Coaching for Workers With Chronic Illness: Evaluating an Intervention

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Working with chronic illness may present challenges for individuals—for instance, managing symptoms at work, attaining accommodations, and career planning while considering health limitations. These challenges may be stressful and lead to strains. We tested a 12-week, 6-session, phone-based coaching intervention designed to help workers manage these challenges and reduce strains. Using theories of stress and resources, we proposed that coaching would help boost workers’ internal resources and would lead to improved work ability perceptions, exhaustion and disengagement burnout, job self-efficacy, core self-evaluations, resilience, mental resources, and job satisfaction, and that these beneficial effects would be stable 12 weeks after coaching ended. Fifty-nine full-time workers with chronic illnesses were randomly assigned to either a coaching group or a waitlisted control group. Participants completed online surveys at enrollment, at the start of coaching, after coaching ended, and 12 weeks postcoaching. Compared with the control group, the coaching group showed significantly improved work ability perceptions, exhaustion burnout, core self-evaluations, and resilience—yet no significant improvements were found for job self-efficacy, disengagement burnout, or job satisfaction. Indirect effects of coaching on work ability, exhaustion and disengagement burnout, and job satisfaction were observed through job self-efficacy, core self-evaluations, resilience, and mental resources. Results indicated that the positive effects of coaching were stable 12 weeks after coaching ended. Results suggest that this coaching intervention was helpful in improving the personal well-being of individuals navigating challenges associated with working and managing chronic illness.

Keywords: chronic illness, coaching, burnout, work ability

Chronic illnesses, such as heart disease, diabetes, and cancer, are diseases of long duration and generally slow progression (World Health Organization, 2008). Chronic illnesses are prevalent in the United States and may cause problems with work. According to the 2010 U.S. census data, 7.2% of people age 16 to 64 years (14.4 million) indicated difficulty finding or maintaining a job due to a physical or mental health condition (Brault, 2012).

Individuals with chronic illnesses who are employed may face challenges related to maintaining work and developing their careers (e.g., communicating about illness, attaining needed accommodations, and maintaining job performance). These challenges can be stressful and result in strains, which are long-term detriments to physical or psychological well-being. Effective interventions to help workers manage challenges related to working with illness may help prevent or alleviate worker strains and improve worker well-being.

The purpose of this study was to evaluate a coaching intervention designed to help individual workers with chronic illnesses manage challenges stemming from working with illness. The intervention included six 1-hr phone-based coaching sessions over 12 weeks. We proposed that the coaching intervention would have positive effects on individual workers’ perceived work ability, job satisfaction, and other personal resources, and would help decrease individuals’ burnout levels. We tested these propositions using a pragmatic randomized control trial design (e.g., Godwin et al., 2003; Hotopf, 2002), with a waitlisted control group, on a sample of full-time working adults with chronic health conditions.

The current study makes a contribution to the literature answering calls for more intervention-based research in occupational health psychology (DeAngelis, 2010), along with a greater focus on marginalized worker populations in organizational research (Maynard & Ferdman, 2009), including workers with chronic illnesses (Beatty & Joffe, 2006). It also contributes to a sparse
Challenges of Working With Chronic Illness

Workers with chronic illnesses face unique work-related challenges that may cause strain. For example, Munir et al. (2007) found that work limitations, difficulties managing illness symptoms at work, coming to work when sick, low levels of workplace support, disclosing illness at work, and long-term sickness absence were related to psychological and health-related distress in a sample of working adults with chronic illnesses. Further, threat of stigmatization was found to relate positively to strain and negatively to perceived work ability in a sample of workers with chronic illnesses (McGonagle & Barnes-Farrell, 2013).

First, meeting expectations for regular and consistent work hours may be difficult (Vickers, 2003). Employees have to find ways to balance their health needs—doctor and clinic visits, side effects from medication, and managing symptoms—within the constraints of their job tasks and employment schedules, and typical organizational absenteeism policies are, many times, inadequate (Munir, Yarker, & Haslam, 2008). If workers come to work when feeling sick, also known as presenteeism, they may experience high levels of burnout (Demerouti, Le Blanc, Bakker, Schaufeli, & Hox, 2009).

Relatedly, self-presentation and impression management may be stressful. Some illnesses have periodic symptom flares, leading to cycles of “good days and bad days” (Charmaz, 1991). Workers with chronic illnesses may find themselves having to explain or justify their variable performance (Tarasuk & Eakin, 1995; Vickers, 2003)—all the more so if their illness symptoms are ambiguous or invisible. Some illnesses are stigmatizing, and fear of discrimination may lead people to hide and suppress information (Clair, Beatty, & MacLean, 2005; Ragins, 2008), which can be both mentally demanding and stressful (Smart & Wegner, 2000). Further, suppression may lead to further harm because it prevents workers from receiving social support to cope. If workers choose to disclose their illness, they must decide what and how much to tell, and whether to handle it through informal or formal channels (Clair et al., 2005; Ragins, 2008). Formal channels are typically necessary if the person expects to receive an accommodation, but they tend to lead to a more adversarial and potentially stressful process (Beatty, 2012).

Career issues may also be of concern. Adjusting to chronic illness may prompt reflection and reprioritization of career goals (Beatty & Joffe, 2006). Additionally, individuals with chronic illness may have lowered career expectations or experience poor person–job fit. For example, in Beatty’s (2012) study of individuals with chronic illness, some participants experienced difficulties managing their physical limitations and responded by setting lower career goals. These participants were grateful to have any job; they were also afraid to leave their jobs because they did not want to lose their health insurance. In some cases, they remained in jobs for which they were mismatched or overqualified because changing jobs was too risky. In sum, many features of working with chronic illness are challenging and may be stressful.

A Resource-Based Approach

Coaching is defined as “partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential” (International Coach Federation, n.d.-a). Coaching is a nonclinical, future-oriented intervention to help individuals grow, adapt, and change behaviors—in contrast to more therapeutic interventions designed to address clinical issues by identifying roots of dysfunction (Feldman & Lankau, 2005). Although individuals in our study did have clinical issues (chronic illnesses), the focus of the intervention was on helping to boost workers’ levels of internal resources to help them manage stress related to working with illness—not to address or improve their clinical issues per se.

Our proposal that coaching helps workers through increasing their levels of internal personal resources (e.g., resilience, self-efficacy) expands upon the idea of “resource activation,” which was first proposed by Grønbech (2004) in the psychotherapy literature. Resource activation (i.e., activating resources within clients to help them face challenges) is a plausible framework to explain why coaching has positive effects across different samples, designs, and formats (Behrendt, 2004; Greif, 2007). In this study, we apply resource activation to workers with chronic illness, drawing upon two theories of stress, the transactional model and conservation of resources (COR) theory.

In the transactional model, Lazarus and Folkman (1984) state that stress is the result of cognitive appraisal. An event or situation becomes a stressor for an individual through a perceived discrepancy between the demands or challenges of a particular situation and his or her physical, psychological, or social systems. Specifically, an individual assesses a threat to his or her well-being (primary appraisal) and his or her resources available to meet the demand (secondary appraisal; Lazarus & Folkman, 1984). If the individual does not perceive his or her resources to be adequate to meet the demand, a stressful appraisal will result and various strains may occur. Resources are central to the transactional model in that they can prevent stressful appraisals, leading an individual, instead, to appraise the situation as a manageable challenge.

Resources are also central to COR theory (Hobfoll, 1989). Resources are defined as “objects, personal characteristics, conditions or energies that are valued in their own right or that are valued because they act as conduits to the achievement or protection of valued resources” (Hobfoll, 2001, p. 339). Resources can be internal, such as dispositions that aid psychosocial adaptation, or external, such as material resources. Hobfoll (1989) maintains that individuals strive to retain, protect, and build resources, and that a threat or actual loss of resources produces stress and strain outcomes. Additionally, individuals are able to draw upon available resources to prevent further resource loss. Applying the transactional model and COR to the challenges of working with chronic illness, internal personal resources may prevent or diminish stressful appraisals and/or resource losses. It follows that an intervention to boost one’s resources should be effective in preventing resource loss and associated strain-related outcomes.
Although the empirical base for coaching may be described as nascent (e.g., Bono et al., 2009; Feldman & Lankau, 2005), some evidence shows that workplace coaching helps to decrease individuals’ stress levels (Grant, Curtayne, & Burton, 2009; Gyllensten & Palmer, 2005; Ladegård, 2011) and improve their resilience and well-being (Grant et al., 2009). Furthermore, there is evidence to suggest that coaching should be helpful for workers with chronic illness. Duijts, Kant, van den Brandt, and Swaen (2007, 2008) tested the effectiveness of a preventative coaching intervention of seven to nine sessions for employees at risk for sickness absence. Compared with a control group, the intervention group showed significant positive effects for self-rated health, life satisfaction, psychological distress, burnout, and need for recovery. However, no significant effects were seen for sickness absence (Duijts et al., 2008).

We propose that a coaching intervention will be effective for workers with chronic illnesses. Specifically, we propose that coaching will be associated with improvements to individuals’ levels of personal resources (job self-efficacy, core self-evaluations, resilience, and mental resources), along with strain-related outcomes (perceived work ability, exhaustion and disengagement burnout, and job satisfaction).

We chose four resources that are important in determining important health and work-related outcomes. It is worthy of note that selecting criteria variables in coaching studies is generally problematic; Smith, Borneman, Brummel, and Connelly (2009) refer to this as a coaching “criterion problem.” Researchers evaluating coaching must select criteria that are appropriate for all individuals, yet coaching is inherently targeted toward meeting individuals’ goals (which differ by person). We worked to identify criteria that were aligned with our theoretical framework and were also broad enough that they may be affected for most of our coaching participants, regardless of their specific concerns and goals for coaching.

First, we examined job self-efficacy, which refers to feelings of competence and confidence in one’s abilities to perform one’s job effectively (Chen, Goddard, & Casper, 2004). Job self-efficacy is important to consider, in that it can buffer the impact of work stressors (e.g., long hours, work overload) on strain (Jex & Bliese, 1999), and it is also related to job performance (e.g., Stajkovic & Luthans, 1998). Second, we examined core self-evaluations, which is “a higher order concept representing the fundamental evaluations that people make about themselves and their functioning in the environment” (Judge, Van Vianen, & De Pater, 2004, p. 326), comprised of self-esteem, generalized self-efficacy, neuroticism, and locus of control. Core self-evaluations have been empirically related to job satisfaction (Judge, Locke, Durham, & Kluger, 1998), motivation and performance (Erez & Judge, 2001), and (lower levels of) job burnout (Best, Stapleton, & Downey, 2005).

Third, we examined resilience, which refers to positive adaptability or ability to thrive in the face of adversity (Campbell-Sills & Stein, 2007; Luthans, 2002). Recent research has highlighted the importance of resilience in determining mental health (Lee, Sudom, & Zamorski, 2013), well-being (Avey, Luthans, Smith, & Palmer, 2010), and sickness absence (Hystad, Eid, & Brevik, 2011). Fourth, we examined mental resources, which are associated with positive mental health and refer to feelings of alertness, hope for the future, and the ability to enjoy daily activities (Tuomi, Ilmarinen, Jahkola, Katajimarne, & Tulkki, 1998). Mental resources have recently been shown to be positively affected by a career development training program (Vuori, Toppinnen-Tanner, & Mutanen, 2012).

In addition, we examined four outcome variables that are related to strain: perceived work ability, exhaustion burnout, disengagement burnout, and job satisfaction. Perceived work ability refers to a worker’s perceived ability to sustain employment in his or her current job in the near future, given the demands of the job and his or her resources (Ilmarinen, Gould, Järvilkoski, & Järvisalo, 2008). Workers with chronic illness are particularly vulnerable to declines in work ability and generally report lower levels of work ability than workers who are not chronically ill (Gould, Ilmarinen, Järvisalo, & Koskinen, 2008). Perceived work ability has been found to predict sick leave (Ahlstrom, Grimby-Ekman, Hagberg, & Delle, 2010), mortality, and disability (von Bonsdorff et al., 2011).

Burnout, a response to chronic work stress (Halbesleben, 2006), is more prevalent in individuals with physical illness than in healthy individuals (Honkonen et al., 2006). Burnout occurs when job demands are high and job resources are limited (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). More recently, researchers have also included personal resources in predicting strain (Xanthopoulou, Bakker, Demerouti, & Schaufeli, 2009). Burnout is important to examine because it predicts many important outcomes, including physical health (Melamed, Shirem, Toker, Berliner, & Shapira, 2006), disability (Ahola, Toppinen-Tanner, Huhtanen, Koskinen, & Vaananen, 2009), unsafe behaviors and injuries (Halbesleben, 2010), and job performance (Shirom, Nirel, & Vinokur, 2006).

Finally, low levels of job satisfaction represent a strain-related outcome that may stem from challenges related to working and managing illness. Job satisfaction is related to turnover (Saari & Judge, 2004), life satisfaction (Tait, Padgett, & Baldwin, 1989), and absenteeism (Wegge, Schmidt, Parkes, & van Dick, 2007). According to COR theory and the transactional model, increasing workers’ resources to handle challenges should help decrease strain outcomes; we therefore expected that coaching would lead to lower levels of exhaustion and disengagement burnout, and higher levels of work ability and job satisfaction. We proposed the following hypotheses.

**Hypothesis 1:** Participants who receive coaching will report improved levels of (a) job self-efficacy, (b) core self-evaluations, (c) resilience, (d) mental resources, (e) work ability, (f) exhaustion burnout, (g) disengagement burnout, and (h) job satisfaction from baseline to postcoaching, compared with a control group.

**Hypothesis 2:** Indirect effects of coaching on (a) work ability, (b) exhaustion burnout, (c) disengagement burnout, and (d) job satisfaction will be observed through job self-efficacy, core self-evaluations, resilience, and mental resources.

We also proposed that the positive effects of coaching on the outcome variables would be stable for an additional 3 months after coaching ended. This is important to examine, as many studies of workplace coaching do not follow participants after coaching ends.

**Hypothesis 3:** Postcoaching levels of (a) job self-efficacy, (b) core self-evaluations, (c) resilience, (d) mental resources, (e)
work ability, (f) exhaustion burnout, (g) disengagement burnout, and (h) job satisfaction will be stable 3 months later.

Method

Study Participants

Study participants were recruited from two Midwestern U.S. universities, a health insurance provider, and a pharmaceutical organization. In addition, flyers were posted in three health care clinics and an advertisement was sent out via online social media (Twitter and blogs). At one university, an advertisement was posted on an internal Web site for faculty and staff; at the other, the advertisement was e-mailed to faculty. The health insurance provider and the pharmaceutical company posted an advertisement in an online newsletter. Hard-copy flyers were posted in waiting rooms of three health clinics. In addition, personal contacts of the researchers, who are active bloggers in the areas of health and chronic illness, posted information about the study on Twitter and their blogs. We originally expected to attain our sample solely from one of the two organizations, but the online posting was small and obscure. As many employees did not see it and we received few responses, we expanded our recruitment efforts as described.

We received requests for additional information from 78 interested individuals; 59 of them met enrollment criteria and completed a baseline survey. Enrollment criteria included working an average of at least 30 hr per week, having one or more chronic health conditions that caused difficulties with work, and not planning to retire within 2 years of study enrollment. Of the 59 enrolled, 31 were recruited via online social media, 13 from the two companies, 11 from the universities, and 5 from the health clinics. No monetary incentives were used for recruitment, but all participants received coaching free of charge, and were given an incentive worth $10 to complete the final study survey (12 weeks after coaching ended).

Participants were predominately female (86%), were generally well educated (73% had a 4-year college degree or graduate degree), and were, on average, 38.7 years of age. Fifty-six percent of participants reported being the primary breadwinners in their homes, and 41% reported having responsibility for children under age 18 at home. Participants worked an average of 41 hr per week, and had an average of 6.5 years’ tenure with their employers. Most participants (69%) reported that their supervisor was aware of their illness, and 66% reported needing a workplace accommodation for their illness. Participants’ job titles included insurance operations (n = 7), mid-level or project manager (n = 7), vice president or senior manager (n = 7), engineering analyst or technician (n = 6), health care worker (n = 6), administrative assistant or clerical worker (n = 5), professor or lecturer (n = 3), instructional developer or trainer (n = 3), marketing or sales worker (n = 3), and researcher (n = 3). All participants except for one were living in the U.S. at enrollment. Participants were asked to report all of their chronic illnesses and to select the one that most affected their lives. The most frequently represented illnesses included ankylosing spondylitis (n = 6), nerve injury or neuropathy (n = 5), fibromyalgia (n = 4), diabetes (Types 1 and 2; n = 3), multiple sclerosis (n = 3), psoriatic arthritis (n = 3), psychiatric illness (n = 3), and Sjögren’s syndrome (n = 3). Chi-square tests and t tests were used to test for differences between the coaching group and waitlisted control group in all demographics and study variables; no significant differences were found (results of t tests are provided in Table 1; chi-square tests are available from the corresponding author upon request).

Upon completion of an online baseline survey, each participant was randomly assigned to either an immediate-start coaching group or a waitlisted control group. Randomization was achieved

Table 1

Participant Demographics, Measures at Baseline, and Coefficient Alphas

<table>
<thead>
<tr>
<th>Measures (demographic)</th>
<th>Coaching group (n = 30)</th>
<th>Waitlisted control (n = 29)</th>
<th>t</th>
<th>All combined (n = 59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>38.30 (8.2)</td>
<td>39.07 (7.79)</td>
<td>.37</td>
<td>—</td>
</tr>
<tr>
<td>Hours worked per week</td>
<td>40.92 (7.29)</td>
<td>41.09 (9.95)</td>
<td>.08</td>
<td>—</td>
</tr>
<tr>
<td>Organizational tenure (years)</td>
<td>6.47 (6.89)</td>
<td>6.57 (5.30)</td>
<td>.06</td>
<td>—</td>
</tr>
<tr>
<td>Illness Severity Scale</td>
<td>3.99 (.49)</td>
<td>4.00 (.82)</td>
<td>.05</td>
<td>.80</td>
</tr>
<tr>
<td>Psychological Distress Scale</td>
<td>1.33 (.68)</td>
<td>1.08 (.83)</td>
<td>—1.23</td>
<td>.87</td>
</tr>
<tr>
<td>Number of medications</td>
<td>3.50 (2.90)</td>
<td>4.03 (3.07)</td>
<td>.69</td>
<td>—</td>
</tr>
<tr>
<td>Number of medical appointments</td>
<td>12.00 (9.17)</td>
<td>13.45 (8.90)</td>
<td>.62</td>
<td>—</td>
</tr>
<tr>
<td>Number of ER visits/hospitalizations</td>
<td>.57 (.94)</td>
<td>1.07 (1.83)</td>
<td>1.33</td>
<td>—</td>
</tr>
<tr>
<td>General health</td>
<td>2.50 (.82)</td>
<td>2.45 (.74)</td>
<td>—.26</td>
<td>—</td>
</tr>
<tr>
<td>Measures (study outcomes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job self-efficacy</td>
<td>3.50 (.65)</td>
<td>3.65 (.58)</td>
<td>.91</td>
<td>.83</td>
</tr>
<tr>
<td>Core self-evaluations</td>
<td>2.83 (.54)</td>
<td>3.04 (.54)</td>
<td>1.47</td>
<td>.84</td>
</tr>
<tr>
<td>Resilience</td>
<td>2.37 (.62)</td>
<td>2.51 (.71)</td>
<td>.77</td>
<td>.88</td>
</tr>
<tr>
<td>Mental resources</td>
<td>2.88 (.80)</td>
<td>3.19 (.93)</td>
<td>1.40</td>
<td>.81</td>
</tr>
<tr>
<td>Work ability</td>
<td>3.35 (.70)</td>
<td>3.27 (.65)</td>
<td>—.47</td>
<td>.71</td>
</tr>
<tr>
<td>Exhaustion burnout</td>
<td>2.96 (.38)</td>
<td>2.87 (.35)</td>
<td>—1.01</td>
<td>.70</td>
</tr>
<tr>
<td>Disengagement burnout</td>
<td>2.44 (.52)</td>
<td>2.49 (.58)</td>
<td>.32</td>
<td>.83</td>
</tr>
<tr>
<td>Job satisfaction</td>
<td>3.61 (.91)</td>
<td>3.56 (.89)</td>
<td>—.21</td>
<td>.89</td>
</tr>
</tbody>
</table>

Note. There were no significant baseline differences between groups in participant demographics or measures at baseline at p < .05. $\alpha =$ coefficient alpha.
by a coin flip. The immediate-start coaching group participants started their 12-week coaching intervention within 2 weeks of their baseline survey completion. The waitlisted control group participants waited for 12 weeks; they then completed another online survey before starting their 12-week coaching intervention. All participants completed an online survey halfway through coaching (at 6 weeks into coaching) to assess whether the intervention was consistent with a coaching protocol, an online survey and exit interview at the end of coaching, and a final online survey 12 weeks after coaching ended. Figure 1 presents the participant flow for this study.

**Study Intervention**

All coaching was provided over the telephone; clients were offered calling cards to cover the cost of phone calls. The main reason we chose to conduct coaching over the phone is convenience. Because individuals who are working with a chronic illness often have to deal with getting time off work to attend doctor’s appointments or other illness management activities, we thought that phone sessions (which could be conducted from any private location before or after work or during a work break) would be more convenient than having to travel to the coach’s office for in-person sessions. We also recruited participants from all over the United States, which made phone coaching the most viable option.

Each individual received six 1-hr coaching sessions (one session every other week for 12 weeks). This duration of coaching was chosen as a reasonable amount of coaching to address illness-related issues, giving the coach and client time to establish a relationship and explore major issues. The 12-week intervention period is consistent with other health-related coaching, such as that by Butterworth, Linden, McClay, and Leo (2006), which also spanned a 3-month period. A review of 190 wellness interventions by Stuifbergen, Morris, Jung, Pierini, and Morgan (2010) found that the majority of the wellness interventions were 12 weeks or less. Examples supporting this duration of coaching can also be found in executive coaching, such as Grant et al.’s (2009) study with four coaching sessions over an 8- to 10-week period.

The coach was certified by the International Coach Federation and followed their competency guidelines (International Coach Federation, n.d.-b). Although the six-session coaching engagement followed a standardized structure, the particular content was tailored to each individual’s needs and goals. The general coaching framework employed follows the GROW model (Alexander, 2006; see also Grant et al., 2009), which outlines a basic process for coaching. The first component is labeled “goal,” in which the coach and client agree on the topic(s) for discussion, and the objectives and desired outcomes for the current session. The client establishes the agenda so that the coaching sessions are customized to meet their needs. Early in each coaching session, the coach asks the client what he or she would like to work on during the day’s call, and the stated goals guide the remainder of the session. The next component is called “reality”, in which the coach helps the client...
client create awareness of their current situation and how it is affecting the identified outcomes or goals. The coach asks the client for more explanation of their current issues and invites self-assessment. Coaching techniques such as “powerful questioning” (International Coach Federation, n.d.-b.) and paraphrasing are used to help the client increase awareness and see their situation from a fresh perspective. The third component is known as “options,” in which possible solutions are identified. The coach invites suggestions from the client; suggestions may also be carefully made by the coach. In the case of chronic illness coaching, the coach’s knowledge and expertise of the domain is helpful for offering new alternatives to address the client’s particular issues, as the client may not be aware of resources or alternatives. For example, the coach may offer suggestions for how to effectively communicate about his or her illness to coworkers. The last component is “way forward”, in which the coach helps the client define next steps and develop action plans. Toward the end of each coaching session, the stated goals for the session are reviewed and assignments are developed for the client to complete prior to the next call. The client may be asked to offer their own ideas on assignments that will address the goals. Examples of assignments include creating task lists and reflecting on them or behavioral routines (such as preparing personal items for the next day the night before they are needed). They could also be reading, journaling, or meditative exercises. The action plans are specific and measurable, and are designed to be accomplished in the time frame between sessions. The client is encouraged to keep records of their actions so that they can reflect on them and discuss them at the next call.

As coaching progresses, the client may improve their knowledge of their values and whether they resonate with their situation, along with their ability to define problems, reflect from multiple perspectives, and generate solutions. These skills contribute to feelings of self-efficacy, control, and resilience. If increased knowledge, insight, and solution generation leads to positive behavior change, further resource building may also occur (e.g., achievement of positive behavior change can lead to increased self-efficacy; Bandura, 1994) and mitigation of strain (as more effective thinking and behaviors replace ineffective ones).

The progression of the six-session coaching engagement was as follows. All clients completed a coaching self-assessment prior to Session 1, including health status and how it affected their current job situation, current work-related challenges, and longer term career prospects. This allowed for reflection and self-observation, and helped the client choose desired outcomes for the coaching engagement. During the first coaching call, the coach and client discussed the self-assessment and set specific desired outcomes for the coaching engagement. An example is improving ability to communicate effectively with one’s manager and coworkers about illness. The coach gave “homework” between each call that was tailored to the clients’ set goals. Prior to Sessions 2 through 6, clients were also encouraged to complete a “meeting prep” form, which included goals for the upcoming call and issues that came up between calls. Clients were encouraged to take notes during each call. Sessions 2 through 6 followed a predictable structure so that clients could know what to expect and take an active role in each session. Each of these calls started with a recap of relevant experiences clients had since the previous session, along with a check-in regarding homework (to promote accountability). Then the coach asked clients what they wanted to explore or focus on during the current session and what the desired outcomes for that session were (to promote client direction and control). During each session, the coach emphasized creating awareness, seeing things from different perspectives, and looking for opportunities by using questioning techniques (International Coach Federation, n.d.-b). The coach also aimed to help each client see any gaps between where he or she was currently and where he or she wanted to be, and focused conversation around strategies to close these gaps. About 5 min prior to the end of each session, the coach asked the client to recap what he or she learned during the session that was particularly helpful. Session 6 (the final session) included a discussion about lessons learned during coaching and insights or perspectives that were helpful.

Measures

The measures described in this section were used in each survey (same items at each time point). Coefficient alphas were calculated using the baseline survey data (n = 59) and are presented in Table 1. Mean composites were computed for each scale, provided there were responses to at least 75% of the items for the scale. In two cases, an individual answered less than 75% of the items in a scale; we did not use those scale composites for those individuals. There were no other composite-level missing data.

Measures of resources.

Job self-efficacy. The eight-item scale from Chen et al. (2004) was used to measure job self-efficacy. A sample item is, “I can successfully overcome obstacles at work.” The response scale ranged from 1 (strongly disagree) to 5 (strongly agree).

Core self-evaluations. The 12-item Core Self-Evaluations Scale (Judge, Erez, Bono, & Thoresen, 2003) was used. A sample item is, “I am confident I get the success I deserve in life.” The response scale ranged from 1 (strongly disagree) to 5 (strongly agree).

Resilience. The 10-item version of the Connor-Davidson Resilience Scale was used (Campbell-Sills & Stein, 2007). A sample item is, “I have been able to adapt to change.” The response scale ranged from 0 (not true at all) to 4 (true nearly all the time).

Mental resources. The Mental Resources subscale of the Work Ability Index (WAI) was used (Tuomi et al., 1998). A sample item is, “Have you recently felt yourself to be full of hope and confidence?” The response scale ranged from 1 (never) to 5 (often).

Measures of strain-related outcomes.

Work ability. We used a four-item scale based on the WAI (Tuomi et al., 1998), which was also used in McGonagle et al. (2013). Respondents were asked to rate their current level of work ability compared with their lifetime best, along with their current work ability with respect to the (a) physical, (b) mental, and (c) interpersonal demands of their work. A Likert-type response scale was used, ranging from 1 (very poor) to 5 (very good).

Burnout. Exhaustion and disengagement dimensions of burnout were measured using the Oldenburg Burnout Inventory (Demerouti, Mostert, & Bakker, 2010). Sample items are, “Over time, one can become disconnected from this type of work” (disengagement) and “After work, I tend to need more time than in the past in order to relax and feel better” (exhaustion). The response scale
ranged from 1 (strongly disagree) to 4 (strongly agree); higher numbers indicate greater levels of burnout.

**Job satisfaction.** We used the three-item scale from Cammann, Fichman, Jenkins, and Klesh (1983). A sample item is, “All in all, I am satisfied with my job.” The response scale ranged from 1 (strongly disagree) to 5 (strongly agree).

**Illness severity.** We used the Consequences subscale of the Revised Illness Perceptions Questionnaire (Moss-Morris et al., 2002). A sample item is, “My chronic illness has major consequences on my life.” The response scale ranged from 1 (strongly disagree) to 5 (strongly agree).

**Psychological distress.** The Symptom Checklist SCL 10-N (Nguyen, Attkisson, & Stegner, 1983) was used to measure psychological distress. Participants were asked to describe how much distress 10 problems had caused them during the past week, for example, “... feeling lonely?” The response scale ranged from 0 (not at all) to 4 (extremely). Müller, Postert, Beyer, Furniss, and Achtergarde (2010) identified a score of 4.0 as a viable cutoff for indicating “high” levels of distress. Participants with sums of exceeding 4.0 (n = 49) were reminded that coaching is a nonclinical intervention, and is not a substitute for therapy or other psychological services. When possible, we also pointed them to potentially helpful services (e.g., employee assistance programs).

**General self-rated health.** We used a single item to rate general health: “Would you say that in general your health is ...?”. The response scale ranged from 1 (poor) to 5 (excellent).

**Demographics.** Participants were asked to report their age, gender, highest level of education attained, breadwinner status, whether they currently needed work accommodations, whether their supervisor was aware of their illness, whether they had any responsibility for children under 18 years at home, hours worked per week, organizational tenure, the number of medications they currently take for their illness, the number of medical appointments they had related to their illness in the past year, and the number of emergency room visits and hospitalizations they had in the past year related to their illness.

**Questions assessing fidelity of coaching.** The survey administered to each participant halfway through coaching contained questions that were written to assess whether the coaching intervention was consistent with a coaching protocol. We developed six questions based on coaching protocol (e.g., International Coach Federation, n.d.-a). Sample questions are, “Who set the coaching meeting agenda for the majority of your coaching sessions?” and “If you asked your coach for advice, how did she respond?”

**Reaction to coaching.** In the postcoaching surveys, we asked participants, “In your opinion, was coaching helpful to you? Feel free to use this space to comment on coaching.”

### Data Analysis Plan

We first used chi-square tests and t tests to evaluate differences between the immediate coaching and control groups on demographics and other baseline measures in order to determine equivalence at baseline and whether any covariates should be included in further analyses. Then, to determine whether coaching participants had improved their standing on each of the outcome variables after coaching compared with a control group (Hypotheses 1a through 1h), we ran a repeated measures MANOVA and a series of univariate repeated measures ANOVAs, examining Time × Group interaction effects. We used MANOVA so we could determine an overall significant omnibus effect prior to assessing univariate effects, given our multiple correlated outcome variables. In order to control for increased risk of Type I error given the eight tests, we used a p value of .019 to determine statistical significance of each univariate test (we used a Bonferroni correction with a family-wise p value set at .15). Effect sizes (partial eta squared, or η²) are presented and interpreted in light of Cohen’s (1988) recommendations (.01 = small, .06 = medium, .14 = large). We then ran analyses to determine the statistical significance of indirect effects (Hypotheses 2a through 2d) using Hayes (2013) process macro, controlling for baseline levels of both the mediators and outcome variables in all equations. Because the control group started coaching when the immediate coaching group ended coaching, we did not have data at 3-months postcoaching for the waitlisted group. Therefore, indirect effects were tested using coaching group as the independent variable, resources at Time 2 (postcoaching) as mediators, and strain-related outcomes also at Time 2 (postcoaching) as outcomes. Significance of indirect effects was determined via bias-corrected bootstrapped (1,000 draws) 95% confidence intervals.

Following tests of indirect effects, we examined mean scores for each outcome variable over three time points (precoaching, postcoaching, 12-week follow-up) using all individuals who went through coaching (immediate start plus waitlisted). We looked for significant main effects of time on each outcome variable using repeated measures MANOVA and univariate ANOVAs (again using a p value of .019) and effect sizes using η². We then conducted a series of paired samples t tests to check for significant differences in each of the outcome variables between postcoaching and 12 weeks postcoaching (Hypotheses 3a through 3h). Finally, we ran chi-square tests and t tests to determine whether attrition was different from those who completed coaching, in terms of demographics or baseline measures.

### Results

#### Baseline Analysis

We tested for significant differences between the immediate coaching and waitlisted coaching groups in demographics and baseline measures using independent t tests and chi-square analyses (see Table 1 for t values). No statistically significant differences were found in either demographics or baseline measures between the two groups. Therefore, we did not include any demographic or other measures as covariates in subsequent analyses.

#### Group × Time Interactions (Hypotheses 1a through 1h)

Results of a MANOVA with all eight outcome variables yielded a statistically significant Time × Group interaction F test, Wilks’ λ = .56, F(8, 39) = 3.52, p < .01, multivariate η² = .44. Univariate within-subjects Time × Group interaction ANOVA tests yielded statistically significant interactions for work ability, F(1, 46) = 5.91, p < .019, η² = .11, exhaustion burnout, F(1, 46) = 8.75, p < .01, η² = .16, mental resources, F(1, 46) = 18.53, p < .001, η² = .29, resilience, F(1, 46) = 7.28, p < .01, η² = .14.
and core self-evaluations $F(1, 46) = 9.73, p < .01, \eta^2_p = .18$. However, no statistically significant interactions were found for job self-efficacy, $F(1, 46) = 4.60, p > .019, \eta^2_p = .09$, disengagement burnout, $F(1, 46) = .17, p > .019, \eta^2_p = .00$, or job satisfaction, $F(1, 46) = .52, p > .019, \eta^2_p = .01$. Table 2 displays all Group × Time interactions.

### Indirect Effects (Hypotheses 2a through 2d)

Table 3 contains all direct and indirect effects of coaching on the four strain-related outcome variables. Indirect effects were observed from coaching group to work ability through core self-evaluations (ab = .16, $p < .05$), resilience (ab = .22, $p < .05$), and mental resources (ab = .41, $p < .05$); from coaching group to exhaustion burnout through mental resources (ab = -.16, $p < .05$), from coaching group to disengagement through job self-efficacy (ab = -.10, $p < .05$), core self-evaluations (ab = -.09, $p < .05$), and resilience (ab = -.09, $p < .05$), and from coaching group to job satisfaction through job self-efficacy (ab = .30, $p < .05$), core self-evaluations (ab = .25, $p < .05$), and resilience (ab = .19, $p < .05$).

### Trajectories Over Time and Stability of Results (Hypotheses 3a through 3h)

To examine overall trajectories of the dependent variables over time, we examined precoaching, postcoaching, and 12 weeks postcoaching survey results from both groups combined, excluding two participants with missing data ($n = 35$). Results of a repeated measures MANOVA with eight outcome variables showed a statistically significant overall $F$ test for the within subjects effects of time, Wilks' $\lambda = .29, F(16, 19) = 2.89, p < .05$, multivariate $\eta^2_p = .71$. Due to statistically significant Mauchly's tests of sphericity for mental resources, $\chi^2(2) = 11.06, p < .01$, work ability, $\chi^2(2) = 14.73, p < .01$, and job satisfaction, $\chi^2(2) = 7.70, p < .05$, we report all univariate $F$ test results with Huynh-Feldt corrections. A significant effect of time was seen for work ability, $F(1,52, 34) = 12.78, p < .001, \eta^2_p = .27$, exhaustion burnout, $F(2, 34) = 15.52, p < .001, \eta^2_p = .31$, mental resources, $F(1,62, 34) = 13.40, p < .001, \eta^2_p = .28$, core self-evaluations, $F(1,90, 34) = 8.17, p < .01, \eta^2_p = .19$, and resilience, $F(1,84, 34) = 5.32, p < .01, \eta^2_p = .14$. No statistically significant effects of time were seen for disengagement burnout, $F(2, 34) = 1.84, p > .019, \eta^2_p = .05$, job self-efficacy, $F(1,98, 34) = 2.07, p > .019, \eta^2_p = .06$, or job satisfaction, $F(1,73, 34) = .21, p > .019, \eta^2_p = .01$. Paired samples $t$-test results indicated no statistically significant differences between postcoaching outcome scores and 12 weeks postcoaching outcome scores, providing support for the stability of effects over 12 weeks postcoaching (Hypotheses 3a through 3h). Table 4 contains means, $F$ tests, effect sizes for linear and quadratic effects, and $t$-test results.

### Attrition Analyses

Of the 30 individuals enrolled in the immediate coaching group, 23 completed coaching (23% attrition from coaching). Of the 29 individuals enrolled in the waitlisted group, 25 provided follow-up responses at the end of the waiting period and started coaching (14% attrition during waiting period)—of these, 16 completed coaching (36% attrition from waitlisted start to end of coaching; 44% attrition from enrollment to end of coaching). Results of chi-square tests and $t$ tests indicated that completers had higher

### Table 2

| Outcome measures | Coaching group
tabular (n = 23)
Mean (SD) | Waitlisted control
tabular (n = 23)
Mean (SD) | $F$ | Partial
$\eta^2$ |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Job self-efficacy</td>
<td>Pre</td>
<td>3.42 (.66)</td>
<td>3.62 (.57)</td>
<td>4.60*</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>3.70 (.58)</td>
<td>3.59 (.80)</td>
<td></td>
</tr>
<tr>
<td>Core self-evaluations</td>
<td>Pre</td>
<td>2.84 (.48)</td>
<td>3.09 (.55)</td>
<td>9.73***</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>3.27 (.59)</td>
<td>3.12 (.57)</td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>Pre</td>
<td>2.40 (.57)</td>
<td>2.54 (.73)</td>
<td>7.28**</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>2.67 (.55)</td>
<td>2.41 (.80)</td>
<td></td>
</tr>
<tr>
<td>Mental resources</td>
<td>Pre</td>
<td>2.91 (.86)</td>
<td>3.28 (.95)</td>
<td>18.53****</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>3.72 (.69)</td>
<td>3.13 (.83)</td>
<td></td>
</tr>
<tr>
<td>Work ability</td>
<td>Pre</td>
<td>3.39 (.75)</td>
<td>3.36 (.66)</td>
<td>5.91**</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>3.82 (.39)</td>
<td>3.23 (.91)</td>
<td></td>
</tr>
<tr>
<td>Exhaustion burnout</td>
<td>Pre</td>
<td>2.92 (.40)</td>
<td>2.86 (.38)</td>
<td>8.75***</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>2.65 (.46)</td>
<td>2.89 (.34)</td>
<td></td>
</tr>
<tr>
<td>Disengagement burnout</td>
<td>Pre</td>
<td>2.42 (.55)</td>
<td>2.46 (.56)</td>
<td>.17</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>2.33 (.57)</td>
<td>2.43 (.44)</td>
<td></td>
</tr>
<tr>
<td>Job satisfaction</td>
<td>Pre</td>
<td>3.62 (.92)</td>
<td>3.49 (.93)</td>
<td>.52</td>
</tr>
<tr>
<td></td>
<td>Post</td>
<td>3.53 (.99)</td>
<td>3.59 (1.00)</td>
<td></td>
</tr>
</tbody>
</table>

* $p < .05$. ** $p < .019$. *** $p < .01$. **** $p < .001$.
### Table 3
Results of Tests for Indirect Effects of Coaching on Mediators (Resources) and Outcomes

<table>
<thead>
<tr>
<th>Outcome variable</th>
<th>Mediator variable</th>
<th>Direct effect</th>
<th>Direct effect 95% CI</th>
<th>Indirect effect</th>
<th>Indirect effect 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work ability</td>
<td>Job self-efficacy</td>
<td>.55*</td>
<td>.16, .94</td>
<td>.03</td>
<td>−.04, .22</td>
</tr>
<tr>
<td></td>
<td>Core self-evaluations</td>
<td>.48*</td>
<td>.10, .86</td>
<td>.16*</td>
<td>.01, .43</td>
</tr>
<tr>
<td></td>
<td>Resilience</td>
<td>.33</td>
<td>−.03, .69</td>
<td>.22*</td>
<td>.03, .51</td>
</tr>
<tr>
<td></td>
<td>Mental resources</td>
<td>.32</td>
<td>−.03, .67</td>
<td>.41*</td>
<td>.20, .75</td>
</tr>
<tr>
<td>Exhaustion burnout</td>
<td>Job self-efficacy</td>
<td>-.28*</td>
<td>−.48, −.08</td>
<td>−.02</td>
<td>−.13, .05</td>
</tr>
<tr>
<td></td>
<td>Core self-evaluations</td>
<td>-.26*</td>
<td>−.47, −.05</td>
<td>−.03</td>
<td>−.14, −.02</td>
</tr>
<tr>
<td></td>
<td>Resilience</td>
<td>-.25*</td>
<td>−.46, −.05</td>
<td>−.03</td>
<td>−.14, .02</td>
</tr>
<tr>
<td></td>
<td>Mental resources</td>
<td>−.13</td>
<td>−.34, .09</td>
<td>−.16*</td>
<td>−.37, −.05</td>
</tr>
<tr>
<td>Disengagement burnout</td>
<td>Job self-efficacy</td>
<td>.01</td>
<td>−.22, .24</td>
<td>−.10*</td>
<td>−.30, −.001</td>
</tr>
<tr>
<td></td>
<td>Core self-evaluations</td>
<td>.003</td>
<td>−.26, .26</td>
<td>−.09*</td>
<td>−.23, −.02</td>
</tr>
<tr>
<td></td>
<td>Resilience</td>
<td>.03</td>
<td>−.22, .28</td>
<td>−.09*</td>
<td>−.26, −.02</td>
</tr>
<tr>
<td></td>
<td>Mental resources</td>
<td>.05</td>
<td>−.24, .34</td>
<td>−.14</td>
<td>−.24, .34</td>
</tr>
<tr>
<td>Job satisfaction</td>
<td>Job self-efficacy</td>
<td>−.30</td>
<td>−.79, .20</td>
<td>.16*</td>
<td>.002, .50</td>
</tr>
<tr>
<td></td>
<td>Core self-evaluations</td>
<td>−.25</td>
<td>−.79, .29</td>
<td>.16*</td>
<td>.01, .46</td>
</tr>
<tr>
<td></td>
<td>Resilience</td>
<td>−.33</td>
<td>−.86, .19</td>
<td>.19*</td>
<td>.01, .57</td>
</tr>
<tr>
<td></td>
<td>Mental resources</td>
<td>−.27</td>
<td>−.84, .31</td>
<td>.22</td>
<td>−.04, .68</td>
</tr>
</tbody>
</table>

**Note.** Independent variable = group (coaching versus waitlisted control). Direct effect refers to the direct effect of group on the outcome variable. Indirect effect refers to the indirect effect of group on the outcome variable through the mediator. 1,000 samples drawn for bootstrap estimates. Both mediator and outcome variables measured at Time 2 (postcoaching for immediate coaching group and post-waitlist period for waitlisted control group). Baseline levels of the mediators and outcome variables were entered as control variables when estimating effects of group on the mediators and effects of mediators on the outcome variables. CI = bias-corrected bootstrapped confidence interval (lower limit, upper limit).

* p < .05.

I then was able to put together a plan to achieve my goals and maintain more balance and integration.” The details of these favorable responses suggest that clients learned skills and tools through the coaching intervention, and that they found it to be helpful for coping with the issues of chronic illness.

### Supplemental Analyses

Because it is possible that some of the participant background variables were moderators of the effects of coaching (i.e., causing some participants to benefit more from coaching than others), we tested for interactions of time by background variables (illness severity, psychological distress, and whether supervisor was aware of the illness) on each of the study dependent variables, using a series of within-subjects univariate ANOVAs. We found no statistically significant interactions; complete Time × Background variable interaction results are available from the corresponding author upon request.

### Discussion

Individual workers with chronic illnesses who received coaching showed significantly improved work ability and decreased exhaustion burnout, along with improved mental resources, resilience, and core self-evaluations after participating in a six-session telephone-based coaching intervention, compared with a control group. In addition, the positive effects of coaching were stable during a 12-week period after coaching ended. Yet no significant results were seen for effects of coaching on job self-efficacy, disengagement coping, or job satisfaction. Overall, our results suggest that coaching may be a good intervention for individuals who are navigating challenges associated with working and managing a chronic health condition, and are looking for improvements to their personal well-being. Our findings are consistent...
with those reported by Duijts et al. (2008), Grant et al. (2009), and Gyllensten and Palmer (2005), who also found evidence for the effectiveness of coaching on workers’ well-being, and with Ladegård (2011), who found stability of effects on stress reduction for a period after coaching ended.

Our framework for coaching as a helpful intervention was based on the notion of resource activation (Greif, 2007), along with theories of stress and resources (COR, Hobfoll, 1989; the transactional model, Lazarus & Folkman, 1984). We argued that workers with chronic illnesses experience unique work-related challenges that can lead to stress and strain, and we proposed that coaching helps build personal internal resources that can help prevent or mitigate strain. In line with this proposition, we found that coaching had positive effects on both personal resource and strain variables (although coaching did not uniformly positively affect all outcomes, as noted). We did not find statistically significant Time \( \times \) Group interactions for job self-efficacy, job satisfaction, or disengagement burnout. Nevertheless, the effect size for job self-efficacy was moderate to large. Similarly, when examining main effects of time on job self-efficacy and disengagement burnout for all clients, effect sizes were moderate despite being non-significant. However, no evidence was seen for coaching positively affecting clients’ job satisfaction.

It is possible that the duration of our study was too brief to affect disengagement burnout and job satisfaction. Perhaps some of the personal resources would translate to improved job-specific cognitions, attitudes, and behaviors during a longer time period. For example, a worker who is feeling better about herself may be more proactive in taking on challenges at work as opportunities arise, and therefore feel more efficacious and satisfied with work—yet this would take time to unfold (perhaps longer than 3 months). We see some initial evidence to suggest that this may be the case in the tests for indirect effects: significant indirect effects were observed for disengagement burnout and job satisfaction via job self-efficacy, core self-evaluations, and resilience (despite the fact that direct effects of coaching on these two outcomes were not observed). Yet, given that both our mediators and outcomes were from the same time point (postcoaching), the indirect effects results should be considered preliminary. Future research should follow participants for a longer time in order to see whether significant direct effects of coaching on job-related outcomes are evident and to provide more rigorous tests of mediation.

Participants in this study were generally young (the average age was 37), which was unexpected, given that the prevalence of chronic health conditions limiting the ability to work increases with age (U.S. Census Bureau, 2013). We can speculate that perhaps individuals around this age are more stressed by their illnesses because they may still be in a career-building stage and may have less autonomy in their jobs than older workers. The interplay of age, chronic illness, and work is an interesting topic that may have less autonomy in their jobs than older workers. The interplay of age, chronic illness, and work is an interesting topic that may have less autonomy in their jobs than older workers.

In addition to assessing coaching’s effectiveness, another purpose of this study was to determine its viability. There are several factors to consider in determining viability. First, coaching was designed to be as convenient as possible for individuals who were busy managing work, health, and, in many cases, families. The coach used an online scheduling tool that allowed clients to reschedule appointments on their own. Clients were not penalized...
for rescheduling. In addition, coaching delivered via phone had the effect of making sessions convenient and private for participants.

Despite these efforts, we had an overall attrition rate of 34% (23% overall in the immediate group and 44% overall in the waitlisted group). Our overall attrition rate is similar to the attrition rate for participants in a coaching intervention for sickness absence (27%; Duijts et al., 2008), yet it is higher than the attrition rate for another workplace stress reduction coaching (13%; Ladhégard, 2011) and the attrition rate in another recent (noncoaching) 12-week mind–body workplace stress reduction intervention (14%; Wolever et al., 2012). It is difficult to make comparisons of our dropout rate with those of other workplace coaching studies because they are not always reported (e.g., Evers, Brouwers, & Tomic, 2006; Grant et al., 2009; Gyllensten & Palmer, 2005). For reference, attrition rates in some other longitudinal studies of workers that do not involve an intervention are as follows: 24% for Schmitt, Zacher, and Frese (2012); 29% for Volmer, Binnewies, Sonnentag, and Niessen (2012); and 26% for Wood, Michaelides, and Totterdell (2013). It is also difficult to determine causes of attrition in this study because, in most cases, individuals simply stopped communicating with the coach. Additionally, we ran into an issue with individuals “no-showing” for coaching appointments (not showing up and not contacting the coach to reschedule); we subsequently implemented a rule partway through the study that if the client no-showed, he or she would forfeit that coaching session; two “no-shows” would result in being removed from the study. We removed just one participant from the study for repeated no-shows.

We saw more attrition in the waitlisted group, in which participants had to wait 3 months to start coaching. It is likely that initial interest in coaching waned for individuals over the waitlist period, causing more waitlisted individuals to drop out. This speaks to the potential importance of timing—individuals may benefit most from coaching when they are able to start when they desire (and are presumably most engaged). Those with lower education levels and greater levels of psychological distress also dropped out of coaching at a higher rate. It is possible that these individuals saw less potential for improving their situations through coaching, although we cannot determine this with the current study data.

Another issue concerning viability is who will pay for coaching: Is coaching an intervention that employers might add to benefits programs? Employers may be interested in providing this type of intervention to help with strain, especially because the types of strain studied here are linked to important work-related outcomes, including workforce exit (von Bonsdorff et al., 2011) and declines in job performance (Wright & Cropanzano, 1998). Offering this type of assistance to employees may also result in them feeling less potential for improving their situations through coaching, although we cannot determine this with the current study data.

The limitations of our study provide guidance for future research. First, our sole use of self-report outcome measures may be seen as problematic. We were unable to incorporate more “objective” physiological measures into the present study because of logistical limitations and a desire to make the study as convenient as possible for participants. Future larger scale coaching studies should incorporate more objective outcomes (for examples of criteria, see Wolever et al., 2012). In addition, it would be beneficial to test for effects of coaching on supervisor ratings of job performance—yet issues of privacy and confidentiality of chronic illness status must be carefully managed. A second limitation concerns the representativeness of our sample. Participants were predominately female and had high levels of education. Regarding the preponderance of female participants, it is worth noting that women are more likely to seek help for distress than men (e.g., Oliver, Pearson, Coe, & Gunnell, 2005); women also have greater incidence of autoimmune diseases (which were well-represented in the sample) than men (e.g., Fairweather & Rose, 2004). However, future studies should attempt to recruit more men and those with lower education levels in anticipation of these gaps.
A further concern is whether individuals with chronic illnesses can reliably respond to survey questions about personal resources, burnout, and strain, given inevitable fluctuations in illness symptoms (and possible corresponding fluctuations in participants’ affect). This issue has been discussed in the common method variance literature. Podsakoff, MacKenzie, and Podsakoff (2012) note that if respondents are motivated to complete the survey accurately (e.g., by a desire to “tell their story”), there is less risk for biased responding. Participants who completed coaching and the surveys were likely to be highly engaged in the study (as indicated by their willingness to spend time and energy on study-related tasks); therefore, they were likely motivated to provide accurate responses. We also examined correlations between study variables. If participants responded based on their affect during a given time period, we would expect to see uniformly high correlations between survey variables during each time period. Yet we found many nonsignificant correlations between outcome variables measured at the same time point. Future research may more fully examine response reliability issues for this population.

In conclusion, a six-session coaching engagement was effective in improving levels of personal resources (core self-evaluations, resilience, and mental resources) and alleviating strain outcomes (work ability, exhaustion burnout) in a sample of individuals working full time and managing a chronic illness. These results suggest that coaching may also be successfully applied to boost resources and enhance well-being in other populations of workers facing adversities. We hope to see continued research on coaching interventions for worker well-being, particularly for workers facing adversities such as chronic illness.

References


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