relation to self-care, another way to view this phenomenon is by examining self-care in a workplace setting, and how organizations influence workers' abilities to engage in such practices.

Self-Care and Workplace Settings

Researchers have investigated how health professionals are engaging, or not engaging, in self-care while also looking at the workplace setting and employment status (e.g., peer support, self-employed, workplace initiatives for self-care; Barlow & Phelan, 2007; Miller et al., 2018; Richards et al., 2010). For example, Barlow and Phelan (2007) wanted to examine how counsellors engaged in self-care within a large health care organization. Specifically, they formed a peer collaboration group to understand how this type of support can be used as a form of self-care, enabling employees to bounce ideas back and forth while promoting open communication channels. The researchers used a qualitative design with a focus group discussion involving three counsellors. Findings suggested two main themes: space and trust. The need for creating a metaphorical space for the practice of self-care both within and outside of the workplace was highlighted. The importance of defining that specific space for self-care was also noted (e.g., taking a leave of absence, allowing room for individual thinking, and self-care while at work). Developing trust involved the idea that employees need to feel supported by their organization to feel comfortable engaging in self-care at work and at home. Barlow and Phelan (2007) described trust as recognizing that there is no right way to collaborate with coworkers in a peer supportive fashion, and that workers have the ability to define their own agendas to support self-care needs in a safe workplace environment. The peer collaboration and safe workplace environments highlighted by Barlow and Phelan (2007), while helpful for those working in a group context, are not typically applicable to those working in other types of

settings, such as private practice (Richards et al., 2010). Thus, future research on self-care among those who are employed independently can be recommended.

In a larger cross-sectional quantitative study, Richards and colleagues (2010) similarly examined the relationship between mental health professionals' (*n* = 148; 43.3% social work; 24.8% counseling psychology; 23.4% clinical psychology; 7.1% other; and 1.4% general psychology) self-care practices and general well-being. Their goal was to examine the effects related to self-awareness including "knowledge of one's thoughts, emotions, and behaviours" (Richards et al., 2010, p. 258), along with the notion of mindfulness, described as the increased awareness regarding oneself and the situations one is in. The professionals came from various workplace settings (15.5% community mental health; 5.4% inpatient hospital; 8.1% partial hospitalization program; 12.8% practicum/internship; 40.5% private practice; 0.7% Veterans Affairs clinic; 2.0% non-profit organization; 4.7% children's writing center; 9.5% university counselling centre; and 8.8% in other mental health setting). Results from the surveys used (e.g., The Self-Reflection and Insight Scale, Mindfulness Attention Scale, Schwartz Outcomes Scale) demonstrated that self-awareness and mindfulness were significantly correlated; that is, as self-awareness increased, so did the degree of mindfulness. Richards and colleagues (2010) suggested that expanding training programs to develop and include self-care and wellness activities could be beneficial – if self-care practices become part of their training, counsellors may be more likely to participate and find the value in it. The authors repeatedly mentioned the need to explore self-care in different work settings (organizational vs. self-employed) and amongst different professionals, as this was not assessed in their study (Richards et al., 2010).

In a more recent study, Miller and colleagues (2018) investigated the self-care practices of child welfare workers (*n* = 192 social work; *n* = 9 psychology or counselling; *n* = 21 other), as

emotional labour runs high in this profession. A cross-sectional study design was used integrating surveys on self-care. Results demonstrated that while the workers participated in a moderate degree of self-care, improvement was still needed. According to the authors, in order to encourage helping professionals to stay working within their professions, administrators should focus on offering a variety of health promoting services and endorse the idea of self-care and wellness as a whole within the organization. Ensuring the well-being of helpers is essential to maintain effective practice for both the helpers and the clients (Miller et al., 2018); and this finding aligns with previous literature (Friedman, 2017). Future recommendations included enhancing the existing foundation regarding self-care in helping professions including further exploration of supports (e.g., emotional, relationships; Miller et al., 2018).

Building on this work, Mills and colleagues (2018) explored the notion of self-care in practice as described by a group of palliative care nurses and doctors (*n = 12 nurses; n = 12 doctors*). According to the authors, because self-care is rarely reported in this profession, but coping is mentioned frequently and used interchangeably with self-care, they wanted to define and differentiate the terms. A qualitative study design was applied, and questions such as "[W]hat is the meaning of self-care, as described by palliative care nurses and doctors?" and "[H]ow do palliative care nurses and doctors describe effective self-care practice?" (Mills et al., 2018, p. 2) were included in the interview guide. Three main themes emerged from the 24 interviews: (1) Self-care was thought of as a proactive and holistic approach to promote personal health/well-being and support professional care: not only on an individual level, but on a workplace relationship level between patients and co-workers; (2) personalised self-care strategies within professional and non-professional contexts are important and should be considered an ongoing practice; and (3) there is a recurrent need to overcome barriers and

determine enablers to self-care for effective practice. A main finding from the study included the idea that self-care can be looked at through a team-like lens to encourage a healthy workplace environment. That is, effective self-care practices may be necessary to ensure proper workplace functioning and teamwork. This recent study also added qualitative perspectives on self-care to a predominantly quantitative body of literature (Mills et al., 2018).

Taken together, the studies on self-care conducted among conventional and allied health professionals demonstrate that self-care is an important aspect of workplace health and wellness. While there is agreement regarding the importance of self-care in practice (e.g., Friedman, 2017; Goncher et al., 2013; Posluns & Gall, 2020), uptake is generally low (e.g., Friedman, 2017; Posluns & Gall, 2020), and more information on specific strategies and the application of self-care in private, non-clinical settings is needed (Alkema et al., 2008; Richards et al., 2010; Rupert & Dorociak, 2019). The majority of previous studies have also been quantitative in nature (e.g., Alkema et al., 2008; Miller et al., 2018; Mills et al., 2017) suggesting that the application of qualitative methodologies exploring various aspects of self-care and accompanying strategies among helping professionals (Bolnick & Brock, 2005; Mills et al., 2017) may elicit novel findings in this context (e.g., enabling follow-up questions and deeper explanations of experiences). Given that 26-44% of Canadian adults suffer from at least one chronic condition requiring ongoing management (e.g., obesity, diabetes, hypertension; Government of Canada, 2019; Twells, Janssen, & Kuk, 2020), and nearly one in five experience a mental health problem in any given year (Canadian Mental Health Association, 2020), the need for and value of helping professionals cannot be overstated: especially during times of crisis where health-related issues and symptoms are often amplified (Engel, 2017; Norcross & Phillips, 2020), and the notion of self-care is particularly important.

Self-Care Among Helping Professionals During a Crisis

On March 11, 2020, the WHO (2020) declared COVID-19 a worldwide pandemic (IPAC, 2020). This viral outbreak has caused drastic global measures to be put in place, such as lockdown and quarantine for many countries and travellers (Cascella et al., 2020). Various facilities and institutions have closed intermittently, including fitness centres, schools, workplaces, and entertainment venues which has led to increased unemployment rates and a spiraling economy (Fetzer et al., 2020). The resulting social isolation and divergence from normality has had a severe impact on people's well-being, with heightened experiences of anxiety, depression, and stress being reported frequently, in addition to other adverse psychosocial outcomes (Fetzer et al., 2020; Pfefferbaum & North, 2020; Xiao, 2020). Concomitantly, there has been increased concern about pandemic-related stress levels and angst being experienced among some helping professionals (Unadkat & Farquhar, 2020). Thus, it has been recommended that the self-care orientated tools and strategies being shared with clients also be used by the helpers themselves (Phillips, 2020). Indeed, while extensive research verifying the efficacy of helping professions exists (Newnham-Kanas, Irwin, & Morrow, 2011; Posluns & Gall, 2020;), little is known about how helping professionals are providing services from self-care and professional practice standpoints during the COVID-19 pandemic (Unadkat & Farquar, 2020). However, some research has been conducted examining self-care among helping professionals during times of crisis which is worthy of review.

In one of the earlier studies conducted in this area, Bolnik and Brock (2005) surveyed school psychologists in California to understand the effects of crisis intervention work (i.e., short-term response to an immediate threat to mental or physical health; Alexis, 2019) on their well-being and self-care strategies. Because care providers can be exposed to the same stressors

as the victims, the authors noted that this particular type of work can be physically and emotionally draining, and lead to experiences of compassion fatigue, high turnover rates, and more sick days being taken (Bolnik & Brock, 2005). A total of 200 participants responded to the survey. Results demonstrated that 94% of the sample felt that self-care strategies were "important" or "very important," and all respondents stated that they engaged in at least one self-care practice during their crisis intervention work (e.g., follow a normal routine, sharing feelings, exercise, rest, spend time with other crisis interveners, do things that feel good, and avoid drugs/alcohol). One limitation of the study involved recall bias. Because participants were asked to reflect on self-care retrospectively, it was not clear whether their responses were influenced by other real-time life events. Thus, more research investigating the effects of a crisis on care providers conducted during or immediately after the experience was recommended. Further, to address shortcomings of survey administration (e.g., terms being interpreted subjectively), the application of qualitative methodologies was also suggested for future studies.

Due to the novelty and immediacy of the COVID-19 pandemic and resultant need for timely research, few empirical studies have been published to date regarding helping professionals. A recent opinion piece published in the British Medical Journal (Unadkat & Farquhar, 2020) called for enhanced mental well-being among National Health Service staff during the pandemic. Engaging in self-care practices, being kind to oneself, and leveraging collegial compassion and support were highlighted. Their review stated that when the pandemic is over, and a return to some sense of normalcy occurs, there will need to be increased conversation and awareness surrounding heightened safety for staff, access to safe resources, and education on what a safe model of care looks like. Having the ability to manage (i.e., overcome challenges; Hong et al., 2018) during such unprecedented times will ultimately depend on

whether healthcare professionals are given the necessary resources to utilize for their own safety and that of the public (Unadkat & Farquhar, 2020).

While the literature regarding self-care among helping professionals during times of crisis is scarce, one area related to professional practice that has shown value in such circumstances is telecommunication and telehealth (Hollander & Carr, 2020). As the public aims to conform to lockdowns and physical distancing guidelines associated with the pandemic (Government of Canada, 2020), a recent and ongoing shift to virtual service delivery models has occurred and warrants further investigation.

A Shift in Service Delivery

Previous large-scale emergencies, such as natural disasters, have increased concerns regarding the need to strengthen mental health initiatives via telephone lines for psychological and self-care counselling (WHO, 2019). In the era of COVID-19 – where physical distancing and telecommunications (e.g., telephone, video platforms) are becoming the new normal and in place for the foreseeable future (Centers for Disease Control and Prevention, 2020) – understanding how modalities are used in practice is vital, not only for the professional, but for the well-being of the patients and clients receiving this form of care (Lattanzio et al., 2014).

Telemedicine provides patients with access to healthcare providers from home or remote locations using virtual technology, thereby allowing them to receive information, education, and medical services more easily (Hollander & Carr, 2020). A study conducted in Northern Ontario, Canada in 13 communities investigated whether a telehealth chronic disease self-management program improved the overall health and self-efficacy of patients (Jaglal et al., 2013). The goal of the research was to increase access to healthcare for those living in rural or remote areas. The sample included 104 patients with chronic disease (e.g., lung disease, heart disease, stroke,

arthritis) who participated for one year using weekly telehealth sessions delivered via video conferencing and focused on self-management skills. Using a repeated measures approach, quantitative survey data from baseline to the four-month follow-up revealed statistically significant improvements in self-efficacy, self-management, and communication with physicians. The authors recommend further research be conducted to examine the impact of telehealth on different age cohorts and populations, and to determine whether telehealth-based interventions are more effective with certain groups (Jaglal et al., 2013).

Similarly involving rural areas, Griffiths, Blignault, and Yellowlees (2006) explored the feasibility of delivering cognitive behavioural therapy (CBT) – which aims to provide clients with realistic and balanced thinking involving rational thoughts (Beck, 1976; Neenan & Dryden, 2013) – via video conference to clients diagnosed with depression or anxiety. Their study involved 15 mental health clients along with their five case managers. Once the clients were instructed in the telemedicine procedures, they participated in six to eight weekly sessions of CBT. Results indicated that there was some clinical improvement in outcome measures using the Mental Health Inventory (MHI) and the Health of the Nation Outcome Scale (HoNOS). While this study illustrated the potential for telemedicine to address mental health needs among patients living in rural areas, future research was recommended regarding its efficacy in other contexts (Griffiths et al., 2006).

In line with this recommendation, Molfenter and colleagues (2015) investigated the use of telemedicine in addiction treatment and recovery services in five states (Iowa, Maryland, Massachusetts, Oklahoma, South Carolina) and one county (San Mateo, California). Those in different states were asked to develop a short list of telemedicine modalities to consider for implementation. The project involved assessing interest in and perceived facilitators and barriers

to implementing telemedicine modalities (telephone, web-based screening, web-based treatments, video conferencing, smartphone mobile applications). Findings demonstrated that even though the interest for increased telemedicine existed, there were some challenges with implementation depending on the preferred methods mentioned above including costs, unfamiliarity with technology, and confidentiality regulations. Future recommendations involved broadening the sample analyzed to help researchers and professional organizations develop a greater understanding of the technology used, including strategies and practices that have been deemed successful.

While the research, thus far, has primarily focused on patients living in rural areas and shown favourable results, it is important to look at telemedicine in the face of a global pandemic, where both rural and urban areas are affected (Hollander & Carr, 2020). A review article, written by Hollander and Carr (2020), discussed the use of telemedicine during the COVID-19 pandemic. They stated that the use of virtual healthcare allows patients to be treated in their homes and see specialists in a more rapid fashion compared to in-person, where providers might not be immediately available. Moreover, this modality allows for healthcare workers who may be quarantined to continue to care for patients using telemedicine-oriented visits. The authors also noted that as disasters and pandemics pose unique challenges to healthcare delivery, as long as infrastructure (e.g., technology, equipment) is intact and clinicians are able to still practice, telemedicine is well positioned to ensure patients receive the care they need (Hollander & Carr, 2020).

Consistent with this notion, Bokolo (2020) recently completed a comprehensive literature review of 35 studies on past telemedicine use with the goal of transferring findings to the COVID-19 pandemic. It was demonstrated through various studies that telemedicine can provide

rapid access to medical care remotely, while offering a safe space for clients to discuss issues and adhere to physical distancing rules set forth with government guidelines. Despite the positive aspects cited, the use of telemedicine presented some challenges regarding effectiveness, such as the quality of the images, video camera, and sound technology. While findings from this literature review can assist in guiding medical practitioners and improving delivery as they continue to employ telemedicine during health crises, additional research in this area should be continued as the pandemic evolves (Bokolo, 2020).

Based on the studies discussed, it appears that telecommunications can be valuable in a health promoting context (e.g., Griffiths et al., 2006; Jaglal et al., 2013; Molfenter et al., 2015). However, little research examining their use during times of crisis exists. Exploration during a pandemic could elicit unforeseen issues not typically observed in ordinary times. As the pandemic ensues and the demand for telehealth-oriented services increases, exploring the personal and professional benefits and challenges experienced among those who have traditionally used telecommunication methods for service delivery is essential. Because most helping professions are clinical in nature (i.e., focused on treating a disease or diagnosable condition; Davis, 2021), they may not be appropriate for individuals seeking self-improvement or addressing non-clinical issues, such as lifestyle change or motivation. Thus, examining a well-established health promotion method focused on these domains may be imperative for understanding self-care practices and remote service delivery methods among helping professionals working with a more general population.

Life Coaching

The field of *"coaching"* has emerged in recent decades as a way to explore personal improvement and professional development (Neenan & Dryden, 2013). Coaching is a strategy

wherein the coach collaborates with the client in guided discovery to help the client reach their own conclusions and solutions (Neenan & Dryden, 2013; Neenan & Palmer, 2001). Building on the principles of CBT, coaching aims to develop a client's capabilities with a focus on their own beliefs, emotions, and behaviours (Neenan & Dryden, 2013). *Life coaching*, in particular, consists of a one-on-one relationship between a coach and a client that is centred around lifestyle changes and goal setting (George, 2013; Losch et al., 2016). Life coaching can be broadly defined as "the systematic application of behavioural science to the enhancement of life experience, work performance, and well-being for individuals, groups, and organizations who do not have clinically significant mental health issues or abnormal levels of distress" (Green, Oades, & Grant, 2006, p. 1). Considered to be highly personalized with elements of emotional labour, goals are discussed with an emphasis on listening and the use of non-directive questioning (George, 2013; Green et al., 2006; Losch et al., 2016). This approach is intended to evoke thought and allow clients to solve challenges on their own, with the guidance of a coach, rather than be diagnosed with a problem (George, 2013; Green et al., 2006).

Co-Active Life Coaching

Because the rigour of training varies considerably within the coaching profession (George, 2013), it is important to differentiate the style being applied in a research context. Co-Active Life Coaching (CALC; Kimsey-House et al., 2011) has been identified as an approach that is useful for bringing the tenets of other helping approaches into action (e.g., Motivational Interviewing [MI]; Miller & Rollnick, 2013; Newham-Kanas, Irwin, & Morrow, 2010). Co-Active coaching is a validated and theoretically-grounded behaviour change technique (Irwin & Morrow, 2005; Newnham-Kanas et al., 2010; Pearson, 2011) that has been studied by researchers since the early 2000's and demonstrated utility as a method for 'doing' health

promotion (Irwin & Morrow, 2005). Moreover, it is traditionally delivered over the telephone, which makes it particularly worthy of investigation during a pandemic.

The CALC Training Process

Co-Active coaches are trained rigorously through the CTI (2020a): the largest in-person training organization in the world that offers courses across North America, Europe, the Middle East, and Asia (CTI, 2020a; Kimsey-House et al., 2011). Accredited by the International Coach Federation (ICF), Co-Active training and certification processes are considered the most respected in the industry (CTI, 2020a). In fact, the Certified Professional Co-Active Coach designation has been termed the "gold standard" in coaching (CTI, 2020b). To become a CPCC, training requires five in-person weekend courses (2 ½ days each) plus a 25-week telephone-based certification program involving weekly classes, extensive hands-on coaching with clients, regular "homework," as well as a written and oral exam (CTI, 2020c). This immersive training experience is intended to push trainees outside of their comfort zones and apply teaching frameworks that can be universally understood (CTI, 2020c).

The CALC Foundations

Co-Active coaching is a conversation centred around respect, openness, compassion, empathy, and commitment to speaking one's own truth (Kimsey-House et al., 2011). Described as being in a relationship where the communication shifts to a deeper connection, this approach taps into a human need for collaboration rather than the usual authoritative, superior-inferior communication style often found in provider-client settings (Kimsey-House et al., 2011). In a Co-Active context, the conversations are concentrated on supporting the client in identifying and clarifying areas for change as well as choice (Kimsey-House et al., 2011). Individuals seek out coaching to do things differently in their lives, or do different things (Kimsey-House et al.,

2011). Rather than focusing on the past, one goal of coaching is to enhance the ability of clients to become more aware of the moment by expanding and exploring the present (Kimsey-House et al., 2011). A great deal of attention is also spent on moving forward, helping clients envision an ideal future, and the path it takes to get there (Kimsey-House et al., 2011). With Co-Active coaching, there is an increased focus on the *experience* in terms of reaching goals, not just creating a list of actions that needs to be completed in order to be successful.

A coach can be described as someone who cares about people's well-being, decisions, and motivation to make a change, whatever that change may be (Kimsey-House et al., 2011). They are present to hold that client accountable and guide the client towards their dreams and goals with meaning and purpose (Kimsey-House et al., 2011). Coaches are trained to engage their client's thinking in ways that help to navigate human emotions and the complexity of reactions (CTI, 2020b). This can be achieved by assisting clients in reducing stress to enable longer-term solutions and sparking new thought patterns aimed at increasing the ability to make sound decisions (CTI, 2020b). The physical and metaphorical environment where a session takes place is crucial for the success of both coach and client (Kimsey-House et al., 2011). It is the coach's role to create and hold a physical and social environment that feels like a safe and courageous space where clients can approach their choices with motivation and autonomy, without fear of judgment (Kimsey-House et al., 2011).

Certified Professional Co-Active coaches deliver coaching through many forms of communication (Kimsey-House et al., 2011). Listening skills are predominant: coaches are trained to hear not only the words being said, but also what is behind and between the words, including silence. These conversations are beneficial as people are more likely to change if they hear themselves say it (Kimsey-House et al., 2011). Co-Active coaches focus on the energy,

emotion, and nuances of the voice, such that the coach's role is to hear what the client may not hear themselves say (Kimsey-House et al., 2011). Coaching sessions are typically administered over the telephone; and the use of telephone-based supports has been shown to be as effective as face-to-face supports in terms of patient outcomes, satisfaction, and relationship building (Tates et al., 2017). The rationale for telephone usage is mostly due to its convenience and accessibility within coaching sessions, and utility in remote communities (Goddard & Morrow, 2015; Pearson et al., 2013). Furthermore, the use of telephone-based support implies clients could be more comfortable in their own home discussing personal and professional challenges (Goddard & Morrow, 2015; Pearson et al., 2013). Overall, it is essential for the coach to help the client discover what is "true, real, and important" (Kimsey-House et al., 2011, p.155) while also enabling them to stop "avoiding, pretending, and denying" (Kimsey-House et al., 2011, p. 155) as they navigate to make meaningful decisions about themselves and their lives (Kimsey-House et al., 2011). The principles and fundamentals of coaching can be applied to many contexts and populations (e.g., Fried et al., 2019; Goddard & Morrow, 2015; Pearson et al., 2013). A growing body of CALC research is described below, while a detailed description of the CALC model can be found in Appendix A.

CALC- and Coach-Focused Research

Since CALC was founded in practice, a number of studies have been conducted to validate its' theoretical grounding (e.g., Irwin & Morrow, 2005; Pearson, 2011) and utilization in various health promoting contexts (e.g., Goddard & Morrow, 2015; Karmali et al., 2020; Mantler et al., 2013; Pearson et al., 2012). For example, CALC's effectiveness has been demonstrated in multiple domains including family weight management (Karmali et al., 2019; 2020), stress and mental resiliency in post-secondary students (Fried, Karmali, Irwin, et al., 2018; Fried, Atkins, &

Irwin, 2019; Fried & Irwin, 2016); physical activity engagement in children and adults (Goddard & Morrow, 2015); smoking cessation (Mantler et al., 2010, 2012, 2014), and obesity among adults (Newnham-Kanas, Irwin, & Morrow, 2011a; Pearson et al., 2012, 2013; van Zandvoort, Irwin, & Morrow, 2009). Sample sizes have ranged between five and 390, applied various study designs such as mixed methods, randomized trials, cross-sectional, and descriptive approaches, and focused on an array of health and wellness-related measures (e.g., physical, psychosocial, behavioural). Taken together, this body of literature has established the utility of CALC. However, very little research on the CPCCs who deliver these interventions exists (Grant & Zackon, 2004; ICF, 2016; Newnham-Kanas et al., 2011; Newnham-Kanas et al., 2012). Because CALC is founded on promoting self-care for others, it is important to understand how coaches achieve this for themselves, especially during times of crisis. Moreover, conducting research focused on CPCCs is imperative for the profession in order to advance the organization as coaching continues to flourish (Newnham-Kanas et al., 2012). In light of the societal movement towards telecommunication models for helping professionals (Government of Canada, 2020; Miller et al., 2018) and the lack of information in a crisis context, it stands to reason that CPCCs may offer unique insights to this end. Indeed, researchers have highlighted the need for more studies to assist professional organizations in further understanding and developing technology for the administration of telehealth, including the type of modalities used, strategies applied, and best practices that have been deemed successful (Molfenter et al., 2015). Gleaning an understanding of existing coaching and CPCC-focused research is imperative for determining next steps in these two areas.

In response to a need for more information on the coaching industry and coaches themselves, Grant and Zackon (2004) administered a 76-item survey to coaches who were ICF

members in order to develop a professional profile. The items consisted of multiple choice and short answer questions. Data were sought in six main areas: (a) coaching professionalism (e.g., training); (b) participant's coaching career (e.g., previous employment, history working as a coach); (c) coaching processes used (e.g., telephone versus face-to-face, session length); (d) coaching practice (e.g., number of clients, recruitment techniques, fees); (e) client profiles (e.g., life coaching, executive coaching); and (f) demographics (e.g., age, gender, education). Results were analyzed from 2,529 respondents and revealed, in general, that the coaches: (a) had come to coaching from an array of professional backgrounds (e.g., consultants, executives, managers, teachers, helping professionals); (b) practiced predominantly on a full-time basis (51.7%); (c) considered themselves to be self-employed (73.7%); and (d) were mostly female (73.1%). Coaching was primarily delivered over the telephone (63%), followed by in-person meetings (34.3%). The results from this study helped establish a better understanding of professional coaching and the backgrounds of the coaches themselves. Grant and Zackon (2004) stated that coaching research could only be furthered by continuing to track trends such as professional backgrounds, coaching organizations, client profiles, and various demographics amongst the coaches continuing to practice. Additional recommendations from the researchers included investigating why coaches choose the telephone compared to face-to-face coaching, along with examining the effectiveness of telephone delivery versus in-person sessions (Grant & Zackon, 2004).

Newnham-Kanas and colleagues (2011b) furthered this research by focusing on Co-Active coaches to create a comprehensive applied profile specific to this style of coaching. Revising Grant and Zackon's (2004) earlier survey, the researchers created a global online measure for CPCCs. Specifically, the researchers were interested in finding out who is drawn to

this type of profession and learning more about this particular coaching approach (Newnham-Kanas et al., 2011b). The sample consisted of 390 CPCCs who were over 18 years of age and had access to the internet (Newnham-Kanas et al., 2011b). Data collected included: (a) demographics (e.g., gender, age, education); (b) coaching professionalism (e.g., credentialing, training); (c) coaching career (e.g., prior professions, length of time working as a coach); (d) coaching processes used (e.g., telephone vs. face-to-face, length of session); (e) coaching practice (e.g., number of clients, techniques for generating new clients); and (f) client profiles (e.g., life or executive coaching). A variety of different response formats such as closed and open-ended questions, scale questions, and multiple response alternatives were included. Similar to Grant and Zackon (2004), the most common coaching delivery method was over the telephone (94%), and 74.9% of coaches identified themselves as self-employed and sole practitioners. While the data obtained from this study were important for supporting and characterizing the nature of the coaching profession further, Newnham-Kanas and colleagues (2011b) stated that future research is still needed on coaches to assist with continually advancing the coaching industry. Therefore, given the ongoing personal and professional changes many individuals are experiencing in line with the COVID-19 pandemic (Fetzer et al., 2020; Waddington & Pearson, 2020), further investigation into coaching profiles is particularly timely.

In keeping with this recommendation, Newnham-Kanas and colleagues (2012) additionally explored what coaches enjoyed about their work to assist with evaluative research being done on coaching services. This paper reported on a qualitative question that was included as part of the 2011 survey: “What do you enjoy most about being a coach?” A total of 351 coaches responded. Findings involved five themes including: (a) witnessing clients change their lives (e.g., coaches explained that assisting clients in their growth and change was one of the

main reasons they enjoyed their job); (b) deriving satisfaction and fulfillment from coaching and working with clients (e.g., they felt they were living their passion through helping others); (c) having a collaborative relationship with clients (e.g., having the ability to connect and be a partner with clients on their journey); (d) flexibility and autonomy of the profession (e.g., being able to coach wherever, whenever was intriguing for coaches, which helped their sessions become more creative with their clients); and (e) gratification obtained from using their skill set (e.g., skills such as those taught within the Co-Active model helped them create an experience of positive change for clients). This study demonstrated that coaching does not only help the client, but it is a profession where the coaches are "truly passionate and committed to the process of facilitating change in their clients' lives" (Newnham-Kanas et al., 2012, p. 54). Perhaps the first qualitative study to explore the perspectives of CPCCs, the researchers noted how this type of research is essential, given that the data can be used to attract prospective coaches to the profession (Newnham-Kanas et al., 2012). This particular study also highlighted the need for exploratory studies related to the coaches themselves in order to feed the knowledgebase of the profession, and assist training bodies with continually assessing their models and methods (Newnham-Kanas et al., 2012).

Building on this notion and recognizing that very few studies have focussed on the process of the coaching from the viewpoints of the coaches, Karmali and colleagues (2020) recently captured the experiences of CPCCs involved in an obesity-based CALC intervention targeting parents with obesity and their children (aged 2.5-10). According to the authors, exploring the perspectives of CPCCs working with specific populations, such as those with obesity, could allow for more information sharing amongst the coaches, thereby increasing their effectiveness when working with clients to meet their needs and goals. The intervention included

nine coaching sessions (20-30 minutes in length) over a three-month period. Semi-structured interviews were conducted immediately post-intervention with eight coaches involved in the study. Examples of questions included: “What was it like for you to coach during this study?”, “What advice do you have when working with this clientele?”, “What insights did you gain coaching individuals/parents struggling with obesity?” (Karmali et al., 2020, p. 118). Findings revealed that the participants found coaching rewarding and impactful, and liked noticing change in their clients. The intervention format was also noted as valuable. The coaches found facilitating the intervention over the telephone easier for the clients, stating that sometimes it is easier to talk about challenges that can leave the client feeling vulnerable using this mode, rather than in-person. Moreover, the client participants who were also interviewed as part of this study, indicated that they too enjoyed the telephone-based intervention as it was more convenient than in-person meetings and they could complete the calls from their homes. The authors concluded that gaining experiences from both the participants and study coaches affirmed the valuable impact that CALC has on behaviour change processes.

To conclude, a growing foundation of research exploring the viewpoints of practicing CPCCs exists; however, most has been conducted to develop a professional profile of coaches or has been related specifically to involvement in a research study. While researchers have identified that most coaches prefer over the telephone, versus in-person sessions (Grant & Zackon, 2004; Newnham-Kanas et al., 2011), additional studies are needed to determine how and why this seems to be effective (Grant & Zackon, 2004), especially during a worldwide pandemic. Moreover, with coaching becoming an increasingly sought-after health promotion alternative where coaches are tasked with providing highly personalized, emotive, and goal focused support for their clients (CTI, 2020a; Kimsey-House et al., 2011), understanding how

they simultaneously care for themselves is essential. In doing so, strategies and techniques may be identified and applied in the future to assist in overcoming challenges these coaches may be facing, with the hope of transferring these strategies to other like helping professions (Waddington & Pearson, 2020).

Co-Active Coaches and the COVID-19 Pandemic

In response to the need for more information on CPCC profiles as well as coaching and self-care during times of crisis, a pilot study was conducted during the spring of 2020. With the goal of uncovering beneficial strategies and barriers to practice that could be used to inform coaches and training bodies during the pandemic, the purpose was to understand coaches' experiences of practicing during COVID-19, including how they were using their training to help others, as well as themselves (Waddington & Pearson, 2020). A qualitative approach integrating semi-structured interviews was applied to explore the viewpoints of CPCCs who had been coaching throughout the pandemic. Questions pertaining to coaching during a crisis, training, self-care practices, and stress levels were included in the interview guide. Two CPCCs involved in an existing study being overseen by the student's supervisor were interviewed and findings revealed several themes and related subthemes. These included: (a) *Being a Co-Active Coach* (how they are coaching, mental health support, personal connection); (b) *The Coaching Model* (agency, collaboration); (c) *Coaching During a Pandemic* (crisis coaching, scheduling, unique opportunity, commitment, personal coping); and (d) *CTI* (preparation, training institute, adaptability). This exploratory approach was useful in revealing perspectives on what it is like to coach during a pandemic, and provided a valuable foundation for furthering related CPCC-oriented research. Due to the very small sample-size, further research was recommended to

replicate and expand upon the findings and determine optimal self-care strategies, as well as explore coaching processes used (Grant & Zackon, 2004; Waddington & Pearson, 2020).

Limitations within the Literature and Study Purpose

To date, the literature regarding self-care among helping professionals has identified its cruciality; being proactive in this regard not only benefits the helpers, but their clients and the overall effectiveness of practice as well (Friedman, 2017; Norcross & Phillips, 2020). Studies conducted have mostly been: (a) quantitative in nature; (b) implemented in larger organizational structures or institutions where professionals work in a team environment (e.g., Barlow & Phelan, 2007; Miller et al., 2018; Rupert & Dorociak, 2019); and (c) involved conventional and allied health professionals (e.g., Alkema et al., 2008; Mills et al., 2017; Richards et al., 2010). Thus, more qualitative research in this area is needed to gain insight into self-care experiences and strategies used, especially for those who are self-employed in private practice (Barlow & Phelan, 2010). Because most helping professions are clinical in nature, they may not be appropriate for individuals seeking self-improvement or addressing non-clinical issues, such as lifestyle change or motivation. Certified Professional Co-Active coaches may offer unique insights in this context given their inherent commitment to promoting self-care among their clients.

Given its demonstrated utility in chronic disease and mental health contexts (e.g., Jaglal et al., 2013; Molfenter et al., 2015), combined with COVID-19 related restrictions regarding in-person contact, studies examining the use of telecommunications are needed at this time. Specifically, exploring experiences with telephone delivery to determine benefits, challenges, and best practices during the pandemic are warranted as this crisis continues to evolve (Bokolo, 2020; Molfenter et al., 2015; Waddington & Pearson, 2020).

Therefore, the *primary purpose* of this qualitative study was to explore CPCCs' views related to: (a) coaching during the COVID-19 pandemic (Casey, 2020; Karmali et al., 2020; McCann et al., 2013), and (b) their own self-care during the COVID-19 pandemic. The *secondary purpose* of this study was to collect insights from CPCCs about the utility of telecommunications for service provision (Grant & Zackon, 2004; Newnham-Kanas et al., 2011; Waddington & Pearson, 2020). By exploring insights into self-care and telecommunication in practice during COVID-19, it was hoped that beneficial strategies and techniques that can be applied during times of crises and leveraged in the future by coaches, clients, and training bodies alike would be identified (Newnham-Kanas et al., 2012; Waddington & Pearson, 2020).

Positionality

In qualitative research, the researcher is typically the main source of instrumentation during the data collection and analysis phases. Therefore, making a statement on personal beliefs and origins is important given that the researcher's own underlying biases may unintentionally inform the research process and findings (Kowalski et al, 2018). This stance is referred to as *positionality* or *reflexivity* (Kowalski et al., 2018), and involves a researcher working to set aside their own experiences, and only focus on those of the participants (Kowalski et al., 2018). In the present study, reflexivity was practiced by the student researcher (KW) through memoing personal beliefs and experiences as they unfolded throughout the research process in relation to the methods, data, and constantly changing COVID-19 restrictions.

For the reader, it is useful to outline social and physical attributes that may have influenced the direction of the research. As a middle-class, able-bodied, heterosexual, Caucasian female, I have been fortunate enough to live a life of privilege, especially during times of crisis (i.e., a worldwide pandemic) in terms of maintaining employment, stable housing, family

connections, and access to healthcare. These attributes could have impacted myself and my views as a researcher throughout this process. I may inadvertently be ignorant to the very real struggles of those living through COVID-19 besides the fear of catching the virus. For example, some interview questions ask about various challenges the coaches face regarding COVID-19, but these questions are in line with the participants' coaching practices, and not the various difficulties that may exist for these participants such as loss of a loved one. Through undertaking this research project, I have realized that I hold a number of personal views on the COVID-19 pandemic; a rather controversial topic when it comes to personal freedoms. As a Master of Science Student, I firmly value science-based evidence and theory. I view COVID-19 as a serious infectious virus that can cause severe illness among those who test positive. As such, I fully agree with related recommendations regarding transmission and prevention (e.g., physical distancing restrictions, wearing masks, obtaining a vaccine) which are taking place across most of the world. These views and values may not align with others. As a qualitative researcher, building rapport with study participants is an integral part of the research process. Because of my keen interest in health promotion and coaching, I believe I was positioned to share a number of mutual interests with the coaches involved, thereby enhancing the feasibility of data collection. For example, there may have been a mutual degree of relatability in terms of privilege and social locations (i.e., education level, common interest in caring for others, valuing the notion of research, experiencing a worldwide crisis). As the data collection process ensued, I became acutely aware of my own beliefs in relation to the pandemic and how these differed greatly from a small portion of the study participants. This may have been due to geographical location, whereby some individuals in certain areas of North America are less concerned about COVID-19 and related protocols compared to others with citizens who do not believe in the virus as an

infectious disease; and nor do these individuals believe in vaccines and related restrictions. In these cases, I worked diligently to manage my own contrasting views on COVID-19 by referring often to my study purpose and focusing on the interview guide to remain neutral. I also reflected back regularly via member checking during the interviews to ensure that I was understanding participant perspectives accurately.

Method

Study Design

This qualitative study used a *descriptive* approach (Kowalski et al., 2018) which involves exploring a phenomenon (e.g., self-care among CPCCs during a pandemic) with no attempt to link the information or explain the outcomes (Kowalski et al., 2018). Qualitative research can consist of conversations and observations that add a personal approach to the data by identifying general themes among participants (Kowalski et al., 2018; McGill, 2018). Regarding a philosophical worldview, a *constructivist* approach was used. Constructivism involves the idea that multiple realities exist, and that meaning can be varied depending on the context or environment in which the research takes place (Kowalski et al., 2018). In doing so, the researcher adopts a stance where there is no distinct set of emotions or outcomes similar across all domains, meaning feelings and experiences are subjective (Kowalski et al., 2018). The researcher took on this constructivist approach by seeking out a variety of views to better understand experiences of CPCCs in regard to coaching during the COVID-19 pandemic, their own self-care during the pandemic, and service delivery provision. This worldview was applied throughout the application of one-on-one, telecommunication-based semi-structured interviews (McGill, 2018).

Participants

Inclusion criteria required that participants were CPCCs who could speak English fluently and had been actively coaching (e.g., at least one client per week) throughout the COVID-19 pandemic (i.e., since March 2020). This would allow participants to reflect on their practice experiences over time, as pandemic related guidelines and restrictions have changed. Furthermore, CPCCs were expected to have been practicing at least six months prior to the pandemic onset to enable reflective comparisons regarding pre- versus during-pandemic experiences. It was expected that coaches would reside in North America in an attempt to avoid extreme variation in COVID-19-related mandates and experiences. The certification criterion was to ensure that all participants had received the same baseline training, thereby maintaining a sense of standardization in treatment fidelity (Karmali et al., 2020). Those with additional coaching qualifications were considered eligible; however, they were asked to speak specifically to their CPCC training and related experiences.

Lastly, as qualitative research continues to grow, there is a continuing need to maintain high standards of rigour, as many studies fail to substantiate their sample size sufficiently (Vasileiou et al., 2018). Therefore, the researcher included two sample size justifications for the present study including data saturation and pragmatic considerations (Vasileiou et al., 2018). According to Vasileiou (2018), these justifications were utilized most often in previous qualitative studies (55.4% and 9.6% respectively). Saturation is the most widely used principle for determining sample size. This involves the idea that gathering new data no longer reveals any new insights or themes (Kowalski et al., 2017; Vasileiou et al., 2018). Pragmatic considerations involve being aware of time constraints or the difficulty of obtaining a specific population needed for the study (Vasileiou et al., 2018). Based on the small number of qualitative studies

focused on CPCCs that exist (Karmali et al., 2020; Newnham-Kanas et al., 2012), it was expected that approximately 12-15 coaches would be recruited for involvement. For example, Karmali et al. (2020) aimed to recruit 12 participants and enrolled eight, which was found to be acceptable in terms of saturation in line with their study goal. In contrast, Waddington and Pearson (2020) had an $n = 2$ (Waddington & Pearson, 2020) and found that saturation was not reached in their pilot study exploring CPCC views on self-care practices while coaching during COVID-19.

Procedures

Upon receiving approval from the Research Ethics Board at Lakehead University, CPCCs were recruited using three techniques outlined in previous CALC studies (Harvey, 2018; Pearson et al., 2013): (1) online advertisements distributed through the Co-Active Network, a website affiliated with CTI intended to promote discussions and support among Co-Active coaches; (2) via contacts made through previous coaching studies conducted by the student researcher's supervisor along with her personal contacts as a CPCC herself; and (3) using snowball sampling where participants contact other colleagues (Kowalski et al., 2018). The online advertisements included the student researcher's email address to enable contact by interested participants. Upon receiving email correspondence from interested coaches, the student researcher sent potential CPCCs an eligibility form (Appendix B), a recruitment letter and poster (Appendix C), a letter of information (Appendix D), and a consent form (Appendix E) to provide more information about the study (e.g., inclusion criteria, details of data collection, types of interview topics, and what will be expected of them). If the CPCC wished to proceed, they were asked if they would like to speak first either over the telephone or Zoom, and then an informed consent and eligibility form was filled out and sent via email. Once consent was obtained, the participant was sent a link to

the demographic questionnaire (Appendix F) via Google Forms to hold confidentiality (participants used a unique ID number). After this was completed, the duo determined an agreed-upon time for the student researcher to call the participant for the semi-structured interview (see Appendix G for interview guide).

Recruitment and data collection were ongoing from February to April of 2021. All interviews took place virtually with a choice of either the telephone using a password-protected recording feature (50%) or via Zoom platform with cameras on (50%). The telephone was chosen as a data collection mode as previous coaching studies have supported its use, deeming it convenient and able to act as an anonymity "shield" when discussing personal experiences (Karmali et al., 2020, p. 122). Similarly, the Zoom platform was selected as this appears to be an acceptable approach when attempting to mimic face-to-face interviews, including being easily accessible, cost effective, and possessing acceptable security measures to maintain confidentiality (Gray et al., 2020). As the interviews were conducted based on the scheduling preferences of the participants and in consideration of differing time zones, interview appointments ranged from within business hours (i.e., 9:00am – 5:00pm) to evenings (i.e., 6:00pm – 9:00pm) and ranged from 30-40 minutes. After each interview was completed, the participant was thanked for their time.

Measures

Demographic and Professional Profile

To capture personal and professional participant characteristics, a questionnaire was administered through Google Forms. A combination of closed- and open-ended questions asking about participant demographics (age, gender, education level, current home city, ethnicity) and coaching careers including pre-and during pandemic (length of certification, prior profession

before coaching, type of coaching [life/executive], techniques for generating new clients, delivery mode [telephone/Skype/face-to-face], number of coaching sessions in a week, number of clients, and coaching hours) were included. Questions were derived from studies conducted by Grant and Zackon (2004), Newnham-Kanas and colleagues (2011a, 2011c, 2012), and Waddington and Pearson (2020). This information was used to create a participant profile of those involved in the study and further the knowledgebase in the field of professional coaching (Newnham-Kanas et al., 2011c). Grant and Zackon (2004) stated that to further research in coaching, trends and profiles should be continually tracked. It was thought that doing so during a pandemic would be particularly valuable in order to determine any noteworthy changes.

Semi-structured Interview Guide

One-on-one semi-structured interviews are beneficial for allowing participants to express their views on their own terms with room for follow-up and expansion throughout the process (Cohen & Crabtree, 2006). Questions were formulated to address the purposes of the study with respect to gaining the perspectives of coaches regarding self-care, coaching during a pandemic, and delivery mode experiences. More specifically, building on previous studies conducted by Newnham-Kanas and colleagues (2012), Miller et al. (2018), and Waddington and Pearson (2020), the interview guide was separated into three sections: (1) *Coaching During a Pandemic* (i.e., “What is it like for you to coach during the COVID-19 pandemic?”; “What do you think has prepared you for coaching during a pandemic?”); (2) *Self-care During COVID-19* (i.e., “How would you describe self-care?”; “To what degree have you been able to prioritize yourself and your own needs during this time?”); and lastly (3) *Delivery Mode* (i.e., “What modality are you currently using to coach and why?”; “To what degree do you think this mode of delivery could be successful for other helping professionals who provide in person services?”).

Data Analysis

Descriptive statistics (e.g., means, frequencies) were used to present the coaches' characteristics derived from the demographic questionnaire. This allowed the student researcher to identify and summarize patterns within the data to gain a better understanding of who was participating in this study, while furthering the profiles of CPCCs in relation to practicing during a worldwide pandemic (Kowalski et al., 2018; Newnham-Kanas et al., 2011). The semi-structured interviews were transcribed verbatim and analyzed using inductive content analysis; a process whereby themes emerge from the data and are not identified in advance (Elo & Kyngas, 2008). The study purposes provided the boundaries for applying a deductive approach, and then within those boundaries, the themes were derived organically from the transcripts (Elo & Kyngas, 2008).

A variety of steps were taken to accurately analyze and code the data inductively by each interview section which provided the boundaries for a deductive approach. Within those boundaries, the themes emerged organically from anywhere in the transcript. Steps included: (1) The data were organized and prepared by reading the selected unit of analysis (i.e., the interview transcripts; Elo & Kyngas, 2008) several times. This way, the researcher was able to form insights about the data and become more familiar with it (Elo & Kyngas, 2008); (2) Next, the researcher read through all the data with the purpose of starting to categorize common phrases and words that were then grouped together to form broad themes; (3) As themes started to become more noticeable throughout all transcripts, a coding process began with all of the data, where categories and subcategories were developed along with complimenting quotations from the participants; 4) The emergence of these themes was used to generate a detailed description of each category or theme; (5) Upon completion of step four, two researchers (ES and KW) then

met to compare identified themes and determine which ones most accurately captured the participants experiences and viewpoints. Then a decision was made on how these findings were represented within the study (Kowalski et al., 2018).

Following manual analysis, the software program, NViVo 12, was used to assist the student researcher in verifying thematic salience via the frequency of codes (Zamawe, 2015; Appendix H). Zamawae (2015) stated that the software program can boost the accuracy of the qualitative analysis phase, aiding the coding process in great detail by enabling one to compare and contrast multiple paragraphs which may be missed with the human eye. Once the transcripts were imported into the software program, the coding was conducted line by line to identify common phrases or words that were then pasted into a coding table that allowed the researcher to examine consistency and a hierarchy of the themes. To determine what was considered salient within the coding process in NViVo, themes were identified by two factors: (1) the frequency that they occurred across all data sets; and (2) how relevant the theme or re-occurring code was in relation to the research purposes (Braun & Clarke, 2006).

Trustworthiness of the Data

Since qualitative research was used for the present study, strategies to enhance the trustworthiness of the data were applied including credibility, transferability, confirmability, and dependability (Lincoln & Guba, 1985). *Credibility* is described as confidence in how accurately the data aligns with the focus of the research study (Elo et al., 2014). Credibility was enhanced as the student researcher followed ethical guidelines, and employed member checking (i.e., summarizing and repeating back the interpretations during an interview; Birt et al., 2016). This occurred between questions to obtain participant validation on the authenticity of their responses and verify accurate understanding by the interviewer (Merriam & Tisdell, 2015). Next,

transferability is described as the potential for the findings to be transferred to other like settings (Elo et al., 2014). The student researcher captured the details needed to maintain a descriptive account of the data within the thesis to help others determine if the findings are transferable to their own subjects and settings, including a detailed audit trail (Merriam & Tisdell, 2015). An audit trail assisted the researcher by capturing detailed steps and procedures of the data collection and analysis processes that led to the final outcomes and decisions regarding the findings (Merriam & Tisdell, 2015). *Confirmability* can be described as objectivity of the findings, meaning that the findings or interpretations can be compatible between participants and researchers who are coding and analyzing the data (Elo et al., 2014). *Confirmability* was addressed as the student researcher and supervisor both performed inductive content analysis on the transcripts independently (Lincoln & Guba, 1985). This allowed the data to be examined for commonalities and differences across the interviews as the themes started to develop (Lincoln & Guba, 1985). This process helped to minimize any potential researcher biases while attempting to ensure that the findings were shaped by the participants more so than the qualitative researcher (Meriam & Tisdell, 2015). Lastly, *dependability* can be described as the "stability" that the data achieves over time and under different conditions that may arise (Elo et al., 2014, p. 2). *Dependability* was addressed by holding regular debriefing meetings between the student researcher, supervisor, and/or members of the thesis committee during the data collection and analysis phases to reflect on and record any biases that may have influenced the study procedures (Lincoln & Guba, 1985). Moreover, honesty demands (Bates, 1991; i.e., telling participants to answer as honestly as possible, with no right or wrong answers) was discussed before the interview began.

Results

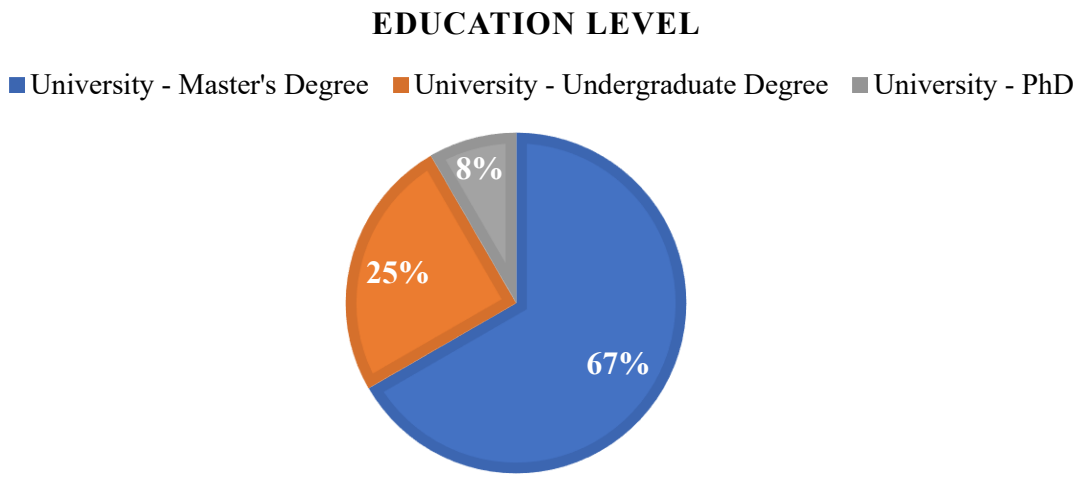
Participants

In total, 12 participants were enrolled in and completed the study. Originally, 13 coaches committed to being involved, but one individual did not follow-up with the student researcher to arrange the interview and could not be reached after two attempts. Participants ranged in age from 40-72 years of age (M = 54.5 years, SD = 8.2), and included 10 female (83.33%) and two male CPCCs (16.67%). All participants identified as Caucasian with the majority stating they were married (92%), and most had obtained a Master's degree (67%; Figure 1). When asked for length of practice as a CPCC, times ranged from less than one year to 14 years in the field (Figure 2). In terms of employment status, 67% of participants identified that they were a full-time CPCC, and 33% identified as part-time coaches. It can be noted that CPCC designation does not require a prerequisite regarding education. For coaches who stated that they coached part-time (33%), their educational background was related to their other profession (e.g., coordinators in business/organizational development, real estate investment, university faculty). Type of coaching practiced was also queried; life coaching (n = 3) and executive leadership coaching in isolation (n = 3) were noted, in addition to various hybrids which were the most common (n = 6; refer to Figure 3 for other types coaching practiced). *Life coaching* revolves more around health areas and lifestyle habits (e.g., diabetes, fitness, obesity, physical activity, dietary intake; Joseph et al., 2001; Newnham-Kanas et al., 2008; Tidwell et al., 2004), whereas *executive coaching* revolves around management consulting and professional development (Kampa-Kokesch & Anderson, 2001). *Leadership coaching* involves identifying various dimensions of leadership and capability among managers or emerging leaders in the workplace (PowerUp, 2021). The primary strategies reported for generating new clients included referrals

(31%) and networking (31%) which participants explained came from conferences, podcasting, workshops, and collaborating with committees. Lastly, delivery mode was tracked via whether the coaches used video or phone to provide their services. Video platforms such as BetterUp, Microsoft Teams, Zoom, and Skype were used by 67% of coaches, all of whom stated that the video was mostly turned on with the exception of a few clients who preferred just the audio. Regarding phone use, 33% of coaches solely used the phone to deliver coaching services.

Figure 1

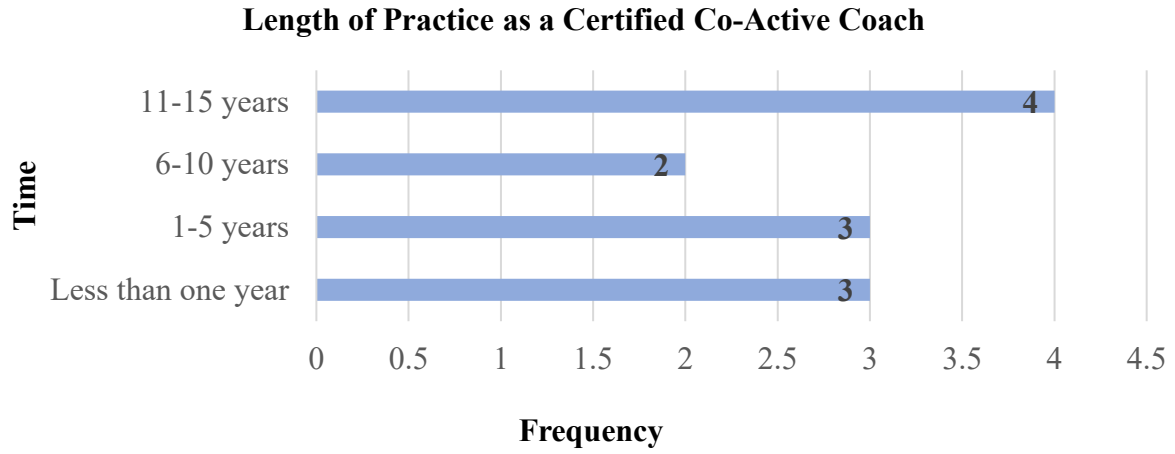
Highest Education Level Completed



Note. This figure demonstrates participants' highest education level completed.

Figure 2

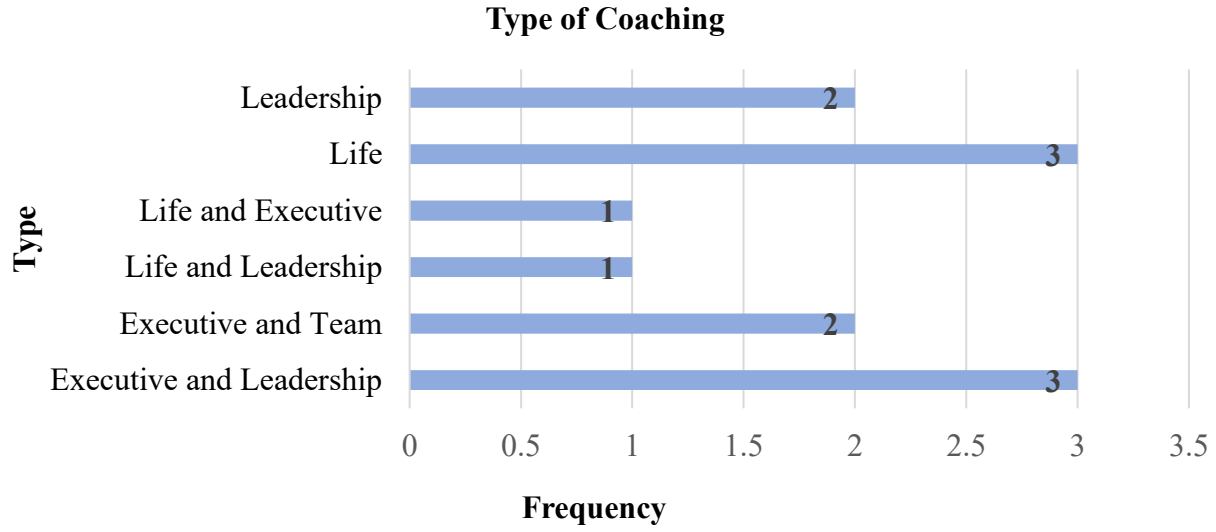
Length of Practice as a Certified Professional Co-Active Coach



Note. This figure demonstrates participants' self-reported time since they started coaching as a CPCC.

Figure 3

Type of Coaching



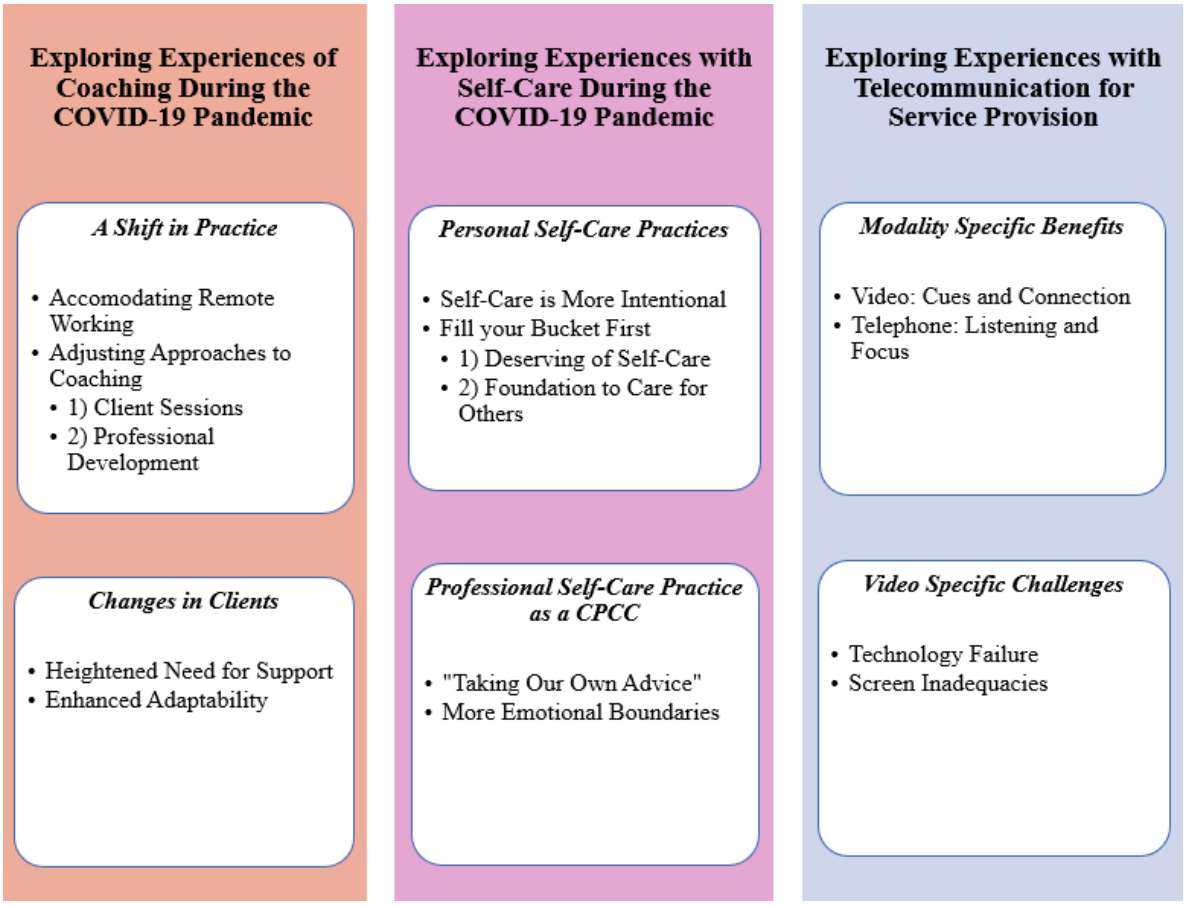
Note. This figure demonstrates the different types of coaching conducted by the CPCCs involved in the study.

Qualitative Findings

Six main themes and twelve related subthemes emerged from the interview transcripts inductively, and were then categorized deductively into three sections in line with the study purposes: (1) Exploring experiences of coaching during the COVID-19 pandemic; (2) Exploring experiences with self-care during the COVID-19 pandemic; and (3) Exploring experiences with telecommunication for service provision. A summary figure (Figure 4) is found below along with a descriptive account of each theme and subtheme with accompanying quotations.

Figure 4

Interview Themes and Subthemes



Note. This figure provides a visual representation of the salient themes and subthemes that emerged from the interviews.

A Shift in Practice

During each interview, changes related to coaching practice (i.e., how coaching is delivered to clients) in response to the COVID-19 pandemic emerged and were divided into two subthemes: *Accommodating remote working* and *adjusting approaches to coaching.* It should be noted that according to participants, these are changes that have taken place since the pandemic began in March 2020.

Accommodating Remote Working

Many participants indicated that they had to make adjustments for clients who were working from home due to the pandemic. According to these CPCCs, scheduling issues, having children present, and stress associated with isolation from work colleagues and being away from the office were noted by their clients and also arose as challenges for the coaches themselves. Trying to work from home while parenting simultaneously was also discussed often as a challenge when it came to scheduling and being present in sessions for coaches and clients, as children were home from school. For example, one coach *mentioned the need to be flexible* for clients as they knew clients had family at home, were working from home, and the pre-COVID expectation of being in a quiet place to coach was not as feasible as it was before when children were at school and other family members were at work.

Adjusting Approaches to Coaching

Several participants discussed how they had to make adjustments to how they coached once the pandemic began, *using different strategies* that they hadn't used regularly before. Two main topics were highlighted across participants: (1) how coaches used certain tools/strategies in their sessions with clients; and (2) how they themselves viewed coaching and how that informed their approach during the pandemic (e.g., professional development). For example, one coach

mentioned the need to stay in the present more often, as the future was so uncertain. Other coaches noted engaging in professional development activities such as "positive intelligence training" that helped them and how they viewed coaching during the pandemic. Supporting quotes can be found in Table 1.

Table 1

A Shift in Practice

Accommodating Remote Working
• "Definitely the **topics that we discuss now have shifted** and changed … there were themes that have cropped up over the last year. You know, initially it was kind of the shock of COVID and going **to remote working** and missing your colleagues at work and those sorts of topics." [P 001]
• "I do think, particularly with the **remote working** aspect of all of this, and especially for **families with young kids.** [T]he thing that surprised me … I hadn't anticipated the impact this would have on the single people stupidly. Um, but you know, they're sitting at home in their apartments, not able to go out, not able to see their friends, **not even be able to go to the work office**." [P 001]
• "I recognized my clients who were **remote working,** there were different holds that they had on their schedules that they sort of wouldn't have if they were in person. So **scheduling was really challenging**." [P 006]
• "[O]ne of the new things that I heard during the pandemic that I hadn't heard before was the **challenge of working from home with kids … that definitely was an issue,** you know? And that just came down to the people who had like, elementary school kids." [P 010]
• "We've [Coaches] pivoted towards **offering more support to people around remote work**, more support around remote communication." [P 012]
• "Initially, I tried to be very strict about, you know…' You have to be in a private quiet space.' And I realized that's not possible for some people … So, I can choose not to coach them, but I'd rather like, find ways to **flex and accommodate**…So you know, trying to just be mindful of this as part of the universe, and I have to meet the client where they are." [P 009]
Adjusting Approaches to Coaching
During Client Sessions
• "[Changes in coaching strategies since the pandemic began?] **I use more um vision exercises** than maybe I used to [before], and I mostly do it through Zoom. I turn off the camera during those and just give people some space, and some non-Zoom camera time can really help them go to a deeper place." [P 003]
• "[W]e have been able to work more with our clients **on topics of resilience and flexibility and goal setting through adversity, and being okay with where we are today** and what's incomplete." [P 006]

- "[Client related changes?] And that [listening] I wasn't expecting, but clearly, they needed someone to talk to, someone to bounce things off of, someone to, you know, help them … **listen deeply** or … **help them make sense** of what was going on in the world, and begin this new uncertainty, or how good they were being, or how were they doing with the uncertainty …." [P002]
- "[W]hen the pandemic hit…it [coach sessions] just sort of **shifted**, like you know, people were like 'The things that I came here to talk about feel so trivial now. Like, **I don't even know what I want to talk about.**' Or 'The challenges that I had are so much easier now.'" [P009]
- "It's about **flexibility and resilience**, I mean there's just so much that this thing [pandemic] has brought us, I just know that as I, as a coach, have tried to grab on to every single one of those moments to coach those topics." [P 006]

Via Professional Development

- "Last March, I was in the very first class for the positive intelligence, and I know they continue to run them for people, so, like that was like great …and then I really got into the whole research and study around **positive intelligence**, and I think it helped me with my attitude and my mindset throughout the pandemic." [P 003]
- "I've had **more interest in learning about emotional intelligence** [since the pandemic started**],** specifically around resilience and stress management than I did before." [P 010]
- "What's different for me is my **practice [has] opened up a new frontier in mental fitness** … some people call it wellness category, but I'm leaning into mental fitness. So that, in the last year, has just really become… I hesitate to give it a percentage, **but maybe close to half of my effort goes into that now, whereas the year ago it didn't."** [P 007]

Changes in Clients

Across many interviews, participants mentioned the changes they noticed in their clients since the pandemic started in March, 2020. The changes can be categorized into two subthemes: *Heightened need for support* and *Enhanced adaptability.*

Heightened Need for Support

Many participants stated that their clients experienced different mental/emotional challenges such as *increased anxiety* and *cancelling sessions due to feeling overwhelmed, as well as a general need for more mental health focused coaching* (i.e., versus their traditional styles such as leadership or executive coaching) compared to before the pandemic began. Furthermore, a contrasting finding emerged regarding an increase in clients versus a decrease in clients since the pandemic started. For example, two coaches said they noticed a higher degree of withdrawal

(i.e., cancelled sessions) in their clients while also stating that most clients in their caseload needed heightened support.

Enhanced Adaptability

Some participants noticed changes in their clients in terms of increased adaptability regarding getting through the pandemic and accommodating such a crisis to take place. For example, coaches mentioned that their clients became more resilient as they were *forced to face their goals during such adversity* within this pandemic. Several coaches spoke in awe regarding their clients' ability to be flexible during these times, and still carry on with their goals when the future is still so uncertain. For example, one coach mentioned how fun it is to see their client's creativity emerge through these times. Supporting quotes can be found in Table 2.

Table 2

Changes in Clients

Heightened Need for Support
• "My clients would either **disengage or become very dependent** on me. There weren't a lot of people who were able to maintain status. They either paused coaching, or it was like an email every other day." [P011]
• "What I found is there's a number of clients that are now putting their sessions on pause because they truly are at that **mental health sort of cracking point**. Like, they just truly can't even think about talking to a coach about moving forward or honouring values." [P 002]
• "People also have come to coaching with maybe **some more emotional stuff** then they might have before and so you're just, sort of be prepared to be spacious within that idea, and just allow people to have their space as you're coaching … It seems even more important now not to have people feel pressed." [P 004]
• "So, during this pandemic …I have now **seen more anxiety** to **generalized anxiety about this situation**." [P 004]
• "…**my mental fitness clients just showed up**. I mean, I've had close to 50 people go through this program with me only in the last six months, so that surprised me." [P 007]
• "For some people, it's, everything is so **much more stressful; 'I need support that I didn't realize I needed to before**.' So, I feel like it's the, you know, kind of the physical impacts and the emotional impacts." [P 009]
• "I mean in terms of the content of what they [clients] might talk about, some of them are referencing more you know… where maybe they would have talked **about anxiety** for other

reasons…now you know, yet another quarantine or curfew, or you know, the requirements that **COVID has imposed is creating stress** in their lives." [P 010]

Enhanced Adaptability

- "I wouldn't say going back to how it was before, [but] **I think they have accommodated** to the changes [a pandemic requires] a lot more." [P 005]
- "I think actually how well people [clients] **have adapted** [has surprised me]." [P 005]
- "But for the most part they have their goals. Those haven't changed; their goals are **adaptable** in a COVID environment. **Staying focused on your goals**, that's been the beautiful part." [P 006]
- "I have seen so many people really taking stock and saying, '[T]his is something! Like, our lives have changed. This is **something we never anticipated** or expected, things are, things about that horrible.' There are things about that that are wonderful; that there's like, this moment of opportunity for them." [P 009]
- "People's **resilience and creativity,** and **it's been fun to watch them realize that they have capacity.** Greater than just this like, what they need to survive day to day." [P 011]

Personal Self-Care Practices

When asked about self-care experiences, many coaches identified changes to their practices related specifically to the COVID-19 pandemic. Two main themes emerged throughout the interviews: *self-care is more intentional* and *fill your bucket first*.

Self-Care is More Intentional

The majority of participants said that their self-care practices had become a conscious routine and effort due to COVID-19. Many explained how they have to be a lot more disciplined about their self-care regimens, and that more effort has been going into their practices. For example, one coach noted that they do not wait for a crisis to happen anymore, and have to be very structured to ensure they are preventing the need to recharge, which has been heightened since the pandemic started.

Fill your Bucket First

When asked about changes in their self-care practices since the pandemic began, many coaches mentioned the necessity of listening to one's own needs as a coach before responding to

those of others. Two main reasons for filling your bucket emerged from the transcripts: (1) Coaches *deserve* to engage in self-care and do what is best for them. For example, some participants noted that they also deserve the care and attention that they teach to their clients; and (2) Self-care serves as a *foundation* whereby one needs to put themself first in order to have the energy to care for and support others (e.g., clients, family, etc.). Descriptive quotes can be found in Table 3.

Table 3

Personal Self-Care Practices

Self-Care is More Intentional
• "So, we had to be **really intentional** about this [self-care] as totally a self and marital care process in order to get through this because it's [pandemic, busy life] just too much." [P 006]
• "Remembering to do it [makes self-care easy]. I'm like, when **it's a routine** and that's a habit when I focus on it." [P 006]
• "It's [self-care] very much more internal in the moment, and I'll say, sort of ongoing. So, I don't wait for a crisis to think 'What do I need to do for myself?' or wait 'til I'm super exhausted to try to recharge." [P 009]
• "[To me, self-care means] … **really listen to yourself.** Get to know what's really important to you. Give yourself a steady diet of that. Don't wait for it to become a crisis." [P 009]
• "… It's really nice to turn off my own needs and wants and care for other people. But that [feelings of burnout, exhaustion] just still comes crashing in. And our **ability to bounce back with no investment in time or care gets diminished over time**." [P 011]
• "Self-care also means not just the physical, but spiritually **understanding my own needs and reflecting on what's most important to me** which, good grief! If there is one thing 2020 taught me, [it] was to **prioritize what's most important to me** and make sure that my energy and my behaviour and my time all aligned with what's most important to me." [P 003]
• "Well self-care to me means really being intentional about my needs…" [P003]
Fill your Bucket First
Deserving of Self-Care
• "[When] my daughter calls… **it fills my bucket**…So, understanding what **fills my bucket** and being aware of that is really important to me." [P 003]
• "[A]s a human, it [self-care] matters … You know what I mean? Like, there's all this other stuff, and I know I keep saying it, **but I feel like people that are helpers tend to forget that a lot.** Not only can we just not show up and be our most effective selves, but like, outside of all of that, **we deserve that care and attention that we're trying to teach other people to do**." [P 011]

- "**Taking care of our own mind and mindset to me is number one** because that's where it all starts, you know?" [P 003]
- "The most important element of self-care that I have discovered and practice is truly, like **being true to myself**. Like, **doing what makes sense to me** and not being so focused on trying to please other people." [P 009]
- "Well, I learned the hard way … **I thought I was taking care of myself and I wasn't.** And I got very sick and the stress got the best of me. So, what's important is about living. It is necessary to live a long life, and it's necessary to be my best for my family and friends, and it's necessary for me to be happy." [P 007]

Foundation to Care for Others

- "For me, that's like the fundamental thing of self-care is starting with '**What do I want?' and then, 'How do I support other people?'"** [P 009]
- "With living in my version of self-care, **I know that I can fully show up for a client, like early on**." [P 009]
- "Oh, it's **foundational to ground yourself** if you want to be able to care with and for others … **You have to have care for yourself,** or have a **wellspring** that you can draw on occasion, and the self-care can provide you with that. It builds internal resources for the coach." [P 005]
- "So, I needed to take care of those things [emotional, mental, physical needs] in order to be, to **have the energy to coach other people,** to have the emotional bandwidth to coach other people." [P 012]
- "It [self-care] provides the **resource foundation to be able to care for others**. I think that coaching is part of a caring profession." [P 005]

Self-Care Practices as a CPCC

The notion of self-care related to being a coach and coaching came up frequently throughout all of the interviews. Two major themes were identified: *sharing of self-care recommendations via "taking our own advice" and more emotional boundaries.*

"Taking Our Own Advice"

Several participants stated that coaching other people on self-care strategies or discussing the importance of self-care with clients actually helped them to engage in more self-care personally. For example, one coach mentioned that they were jotting down notes on self-care when working with a client with the idea that they should also be doing this activity. Many of the participants shared that this heightened focus on self-care with clients was more common since the pandemic began. Some coaches noted that it was nice to just talk with others and relay ideas of self-care

that they may have forgotten due to COVID-19. The coaches said that once talking about self-care, they realized they should also be following their own guidance.

More Emotional Boundaries

The coaches noted that COVID-19 has escalated highly emotive sessions, and that these are occurring more often since the pandemic began. As a result, being purposeful about setting emotional boundaries in this regard was discussed frequently. Some coaches shared the idea that in a helping profession, becoming an emotional sponge can occur. This is when the coach or the helper starts to absorb a lot of emotions in relation to the client, leading to feelings of excess stress or negative emotions (Fader, 2021). For example, some coaches mentioned the need to separate their coaching from their own feelings as an act of self-care, and that they needed to be aware of how much they could absorb as a helper in a coaching session. Supporting quotes can be found in Table 4.

Table 4

Personal Self-Care Practices

"Taking Our Own Advice"
• "I remember when I was in coach training, often you'll end up giving homework assignments or action items to clients and **you're kinda partly scribbling it down for yourself, going 'Oh yeah. I should totally do that!'**" [P 001]
• "Yeah, my **coaching makes it easier** [to practice self-care?] because oftentimes you deal with the issues that other people have. And [so you're] prioritizing, and having balance and well-being, and being the person that they want to be … I'm a coach to them. So, I need to be [this] to myself too. And that actually helps me a lot." [P 004]
• "Know what your needs are and do them … **Reflect over the content that comes up in your coaching sessions** around their self-care and probably **do that yourself**." [P 006]
• "I think it's [coaching and self-care] just **intricately connected.** because I focus so much on that [self-care] with my clients. Like, telling them to tell themselves [that] they love themselves in the mirror, or meditate, or you know, mindfulness practices." [P 008]
More Emotional Boundaries
• "In coaching relationships … part of my job is to care for my clients and to be there for them and to listen very deeply and you know, to want to bring out the best for them [and]

supporting them in achieving that…But the consequence of that, is that there can be times particularly when things get tough. I've had plenty of clients who have gotten very emotional … but in this circumstance [COVID-19] you know, I've had clients… sort of back-to-back, highly emotional sessions … really struggling, really feeling overwhelmed, really feeling challenged. And that **definitely has an impact on me. I have to be quite careful about how much of that I'm able to absorb**." **[P 001]**

- "I think also being kind to yourself and **recognizing that you may not be getting everything done as you did before.** And things have a different meaning to them, and that people can also come to coaching with maybe some **more emotional stuff**, then they might have before." [P 004]
- "It's more for me. It's the little things that are **much more disciplined** around um, breaks between sessions, or it's a really small point, but I always get up and leave the room. And even if I just go to the kitchen and grab a glass of water or something, but something about changing the physical location and being able to shake off the previous session." [P 001]
- "Well, the nature of coaching itself is, is personal, or is caregiving or…personal development, support.... and so, you kind of get **sucked into other people's things** and shutting down, shutting down a client day mentally and emotionally can be sometimes tough. It's I'm not saying that I have a crisis of **self-management**, but, but I have to unwind the day." [P 006]
- "… I don't really get tripped up by like, client needs or client's issues …. **I don't take that home with me**." [P 010]

Modality Specific Benefits

Many coaches discussed the positive aspects of using video platforms and the telephone as delivery modes for their coaching sessions. Common benefits noted included: **(**1) *video allowed for cues and connection* and (2) the *telephone allowed for listening and focus*. It should be noted that most coaches already used virtual technology before the pandemic or used a combination of both (video platforms and telephone; $n = 11$); one coach had to shift from in-person coaching to virtual coaching.

Video: Cues and Connection

Many coaches shared that they preferred the video format compared to the telephone modality as this enabled them to see the client while coaching. More specifically, this feature allows for visual cues to be integrated into the sessions such as body language (e.g., posture) and facial expressions: fostering a connection that could mimic in-person sessions. For example,

some coaches expressed that it was comforting to see who they were coaching and this facilitated a feeling of being in person. One coach mentioned the idea of being able to reflect back to their client and mimicking their body language for added emphasis.

Telephone: Listening and Focus

A common benefit mentioned by many coaches was the fact that phone coaching allowed for deeper listening and less distractions due to just using the audio and sound of voice. For example, coaches described how phone coaching allows for level three listening, and mentioned hearing nuances in the voice that can often be missed when you can see the client in video. Supporting quotes can be found in Table 5.

Table 5

Modality Specific Benefits

Video: Cues and Connection
• "It's [video] a pretty reliable tool where **I can see the non-verbal of my clients**. They can see mine. And so, being able to see each other and to connect with each other is really important in coaching, and [to] establish that relationship." [P 003]
• "There's a level of comfort I think for people, at least initially, to see one another, that people like. You have the **visual cues** also." [P 005]
• "And I can watch, it's [being able to see my client] just such important information. **I'm like, 'What just happened to your face?'** and they know…to stop and like [ask], 'What's going on?' Or we can see their shoulders, like they'll go, like this [shrugs shoulders]. Or you know … for some people, just telling them they're doing that, is like this massive breakthrough. They're like, 'Oh wait! I do this all the time!'" [P 011]
• "I think people feel more comfortable … **seeing who they are talking to**." [P 005]
• "I'm very physical. Like, if you were my client, I would be asking you questions about **things hanging on your door** … because I bring the **clients entire space** into the coaching. And so, there would be something there which I would totally use. And so, there is something about that as a tool that's kind of cool and fun, so there's a lot available." [P 006]
• "I do think there's **value in seeing people**. I've had coaches say that they can sometimes find a more intimate conversation on the phone without the video. I would say I don't think my coaching suffers if it's on the phone. I just**, I'm a visual person**, I get a lot out of it." [P 009]
• "I've been surprised about how I am able to **connect with people on video,** which I really love." [P 009]
Telephone: Listening and Focus

- "So, you know, depends on the person but that's how I do my best work [coaching over the telephone]. **I think coaching is listening**. [P 004]
- "[When using the telephone] **I can also hear nuances** and I can, working [with] someone directly also, it's really not a problem. But it's some, there's something about this kind of hearing, something like, with his face, people sort of try to control their face in certain ways. They can't really control your voice very well, not ongoingly. I never thought about this before, it hasn't occurred to me. **And so, there's something very revealing that hearing a person's voice [allows]**." [P 004]
- "I have found and believe that phones, **phone is more focused …** I can actually focus better on you and your questions when I'm not looking at you." [P 007]
- "I can sit on the phone and I'm really just like, **all in with my client, listening** to what they're saying, what they're not saying, what their voice sounds like, what their breathing sounds like. I actually think **I would be more distracted if I were seeing them.**" [P 010]

Video Modality Specific Challenges

Contrary to the benefits of video and telephone-based coaching which were discussed frequently, very few direct drawbacks were mentioned. However, two challenges regarding video as a delivery mode were highlighted by some participants: *technology failure* and *the inadequacy of the screen*.

Technology Failure

When asked about the challenges of using video for delivery mode, several coaches mentioned that technology failure was an issue when coaching. The internet would cut out and sometimes slow down the flow of the session. One coach even mentioned having to upgrade their home Wi-Fi to coach more effectively.

Screen Inadequacies

Some coaches mentioned the challenge of the screen size when using the video modality for coaching emphasizing spatial challenges which were often distracting for the coach and client. For example, one coach noted that the automated backgrounds can be distracting. Another mentioned the distracting screen size when trying to do movement activities. A third discussed how the screen caused issues with coach-client connection in terms of missing body parts (i.e.,

all you see is the clients head and face rather than the whole person). Supporting quotes can be found in Table 6.

Table 6

Video Specific Challenges

Technology Failure
• "[Challenges of using video platforms] Having there be **internet trouble, the challenge**." [P 003]
• "The major [challenge] on occasion … people can't get on when their **internet is unstable**." [P 005]
• "Sometimes the **technology drops** and that kind of thing. And it's just frustrating." [P 006]
• "I**f the internet isn't stable** or, you know, those kinds of things. It freezes, or they cut out, or you know, things like that sometimes." [P 008]
• "Yes, like **when the Wi-Fi glitches,** it can be really problematic. Especially when someone's like baring their soul. Yeah, it's like, really rough…It's just, that can be really disruptive." [P 011]
• "Well, we did have to **upgrade our home Wi-Fi** when everybody came home last March. After a few weeks, I was like, 'Okay, so this is obviously not going to work.'" [P 012]
Screen Inadequacies
• "Candidly, it [video platforms] does change the nature of the coaching a little bit. Having this sort of **screen size** area to work from. Um, a lot of the CTI coaching surrounds embodiments you know? Changing and shifting positions, and that sort of thing. And really, the geography of the moments … and that is slightly more challenging. I think it's actually more challenging on Zoom than it is on telephone, because you can ask a client to walk around the room or go stand and look out the window or you know, something on the phone would be easier than you doing it through a Zoom meeting." [P 001]
• "Just **internet and camera fatigue [have been challenging]**; being able to actually look at the person, give them eye contact often means looking into the camera instead of their face on the screen. And that's challenging because you want to be fully present." [P 003]
• "It's [coaching sessions] incorporating all of your environments into the call with the client. It's having it be much more inclusive and expansive and thrilling and exciting with coaching, rather than just sitting there staring at **someone's head on the screen**." [P 002]
• **"I would get very caught up in my own Zoom Square** and like, what I felt like, you know the background looked like. So that was a little bit challenging. **I do find it very distracting when people have either the fake backgrounds, or the blurred backgrounds**, with which Team allows." [P 009]
• "I'm not going to design something [coach business] where I have to sit on my ass in a chair **looking into a screen all day**, with a big head in the screen, and they see my big head, and that's all you see is the client, and the client stuck there looking at your head, you know?" [P 002]

- "If someone's hair disappears or their hand disappears, I'm like, it's a real challenge to stay. It's still a whole person, even though limbs are missing. It's still a whole person. So, it [video] can be **distracting in that regard**." [P 009]

Discussion

Primarily, this study sought to explore CPCCs' views related to the experience of coaching and their own self-care during the COVID-19 pandemic; telecommunication use for service provision was a secondary focus. As helping professionals are at risk for burnout, increased stress, and lack of self-care (Posluns & Gall, 2020; Richards et al., 2010), uncovering these views is vital for identifying strategies and challenges associated with assisting others and oneself during a crisis (Phillips, 2020). As the first CALC study conducted looking at these concepts, many of the coaches mentioned the need for a shift in both their coaching practice and self-care due to the pandemic; insights into the benefits and challenges of using virtual modalities such as the telephone and video platforms for services were also shared. For example, coaches highlighted remote working difficulties, but also saw the pandemic as an opportunity to grow professionally by adopting new strategies so that they might accommodate their clients and sessions. In regards to self-care, it was noted often how maintaining a regimen is important for personal well-being and effective practice as a coach, especially as the pandemic continues. As CPCCs are trained to use virtual technology for delivering their services (CTI, 2020a; Pearson, 2011), these participants were able to offer insights into their utility during a pandemic: information that may assist other helping professionals delivering services similarly as the world continues to shift virtually. Together, these findings underscore the value of prioritizing self-care for helping professionals and provide several points for consideration when delivering services remotely during a worldwide crisis. A more in-depth discussion to this end is provided below.

Coaching During the COVID-19 Pandemic

A Shift in Practice

Several participants mentioned that they had to make adjustments to their practices to accommodate remote working for both themselves and their clients. Due to the pandemic, many clients were stationed at home, along with other family members working remotely, and children who were being homeschooled. These challenges were experienced for many coaches as well: having a private space to coach, ensuring all aspects of the coaching session were confidential, and meeting the client where they are at (e.g., more interruptions due to children being home, not having a private space due to family) were noted frequently. Van Kessel and colleagues (2020) recently published a summary on the impact of the COVID-19 pandemic, which included employment insights among 9,220 Americans. Regarding remote working, 23% of participants stated that the pandemic has negatively affected their work citing more stress at home, enhanced frustration, and anxiety about job loss as contributors (Van Kessel et al., 2020). Similarly, Wang and colleagues (2020) found that employees working from home were often interrupted by family demands (e.g., children due to daycare or school closures). And yet, the percentage of full-time remote workers is expected to increase globally compared to pre-pandemic levels in the coming years (16.4% to 34.4%; Chavez-Dreyfuss, 2020) suggesting that ongoing accommodations will be necessary for employers and employees alike moving forward. Indeed, it is recommended that businesses and mental health workers be prepared to make wellness a priority (e.g., provide mental health days, paid time off, sessions on mindfulness, and no meeting days) to combat heightened mental health challenges and excess stress from the changing demands of remote working (Stahl, 2020). According to the CPCCs in the present study, finding ways to “flex,” “offer more support around remote work,” and “meet the client where they are”

will be necessary to optimize client experiences. Future recommendations from Taylor (2021), a CPCC, state that in order to support remote workers, incorporating various coaching skills such as deep listening (e.g., listening to what clients do and do not say) and applying questioning using the GROW (Goal, Reality, Options, Way forward) model (Whitmore, 1992) will be important to ensure that individuals are feeling heard and valued while away from the workplace. Taylor (2021) also suggests that the GROW model can be particularly useful for employees who may not know how to get their feelings across or do not know what to talk about. For example, the model involves questions such as, "What is your goal?; What is your current reality or situation?; What could you do to change your situation?; and What are the next steps?" (p. 1). In line with findings from the current study, coaches may need to make space and time to discuss pandemic-related issues prior to addressing session specific agendas. Recognition of such realities may serve as important precursors to client engagement and subsequent session successes.

When asked about differences in their coaching since the pandemic began, several participants talked about professional development enhancements whereby courses in areas like "positive intelligence" and "mental fitness" were being taken. This attention to professional growth is somewhat counterintuitive given the noted demands placed upon many helping professionals during the pandemic (e.g., heightened work pressure, excess emotional stress, heavy client load, balancing work and home life; Joshi & Sharma, 2020). It may be that this developmental focus is linked to perceived behavioural control (PBC; i.e., the perception of how difficult or easy it may be to perform a behaviour; Wallston, 2001), a construct ascribed from the Theory of Planned Behaviour (TPB; Ajzen & Fishbein, 1980). This theory posits that behavioural intention can be predicted by a person's, or coach in this case, expectations of a

behavioural outcome (e.g., a client's success with treatment, feeling efficacious regarding coaching practices), perceptions of control over the behaviour (i.e., coaching delivery), along with related attitudes. Perceived behavioural control attempts to account for concepts or events that typically happen outside of the person's control (Godin & Kok, 1996). This could include a lack of resources, relevant skills, or techniques, all of which could impede on the person's behaviour (Rosenstock, 1974). In the present study, the pandemic could be considered outside of the coach's control, impacting directly upon the way in which services are being delivered. It is possible that through engagement in professional development opportunities, the participants were attempting to reinstate some control with a view to enhance their coaching aptitude to fit the needs of their clients and improve service delivery. According to Godin and Kok (1996), an individual's motivation for professional development in relation to their business will ultimately benefit their clients' outcomes. The coaches in the present study were adamant about staying up-to-date regarding the pandemic and being responsive to related shifts in their clients: notable actions that may be worthy of consideration by helping professionals as the pandemic ensues.

Changes in Clients

Many participants discussed the various mental and emotional health challenges their clients were facing in relation to the pandemic. Some coaches noted that clients were either dropping out of coaching due to an increase in mental health concerns, while others emphasized that clients needed more emotional support compared to pre-pandemic. This finding is not surprising given that seven out of 10 Ontarians believe there is a mental health crisis resulting from the pandemic (CMHA, 2020). The CMHA (2020) claims that COVID-19 has caused stress levels to double as people live with extreme uncertainty in their lives (e.g., employment, finances, isolation, quarantine). Similarly, Moreno and colleagues (2020) state that increased

mental health challenges and a need for heightened support are being seen in people with *and without* pre-existing mental health disorders, thereby emphasizing the magnitude of the pandemic and its effects. This finding aligns with the participants experiences wherein their clients portrayed needing more mental and emotional health support, even if this was not their priority upon beginning coaching. In order to address this finding, coaches may need to refer their clients to other regulated health professionals depending on the degree of support the client may need (ICF, 2021). The ICF (2021) recommends reviewing their code of ethics in light of this concern when responding to situations where a client may need to be referred elsewhere based on their unique circumstances.

On a positive note, many coaches expressed feelings of awe and admiration for their clients in terms of their ability to adapt to the pandemic. The concepts of staying focused on goals, being creative, and resilience were highlighted. According to the American Psychological Association (2020) resilience plays an important role in people's ability to adapt to change, even if change affects people differently. Luraschi (2020) agrees, stating that people were made to adapt to life-changing and stressful situations (e.g., the COVID-19 pandemic), where peoples' day-to- day lives are shifted to accommodate various restrictions. Two strategies for facing the pandemic that can used by clients and helping professionals alike include: (1) being compassionate with oneself times of fear and uncertainty; and (2) understanding that having courage does not mean one does not have fear (David, 2016; Luraschi, 2020). These strategies fall in line with participant quotes regarding how the clients responded to the pandemic, viewing it as an opportunity to see what they can do, rather than just "surviving the day."

Overall, according to these participants, the COVID-19 pandemic has caused a shift in coaching practice in the realms of remote working, professional development, and client needs.

Moving forward, it will be important for coaches to remain flexible when working with clients as the pandemic shows little sign of subsiding completely. Including coaching skills to enhance support for clients such as deep listening and incorporating models of growth, considering professional development opportunities, staying up-to-date regarding pandemic trends, and maintaining awareness of coach ethics outlined by the ICF (Beauchemin et al., 2021; ICF, 2021; Taylor, 2021) may be particularly relevant.

Self-Care Practices for CPCCs During the Pandemic

Personal Self-Care Practices

Collectively, participants noted putting more effort into their personal self-care routines since the pandemic began: a finding that aligns with recent research (Clay, 2020; Norcross & Phillips, 2020). In a 2020 review of the literature looking at self-care among practicing psychologists during COVID-19, Norcross and Phillips identified several methods of self-care that can be part of a specific, intentional routine used to decrease feelings of anxiety, depressed mood, and stress. For example, according to the authors, clearing your mind and *intentionally* putting aside negative thoughts from one's session as a helper can allow a smoother transition to the next session (Norcross & Phillips, 2020). This notion of heightened intentionality coincides with participants who mentioned being more deliberate about breaks and metaphorical space between sessions in order to fully "show up" for the client they are supporting. Furthermore, Clay (2020) claims that having a self-care practice has never been more important since the start of the pandemic. This is because COVID-19 is a universal experience to all, and while helping professionals are supporting others, deep down, they have these same concerns.

Many participants indicated that self-care during the COVID-19 pandemic involves *filling your bucket*. Two major concepts arose from this theme whereby the participants stated

that they, as helpers, deserve self-care for themselves, and having this self-care practice is foundational to enable caring for others effectively. Dear (2020) describes this notion using a similar metaphor:

> Imagine there is a bucket that is full of water. The bucket is representative of all of your time, energy, and responsibilities. All day long you take a scoop of water out of the bucket for each person that you help or responsibility that you take care of. At the end of the day, how much water would be left? (p. 1).

Dear (2020) explains further that by having an effective self-care practice, water can then be added to one's own bucket, and a continuous supply will occur with a consistent routine. This finding also aligns with Kurki (2020), who states one cannot pour something from any already empty cup, and in order to give someone something from their cup, it needs to be filled; this is why taking care of oneself *first* is so important. When thinking about taking care of the carer and looking for bucket fillers, Nanyonga (2020) claims that being intentional about always trying to fill one's own bucket can help sustain the helper. Some recommendations include intentionally connecting with others who add value to one's life, seeking events and activities that are fulfilling, and pacing oneself on external sources such as social media and anyone who can deplete one's happiness. Instead, focussing limited energy on areas that personally bring joy, relaxation, and minimize stress was recommended (Nanyonga, 2020). In essence, having this self-care practice and keeping the bucket analogy in mind brings together the notion of treating oneself with compassion and kindness as a helper of others. According to a study conducted by Karmali and colleagues (2020), the most important tool coaches stated they use in their sessions is listening with compassion and without judgement for their clients. The present study now extends this notion further, identifying that this is also true for the coaches themselves.

Self-Care Practices as a CPCC

Many participants stated that coaching and supporting others served as a form of self-care, and made the process easier for themselves. Pogosyan (2018) commented that helping others boosts many feel-good chemicals that help lower depressive symptoms and increase a sense of purpose and emotional regulation (Post, 2005). Furthermore, many participants mentioned that during their sessions, a lot of what the client was experiencing in relation to the pandemic, the coach was too (e.g., heightened stress about catching a deadly virus, keeping loved ones safe). Thus, having someone to talk with helped them as well. This concept can be referred to as therapeutic empathy, and occurs when helpers have and communicate a shared understanding of the client and their experiences (Howick et al., 2018). Howick and colleagues (2018) claim that the new and growing concept of therapeutic empathy can benefit clients. Having therapeutic empathy has also been shown to reduce burnout in helpers, as understanding what the client is going through is clearer when empathy is involved (Shanefelt et al., 2015).

The notion of therapeutic empathy can similarly be connected to research conducted by Dore and colleagues (2017). They completed a three-week study involving 82 participants who shared stressful life stories and events in an online forum. A second set of randomly assigned participants commented on these stories with empathy and compassion. Results showed that those giving out the kind messages experienced a heightened sense of emotional and cognitive regulation. In addition, those who helped others or offered recommendations also experienced psychological benefits such as a drop in depressive symptoms and increased value for life (Dore et al., 2017). Taken together, these finding align well with the present study, wherein the coaches stated that being a coach and supporting others increased self-awareness regarding ways they could care for themselves. Recommendations from Dore and colleagues (2017) stated that future

studies on peer support and collaborative empathetic environments should include participants categorized by personality traits and life history (e.g., people who identify as empathetic or are generally more expressive in their emotions). This is an interesting recommendation given that the profession of Co-Active coaching inherently involves nurturing and provision of a supportive environment for clients (Newnham-Kanas et al., 2011). For example, one finding from a global survey conducted to examine why coaches enjoyed coaching revolved around coaches witnessing their clients change their lives and "supporting people in recognizing and stepping into their greatness" (Newnham-Kanas et al., 2011, p. 51). Thus, therapeutic empathy appears to be an integral component of coaching and self-care: especially during times of crisis. Future studies may wish to address this notion further by examining client benefits and mechanisms of change (e.g., specific coaching techniques used).

In contrast to therapeutic empathy, a noteworthy theme that arose across participants was being able to set purposeful boundaries between business and home life. Many coaches described being an *emotional sponge* and a need to not get overly involved in their client's feelings. Delgado (2020) mentions that being an emotional sponge is common in helping professions, especially for those who are more naturally emotive and unable to compartmentalize life facets. This can result in absorbing and digesting a client's feelings, which can lead to losing a sense of self due to overconsumption with others. Mathieu (2018) claimed similarly that being an emotional sponge can cause compassion fatigue, an occupational hazard, and described as the cost of caring for others, leading to emotional exhaustion. Mathieu (2018) recommended taking breaks and mental health days, as well as assessing workloads as crucial to avoid this exhaustion in helping professionals. It was also noted that self-care is occurring by setting these work boundaries which are thought to be the cornerstone of compassion fatigue prevention (Mathieu,

2018). Regarding therapeutic empathy and setting appropriate emotional boundaries, there is the question of whether one can have too much empathy (Reynolds, 2017; Shimoda & Williams, 2018). Reynolds (2017) stated that even though some empathy is important in therapeutic relationships, too much (i.e., problematic empathy) can cause increased stress for both the client and the therapist. Instead of understanding what they feel, which is the basis of empathy, the therapist can push it too far and almost "mirror it back" (p. 1) to the client. Shimoda and Williams (2018) recommended that research focus on how therapists and counsellors manage problematic empathy when it starts to occur with a client. Co-Active coaches may be a demographic in which to explore this phenomenon, further based on the current findings (i.e., the identified need to set appropriate emotional boundaries to protect themselves and the client).

Relatedly, a recent study examined caregivers of patients with COVID-19 and compassion fatigue experienced during the pandemic (Altimier & Boyle, 2020). Several positive self-care concepts were identified to avoid health-related crises including setting clear boundaries on what a caregiver/helper is willing and not willing to do. This allows for the helper to set and respond to expectations before compassion fatigue starts to develop. Another recommendation was to take meaningful breaks to help separate life and caregiving responsibilities (Altimier & Boyle, 2020). The findings from the present study similarly highlight the importance of self-care as a helping professional in order to maintain effective practice while also outlining what needs to be done to maintain this care such as taking one's own advice and setting emotional boundaries. While these strategies will be helpful for helping professionals, DeMarchis and colleagues (2020) indicate there is still room for improvement at the institutional level and recommend that educational bodies enhance self-care teachings further by making it an ethical practice or competency, and to standardize this across all helping professions. Perhaps in

the coaching profession, training bodies could adopt a similar outlook by incorporating aspects of self-care as a standardized practice during the certification process.

Telecommunications for Service Provision

Benefits

Many participants who used video platforms for their coaching practice mentioned how they liked the visual aspect, including environmental cues, facial expressions, and body language. Brenes and colleagues (2012) found similarly that having some video in CBT is beneficial, not just for the practice, but also for demonstrating exercises (e.g., in vivo exposure exercises). For example, a participant in the present study explained that they like the video to demonstrate holding their hand to their heart, which they considered awkward over the telephone. Moreover, Fernandez (2021) stated that video platforms are more information-rich via visual cues, eye contact, and body language. The therapist or helper can also make note of non-verbal cues (e.g., facial expressions, changes in body posture during the session) and identify specific behaviours that may be missed over the telephone. Schmidt (2020) corroborated these sentiments stating that during a crisis such as the COVID-19 pandemic, video platforms allow for more natural settings which can lead to enhanced feelings of comfort within the client's world. This concept could be linked to the notion of therapeutic empathy as being able to see the coach or counsellor and put a face to their voice could result in enhanced connection and outcomes for the client. Indeed, Cole (2001) states that empathy needs a face when seeking to understand interpersonal relatedness and visible facial expressions.

Several participants who used the telephone for their coaching practice mentioned how they are able to sharpen their focus through this modality. According to these coaches, using audio only allows for deep listening, specifically at level three (i.e., global listening; Kimsey-

House et al., 2011). Global listening is important in a helping context whereby it involves everything you can sense (e.g., hearing, feeling, seeing) while also including the action and inaction of the client, and the interaction between coach and client. This type of listening includes intuition, reading client energy, and taking in the whole environment the client is in (Kimsey-House et al., 2011). Lassiter (2019) identifies many benefits of coaching over the telephone, the first being that the conversations are more focused and less distracting. This may be because just hearing the audio allows for more attention to be placed upon the words being said, rather than distracting visual surroundings. Additionally, Brenes and colleagues (2012) claimed similarly that the helper's level of focus can increase during telephone sessions as the visual cues are removed from the surrounding, allowing for deeper concentration on what is being said. These findings align well with what was found in the present study when asking coaches about the benefits of the telephone modality.

According to Brenes and colleagues (2012) the telephone can also benefit those who otherwise would not receive care (e.g., homebound individuals, avoidant individuals, incarcerated patients, underserved populations). During a time where isolation is common (i.e., a worldwide pandemic), and individuals may have limited access to services, this notion becomes increasingly important. Furthermore, Brenes and colleagues (2012) completed their literature review on client acceptance of telephone-delivered care from psychotherapists and found that this modality had high satisfaction rates compared to face-to-face care. This may have been due to convenience, feeling like of a less threatening medium, and enabling flexible appointment times (Simon et al., 2004). Karmali and colleagues (2020), who interviewed CPCCs on the use of the telephone for delivering services, also found that there was a sense of comfort and safety when discussing sensitive topics. While there were no mentioned challenges associated with

telephone use in the present study, Brenes and colleagues (2012) identified some issues related to the logistics of the telephone rather than the actual sessions. For example, privacy and confidentiality issues in more public places (Mozer et al., 2008), crisis situations (Luxton et al., 2010), and lack of control over the environment have been discussed, suggesting there needs to be boundaries set on when the client can call, along with where the client and/or helper is located (Haas et al., 1996).

In a recent position paper (Moreno et al., 2020), the authors stated that the pandemic has allowed mental health professionals and patients to reflect on how related services are delivered, and it is clear that the previous support system has failed (Crawford et al., 2011; Fiscella et al., 2016; Moreno et al., 2020). More specifically, shortcomings revolve around a predominant focus on the quantity of available mental health supports rather than prioritizing high-quality equitable care (Crawford et al., 2011; Fiscella et al., 2016). According to Moreno and colleagues (2020) suitable mental health supports should be sustainable, efficient, and equitable, which has not been the case until now. The pandemic has shined a light on the need to ensure better support initiatives moving forward (Moreno et al., 2020). How such supports are delivered may be an important consideration in this regard.

Challenges

Almost all study participants who use video platforms for coaching sessions mentioned challenges such as Wi-Fi glitches, internet failure, and inability to connect to services. This finding aligns with DeGrove (2021), who says the most common challenge of telehealth and telecommunication is the disparity amongst clients' personal devices and internet connections. For example, depending on where the client lives, using general internet apps like YouTube, Netflix, and social media seems to work, but when trying to have a video call, the internet can

often crash due to broadband issues and interference. DeGrove (2021) recommends having a backup plan if the internet is not cooperating, such as switching to a telephone. This suggestion was supported by the findings of the present study. Furthermore, some coaches mentioned they have learned to always have the telephone on hand to avoid interrupting the session's flow and continue a session, even when internet issues arise. With the increased use of telecommunications throughout the pandemic and related technological challenges, the basic social determinants of health emerge when thinking about equity and access to adequate care. Kichloo et al. (2020) state that telecommunications for healthcare have the potential to be the solution for the rural population in receiving care as 85% of adults in these areas report using the internet. Studies involving CALC have found that using the telephone to facilitate services shows promise in terms of attaining a wider reach, granted the client and coach take into consideration factors such as time differences and long-distance charges (Pearson et al., 2012; 2013). The use of telecommunications can address these criteria (Moreno et al., 2020) through enhancing efficiency (i.e., using telephone or Zoom is more timely than going to an office), and equity (e.g., removing the need for long commutes or transportation costs), especially for those in rural areas or those who are struggling financially. Given CALC's traditional focus on the use of telecommunications for delivery, it would seem that coaches are well-positioned to assist in addressing such burdens (Brenes et al., 2012; Fernandez, 2021; Pearson et al., 2012). Based on the present study, perhaps simply having the telephone as a back-up could offer a temporary solution for those with technological issues and receiving video centred telecommunication care. Alternatively, it may be useful and equitable to consider using the telephone more frequently for service provision given it is less prone to such issues. Indeed, regarding strategies for effective telecommunication, going back to the basics (i.e., the telephone) was recommended by some

participants in the study. Bufka (2020) stated that to have effective telephone sessions, the helper needs to: (1) verify the patient location; (2) ensure privacy and confidentiality; (3) minimize distractions; (4) maintain ethical guidelines; and (5) acknowledge communication differences with no visual cues. As the pandemic ensues and virtual shifts become increasingly common, training bodies for helping professionals may wish to consider including applied sessions on the use of the telephone in practice similar to those provided by CTI to their trainees.

A second limitation of using video platforms for coaching was related to screen size. Some participants mentioned it was challenging to do movement exercises as only part of the client could be seen. For example, a couple of coaches said that when asking their clients to stand up and walk around, they could only see their waist, or could not see them at all when they left. TheraNest (2021) claims that using any telecommunication can come with having to adjust treatment or therapeutic techniques to account for various emerging limitations such as privacy when family is home, and using Health Insurance Portability and Accountability Act (HIPAA) compliant telehealth software (e.g., Skype). It is also recommended that helpers seek continual feedback from the client on comfort levels when using technology (TheraNest, 2021). Parker (2020) adds that while body language and facial expressions are more available through video, movement through the screen can be delayed, distorted, and misaligned from the audio, causing confusion and frustration when trying to have a deep conversation. This statement aligns with a participant who mentioned at times experiencing blurred backgrounds and distorted images, which was often distracting and disrupted the flow of the session. Furthermore, video conferencing is not suitable for all helping professionals, especially for those who need to be in the homes of their clients (Banks et al., 2020). A study that surveyed 74 social work students found that they struggled to do their job to the fullest when they could not enter the home; video

platforms limited their ability to evaluate conditions of the home or detect dangerous situations (Banks et al., 2020). This study also identified privacy issues (e.g., family being home either on the social worker's end or the client's) as problematic: a sentiment also mentioned in the present study. The authors (Banks et al., 2020) recommended that the government recognize limitations associated with virtual care (e.g., technological, confidentiality) and rethink the ethical implications of the digital world when endorsing remote service provision for all populations and helping professionals.

Even though these technical challenges exist, Reynolds and colleagues (2006) found that online versus face-to-face therapy did demonstrate any differences with sessions or client outcomes. Thus, it would seem that coaching holds merit and may in fact, represent a gold standard when it comes to online delivery given the training provided and resultant preferences for delivery in practice. In line with recommendations made by Karmali and colleagues (2020), a mixture of both face-to-face and telephone use may be advised depending on the client's needs. Future studies should examine further the benefits and drawbacks of each mode for clients and coaches alike, and how this might differ for other helping professions during and outside of a worldwide pandemic.

Study Strengths, Limitations, and Future Recommendations

As the first study of its kind, these findings can be leveraged by both coaches and training bodies (i.e., CTI) regarding what CPCCs are experiencing while practicing during the pandemic, recommendations for self-care, and the use of telecommunications. While participants did discuss the challenges that COVID-19 imposed on their clients and practices, they also expressed their appreciation for participating in a study like this, wherein not a lot is known regarding helping professions during the pandemic. This study contained a variety of viewpoints on

COVID-19 which could be considered a noteworthy strength. A few participants held what might be considered unconventional views on the pandemic (e.g., the virus is not severe and related restrictions are not needed), yet still chose to participate. While these participants shared different views from the majority of the sample, they added insight into how the pandemic has impacted those who do not agree with the restrictions but still have to follow them and speak about them with their clients. For example, one coach mentioned having to be mindful of keeping their own opinions to themselves when discussing pandemic-related stress with their clients.

The main factor that facilitated recruitment of participants for this study was the use of virtual modalities to complete the interviews. This was especially important given all in-person research was prohibited for the duration of this thesis. Due to physical distancing requirements and the participants' geographical locations, all interviews were conducted using the telephone (50%) or Zoom (50%). This enabled a wide reach of participants and diverse viewpoints to be shared on pandemic experiences while also serving as a convenient way to reach this specific population of helpers. Lastly, this study is unique as it covers a wide range of essential topics related to the COVID-19 pandemic and the shift to telecommunication in practice. Valuable insights on what it is like to practice and support others during a crisis, where the helper is also being affected were provided. Furthermore, this study revealed a variety of recommendations pertaining to self-care practices, and identified telecommunication benefits and challenges which can be useful for other helping professionals as they continue to support their clients while taking care of themselves.

One limitation of the present study was the wide geographical range of participants. The original research proposed that all participants reside in Ontario, Canada, to keep the pandemic

restrictions similar across participants and account for regional variation in experiences. However, to facilitate recruitment, the researcher had to put forth an ethics amendment to expand further across North America, where a wider variety of restrictions took place (e.g., almost no restrictions in some places and complete lockdown in others). This variation posed some difficulty for the student researcher regarding getting a sense of what these coaches were experiencing in relation to COVID-19. Still, the majority had a very similar consensus regarding how the pandemic impacted their professional practice and clients (Table 1). Therefore, there is a chance that data saturation was not thoroughly met for this group of participants. Recommendations for future studies could involve a more concentrated focus on one or two geographical regions so as to take into consideration restriction differences across the continent. A further limitation is the smaller sample size. The numerical goal for participants was between 12-15 coaches, and even though this study did meet the minimum ($N = 12$), having a larger sample could have helped to meet thematic saturation.

By exploring CPCCs' insights on how the pandemic has impacted them, their clients, and their practice, future larger-scale studies can now be developed as we continue to learn more about this worldwide crisis. Future recommendations could include obtaining a larger number of participants for the interviews. Based on what is now known, conducting a larger qualitative study in an attempt to reach thematic saturation is warranted. Furthermore, exploring viewpoints on those who have received coaching since the pandemic started may provide valuable insights from a client perspective on what they would like to see changed (if anything) regarding service provision, recommendations for coaches, and their knowledge of using telecommunications. Involving clients in future studies could help identify needs that are not seen by the helpers. For example, according to Karmali and colleagues (2020), their coaches and clients had different

viewpoints on the delivery mode, so helpers cannot simply assume what works for them in practice works for their clients; further research can attempt to explore this area. There is also an opportunity to further explore the idea of problematic empathy as outlined by Shimoda and Williams (2018) and setting emotional boundaries. The relationship seems interconnected, but needs to be researched further to determine relationship pathways and outcomes.

Conclusion

With the COVID-19 pandemic looming onwards, an exploration into practice-related experiences and self-care views was warranted (Bokolo, 2020; Molfenter et al., 2015; Waddington & Pearson, 2020). While it is clear that practicing self-care is valuable for helping professionals to avoid feelings of burnout, increased stress, and depersonalization, along with enhancing the effectiveness of their practice (Posluns & Gall, 2020), self-care as a whole is not practiced as much as it could be within this group (Friedman, 2017; Posluns & Gall, 2020). Co-Active coaching embodies the notion of self-care and coaches are trained predominantly using telecommunication methods, making them a worthy demographic to study in the context of helping professionals and pandemic-related issues (CTI, 2020c; Pearson et al., 2012). This study uncovered practice- and client-related challenges regarding COVID-19, such as remote working and adjusting coaching sessions to meet the client where they are at. An interesting finding revolved around the feeling of opportunity this pandemic gave the coaches in terms of advancing their professional development and feeling more equipped and accommodating for their clients. Regarding personal and practice-related insights towards their self-care, coaches stated it is necessary to have a self-care routine to care effectively for their clients, such as filling their bucket first and making it an intentional aspect of the day. Coaches identified challenges (i.e., technology failure and screen size) and benefits (i.e., verbal cues and deep listening) of using

telecommunication for effective session delivery. Going back to basics (i.e., the telephone) may be one avenue to offset the limitations identified while maintaining the flow of dialogue within sessions. Future training bodies should explore this notion further.

Some discrepancies surrounding COVID-19 and coaching highlight the need for future research. For example, further identifying the relationship between therapeutic empathy for a client and attempting to set emotional boundaries. It would also be beneficial to conduct a larger-scale qualitative study to identify any replicable findings and enhance thematic saturation. Other studies could involve clients when exploring best practices for helping professionals during the pandemic to provide another lens with regards to utility. Taken together, these study findings highlight the value of practicing self-care as a helping professional or client – especially during a worldwide pandemic.

References

Alexis, I. (2019). *What is a crisis intervention?* Vertava Health. https://vertavahealth.com/addiction-treatment/intervention/crisis/

Alkema, K., Linton, J. M., Davies, R. (2008). A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *Journal of Social Work in End of Life & Palliative Care, 4*(2), 101-119. http://doi.org/10.1080/15524250802352934

Altimier, L., & Boyle, B. (2020). Global pandemic of COVID-19. *Journal of Neonatal Nursing, 26*(4), 181-182. https://dx.doi.org/10.1016%2Fj.jnn.2020.06.001

American Counseling Association. (2020). *Vicarious trauma*. https://www.counseling.org/docs/trauma-disaster/fact-sheet-9---vicarious-trauma.pdf

American Psychological Association. (2020). *Building your resilience.* https://instituteofcoaching.org/resourcefile/building-your-resilience/15451

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behaviour*. Prentice Hall.

Banks, S., Cai, T., de Jonge, E., Shears, J., Shum, M., Sobocan, A. M., Strom, K., Truell, R., Uriz, M. J., & Weinberg, M. (2020). Practising ethically during COVID-19: Social work challenges and responses. *International Social Work, 63*(5), 569-583. https://doi.org/10.1177%2F0020872820949614

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. P. (2007). In pursuit of wellness: The self-care imperative. *American Psychological Association, 38*(6), 603-612. http://doi.org/10.1037/0735-7028.38.6.603.

Barlow, A. C. & Phelan, A. M. (2007). Peer collaboration: A model to support counsellor self

care. *Canadian Journal of Counselling, 41*(1), 3-15. https://cjc-rcc.ucalgary.ca/article/view/58802

Bates, B. L. (1992). The effect of demands for honesty on the efficacy of the Carleton skills-training program. *The International Journal of Clinical Experimental Hypnosis, 40*(2), 88-102. https://doi.org/10.1080/00207149208409650

Beck, A. T. (2019). A 60-year evolution of cognitive theory and therapy. *Perspectives on Psychological Science, 14*(1), 16-20. http://doi.org/10.1177/1745691618804187

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* International Universities Press.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Innovative Methods, 26*(13), 1802-1811. http://doi.org/10.1177/1049732316654870

Bolnik, L., & Brock, S. E. (2005). The self-reported effects of crisis intervention work on school psychologists. *The California School Psychologist, 10*, 117-124. http://doi.org/10.1007/BF03340926

Bokolo, A. J. (2020). Use of telemedicine and virtual care for remote treatment in response to COVID-19 pandemic. *Journal of Medical Systems, 44*(132), 1-9. http://doi.org/10.1007/s10916-020-01596-5.

Bratton, B. (2018). Self-care for the caregiver: What are the risks if we don't care for ourselves? *Journal of Pediatric Surgical Nursing, 7*(1), 3. http://doi.org/10.1097/jps.0000000000000163.

Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Brenes, G. A., Ingram, C., & Danhauer, S. C. (2012). Benefits and challenges of conducting psychotherapy by telephone. *Professional Psychology Research, 42*(6), 543-549. https://dx.doi.org/10.1037%2Fa0026135

Bufka, L. (2020). *Tips for doing effective phone therapy.* American Psychological Association. https://www.apaservices.org/practice/legal/technology/effective-phone-therapy

Canadian Mental Health Association (CAMH). (2020). *Fast facts about mental illness.* https://cmha.ca/fast-facts-about-mental-illness

Canadian Mental Health Association (CAMH). (2020). *Mental health in Canada: Covid-19 and beyond – CAMH policy avenue*. https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/covid-and-mh-policy-paper-pdf.pdf

Cascella, M., Rajnik, M., Cuomo, A., Dulebohn, S. C., & Di Napoli, R. (2020). *Features, evaluation and treatment of coronavirus (COVID-19)*. NCBI. https://www.ncbi.nlm.nih.gov/books/NBK554776/

Casey, J. (2020). *Self-care for coaches: Why over scheduling will kill your ability to make a living (and a life).* Coaching Blueprint. https://www.coachingblueprint.com/self-care-for-coaches/

Centers for Disease Control and Prevention. (2020). *Using telehealth services.* https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html

Chavez-Dreyfuss, G. (2020). *Permanently remote workers seen doubling in 2021 due to pandemic productivity – survey.* Reuters. https://www.reuters.com/article/uk-health-coronavirus-technology/permanently-remote-workers-seen-doubling-in-2021-due-to-pandemic-productivity-survey-idUKKBN2772P8

Clarke, E. (2019). *Self-care, coping self-efficacy and stress among graduate students in the*

helping professions. KU ScholarWorks. https://kuscholarworks.ku.edu/handle/1808/26136

Clay, R. A. (2020). Self-care has never been more important. *American Psychological Association, 51*(5), 60. https://www.apa.org/monitor/2020/07/self-care

Cleveland Clinic. (2020). *Stress: Coping with life's stressors*. https://my.clevelandclinic.org/health/articles/6392-stress-coping-with-lifes-stressors

Co-Active Training Institute. (2020a). *About CTI: Our story*. https://coactive.com/about/our-story

Co-Active Training Institute. (2020b). *Science of transformational coaching*. https://learn.coactive.com/science-of-transformational-co-active-coaching

Co-Active Training Institute. (2020c). *Professional coach certification*. https://coactive.com/training/professional-coach-certification/

Cohen, D., & Crabtree, B. (2006). *Qualitative research guidelines project*. https://sswm.info/sites/default/files/reference_ attachments/COHEN% 202006%20Semistructured%20Interview.pdf

Cole. J. (2001). Empathy needs a face. *Journal of Consciousness Studies, 8*(5-7), 51-68. https://psycnet.apa.org/record/2001-07704-003

Crawford, M. J., Robotham, D., & Thana, L. (2011). Selecting outcome measures in mental health: The views of service users. *Journal of Mental Health, 20*(4), 336-346. https://doi.org/10.3109/09638237.2011.577114

David, S. A. (2016). *Emotional agility: Get unstuck, embrace change, and thrive in work and life.* Penguin Random House.

Davis, C. P. (2021). *Medical definition of clinical.* MedicineNet.

https://www.medicinenet.com/clinical/definition.htm

Dear, H. (2020). *Filling your bucket.* Renewed Mental Health Senior Services. https://www.renewedseniors.com/post/filling-your-bucket

DeGrove, E. (2021). *3 Challenges of telehealth video conferencing and how to overcome them*. Telehealth.training. https://telehealth.training/articles/3-Challenges-of-Telehealth-Video-Conferencing-and-How-to-Overcome-Them

Delgado, J. (2020). *The dangers of becoming an "emotional sponge".* Psychology Spot. https://psychology-spot.com/projective-identification-emotional-sponge/

DeMarchis, J., Friedman, L., & Garg, K. E. (2020). An ethical responsibility to instill, cultivate, and reinforce self-care skills. *Journal of Social Work Education.* https://doi.org/10.1080/10437797.2021.1895932

Dore, B. P., Morris, R. R., Burr, D. A., Picard, R. W., & Ochsner, K. N. (2017). Helping others regulate emotion predicts increased regulation of one's own emotions and decreased symptoms of depression. *Personality and Social Psychology, 43*(5), 729-739. https://doi.org/10.1177%2F0146167217695558

Elo, S., Kaariainen, M., Kanste, O., Polkki, T., Utrainen, K., & Kyngas, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE OPEN,* 1-10. http://doi.org/10.1177/2158244014522633.

Elo, S., & Kyangas, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115. http://doi.org/10.1111/j.1365-2648.2007.04569. x.

Empowerment Counselling Associates. (2020). *What about self-care and balance for helpers?* http://www.counselingtoempower.com/self-care-for-helpers.html

Engel, E. (2017). *Helping professions and burnout with 10 proven prevention methods.* Psycho

nephrology. https://psychonephrology.com/helping-professions-and-burnout/

Ericson-Lidman, E., & Strandberg, G. (2007). Burnout: Co-workers' perceptions of signs preceding workmate's burnout. *Wiley Online Library, 60*(7), 199-208. https://doi.org/10.1111/j.1365-2648.2007.04399.x

Erlingsson, C., & Brysiewicz. (2017). A hands-on guide to doing content analysis. *African Journal of Emergency Medicine, 7*(3), 93-99. https://doi.org/10.1016/j.afjem.2017.08.001

Fader, S. (2021). *Hands on carers for sensitive people – Being an empath in the working world.* Better Help. https://www.betterhelp.com/advice/careers/hands-on-careers-for-sensitive-people-being-an-empath-in-the-working-world/

Fernandez, E., Woldgabreal, Y., Day, A., Pham, T., Gleich, B., & Aboujaoude, E. (2021). Live psychotherapy by video versus in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment. *Clinical Psychology & Psychotherapy.* Advance online publication. https://doi.org/10.1002/cpp.2594

Fetzer, T., Hensel, L., Hermle, J., Roth, C. (2020). *Coronavirus perceptions and economic anxiety*. VOX. https://voxeu.org/article/coronavirus-perceptions-and-economic-anxiety

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*(11), 1433-1441. http://doi.org/10.1002/jclp.10090

Fiscella, K., Sanders, M. R. (2016). Racial and ethnic disparities in the quality of health care. *Annual Review of Public Health, 37*, 375-394. https://doi.org/10.1146/annurev-publhealth-032315-021439

Fountoulakis, A. L., Kaprinis, S. T., & Kaprinis, G. (2002). The relationship between job stress, burnout, and clinical depression. *Journal of Affective Disorders, 75*(3), 209-221.

Fried, R. R., Atkins, M. P., & Irwin, J. D. (2019). Breaking grad: Building resilience among a

sample of graduate students struggling with stress and anxiety via a peer coaching model – an 8-month pilot study. *International Journal of Evidence Based Coaching and Mentoring, 17*(2), 3-19. https://doi.org/10.24384/sa09-av91.

Fried, R.R., Karmali, S., Irwin, J. D., Gable, F. L., & Salmoni, A. (2018). Making the grade: Perspectives of a course-based, smart, healthy campus pilot project for building mental health resiliency through mentorship and physical activity. *International Journal of Evidence-Based Coaching and Mentoring*, *16*(2), 84-98. https://doi.org/10.24384/000566

Fried, R. R., & Irwin, J. D. (2016). Calmly coping: A motivational interviewing via Co-Active life coaching (MI-via-CALC) pilot intervention for university students with perceived levels of high stress. *International Journal of Evidence Based Coached and Mentoring, 14(1)*, 16-33. https://www.researchgate.net/publication/292332362_Calmly_coping_A_Motivational_Interviewing_Via_Co-_Active_Life_Coaching_MI-VIACALC_pilot_intervention_for_university_students_with_perceived_levels_of_high_stress

Friedman, K. (2017). Counselor self-care and mindfulness. *Contemporary Buddhism, 18*(3), 321-330. https://doi.org/10.1080/14639947.2017.1373437

Fulton, C. L., & Cashwell, C. S. (2015). Mindfulness-based awareness and compassion: Predictors of counselor empathy and anxiety. *Counselor Education & Supervision, 54,* 122-133. https://doi.org/10.1002/ceas.12009

George, M. (2013). Seeking legitimacy: The professionalization of life coaching. *Sociological Inquiry, 83*(2), 179-208. https://doi.org/10.1111/soin.12003

Goddard, A.M., & Morrow, D. (2015). Assessing the impact of motivational interviewing via co-

active life coaching on engagement in physical activity. *International Journal of Evidence Based Coaching and Mentoring, 13*(2), 101-121. https://psycnet.apa.org/record/2016-40282-008

Godin G., & Kok, G. (1996). The theory of planned behaviour: A review of its application to health-related behaviours. *American Journal of Health Promotion, 11*(2), 87-98. http://dx.doi.org/10.4278/0890-1171-11.2.87

Goncher, I. D., Sherman, M. E., Barnett, J. E., & Haskins, D. (2013). Programmatic perceptions of self-care emphasis and quality of life among graduate trainees in clinical psychology: The mediational role of self-care utilization. *Training and Education in Professional Psychology, 7*(1), 53–60. https://doi.org/10.1037/a0031501

Goodman, M.J., & Schorling, J.B. (2012). A mindfulness course decreases burnout and improves wellbeing among healthcare providers. *International Journal of Psychiatry in Medicine, 43*(2), 119-128. http://doi.org/ 10.2190/PM.43.2.b

Government of Canada. (2019). *Prevalence of chronic disease among Canadian adults*. https://www.canada.ca/en/public-health/services/chronic-diseases/prevalence-canadian-adults-infographic-2019.html

Government of Canada. (2020). *Physical distancing: How to slow the spread of COVID-19.* https://www.canada.ca/en/public-health/services/publications/diseases-conditions/social-distancing.html

Grant, A.M., & Zackon, R. (2004). Executive, workplace and life coaching: Findings from a large-scale survey of international coach federation members. *International Journal of Evidence Based Coaching and Mentoring, 2*(2), 1-15. http://www.targetcoaching.co.il/?categoryId=72543&itemId=152779

Gray, L. M., Wong-Wylie, G., Rempel, G. R., & Cook, K. (2020). Expanding qualitative research interviewing strategies: Zoom video communications. *The Qualitative Report, 25*(5), 1292-1301. http://ezproxy.lakeheadu.ca/login?url=https://www.proquest.com/scholarly-journals/expanding-qualitative-research-interviewing/docview/2405672296/se-2?accountid=11956.

Green, L.S., Oades, L.G., & Grant, A.M. (2006). Cognitive-behavioural, solution-focused life coaching: Enhancing goal striving, wellbeing, and hope. *The Journal of Positive Psychology, 1*(3), 142-149. https://doi.org/10.1080/174397606006198849.

Greenstone, J. L., & Leviton, S. C. (1982). *Crisis intervention: A handbook for interveners.* Kendall/Hunt Publishing Co.

Griffiths, L., Blignault, I., & Yellowlees, P. (2006). Telemedicine as a means of delivering cognitive-behavioural therapy to rural and remote mental health clients. *Journal of Telemedicine and Telecare, 12*(3), 136-140. http://doi.org/ 10.1258/135763306776738567

Hakkennes, S., Dodd, K. (2007). Guideline implementation in allied health professions: A systematic review of the literature. *Developing Research and Practice, 17,* 296-300. http://doi.org/10.1136/qshc.2007.023804

Harpham, W. S. (2011). *Depersonalization of the patient and the loss of compassion*. KevinMD.com https://www.kevinmd.com/blog/2011/01/depersonalization-patient-loss-compassion.html

Harvey, J., Pearson, E. S., Mantler, T., & Gotwals, J. K. (2018). “Be kind to yourself – because

you're doing fine": using self-determination theory to explore the health-related experiences of primiparous women participating in a motivational interviewing-via-co-active life coaching intervention. *Coaching: An International Journal of Theory, Research, and Practice, 13*(1), 78-91. https://www.tandfonline.com/action/showCitFormats?doi=10.1080/17521882.2018.1545137

Hollander, J. D., & Carr, B. G. (2020). Virtually perfect? Telemedicine for COVID-19. *New England Journal of Medicine, 382*, 1679-1681. https://doi.org/10.1056/NEJMp2003539

Howick, J., Bizzari, V., & Dambha-Miller, H. (2018). Therapeutic empathy: What it is and what it isn't. *Journal of the Royal Society of Medicine, 111*(7), 233-236. https://doi.org/10.1177%2F0141076818781403

International Coach Federation. (2021). *ICF code of ethics.* https://coachingfederation.org/app/uploads/2021/01/ICF-Code-of-Ethics-1.pdf

International Coach Federation. (2021). *New ICF resource helps coaches understand when and how to refer clients to therapy.* https://coachingfederation.org/blog/new-icf-resource-helps-coaches-understand-when-and-how-to-refer-clients-to-therapy

International Coach Federation. (2020). *ICF international coaching study*. https://coachfederation.org/research/global-coaching-studY

International Coach Federation. (2016). *2016 ICF global coaching study: Executive Summary.* https://mail.google.com/mail/u/0/#inbox/FMfcgxwJXLml TpBRRKBcspXdFQWQWSWW?projector=1&messagePartId=0.1

Irwin, J.D., & Morrow, D. (2005). Health promotion theory in practice: An analysis of co-Active coaching. *International Journal of Evidence Based Coaching and Mentoring, 3*(1), 29-38.

http://www.monarchsystem.com/wp-content/uploads/2014/03/Irwin-Morrow-h-promo-analysis-of-CALC-2005-IJEBCM-article.pdf

Jaglal, S. B., Guilcher, S. TJ., Hawker, G., Lou, W., Salbach, N. M., Manno, M., & Zwarenstein, M. (2014). Impact of chronic disease self-management program on health care utilization in rural communities: A retrospective cohort study using linked administrative data. *BMC Health Services Research, 14*(198), 1-8. http://www.biomedcentral.com/1472-6963/14/198

Joseph, D.H., Griffin M., Hall, R., & Sullivan, E. (2001). Peer coaching: An intervention for individuals struggling with diabetes. *Diabetes Educator, 27(5)*, 703-710. https://doi.org/10.1177/014572170102700511

Joshi, G., & Sharma, G. (2020). Burnout: A risk factor amongst mental health professionals during COVID-19. *Asian Journal of Psychiatry, 54*, 1-4. https://dx.doi.org/10.1016%2Fj.ajp.2020.102300

Kampa-Kokesch, S., & Anderson, M.Z. (2001). Executive coaching: A comprehensive review of the literature. *Consulting Psychology Journal: Practice and Research, 53*, 205-228. https://doi.org/10.1037/1061-4087.53.4.205

Karmali, S, Battram, D.S., Burke, S.M., Cramp, A., Mantler, T., Morrow, D., Ng, V., Pearson, E.S., Petrella, R., Tucker, P., & Irwin, J. D. (2020) Clients' and coaches' perspectives of a life coaching intervention for parents with overweight/obesity. *International Journal of Evidence Based Coaching and Mentoring*, *18*(2), 115-132. https://doi.org/10.24384/2wjj-py19

Keim, J., Marley, S. C., Olguin, D. L., & Thieman, A. (2008). Trauma and burnout: Counsellors

in training. https://www.counseling.org/resources/library/VISTAS/2008-V-Print-complete-PDFs-for-ACA/Keim_Article_28.pdf

Kichloo, A., Albosta, M., Dettloff, K., Wani, F., El-Amir, Z., Singh, J., Aljadah, M., Chakinala, R. C., Kanugula, A. K., Solanki, A., & Chugh, S. (2020). Telemedicine, the current COVID-19 pandemic and the future: A narrative review and perspectives moving forward in the USA. *Family Medicine and Community Health, 8*(3), 1-9. https://dx.doi.org/10.1136%2Ffmch-2020-000530

Killian, K.D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14*(2), 32-44. https://doi.org/10.117/1534765608319083.

Kimsey-House, H., Kimsey-House, K., Sandahl, P., & Whitworth, L. (2018). *Co-active coaching: The proven framework for transformative conversations at work and life.* Nicholas Brealey Publishing.

Kimsey-House, H., Kimsey-House, K., Sandahl, P., & Whitworth, L. (2011). *Co-active coaching: changing business, transforming lives.* Nicholas Brealey Publishing.

Kowalski, K. C., McHugh, TL. F., Sabiston, C. M., & Ferguson, L. J. (2018). *Research methods in kinesiology.* Oxford University Press.

Kumar, S. (2011). Burnout and psychiatrists: What do we know and where to from here? *Epidemiology and Psychiatric Sciences, 20*, 295–301. https://doi.org/10.1017/S204579601100059X

Kurki, S. (2020). *You can't pour from an empty cup. Take care of yourself first.* https://helda.helsinki.fi/bitstream/handle/10138/319893/Kurki_Sannamari_pro_gradu_2020.pdf?sequence=2

Lassiter, S. (2019). *Why phone coaching is more effective than in-person*. Lassiter Enterprises. https://sandralassiter.com/why-phone-coaching-is-more-effective-than-in-person/

Lattanzio, F., Abbetecola, A.M., Bevilacqua, R., Chiatti, C., Corsonello, A., Rossi, L., Bustacchini, S., & Bernabei, R. (2014). Advanced technology care innovation for older people in Italy: Necessity and opportunity to promote health and well-being. *JAMDA, 15*(7), 457-466. https://doi.org/ 10.1016/j.jamda.2014.04.003

Losch, S., Traut-Mattausch, E., Muhlberger, M. D., & Jonas, E. (2016). Comparing the effectiveness of individual coaching, self-coaching, and group training: How leadership makes the difference. *Frontiers in Psychology, 7*, 629. https://doi.org/10.3389/fpsyg.2016.00629.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic Inquiry*. Sage Publications.

Luenendonk, M. (2019). *Theory of planned behaviour: Definition, explained, examples*. Cleverism. https://www.cleverism.com/theory-of-planned-behavior/

Lundahl, B.W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice, 20*(2), 137-160. https://doi.org/10.1177/1049731509347850

Luraschi, O. (2020). *Facing the pandemic with emotional agility.* Institute of Coaching. https://instituteofcoaching.org/blogs/facing-pandemic-emotional-agility

Mantler, T., Irwin, J.D., Morrow, D., Hall, C., & Mandich, A. (2014). Assessing motivational interviewing via-co-active life coaching on selected smoking cessation outcomes. *Addiction Research and Theory, 22*(5), 1-12. https://doi.org/10.3109/16066359.2014.946410

Mantler, T., Irwin, J.D., Morrow, D. (2013). The experience and impact of motivational

interviewing via coaching tools on national smokers' telephone hotline employees. *International Journal of Evidence-Based Coaching and Mentoring, 11*(1), 55-68. http://www.monarchsystem.com/wp-content/uploads/2012/06/Mantler-smokers-phone-hotline-IJEBCM-2013-vol11issue1-article.pdf

Mantler, T., Irwin, J.D., Morrow, D. (2010). Assessing motivational interviewing thought co-active life coaching tools as a smoking cessation intervention: A demonstration study. *International Journal of Evidence-Based Coaching and Mentoring, 8*(2), 49-63. https://www.monarchsystem.com/wp-content/uploads/2019/07/Mantler-2010-Assessing.pdf

Mathieu, F. (2018). *Running on empty: Compassion fatigue in health professionals*. https://www.tendacademy.ca/wp-content/uploads/2007/04/Solutions-article-revised-2018.pdf

Martins, M. (2019). *Research paper: Cognitive behavioural therapy in coaching*. International Coach Academy. https://coachcampus.com/coach-portfolios/research-papers/maria-martins-cognitive-behavioral-therapy-in-coaching/

Mayo Clinic. *Job burnout: How to spot it and take action*. https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/burnout/art-20046642#:~:text=Job%20burnout%20can%20result%20from,need%20to%20do%20your%20work

McCannm C.M., Beddoe, E., McCormick, K., Huggardm P., Kedge, S., Adamson, C., & Huggard, J. (2013). Resilience in the health professions: A review of recent literature. *International Journal of Wellbeing, 3*(1), 60-81. https://doi.org/10.5502/ijw.v3il.4

Merriam, S. B. & Tesdell, E. J. (2015). *Qualitative research: A guide to design and*

implementation. http://ebookcentral.proquest.comCreated from lakehead-ebooks on 2018-11-16 10:50:46.

Miller, J. J., Donohue-Dioh, J., Chunling, N., & Shalash, N. (2018). Exploring the self-care practices of child welfare workers: A research brief. *Children and Youth Services Review, 84*, 137-142. https://doi.org/10.1016/j.childyouth.2017.11.024

Miller, W. R., & Rollnick, S. (2013). *Motivational Interviewing: Helping people change.* A Division of Guilford Publications, Inc.

Mills, J., Wand, T., & Fraser, J.A. (2018). Exploring the meaning and practice of self-care among palliative care nurses and doctors: A qualitative study. *BMC Palliative Care, 17*(63), 7-12. https://doi.org/10.1186/s12904-018-0318-0

Mills, J., Wand, T., & Fraser, J. (2017). Self-care in palliative care nursing and medical professionals: A cross-sectional survey. *Journal of Palliative Medicine, 20*(6), 625-630. https://doi.org/ 10.1089/jpm.2016.0470

Moate, R. M., Gnika, P. B., West, E. M., & Bruns, K. L. (2014). Stress and burnout among counselor educators: Differences between adaptive perfectionists, maladaptive perfectionists, and nonperfectionists. *Journal of Counseling & Development, 94*(2), 161-171. https://doi.org/10.1002/jcad.12073

Molfenter, T., Boyle, M., Holloway, D., & Zwick, J. (2015). Trends in telemedicine use in addiction treatment. *Addiction Science & Clinical Practice, 10*(14), 1-9. https://doi.org/10.1186/s13722-015-0035-4

Moreno, C., Wykes, T., Galderisi, S., Nordentoft, M., Crossley, N., Jones, N., Cannon, M., Correll, C. U., Byrne, L., Carr, S., Chen, E. CY., Gorwood, P., Johnson, S., Karkkainen, H., Krystal, J. H., Lee, J. M., Lieberman, J., Lopez-Jaramillo, C., Mannikko, M, Phillips,

M. R., Uchida, H., Vieta, E., Vita, A. & Arango, C. (2020). How mental health care should change as a consequence of the COVID-19 pandemic. *Lancet Psychiatry, 7*(9), 813-824. https://doi.org/10.1016/S2215-0366(20)30307-2

Morton, K., Beauchamp, M., Prothero, A., Joyce, L., Saunders, L., Spencer-Bowdage, S., Dancy, Bernadette., & Pedlar, C. (2015). The effectiveness of motivational interviewing for health behaviour change in primary care settings: A systematic review. *Health Psychology Review, 9*(2), 205-223. https://doi.org/10.108-/17437199/2014.882006

Myers, S. B., Sweeney, A. C., Popick, V., Wesley, K., Bordfeld, A., & Fingerhut, R. (2012). Self-care practices and perceived stress levels among psychology graduate students. *Training and Education in Professional Psychology, 6*(1), 55–66. https://doi.org/10.1037/a0026534

Nanyonga, R. C. (2020). *Resilience and renewal*. https://ciu.ac.ug/media/attachments/2020/12/31/resilience-renewal-rcn-2020-min.pdf

National Cancer Institute. (2020). *Conventional medicine.* https://www.cancer.gov/publications/dictionaries/cancer-terms/def/conventional-medicine

Neenan, M., & Dryden, W. (2013). *Life coaching: A cognitive behavioural approach*. Routledge.

Neenen, M., & Palmer, S. (2001). Cognitive behavioural coaching. *Stress News, 13*(3), 1-8. https://www.researchgate.net/publication/323075827_Cognitive_Behavioural_coaching

Newnham-Kanas, C., Morrow, D., & Irwin, J.D. (2012). Certified professional co-active coaches: Why they enjoy coaching. *International Journal of Evidence Based Coaching and Mentoring, 10*(1), 48-56. http://www.monarchsystem.com/wp-content/uploads/2014/03/Newnham-Enjoy-Coaching-2012-IJEBCM-article.pdf

Newnham-Kanas, C., Irwin, J., Morrow, D. (2011a). Participants' perceived utility of motivational interviewing using co-active life coaching skills on their struggle with obesity. *Coaching: An international Journal of Theory, Research and Practice, 4*(2), 104-122. http://www.monarchsystem.com/wp-content/uploads/2014/03/Newnham-Utility-of-MI-2011-CIJTRP-article.pdf

Newnham-Kanas, C., Irwin, J., Morrow, D. (2011b). Findings from a global survey of certified professional co-active coaches. *International Journal of Evidence Based Coaching and Mentoring, 9*(2), 23-36. https://www.researchgate.net/publication/264825063_Findings_from_a_global_survey_of_certified_professional_co-active_coaches

Newnham-Kanas, C., Irwin, J., Morrow, D. (2011c). Motivational coaching: Its efficacy as an obesity intervention and profile of professional coaches. (243). [Doctoral Thesis, Western University]. Electronic Thesis and Dissertation Repository.

Newnham-Kanas, C., Morrow, D., & Irwin, J.D. (2010). A Functional juxtaposition of three methods for health behaviour change: Motivational interviewing, coaching, and skilled helping. *International Journal of Evidence-Based Coaching and Mentoring, 8*(2), 27-48. https://www.researchgate.net/publication/270817817_Motivational_Coaching_A_Functional_Juxtaposition_of_Three_Methods_for_Health_Behaviour_Change_Motivational_Interviewing_Coaching_and_Skilled_Helping

Newnham-Kanas, C., Irwin, J.D., & Morrow, D. (2008). Life coaching as a treatment for individuals with obesity. *International Journal of Evidence-Based Coaching and Mentoring, 6(2)*, 1-12. http://www.monarchsystem.com/wp-content/uploads/2014/03/Newnham-Obesity-2008-IJEBCM-article.pdf

Norcross, J. C., & Phillips, C. M. (2020). Psychologist self-care during the pandemic: Now more than ever. *Journal of Health Service Psychology, 46,* 59-63. https://doi.org/10.1007/s42843-020-00010-5

Parker, S. M. (2020). On practicing psychotherapy in a socially distant world. (Not given). [Higher Diploma in Counselling and Psychotherapy, Dublin Business School]. Electronic Thesis and Dissertation Repository.

Parsons, R. D. (2001). An introduction to the formal process of helping (Eds.). In *Helping: The role and influence of the helper* (pp. 3-20). Allyn & Bacon. https://wps.pearsoncustom.com/wps/media/objects/7169/7341895/PSY430_Ch01.pdf

Pearson, E. S., Irwin, J. D., & Morrow, D. (2013). The CHANGE program: Methodology for comparing interactive Co-Active coaching with a prescriptive lifestyle treatment for obesity. *The International Journal of Evidence-Based Coaching and Mentoring, 11*(1), 69-84. http://www.monarchsystem.com/wp-content/uploads/2015/01/Pearson-CHANGE-IJEBCM-2013-vol-11issue1-article.pdf

Pearson, E.S., Irwin, J.D., Morrow, D., & Hall, C.R. (2012). The CHANGE program: Comparing an interactive versus prescriptive obesity intervention on university students' self-esteem and quality of life. *Applied Psychology: Health and Well-Being, 4*(3), 369-389. http://www.monarchsystem.com/wp-content/uploads/2012/06/aphw1080.pdf

Pearson, E. (2011). The 'how-to' of health behaviour change brought to life: A theoretical analysis of the co-active coaching model and its underpinnings in self-determination theory. Coaching: An International Journal of Theory, Research and Practice, *4*(2), 89-103. https://doi.org/10.1080/17521882.2011.598461

Pfefferbaum, B., & North, C. S. (2020). Mental health and the covid-19 pandemic. *The New*

England Journal of Medicine, 383(6), 510-512. https://doi.org/10.1056/NEJMp2008017

Phillips, L. (2020). *Coping with the (ongoing) stress of COVID-19*. Counseling Today. https://ct.counseling.org/2020/05/coping-with-the-ongoing-stress-of-covid-19/

Pogosyan, M. (2018). *In helping others, you help yourself.* Psychology Today. https://www.psychologytoday.com/ca/blog/between-cultures/201805/in-helping-others-you-help-yourself

Posluns, K., & Gall, T.L. (2020). Dear mental health practitioners, take care of yourselves: A literature review on self-care. *International Journal for the Advancement of Counselling, 42*(1), 1-20. https://doi.org/10.1007/s10447-019-09382-w

Post, S. G. (2005. Altruism, happiness, and health: It's good to be good. *International Journal of Behavioural Medicine, 12*, 66-77. https://doi.org/10.1207/s15327558ijbm1202_4

PowerUp. (2021). *Leadership coaching*. https://powerupleadership.ca/leadership-coaching/

Reynolds, M. (2017). *Can you have too much empathy?* Psychology Today. https://www.psychologytoday.com/ca/blog/wander-woman/201704/can-you-have-too-much-empathy

Reynolds, D.J., Stiles, W. B., & Grohol, J. M. (2006). An investigation of session impact and alliance in internet-based psychotherapy: Preliminary results. *Counselling and Psychotherapy Research, 6*(3), 164-168. http://dx.doi.org/10.1080/14733140600853617

Richards, K.C., Campenni, E.C., & Muse-Burke, J.J. (2010). Self-care and wellbeing in mental health professionals: The mediating effects of self-awareness and mindfulness. *Journal of Mental Health Counselling, 32*(3), 247-264. https://doi.org/10.17744/mehc.32.3.0n31v88304423806

Robinson, T., Morrow, D., & Miller, M.R. (2017). From Aha to Ta-dah: Insights during life coaching and the link to behaviour change. Coaching: An *International Journal of Theory, Research and Practice, 11*(1), 3-15. https://doi.org/10.1080/17521882.2017.1381754.

Rosenstock, I. M. (1974). Historical origins of the health belief model. *Health Education Monographs, 2*(4), 328-335. https://www.jstor.org/stable/45240621

Rupert, P.A., & Dorociak, K.E. (2019). Self-care, stress, and wellbeing among practicing psychologists. *Professional Psychology: Research and Practice, 50*(5), 343-350. https://doi.org/10.1037/pro0000251

Schmidt, M. (2020). *A psychologist explains how to cope with video chat when you're socially anxious*. Discover. https://www.discovermagazine.com/technology/a-psychologist-explains-how-to-cope-with-video-chat-when-youre-socially

Shanefelt, T. D., Gorringe, G., Menaker, R., Storz, K. A., Reeves, D., Buskirk, S. J., Sloan, J. A., & Swensen, S. J. (2015). Impact of organizational leadership on physician burnout and satisfaction. *Mayo Clinic Proceedings, 90*(4), 432-440. https://doi.org/10.1016/j.mayocp.2015.01.012

Sherman, D. (2004). Nurses' stress & burnout: How to care for yourself when caring for patients and their families experiencing life-threatening illness. *American Journal of Nursing, 104*(5), 48-56. https://doi.org/10.1097/00000446-200405000-00020.

Shimoda, A., & Williams, E. N. (2018). *Problematic empathy in counseling and psychotherapy*. Society for Psychotherapy. https://societyforpsychotherapy.org/problematic-empathy-in-counseling-and-psychotherapy/

Stahl, A. (2020). *What the future of work means for our mental health.* Forbes.

https://www.forbes.com/sites/ashleystahl/2020/10/09/what-the-future-of-work-means-for-our-mental-health/

Tates, K., Antheunis, M. L., Kanters, S., Nieboer, T. E., & Gerritse, M. BE. (2017). The effect of screen-to-screen versus face-to-face consultation on doctor-patient communication: An experimental study with stimulated patients. *Journal of Medical Internet Research, 19*(12), e421. https://doi.org/10.2196/jmir.8033.

Taylor, A. (2021). *How to coach team members remotely*. The People Space. https://www.thepeoplespace.com/practice/articles/how-coach-team-members-remotely

TheraNest. (2020). *A therapist's guide to working remotely*. https://theranest.com/blog/a-therapists-guide-to-working-remotely/

Tidwell, L., Holland, S., Greenberg, J., Malone, J., Mullan, J., & Newcomer, R. (2004). Community-based nurse health coaching and its effect on fitness participation. *Lippincott's Case Management, 9*(6), 267-279. https://doi.org/ 10.1097/00129234-200411000-00006.

Twells, L. K., Janssen, I., & Kuk, J. L. (2020). *Canadian adult obesity clinical practice guidelines: Epidemiology of adult obesity.* Obesity Canada. http://obesitycanada.ca/wp-content/uploads/2020/08/2-Epidemiology-of-Adult-Obesity-4-FINAL.pdf

Unadkat, S., & Farquhar, M. (2020). Doctors' wellbeing: Self-care during the Covid-19 pandemic. *BMJ, 368*, 1-2. https://www.bmj.com/content/bmj/368/bmj.m1150.full.pdf

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology, 18*(148), 1-18. https://doi.org/10.1186/s12874-018-0594-7

Van Kessel, P., Baronavaski, C., Scheller, A., & Smith, A. (2020). *In Their Own Words, Americans Describe the Struggles and Silver Linings of the COVID-19 Pandemic*. Pew Research Center. https://www.pewresearch.org/2021/03/05/in-their-own-words-americans-describe-the-struggles-and-silver-linings-of-the-covid-19-pandemic/

Van Zandvoort, M., Irwin, J.D., & Morrow, D. (2009). The impact of co-active life coaching on female university students with obesity. *International Journal of Evidence Based Coaching and Mentoring, 7*(1), 104-118. http://www.monarchsystem.com/wp-content/uploads/2014/03/van-Zandvoort-CALC-on-Univ-Students-2009-IJEBCM-article.pdf

Waddington, K., & Pearson, E.S. (manuscript in preparation). How can coaches be coaches? Exploring the experience of Co-Active coaching during the COVID-19 pandemic: A pilot study.

Wallston, K. (2001). Control beliefs: Health perspectives. *International Encyclopedia of the Social & Behavioural Sciences,* 2724-2726. https://doi.org/10.1016/B0-08-043076-7/03799-2

Wang, B., Liu, Y., Qian, J., & Parker, S. K. (2020). Achieving effective remote working during the COVID-19 pandemic: A work design perspective. *Applied Psychology: An International Review, 70*(1), 16-59. https://doi.org/10.1111/apps.12290

Westergaard, J. (2013). Supervision in the helping professions: Making the case for support and supervision for career counsellors. *Australian Journal of Career Development, 22*(1), 21-28. https://doi.org/10.1177/1038416213478805.

Whitworth, L., Kimsey-House, K., Kimsey-House, H., & Sandahl, P. (2007). *Co-Active*

coaching: New skills for coaching people toward success in work and life (2nd ed.). Davies-Black Publishing.

Whitworth, L., Kimsey-House, H., & Sandahl, P. (1998) *Co-Active coaching: New skills for coaching people toward success in work and life*. Davies-Black Publishing.

World Health Organization [WHO]. (2019). *Mental health emergencies*. https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies

Zamawe, F. C. (2015). The implication of using NViVo software in qualitative data analysis: Evidence-based reflections. *Malawi Medical Journal, 27*(1), 13-15. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4478399/pdf/MMJ2701-0013.pdf

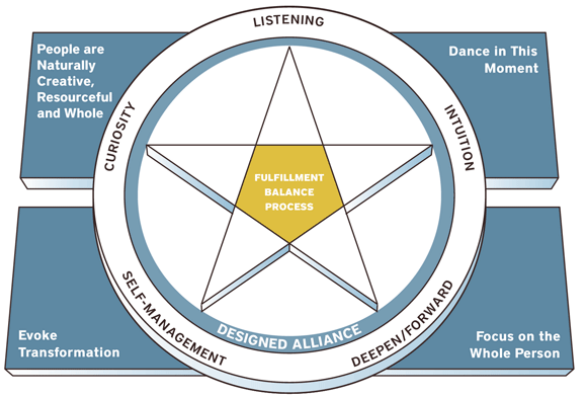
Appendix A: The Co-Active Model Description

The CALC Model

The CALC Model contains several components that are used in conjunction with one another in any given coaching session. These include a designed alliance, four cornerstones, five contexts, and three types of coaching (Kimsey-House et al., 2011, 2018). The *designed alliance* refers to the coaching relationship whereby the coach and client work together to determine the 'rules' that will govern each interaction in service of fostering an effective working relationship and growth (Kimsey-House et al., 2011). This alliance is meant to encircle the client and their agenda which is represented by an 'A' located at the heart of the model (refer to Figure 5; Kimsey-House et al., 2011). This alliance is crucial for the client to be able to express how they want to be coached, what they want their sessions to include, and how sessions can compliment their style of learning (Kimsey-House et al., 2011). This designed alliance typically takes place at the beginning of a preliminary session so the coach and client can choose a communication approach that works best for both parties, and begin to build rapport with each other before the coaching process fully begins (Kimsey-House et al., 2011). The outcome of this alliance process will ultimately teach clients that they are in control of the relationship and coaching sessions, along with any behaviour changes they are seeking to engage in (Kimsey-House et al., 2011).

Figure 5

The Co-Active Model



Notes. This figure demonstrates the concepts of being Co-Active with different contexts that help shape the coaching process such as the heart of it, cornerstones, and contexts (Kimsey-House et al., 2011).

At the outer edge of the model, four *cornerstone* concepts are presented: *people are naturally creative, resourceful, and whole (NCRW)*; *focus on the whole person*; *dance in this moment*; and *evoke transformation* (Kimsey-House et al., 2011). Coaches try to hold these cornerstones in every session for the client, and they provide the foundation of the entire coaching relationship. The idea that Co-Active coaches view the client as *NCRW* connotes that the client does not need fixing; they can be empowered to explore and discover what is important to them based on their innate resources and capabilities. The concept of wholeness within the client is a reminder that their *whole life* is to be explored, rather than focusing on one facet, challenge, behaviour, or goal (Kimsey-House et al., 2011). Another cornerstone of CALC is to *dance in this moment*, which involves a conversation of powerful and dynamic exchanges between coach and client in real time. The idea of dancing comes from being in the moment of conversation, focusing on what is happening presently, and responding based on current events rather than a pre-determined plan (Kimsey-House et al., 2011). Finally, because the Co-Active

conversation is focused on the client's full life, the coach is able to trace the client's goals and behaviours back to their roots in order to form a deeper connection, thereby producing a *transformative effect* (Kimsey-House et al., 2011). Once this transformative learning emerges, deeper awareness arises where the coach has helped the client expand their capacity to reach their potential, and gain or recover the inner strength they need to evolve and grow (Kimsey-House et al., 2011).

The *five contexts* of the CALC model include *listening, intuition, curiosity, forward and deepen, and self-management* (Kimsey-House et al., 2011). During each session, the coach draws from these contexts to varying degrees dependent upon the client and their agenda (Kimsey-House et al., 2011). *Listening* serves as an essential form of communication between coach and client, often on a deeper level and beyond the words the client is saying (Kimsey-House et al., 2011). Coaches are trained to listen for the meaning behind the story that will help deepen the vision, value, and purpose of the session in addition to any resistance, fear, or uncertainty that may hinder the change process (Kimsey-House et al., 2011). *Intuition* is a deep sense of knowing the unspoken that remains in the background (Kimsey-House et al., 2011). While not necessarily validated as a reliable means of drawing conclusions, intuition can be one of the most powerful gifts a coach can bring into their sessions (Kimsey-House et al., 2011). This context is valuable to CPCCs because it assists in synthesizing more impressions and information that one could never analyze consciously (Kimsey-House et al., 2011). Coaches are continually asking meaningful questions from a place of *curiosity*, without which, the discovery process may be halted (Kimsey-House et al., 2011). Curiosity promotes the uncovering of answers by being open, inviting, and spacious. This then allows the coach and client to enter the most profound areas of the client's life (Kimsey-House et al., 2011). Action and learning are

significant outcomes the client and coach strive towards together (Kimsey-House et al., 2011). These two forces can combine and create change because of the notion of action which moves the client forward while experiencing and learning during the process (i.e., *forward and deepen*; Kimsey-House et al., 2011). *Self-management* resides internally within the coach whereby personal opinions, preferences, pride, and ego are set aside in service of the client and their agenda (Kimsey-House et al., 2011). Self-management means giving up the need to be right as the light should be shining on the client (Kimsey-House et al., 2011).

The centre of the Co-Active model contains *fulfillment, balance, and process coaching* – all underlying conceptual goals and styles of coaching which completely centre around the client and their life (Kimsey-House et al., 2011; Robinson, Morrow, & Miller, 2017). *Fulfillment* is considered personal and focuses on both external and internal measures for success. External measures might include money and career promotion while internal measures typically consist of values, morals, and personal beliefs (Kimsey-House et al., 2011). To achieve fulfillment, clients have to explore what is important to them in the present by identifying and discovering ways to achieve a more satisfying life that aligns with their values and beliefs (Kimsey-House et al., 2011). Co-Active coaching recognizes the idea that life tends to focus on responsibilities and various distractions, which can lead to a sense of feeling unbalanced. *Balance* coaching helps clients to discover and draw from different perspectives and choices when viewing life situations where they may feel 'stuck' (Kimsey-House et al., 2011). Clients move toward or away from their idea of balance, which is considered dynamic as clients are continuously choosing yes or no based on their vision of a balanced life (Kimsey-House et al., 2011). The *process* involved in coaching comes from the analogy of a river; when life flows, some periods will occur very fast where "white-water" (Kimsey-House et al., 2011, p. 10) rushes, accompanied by days of "calm,

steady currents" (Kimsey-House et al., 2011, p. 10). During these changes, the coach's job is to notice where the client is at and provide encouragement and support around the "rocks" (Kimsey-House et al., 2011, p. 10) and "dark waters" (Kimsey-House et al., 2011, p. 10). The decisions a client makes in a day, no matter how many, contribute to creating a life either less or more fulfilling; the decisions they make can alter whether a life is perceived to be balanced or not. Lastly, these choices contribute to more or less effective life processes. Together, these three core principles have been chosen as they are fundamental to the "liveliness of life" (Kimsey-House et al., 2011, p. 8).

Appendix B: Participant Eligibility Form

t: (807) 345-8544
@lakeheadu.ca

Participant Eligibility Questionnaire

Date: _____

Certified Professional Co-Active Coach: Yes No

Are you coaching currently?

Fluent in English: _____

Reside in North America: Yes No

Willingness to be a part of an interview regarding experiences and perspectives of Coaching during a pandemic? _____

Have been practicing 6-months prior to March 2020 (pre-pandemic): Yes No

Coach at least one client per week currently: Yes No

Comments:

_____

_____

For research use only:

What day of the week would be convenient for you to participate? _____

What time of day would be convenient for you to participate? _____

Preferred mode of delivery for interview (e.g., telephone, WhatsApp): _____

Eligible to participate in the study: Yes ☐ No ☐

Appendix C: Recruitment Letter and Poster

Hello,

I am Kayla Waddington, a Kinesiology Master's student at Lakehead University, supervised by Dr. Erin Pearson. I am keen on exploring Co-Active Coaches experiences related to coaching during the COVID-19 pandemic as well as their own self-care during the pandemic. I am also interested in gaining insights of CPCCs on the use of telecommunications in practice (e.g., telephone, skype, etc.) and add more information to what we know about practicing CPCCs, in general. I am distributing a survey and conducting a one-on-one interview to learn more about your experiences and perspectives regarding this topic. Given your credentials as a Certified Professional Co-Active Coach, I am hoping you will consider providing some insights into what this experience has been like for you, especially as it relates to the pandemic that we are all currently facing.

If you would like to participate, please let me know your availability to meet for a phone or WhatsApp interview (due to existing physical distancing requirements). I can be reached via email or phone. Involvement in the study should take about 60 minutes. I would be most grateful for your involvement should you find you are interested and free.

You can contact me via email at [redacted] or by cell phone at [redacted]

Thank you for your time!

Kayla Waddington

Seeking Co-Active Coaches for Research Study on Coaching & Self-Care

Are you a practicing Certified Professional Co-Active Coach?

Are you interested in sharing your experiences on coaching and self-care during the COVID-19 pandemic?

Do you reside in North America?

If you answered **YES** to all of these questions, you may be eligible to participate!

Participants will be asked to complete a brief demographic and coach profile questionnaire and participate in a 45-minute one-on-one telephone interview.

Discussing helpful strategies will hopefully assist others in your position while the pandemic continues!

For more information please contact:
Kayla Waddington, Master's Student
School of Kinesiology, Lakehead University
[redacted]

Supervisor
Dr. Erin Pearson, CPCC, Associate Professor
School of Kinesiology, Lakehead University

This study has been approved by the Lakehead Research Ethics Board.

Appendix D: Letter of Information

Lakehead UNIVERSITY

School of Kinesiology
t: (807) 343-8544
f: (807) 343-8944

Certified Professional Co-Active Coach Letter of Information

Dear Potential Participant,

We are currently seeking Certified Professional Co-Active Coaches for involvement in a research study titled "Exploring the Experiences of Co-Active Life Coaches on Self-Care and Professional Practice during the COVID-19 Pandemic." I, Kayla Waddington, a Lakehead University Master's Student in Kinesiology, will conduct this study under the supervision of Dr. Erin Pearson, Associate Professor in the School of Kinesiology. You have been invited to participate because you are a Certified Professional Co-Active Coach, are currently practicing during the COVID-19 pandemic, and speak English fluently.

PURPOSE OF THE STUDY

While the research surrounding the benefits of coaching is well established, little has been conducted on the coaches themselves, especially during a world-wide pandemic. The primary purpose of this study is to explore CPCC's experiences related to coaching during the COVID-19 pandemic as well as their own self-care during the pandemic. We are also interested to gain the insights of CPCCs on the use of telecommunications in practice (e.g., telephone, skype, etc.) and add more information to what we know about practicing CPCCs, in general.

WHAT INFORMATION WILL BE COLLECTED?

First, the researchers will ask you a number of demographic and coaching oriented questions via a questionnaire to learn more about you and your coaching history (e.g., gender, age, time spent in practice). Second, a one-on-one telephone or WhatsApp interview will then be arranged with the student researcher (K.W.) at a mutually convenient time. She will ask you more specific questions pertaining to your experiences of coaching during the pandemic (e.g., tools and resources that have been useful; the notion of self-care; and using a telephone-based delivery mode). The interviews will be audio recorded and the content will be kept confidential during all phases of the study. The survey and interview will take approximately 45 minutes and it is expected that the total time involved in the study will take no longer than ninety minutes (e.g., sign consent form, complete questionnaire and interview).

POTENTIAL HARMS AND BENEFITS OF INVOLVEMENT

There will be no direct, physical harm to any participant completing this study. However, this study may elicit some feelings of discomfort through providing reflections and perspectives on the coaching practice and with the added global pandemic. Every effort will be made to alleviate these experiences. We would ask that as a participant, you be as honest as you can with your responses and share only what you feel comfortable with. It is also important that you know that you do not have to answer any question you do not want to, and can withdraw from the study at any time without penalty. Some potential benefits of involvement may include increased self-awareness, and having the ability to reflect and debrief on your practice. A "helper's high" could also be experienced whereby you have a heightened sense of your role in assisting others with their self-care, telecommunication strategies, and growth during this unprecedented time, while contributing to the growing body of coaching-based research. As a participant, you can receive the study findings upon request, which could provide you with useful information regarding coaching practices during a global pandemic, self-care practices, and the use of telecommunication. In addition, there are also some indirect benefits of participating in the study. Information obtained from participants may be used to uncover useful strategies that can be used in other helping professions and coach training bodies as we continue on with this pandemic.

STORAGE OF DATA

Throughout the research study, all and your information will be securely stored in the password protected computer of the student researcher. As the study is being conducted over electronic databases such as Google Forms, all electronic documents will be password protected. After the completion of the study, all paper and electronic files will be transferred and stored in the locked cabinet in the principle investigators office within the School of Kinesiology for a minimum of five years. After this point, the data will be destroyed using confidential means. During the study, the data will be securely stored in the password protected computer of the student researcher. Access to this information will only be allowed by the researchers involved (student and supervisor). Any hard copies will be stored securely in the home offices of the researchers (until the quarantine is over; at which time, the data will be transferred to the university), while digital information including raw data and analysis, will be password protected on the student researcher's password protected computer.

CONFIDENTIALITY

All efforts will be made to ensure full confidentiality and anonymity for all study results. Personal information regarding your participation will remain anonymous (i.e., you will be given an ID number). The results will be presented at the student researchers thesis defence using the Zoom platform and may also be published; however, you will always remain anonymous.

PARTICIPANT RIGHTS

As a participant, it is important to understand that your involvement in the study is completely voluntary. You may refuse to answer any questions within the questionnaire or during the interview without judgement. You may also withdraw from this study at any time without penalty. Each participant also has the right to remain anonymous. This study has been approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca

RESEARCHER CONTACT INFORMATION:

If you have any questions or concerns about the research, please feel free to contact us via the contact information below.

Thank you for your interest in this study.

With warm regards,

Kayla

Kayla Waddington, Master's Student
Student Researcher
School of Kinesiology, Lakehead University
[redacted]

Erin Pearson, PhD, CPCC
Associate Professor and Student Supervisor
School of Kinesiology, Lakehead University
[redacted]

Appendix E: Letter of Consent

Lakehead UNIVERSITY

School of Kinesiology

t: (807) 343-8544
f: (807) 343-8944

Consent Form

I agree to the following:

- ✓ I have read and understood the information contained in the Information Letter
- ✓ I understand the potential risks and/or benefits of the study, and what those are
- ✓ I understand that I am a volunteer and can withdraw from the study at any time and may choose not to answer any questions
- ✓ I understand that the data will be securely stored in the home/school offices of the researchers, while digital information including raw data and analysis, will be password protected on the student researcher's password protected computer
- ✓ I understand that the research findings will be made available to me upon request via email
- ✓ I understand that all data collected from me will be anonymous and protected when publication and/or public presentations of the research findings occurs
- ✓ I give my permission for my anonymous data to be published and presented publicly
- ✓ I agree to participate

_____ _____

(Signature of Participant) *(Date)*

_____ _____

(Signature of Researcher) *(Date)*

Date for Meeting: _____ Time: _____

Interview Contact Number: (___) _____

Please Indicate if you would like a summarized copy of the results from the study:

Yes, I would like a copy _____ *E-mail:* _____

Appendix F: Demographic Questionnaire and Coach Profile

Lakehead UNIVERSITY

School of Kinesiology
t: (807) 343-8544
f: (807) 343-8944

Co-Active Coaching Demographic and Professional Profile Questionnaire

To be administered via Google Forms

ID #: _____

Date: _____

Note: Questions asking about *pre-pandemic* information is all information before March, 2020. Questions asking about *during the pandemic* is any event occurring March, 2020 and onwards.

Demographics

1. Age: _____
2. Gender: _____
3. Highest Education Level Completed (Drop-Down menu):
    - Some high-school
    - High school diploma
    - Some college
    - College Diploma/Certificate
    - Trade/Vocational School
    - Some University
    - University Degree
        - Undergraduate
        - Master's
        - PhD
    - Other _____
4. Estimated Yearly Income: _____
5. Number of people supported by this income: _____
6. Relationship Status:
    - Single
    - Common-Law Partnership
    - Married
    - Widowed
    - Separated/Divorced

7. At present, how many people currently reside in your home? Please include ages and relationships:

_____

_____

_____

8. Name of District Health Unit you follow: _____

9. Ethnicity (Drop-Down Menu):
    - Aboriginal
    - European-Canadian
    - African-Canadian
    - Asian-Canadian
    - _____

Professional Profile of Coaching

10. How long have you been a Certified Professional Co-Active Coach? _____
    a. Date of certification completion: _____
    b. Other types of coach or related training: _____

11. Coaching is your:
    - Full-time occupation ☐
    - Part-time occupation ☐
    - If applicable, what is your other occupation? _____
    - How much of your time is allocated towards each occupation in a typical month (by percentage to = 100)?

12. What was your prior profession before coaching, if anything? _____
    a. How long were you employed in this profession? _____

13. What type of coaching do you primarily engage in (e.g., life, executive, both, other)? _____

14. What strategies do you typically use to generate new clients? _____
    a. How has this changed during the pandemic, if at all? _____

15. Which coaching delivery mode(s) do you use to coach clients (e.g., Telephone/ Face-to-Face/ Skype / Other)
    a. Please indicate the percentages of use if more than one mode is applied (to = 100%):

       _____

    b. Has this changed since the pandemic started? If so, please explain

       _____

16. How many total coaching sessions do you typically provide in a week?
    a. Pre-pandemic: _____
    b. During-pandemic: _____

17. How long is a typical coaching session (minutes)?
    a. Pre-pandemic: _____
    b. During-pandemic: _____

18. How many clients are you coaching currently during the pandemic (March 2020-Present)? _____
    a. How many of these clients started and finished since the pandemic started (March 2020)? _____
    b. How many of these clients continue to coach with you?

19. How have your total coaching hours been impacted per week since the pandemic started?
    a. Increase in coaching hours: 1-2hrs, 3-4hrs, 5-6hrs, other, no change
    b. Decrease in coaching hours: 1-2 hrs, 3-4hrs, 5-6hrs, other, no change
    c. Other

    Comments: _____

Questions derived from Grant & Zackon (2004), Newnham-Kanas et al. (2011a, 2011c, 2012), and Waddington & Pearson (2020)

Appendix G: Interview Guide

Lakehead UNIVERSITY

t: (807) 343-8544

@lakeheadu.ca

Interview Guide

Welcome/Ice Breaker Script: Thank you for agreeing to participate in a discussion about your coaching experiences, self-care practices, and use of telecommunications during the COVID-19 pandemic. Your views are highly valued and I appreciate you taking the time to speak with me today. As indicated in the consent form you completed online, our discussion today will be audio-recorded. I am reminding you here that there are no right or wrong answers – please just state what you feel comfortable with. My only request is that you be as honest as you can with what you choose to share with me today. Of course, you can choose not to answer any questions you don't want to, as well as withdraw from the interview at any time. I would also like to remind you that this is a private and confidential interview, meaning that anything you say here will not be relayed to others with your name attached. Finally, another reminder, t**he primary purpose** of this interview is to explore your experiences related to: a) coaching during the COVID-19 pandemic and b) your own self-care during the COVID-19 pandemic. The secondary purpose of this study is to collect insights from you about the use of telecommunication delivery (such as the telephone) during your coaching sessions. Before we get started, are there any other questions I can answer for you? (Pause and answer as needed). Great. Well, then we will begin!

Introductory Questions

1. What drew you to coaching initially?
2. What do you enjoy about coaching currently?

Coaching During a Pandemic

1. Compared to before the pandemic began in March, what is different about coaching for you now?
    a. For your clients?
2. What has surprised you most about coaching during a pandemic?
3. How have your coaching sessions changed since the pandemic started, if at all?
    a. Probes: Regarding general content; tools/strategies used; methods of coaching; structure/delivery
4. What coaching-related challenges have you experienced during the pandemic?
    a. What has helped you to overcome these challenges?
5. What motivates you to continue coaching during this pandemic?
6. What do you think has most prepared you for coaching during a pandemic?
7. What would you recommend CTI consider to ensure coaches have the appropriate resources and skills to practice effectively during times of crisis, such as a pandemic?
    a. Probe: coaching others; using coaching personally, other helping professions

Self-Care as a CPCC During COVID-19

1. Self-care is typically viewed as a proactive approach to health and wellbeing. What does self-care mean to you?
    a. What is important to you about self-care?
2. What does your own self-care typically look like? (Probe: specific practices)
    a. How has this changed since the pandemic began, if at all?
3. How is your role as a coach connected to your views on self-care?
4. What self-care practices or resources do you use?
    a. What self-care practices do you find less helpful?
5. You noted earlier that you are using a number of tools and strategies currently to assist your clients. Which have you been applying to your own life during the pandemic (if any)?
    a. Which have you used most often and why?
6. How does your work environment impact your self-care (positively/negatively)?
    a. (Probes: peer collaboration, peer support, workplace environment)
7. What makes it hard to prioritize your own self-care needs during this time?
    a. What makes it easy to prioritize yourself?
8. What advice do you have for other coaches in terms of personal self-care during the pandemic?
    a. Would your advice be different for other helping professionals (e.g., nursing, social work, psychology)?

Delivery Mode during COVID-19

1. What modalities are you currently using to coach clients right now during COVID-19 (e.g., telephone, Skype, WhatsApp)?
    a. Which do you use most often and why?
2. What makes this mode work for clients?
    b. What makes this mode work for you?
    c. What are the challenges associated with using this mode? (for clients/you)
    d. How do you overcome these challenges to ensure effective delivery?
3. Assuming telecommunications are the new normal in the foreseeable future, what do you feel is important for clients to know?
4. What haven't discussed already that you'd like to share your thoughts on before we complete the interview?

Questions derived from Karmali et al. (2020), Miller et al., 2018, Newnham-Kanas et al. (2011, 2012), and Waddington and Pearson (2020).

Appendix H: Exported NViVo Codebook

Name	Description	Files	References
Adaptability to Change		4	6
Client and Practice Changes Because of COVID		8	29
Coach Skills and Related Training		5	6
Coaching is more meaningful now with COVID		4	4
Coaching makes Self-Care Easier		6	10
Connection with Coaches and People		4	5
CTI Recommendations		8	11
Emotional Health for Coaches		5	9
Love for Coaching		4	5
Mental Health		6	12
Normalizing and Listening COVID Experience		2	9
Phone-Deep Listening		4	5
Phone-It really works		4	5
Phone-Movement		3	4
Phone-No Distractions		3	3
Provides the Foundation to Care for Others Effectively		6	8
Remote Working		8	23

Name	Description	Files	References
Resilience		3	6
Self-Care is more Intentional		4	6
Self-Care Strategy-Mindfulness		3	4
Self-Care Strategy-Nutrition		3	3
Self-Care Strategy-PA		8	9
Self-care Strategy-Sleep		2	2
Strategies-Listening to your Needs		8	14
Transformation		3	3
Travel Time to Work		4	4
True to Yourself		2	2
Video-Fatigue		4	4
Video-Next Best Thing to In-Person		3	3
Video-Screen Size		3	5
Video-Technology Failure		6	8
Vide-Visual Aspect		5	7
Virtual Strategies		6	9
Virtual-More Access to People		6	7