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A mixed-methods pilot study of a psychoeducational group programme for nurse managers during the COVID-19 pandemic

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Abstract

Aim: This mixed-methods pilot study aimed to measure the feasibility and acceptability of a psychoeducational group programme and determine its impact on mental well-being.

Background: The programme was developed to promote self-care, growth and adaptive coping for nurse managers. The programme themes were resilience, insight, self-compassion and empowerment.

Methods: The sample included 19 hospital-based nurse managers. Outcomes included post-traumatic growth, resilience, insight, self-compassion, empowerment, perceived stress, burnout and job satisfaction. Paired samples *t* tests were conducted to compare outcomes at baseline to follow-up. Qualitative interviews were conducted. Thematic analysis was used to code the qualitative responses by keyword, which were then aggregated into themes.

Results: Participants reported higher post-traumatic growth and psychological empowerment after the intervention. The following six themes emerged most consistently from the qualitative interviews: feasibility of the programme, benefits of peer support, sources of stress, barriers to self-care, sources of strength and sustainability of effects.

Conclusions: The results support the acceptability and feasibility of the psychoeducational group programme.

Implications for nursing management: Health care organizations can support and promote the implementation of programmes to alleviate burnout and improve mental well-being amid the complex demands of nursing management (ClinicalTrials.gov: NCT04987697).

KEYWORDS
cognitive/behaviour therapy, mindfulness, psychoeducation, resilience, stress

1 | BACKGROUND

Nurse managers have an important and complex role in hospitals. They influence outcomes for patients and staff and affect the health of organizational culture (Hughes, 2019). Sources of stress include heavy workloads, lack of resources and financial responsibilities, whereas peer and supervisory support, autonomy and empowerment are key factors in reducing work stress and improving job satisfaction

(Labrague et al., 2018; Steege et al., 2017). Chronic stress, in addition to lack of support and low autonomy, can lead to burnout. Warshawsky and Havens (2014) identified burnout as a common reason for nurse manager turnover, dissatisfaction and intent to leave. In addition, the COVID-19 pandemic has magnified nurses' physical, emotional and moral distress and led to a staffing shortage (Lavoie-Tremblay et al., 2021). As a result, nurse managers have been responsible for leading nurses who have experienced significant psychological and emotional strain (Udod et al., 2021). Furthermore, the extreme changes and losses associated with the pandemic can be considered a collective trauma experienced by health care workers, including nurse managers (Bender et al., 2021).

Given the detrimental effects of stress and burnout, it is essential to provide support, skill development and targeted interventions to help nurse managers feel connected to joy and satisfaction in work, feel empowered in their roles and encourage healthy self-care behaviour (Kelly et al., 2019; Markey et al., 2021; Penconek et al., 2021). RISE© for Nurse Managers is a psychoeducational group programme developed to address stress, burnout and trauma through mindful self-care, coping and support (Hofmeyer & Taylor, 2021; Jackson & Nowell, 2021; White, 2021) to allow for personal and professional growth and psychological healing. The programme's name is an acronym for the four themes of resilience, insight, self-compassion and empowerment. This pilot study aimed to measure the feasibility and acceptability of the psychoeducational group programme and determine its impact on their post-traumatic growth, resilience, insight, self-compassion and empowerment, as well as perceived stress, burnout and job satisfaction.

2 | METHODS

2.1 | Setting

This study was a mixed-methods pilot study conducted at a multi-campus health care system headquartered in Florida. Recruitment occurred in April 2021. The intervention was held for 9 weeks, from May through July 2021. Data collection occurred at baseline in May 2021 and follow-up in July 2021. The follow-up time point coincided with the COVID-19 Delta surge in Florida. The health care system moved into various stages of emergency management, beginning with yellow status, then red status and eventually black status between July 2021 and September 2021.

2.2 | Sample

In this pilot study, the target sample size was 20 participants. Although a sample size of 12 participants is considered to be an adequate in a pilot study (Julious, 2005), a relatively high attrition rate was expected due to the pandemic. Recruitment occurred via email and followed the organizational policy for selecting and enrolling hospital employees for research studies. Study inclusion criteria were adult ≥ 18 years old; licenced as a registered nurse (RN); nurse manager employed by the health care organization in a hospital-based setting at selected campuses in Florida; and able to speak, read and understand English fluently. The exclusion criterion in this study was employed as a direct care nurse or in another level of nursing leadership (i.e., assistant nurse manager, director of nursing and executive leader).

2.3 | Intervention

Bailey et al. (2021) previously described the rationale, theoretical framework and development of the programme, and a randomized controlled trial was conducted with direct care nurses (Sawyer et al., 2021). Briefly, this psychoeducational group programme combines education, therapeutic process, skill development and social support in nine weekly 90-min sessions. The four themes are conceptualized as skill sets to buffer the effects of high stress and burnout and enhance protective factors for mental health and well-being (Bailey et al., 2021). Participants gain knowledge and skills while processing emotional experiences and receiving support from others.

The intervention was developed and facilitated by a licenced mental health counsellor (LMHC) employed by the organization's research institute. The approach is informed by an integrative theoretical framework including mindfulness (Kabat-Zinn, 2003; Lomas et al., 2018), acceptance and commitment therapy (ACT) (Hayes et al., 1999; Towey-Swift et al., 2022) and cognitive-behavioural therapy (CBT) (Beck, 1964; Beck, 1976; Kazantzis et al., 2018). The programme's elements, format and delivery of were based on group counselling theory, best practice standards and legal and ethical requirements for group practice (American Counseling Association, 2014; American Group Psychotherapy Association, 2007; Bailey et al., 2021; Corey et al., 2014; Thomas & Pender, 2008; Yalom & Leszcz, 2020).

The programme components were facilitated using three main methods: education, self-reflection and experiential learning. Table 1 presents the session content. The intervention in this pilot study was adapted for nurse managers to include content related to post-traumatic growth and authentic leadership (Raso et al., 2020). The adaptation process incorporated input from nurse leaders consulted through focus groups.

2.3.1 | Intervention adaptation during the pandemic

Post-traumatic growth was included as a conceptual underpinning in the programme, which informed the curriculum, facilitation methods and group process. Post-traumatic growth is a positive psychological change experienced through the struggle with adversity, traumatic events or crises, such as the pandemic (Tedeschi & Calhoun, 2004). The growth is not a result of the event itself but the process of coping with it. Studies suggest that post-traumatic growth and

TABLE 1 Programme session content

Session #	Topic	Content
1	Introduction and Background	Group process and guidelines Programme framework Drivers and symptoms of burnout Mindfulness Authentic living
2	Resilience	Definition of resilience and myths Building resilience/personal coping resources Oscillation between stress and recovery Post-traumatic growth
3	Resilience	Connecting to joy Connecting to purpose and meaning Resilience behaviours in leaders
4	Insight	Self-awareness and self-reflection Cognitive insight Common thought distortions Exploring core beliefs
5	Insight	Emotional literacy Emotional avoidance vs. acceptance Practice of expansion
6	Self-compassion	Compassion fatigue and compassion satisfaction Definition of self-compassion Self-compassion skills
7	Empowerment	Definition of personal empowerment Environmental impact on empowerment Learned helplessness Healthy boundaries
8	Empowerment	Empowerment and authentic living Personal values identification Values-behaviour alignment
9	Closing	Closing and goodbye Synthesis of learning Self-care guide

post-traumatic stress often co-exist, which supports existing theories that reactions to crises are not only negative, and adversity can be a catalyst for growth (Calhoun & Tedeschi, 2014; Finstad et al., 2021; Kashdan & Kane, 2011). Areas of growth include relating to others, new possibilities, personal strength, spiritual change and appreciation of life (Calhoun & Tedeschi, 2006). The programme aimed to facilitate post-traumatic growth given the risk of traumatic stress due to work in nursing leadership during the pandemic (d'Ettorre et al., 2021; Fowler & Wholeben, 2020).

The pandemic spurred the use of online platforms for learning and support in various settings (Henderson et al., 2020; Khurshid et al., 2020; Weinberg, 2021). Participants attended the programme sessions virtually on the Microsoft Teams video conferencing platform. The curriculum and facilitation activities were adapted for the online synchronous group format, focusing on strategies to build group member trust and cohesion. Workbooks were mailed to participants as a tool for writing notes and reflections during sessions and tracking learning and growth.

2.4 | Instruments

Eight instruments were used to measure study outcomes related to mental well-being indicators. The Posttraumatic Growth Inventory (Cronbach's $\alpha = .90$) is a 21-item instrument with item responses ranging from 0 'I did not experience this change as a result of crisis' to 5 'I experienced this change to a very great deal as a result of crisis' and an overall score between 0 and 105 (Tedeschi & Calhoun, 1996). The domain scores range between 0 and 35 in the Relating to Others domain, 0 and 25 in the New Possibilities domain, 0 and 20 in the Personal Strength domain, 0 and 10 in the Spiritual Change domain and 0 and 15 in the Appreciation of Life domain.

The Brief Resilience Scale (Cronbach's $\alpha = .80–.91$) is a six-item instrument with item responses ranging from 1 'Strongly disagree' to 5 'Strong agree' and an overall average score between 1 and 5 (Smith et al., 2008). The Self-Reflection and Insight Scale (self-reflection subscale Cronbach's $\alpha = .91$; insight subscale Cronbach's $\alpha = .87$) is a 20-item instrument with item responses ranging from 1 'Strongly disagree' to 6 'Strongly agree' and domain scores between 6 and 36 on the Engagement in Self-Reflection domain, 6 and 36 on the Need for Self-Reflection domain and 6 and 48 on the Insight domain (Grant et al., 2002). The Self-Compassion Scale—Short Form (Cronbach's $\alpha \geq .86$) is a 12-item instrument with item responses ranging from 1 'Almost never' to 5 'Almost always' and an overall average score between 1 and 5 (Raes et al., 2011). The Psychological Empowerment Instrument (Cronbach's $\alpha = .62–.72$) is a 12-item instrument with item responses ranging from A 'Very strongly disagree' to G 'Very strongly disagree' and an overall average score between 0 and 7 (Spreitzer, 1995). The average domain scores also are between 0 and 7 in the four domains of Meaning, Competence, Self-Determination and Impact.

The Perceived Stress Scale (Cronbach's $\alpha = .84–.86$) is a 10-item instrument with item responses ranging from 0 'Never' to 4 'Very Often' and an overall score between 0 and 40 (Cohen et al., 1983). The Maslach Burnout Inventory—General Survey (Exhaustion scale Cronbach's $\alpha = .88$; Cynicism scale Cronbach's $\alpha = .76$; Professional Efficacy scale Cronbach's $\alpha = .76$) (Maslach et al., 1996) is a 16-item instrument with item responses ranging from 0 'Never' to 6 'Every day' (Maslach et al., 1996). The domain scores range between 0 and 30 in the Exhaustion subdomain, 0 to 30 in the Cynicism domain and 0 to 36 in the Professional Efficacy domain. The Brief Index of Affective Job Satisfaction (Cronbach's $\alpha = .78$) is a four-item instrument with item responses ranging from 1 'Strongly disagree' to 5 'Strongly agree' and an overall average score between 1 and 5 (Thompson & Phua, 2012).

2.5 | Data collection

Quantitative data were collected through an electronic data capture system called OpenClinica. A survey incentive of $100 was provided to participants upon completion of all survey packages. After completing the intervention, all participants were invited to attend a one-on-one interview on Microsoft Teams for qualitative data collection. Interested participants were self-selected into a convenience sample. A Ph.D. researcher, trained and experienced in interview facilitation, led the 30- to 60-min interviews. She had no relationship with the participants before the interviews. A semi-structured interview guide was utilized to ask participants about their experiences as nurse managers, their experiences in the programme, definitions and facilitators of well-being and self-care, personal and professional impacts of the pandemic and opportunities for programme improvement. The interviews were recorded and transcribed.

2.6 | Data analysis

Paired samples *t* tests were conducted to compare the quantitative outcomes of the participants at baseline to follow-up. Thematic analysis was used to code the qualitative responses by keyword, which were then aggregated into six themes (Braun & Clarke, 2022). Two data coders coded the data. After coding was completed, alignment between the two coders was confirmed. No modifications were necessary to the original coding. Although there were only eight self-selected interviewees, saturation of the data was detected through the redundancy of participants' contributions. However, this study does not intend to generalize the qualitative findings but rather to provide details about the nurse managers' experiences related to the programme.

2.7 | Ethical considerations

The study was approved by the institutional review board and registered on ClinicalTrials.gov (NCT04987697). Informed consent was obtained before any study activities. In addition, each participant completed a pre-group screening meeting with the LMHC facilitator, which can be described as a clinical interview to determine the appropriateness of fit for the group intervention. The screening included a review of programme objectives and informed consent, a brief risk assessment (i.e., suicidal, homicidal and psychosis symptoms) and a discussion about personal goals and commitment to the programme (Bailey et al., 2021).

3 | RESULTS

A total of 19 participants were enrolled in this pilot study. Sixteen participants completed the intervention and the data collection time points. Table 2 shows the participants' demographic summary. In addition, eight participants attended an interview scheduled for August 2021.

TABLE 2 Demographics

Age	
30–34	7 (43.8%)
35–39	2 (12.5%)
40–44	1 (6.3%)
45–49	1 (6.3%)
50–54	3 (18.8%)
55–59	0 (0%)
60–64	0 (0%)
65–69	2 (12.5%)
Gender	
Female	16 (100%)
Male	0 (0%)
Race	
American Indian or Alaska native	0 (0%)
Asian	1 (6.3%)
Black or African American	1 (6.3%)
Multi-racial/multi-heritage	0 (0%)
Native Hawaiian or Pacific Islander	0 (0%)
Other	1 (6.3%)
White	13 (81.3%)
Ethnicity	
Hispanic/Latino	1 (6.3%)
Non-Hispanic/non-Latino	15 (93.8%)
Marital status	
Single	1 (6.3%)
Married	11 (68.8%)
Separated	2 (12.5%)
Divorced	2 (12.5%)
Partnered	0 (0%)
Widowed	0 (0%)
Education level	
Associate degree in nursing	0 (0%)
Bachelor's degree in nursing	9 (56.3%)
Master's degree in nursing	7 (43.8%)
Doctoral degree in nursing	0 (0%)
Years of experience as nurse manager	
0–1	6 (37.5%)
2–5	6 (37.5%)
7–10	1 (6.3%)
11–15	3 (18.8%)

3.1 | Quantitative results

3.1.1 | Post-traumatic growth

Table 3 shows the results of the paired samples *t* tests. The overall mean score on the Posttraumatic Growth Inventory was significantly higher at follow-up than at baseline (65.13 vs. 77.31, $t = -3.63$,

TABLE 3 Paired samples *t* test

	Paired differences						
				95% CI			
	Mean	SD	SE mean	Lower	Upper	*t*	*p* value
Brief Resilience Scale	−0.07	0.46	0.12	−0.32	0.17	−0.63	.54
Self-Compassion Scale	−2.31	9.07	2.27	−7.14	2.52	−1.02	.32
Psychological Empowerment Instrument	−0.25	0.40	0.10	−0.46	−0.04	−2.50	.03
Psychological Empowerment Instrument—Meaning	0.04	0.47	0.12	−0.21	0.29	0.36	.73
Psychological Empowerment Instrument—Competence	−0.54	0.57	0.14	−0.85	−0.24	−3.81	<.01
Psychological Empowerment Instrument—Self-Determination	−0.21	0.69	0.17	−0.57	0.16	−1.21	.24
Psychological Empowerment Instrument—Impact	−0.29	0.53	0.13	−0.57	−0.01	−2.21	.04
Self-Reflection and Insight Scale—Engagement in SR	−0.44	4.47	1.12	−2.82	1.95	−0.39	.70
Self-Reflection and Insight Scale—Need for SR	0.69	3.89	0.97	−1.39	2.76	0.71	.49
Self-Reflection and Insight Scale—Insight	−0.69	4.80	1.20	−3.24	1.87	−0.57	.58
Posttraumatic Growth Inventory	−12.19	13.43	3.36	−19.35	−5.03	−3.63	<.01
Posttraumatic Growth Inventory—Relating to Others	−5.00	7.92	1.98	−9.22	−0.78	−2.53	.02
Posttraumatic Growth Inventory—New Possibilities	−2.63	5.19	1.30	−5.39	0.14	−2.02	.06
Posttraumatic Growth Inventory—Personal Strength	−2.44	3.85	0.96	−4.49	−0.39	−2.54	.02
Posttraumatic Growth Inventory—Spiritual Change	−0.81	1.64	0.41	−1.69	0.06	−1.98	.07
Posttraumatic Growth Inventory—Appreciation of Life	−1.31	2.24	0.56	−2.51	−0.12	−2.34	.03
Maslach Burnout Inventory—Exhaustion	2.06	4.93	1.23	−0.57	4.69	1.67	.12
Maslach Burnout Inventory—Cynicism	1.13	5.88	1.47	−2.01	4.26	0.77	.46
Maslach Burnout Inventory—Professional Efficacy	−0.13	3.84	0.96	−2.17	1.92	−0.13	.90
Brief Index of Affective Job Satisfaction	0.03	0.44	0.11	−0.20	0.26	0.29	.78
Perceived Stress Scale	1.19	4.51	1.13	−1.21	3.59	1.05	.31

$p < .01$). Mean scores in the following domains were significantly higher after the programme: Relating to Others (19.69 vs. 24.69, $t = -2.53$, $p = .02$); Personal Strength (12.81 vs. 15.25, $t = -2.54$, $p = .02$); and Appreciation of Life (10.38 vs. 11.69, $t = -2.34$, $p = .03$). There were no statistically significant differences in the mean scores in the domains of New Possibilities (15.50 vs. 18.13) and Spiritual Change (6.75 vs. 7.56) between baseline and follow-up.

3.1.2 | Resilience

There was no statistically significant difference in the mean score on the Brief Resilience Scale (3.89 vs. 3.96) between baseline and follow-up.

3.1.3 | Insight

There were no statistically significant differences in the mean scores in the following domains of the Self-Reflection and Insight Scale between baseline and follow-up: Engagement in Self-Reflection (27.50 vs. 27.94), Need for Self-Reflection (30.75 vs. 30.06) and Insight (36.38 vs. 37.06).

3.1.4 | Self-compassion

There was no statistically significant difference in the mean score on the Self-Compassion Scale–Short Form (36.38 vs. 38.69) between baseline and follow-up.

3.1.5 | Empowerment

The overall mean score on the Psychological Empowerment Instrument was significantly higher at follow-up than at baseline (5.81 vs. 6.06, $t = -2.50$, $p = .03$). Mean scores in the following domains were significantly higher after the intervention: Competence (5.42 vs. 5.96, $t = -3.81$, $p < .01$) and Impact (5.90 vs. 6.19, $t = -2.21$, $p = .04$). There were no statistically significant differences in the mean scores in the domains of Meaning (6.42 vs. 6.38 vs. 6.23) and Self-Determination (5.52 vs. 5.73 vs. 5.69).

3.1.6 | Perceived stress

There was no statistically significant difference in the mean score on the Perceived Stress Scale (18.81 vs. 17.63) between baseline and follow-up.

3.1.7 | Burnout

There were no statistically significant differences in the mean scores in the following domains of the Maslach Burnout Inventory—General Survey between baseline and follow-up: Exhaustion (20.50 vs. 18.44), Cynicism (11.00 vs. 9.88) and Personal Efficacy (29.81 vs. 29.94).

3.1.8 | Job satisfaction

There was no statistically significant difference in the mean score on the Brief Index of Affective Job Satisfaction (4.13 vs. 4.09) between baseline and follow-up.

3.2 | Qualitative results

Eight participants provided in-depth perspectives on their experience in the programme and its impact on their personal and professional lives. Table 4 shows the six themes that consistently emerged: (1) feasibility of the programme, (2) benefits of peer support, (3) sources of stress, (4) barriers to self-care, (5) sources of strength and (6) sustainability of effects. Each theme and its categories are documented below with an overview, followed by the participants' own words to illustrate their perceptions and experiences.

TABLE 4 Qualitative themes and categories

Themes	Categories
1. Feasibility of the programme	Unanimous Attribution of Benefits Participants' Willingness to Engage Curriculum Highlights Benefits of Virtual Environment
2. Benefits of Peer Support	Relief from Isolation Reassurance of Shared Experiences Learning from Multiple Perspectives
3. Sources of Stress	The Unknown Attrition of Nurses Quality of Care and Safety Concerns Competing Priorities
4. Barriers to Self-Care	24/7 Culture Culture of Selflessness
5. Sources of Strength	Sanctioned Self-Care Community of Participants
6. Sustainability of Effects	Ongoing Follow-Up Scaling

3.2.1 | Theme 1. Feasibility of the program

The pilot study participants spoke about the programme's feasibility in learning content, engagement with psychoeducational methodology and perceived benefits. Four categories in this theme appeared: (a) unanimous attribution of benefits to the programme, (b) participants' willingness to engage in psychoeducation, (c) relevance and effectiveness of the curriculum and (d) benefits of a virtual environment.

Every interviewee attributed positive changes to their participation in the programme. The benefits they cited ranged from improved self-awareness to the decision to undertake individual therapy.

> It was an amazing experience, and it made me much more aware of how I am feeling and my day-to-day activities and thoughts. I am much more aware of other people's feelings now, as well.

> The [program] made me realize I needed to start seeing someone for ongoing psychological help. It pushed me to do that, and it has lasting effects even to now.

Although some nurse managers reported being initially hesitant to communicate openly with other participants, they explained their willingness to do so increased over time. Group development models suggest that it is common for group members to need more direction from the facilitator early on as group cohesion forms and members build trust. In later stages of group development, group members will take more risks related to self-disclosure and vulnerability, engage one another directly and rely less on facilitator prompting (Brown, 2018; Corey et al., 2014; Yalom & Leszcz, 2020).

> Once we all got talking, we saw we are all in the same boat. We all had similar situations. We could be there for one another, and it became something we looked forward to.

Participants unanimously confirmed the applicability of what they had learned about the programme's four themes of resilience, insight, self-compassion and empowerment (Bailey et al., 2021), and they shared examples of how the content related to the challenges they were facing in their professional and personal lives.

> One thing that really stood out to me is the oscillations you go through within a day, a week, a month, or even a year and how we have those peaks and valleys. When you are in those down times, we learned what you can do to build up that resilience.

The participants' description of their experience with Microsoft Teams speaks to the feasibility of online delivery, especially for large and geographically dispersed audiences. Although many participants assumed that face-to-face interaction would have been better, no one

felt they could not connect with other participants because of the virtual setting. They also discussed the convenience of meeting online rather than travelling to a meeting venue.

> I enjoyed [the virtual aspect] because I still felt safe. I was in my office, my own personal space. I didn't have to go anywhere, so that was great. I still have that connection with everyone, so I actually preferred it.

3.2.2 | Theme 2. Benefits of peer support

Participants discussed the peer support they received during the programme, which offered (a) relief from isolation, (b) reassurance of shared experiences and (c) learning from multiple perspectives. Known benefits of group settings include connecting with others, universality, interpersonal learning and gaining new perspectives (Corey et al., 2014; Yalom & Leszcz, 2020). Interviewees identified all these benefits of the programme.

Participants shared that the programme offered relief from isolation, particularly relevant during the pandemic. In addition, the interviewees unanimously recognized the sessions as an opportunity to communicate with others in similar roles facing similar challenges, bringing feelings of relief and shaping a more realistic and hopeful perspective. This aspect of peer-supported growth is consistent with results from the Posttraumatic Growth Inventory that participants improved significantly in relating to others.

> There are other people out there that I perceived to be strong, independent, amazing leaders that are literally falling apart sometimes like I am, so that was very eye-opening, but also reassuring that you're normal. There's nothing wrong with you.

The programme itself served as a shared experience that influenced the relationships among participants. Participants reported appreciation for the reassurance they felt sharing their challenges with other nurse managers and hearing their stories.

> One of the biggest things that stuck out to me about the program is feeling like I almost had a peer support group – a group of leaders who share challenges they faced personally and professionally.

Every interviewee agreed that the programme leads to growth in nurse managers, allowing them to broaden their thinking and discover new tools and resources. This shared assessment aligns with the survey finding that participants' competence and impact improved.

> We could share ways that we overcame certain things or how it impacted us differently, and that really did help…understanding what worked for others. Those little things about what kept other people resilient, how they kept on task, or what helped them through a difficult time. That gave us the opportunity to evaluate things differently from someone else's perspective.

3.2.3 | Theme 3. Sources of stress

Within this theme, participants explained the sources of stress that affected them during the pandemic in their role as nurse managers. They identified four categories: (a) the unknown, (b) attrition of nurses, (c) quality of care and safety concerns and (d) competing priorities.

The pandemic introduced much uncertainty into daily life, especially for health care providers. The unknown was a primary source of stress among nurse managers (White, 2021).

> When the pandemic first started, no one really knew what we were doing. There was a lack of personal protective equipment. There was a lack of protocols. There was a lack of knowledge around the virus.

There was high attrition of nurses during the pandemic (Labrague & de Los Santos, 2021; Lavoie-Tremblay et al., 2021), leading to understaffing, reliance on inexperienced nurses and challenges to the safety and health of clinical staff.

> When we were going through the pandemic, we were all stretched thin anyway because staffing is tough. There are not enough nurses. The pandemic ran out a bunch of nurses. You know they just said, 'Forget this, I am out; it is not worth it'.

> They are burnt out. They are done. They are leaving. My night shift is almost completely gone. I took it personally for a long time and beat myself up because I was like, 'What am I doing? Why are they leaving?' But there is nothing that I can do. I cannot stop the pandemic. I cannot change the patients. I cannot change the census.

Another source of stress during the pandemic has been quality of care and safety concerns. For example, in a systematic review of nurses' experiences of working in acute care hospital settings during a respiratory pandemic, Fernandez et al. (2020) found that these experiences commonly involved a continued sense of duty, dedication to patient care and personal sacrifice; concerns for personal and family safety; and perceptions of the responsiveness of systemized and organizational reaction in terms of a lack of protection and safety and low organizational preparedness (i.e., provision of adequate leadership, staffing and policy).

> With the COVID numbers increasing the last couple of months, we have slowly and steadily gone from a 3:1

> ratio to all 4:1 to all 5:1, and now we're 7:1. It's just the worst feeling. I mean, I sat in this office the other day and just cried because I just felt completely defeated. The nurses are used to giving such good care. So, even though they survived their shift with seven patients, and no one died, they didn't get to be the nurse they wanted to be. I feel for them because that's what fills their cup; that's the reason why they became nurses.

While many sources of stress existed in their work environment, many participants also described competing priorities in balancing work and home life.

> I struggle a lot with guilt because I feel like when I am not here at work, I feel like I should be here, so I am not really fully present at home. So then, I feel guilty about that. And when I am not at home, and I am here, I feel like I should be at home. I feel guilty about that. So, I am essentially working non-stop.

3.2.4 | Theme 4. Barriers to self-care

The nurse managers demonstrated an understanding and appreciation for the importance of self-care. Most spoke to their responsibility for ensuring their team members care for themselves, but they all spoke of barriers to self-care for nurse managers that got in the way of their self-care practice. Participants identified two in particular: (a) the expectation of being available '24/7' and (b) a culture of selflessness in their profession and across their work organization. This finding is consistent with research on the job role of nurse manager (Steege et al., 2017; White, 2021).

Many participants spoke of the expectation that nurse managers be available as needed, all day and every day.

> We have this mentality of 24/7 work. You almost feel guilty to step away from it.

> I get texts 24 hours a day, so there really is not ever a break.

Interviewees described a culture of selflessness among nurse managers that encourages them to sacrifice their own needs—and the needs of their families—to care for patients and their clinical teams. As a result, normal self-care routines have been disrupted or abandoned.

> Some of the challenges we're going through - you know, the shortage of staffing, dealing with COVID. Some of the same things were impacting and causing stress for all of us, and I know for me, I wasn't taking time for myself. I still find that difficult because my focus is on everybody else all the time.

3.2.5 | Theme 5. Sources of strength

The literature provides evidence for the benefits of robust self-care. For example, prior to the pandemic, Dyess et al. (2018) found a simple meditation practice—sanctioned by the organization and practised regularly—significantly reduced perceived stress among nurse leaders. During the pandemic, nurse managers found sources of strength amid the many workplace stressors and barriers to self-care. Interview participants identified two: (a) sanctioned self-care and (b) the community of participants.

The programme encouraged nurse managers to practise self-care regularly. A recent study identified 'the need for permission' as key in enabling nurses to practise self-care and self-compassion (Andrews et al., 2020). This permission was not only from others but also from themselves.

> We loved it because it made us stop for an hour and a half, close the door, and put a do not disturb on it. My boss knew I was participating in it, supported it, knew not to bother us.

Notable among interviewees, they identified the community of participants as a source of strength. Most interviewees reported that participants were reaching out to each other outside of meeting sessions or contacting each other by text or email within a few weeks.

> It was this tight little group, and we will text or email each other and just check in on each other.

3.2.6 | Theme 6. Sustainability of effects

Participants discussed the sustainability of the effects of the 9-week programme. Most notably, nurse managers supported the ideas of (a) ongoing follow-up and (b) scaling. Many agreed that ongoing follow-up would likely help them sustain the improvements they gained from the programme. Similar to physiotherapy that requires ongoing training to sustain good results, there is a need for ongoing structured support from and access to psychotherapeutic interventions.

> The managers need a support group. We need to know that we're all in this together … Because I can't go home and talk about what's happening here. My husband doesn't understand. My kids don't want to hear it. So, you need your battle buddies. You need that support group, and that's really what it was for us. We were all so very saddened when it came to an end, and we asked, 'Could we all please do this regularly?'

All interviewees were very positive about the value of providing opportunities to participate in the programme to nurse leaders across the organization.

> I think every manager needs to participate in it, whether they are brand new or have been in it for years.

> I think everybody should do it. It was really helpful for me … especially in the world we are in right now; I feel like everybody can benefit from it.

4 | DISCUSSION

The quantitative and qualitative data in this pilot study support the twofold objective of assessing feasibility and acceptability of this virtual synchronous psychoeducational group programme and evaluating the impact of the intervention on the mental well-being indicators. It is important to note that statistically significant improvements were only captured in the variables of post-traumatic growth and psychological empowerment, which suggests that participation in the programme can facilitate psychological recovery and post-traumatic growth in nurse leaders during crisis. However, sustainability of effects from individual-level interventions would require system interventions at the managerial, team, cultural and organizational levels, particularly during crises (Henshall et al., 2020; NASEM, 2019). These changes can include adequate staffing, leadership support and engagement, effective communication and access to information, structural empowerment processes, such as shared governance and workflow efficiency with reduced bureaucratic tasks.

Furthermore, findings from this pilot study support the benefits of a virtual synchronous group format for busy nurse leaders. The qualitative analysis highlights the importance of peer support, social belonging and interpersonal sharing during times of high stress. Group members reported feeling connected to and supported by each other in this online format, which is consistent with other studies involving online interventions (Karagiozi et al., 2021; Lenferink et al., 2020). This type of psychoeducational intervention may best be integrated into the broad strategic approach of health care organizations to support their nurses and nurse leaders.

4.1 | Post-traumatic growth

The results showed significant changes in the participants' primary outcome of post-traumatic growth. This finding is particularly relevant given the timing of the intervention and data collection during the COVID-19 Delta surge. Results from a large-scale survey study indicate high post-traumatic growth scores for nurses who worked in intensive care departments and provided care for patients with COVID-19 (Chen et al., 2021). In the current study, increases in post-traumatic growth among participants in relating to others, personal strength and appreciation of life are supported by the perceived benefits reported by interviewees.

In addition, there are ways to facilitate growth after adversity to prevent the development of post-trauma disorders. Facilitators include cognitive processing, active coping and sharing negative emotions (Henson et al., 2021; Kashdan & Kane, 2011; Tedeschi & Calhoun, 2004). Social support, spirituality and a sense of belonging are considered mediators of post-traumatic growth (Henson et al., 2021). These components are a significant part of the programme.

4.2 | Programme themes

Quantitative results showed improved empowerment scores among participants after the intervention, including the competence and impact domains. Empowerment comprises the four cognitions of meaning, self-determination, competence and impact (Seibert et al., 2011). Empowerment can mitigate feelings of helplessness that stem from stressors in one's environment (Bailey et al., 2021).

The programme curriculum teaches how intrapersonal and professional factors can influence perceptions of empowerment and how to care for oneself in a system that can often leave nurses and nurse leaders feeling disempowered. The skills can be applied personally (e.g., decision-making), interpersonally (e.g., healthy boundary-setting) and professionally (e.g., the impact of values-driven behaviour on favourable choices for themselves, their staff and their patients) (Bailey et al., 2021).

The study outcomes of resilience, insight and self-compassion did not significantly improve but were maintained between the baseline and follow-up time point and remained in the average range. The qualitative data support the applicability of the themes in participants' professional and personal lives.

4.3 | Perceived stress, burnout and job satisfaction

The maintenance of scores on the perceived stress and burnout measures during the COVID-19 Delta surge in Florida at the follow-up time point supports that the themes are skill sets that can buffer the effects of severe stressors. A significant negative relationship exists between job stress and nurse manager job satisfaction (Penconek et al., 2021). Nurse managers' job satisfaction determinants include autonomy and structural empowerment, social support, relationships among team members and practice environments and individual health and well-being (Penconek et al., 2021), all of which might have been influenced by the COVID-19 Delta surge. Interventions that promote mental health and well-being, improve empowerment, leverage support systems and address work-related stress are necessary to retain nurse managers and support them in their roles (Penconek et al., 2021).

4.4 | Limitations

Due to self-reported data collection, there is the possibility of social desirability bias, which involves the tendency of respondents

to answer survey questions favourably. Also, this pilot study occurred during the pandemic, which might have affected the participants' experiences and outcomes. Finally, at the follow-up data collection time point, the hospital census of COVID-19 positive patients was persistently high, and the workloads of nurse managers at this time may have affected their responses to the survey package.

5 | CONCLUSIONS

The results of this mixed-methods pilot study support the acceptability and feasibility of this psychological group programme. Next, a randomized controlled trial with a larger sample size ($n = 80$) will be conducted to further examine this programme's impact and sustainability and to identify changes among key indicators of well-being.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Nurse managers can attend psychoeducational and emotional support programmes to help their mental well-being, particularly during crises. Fellow clinical leaders and executive leadership can support and promote such programmes to alleviate burnout and improve adaptive coping to manage the complex demands of nursing management. A psychologically healthy nurse manager can influence the culture of the work environment and model healthy self-care behaviours for nurses.

CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

ETHICS STATEMENT

The study was approved by the institutional review board and registered on ClinicalTrials.gov (NCT04987697). Informed consent was obtained before any study activities. In addition, each participant completed a pre-group screening meeting with the LMHC facilitator, which can be described as a clinical interview to determine the appropriateness of fit for the group intervention. The screening included a review of programme objectives and informed consent, a brief risk assessment (i.e., suicidal, homicidal and psychosis symptoms) and a discussion about personal goals and commitment to the programme (Bailey et al., 2021).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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