

**Dr. Melyn Leszcz**  
**Transcript of Interview from 8/31/2020**

**Dr. Diederich**

Welcome. Before we get started on this interview with Dr. Leszcz, I wanted to note that we assume that viewers watching this are enrolled in, or at least have taken, one graduate-level course on group psychotherapy. These courses offer an introduction to group development, basic theories and an overview of the types of groups typically run, but rarely have time to dive into a specific type of group.

Moving into the interview for today, thus, I'm really excited to focus on support groups for healthcare workers. It's my pleasure to introduce Dr. Melyn Leszcz, who is the former Psychiatrist-in-Chief at Mt. Sinai Hospital, a professor in Toronto at the University of Toronto and the current President of the American Group Psychotherapy Association, AGPA.

Dr. Leszcz lectures broadly and has published in the group therapy literature regarding interpersonal approaches in group psychotherapy, group psychotherapy for patients with schizophrenia, evidence-based approaches to group therapy and modified interpersonal psychotherapy for patients with substance abuse. He also focused on applications for geriatric depression and for the medically ill.

The topic of today's focus will be support groups for healthcare workers. Finally, Dr. Leszcz has co-authored with Dr. Irvin Yalom the fifth and sixth editions of the classic, *The Theory and Practice of Group Psychotherapy* with the sixth edition being released this fall. Thank you so much for being with us today.

**Dr. Leszcz**

I'm happy to be with you, Leann.

**Dr. Diederich**

First, let's start with a bit of a historical question. Can you share with us when you first got interested in running therapy groups?

**Dr. Leszcz**

It goes back many years now and I trained as resident in psychiatry, both in Winnipeg, at first, at the university in Manitoba and then, in Toronto at the University of Toronto.

As I finished my residency, I spoke with the chief of psychiatry at the time and asked what needs to be grown and developed in this department. He said, “Group psychotherapy. Are you interested?” I’d had brief experiences as a group psychotherapist in my residency and my chief of psychiatry at the time, Stan Greben, said, “Many years ago, I was at Johns Hopkins with Irv Yalom. I was his chief resident. Would you be interested in going to California for a year and working with Irv Yalom?”

Really, it was great good fortune. It took a phone call. I received some support from the University of Toronto to go to Stanford. I spent a year and that’s really when my work in group psychotherapy and my relationship with Dr. Yalom took shape. It’s been a 40-year collaboration. I would say group psychotherapy has defined my academic work. It also has been of enormous value in leadership positions, both at the hospital and at the university and organizational.

**Dr. Diederich**

Absolutely. That’s a great bit of history. I didn’t realize that connection with Dr. Yalom went back so far. That’s wonderful. When did you shift to then really focusing in on support groups for healthcare workers?

**Dr. Leszcz**

It was an area in which I had not done work until 2003, when SARS hit Toronto. SARS was a kind of very disruptive, severe, acute respiratory syndrome, kind of foreshadowing what we are dealing with now with COVID. But SARS hit some hospitals in particular and Toronto Hospital was one of the hospitals that was hard-hit. Toronto was one of the cities that was very hard-hit. There was a World Health Organization ban on travel to Toronto for a stretch of time. I got involved with providing psychological support for frontline workers with SARS.

We wrote about that quite extensively and then, brought those lessons to bear, again, with the H1N1 pandemic, which we thought was going to be a big event. We are bringing all of those lessons to bear now with COVID.

What we learned was that we had to do more than make ourselves available to frontline workers. The themes around SARS and COVID are very, very similar, even though they are different viruses. SARS had a much higher mortality rate, was harder to spread, was hospital-based. COVID-19 has a lower mortality rate, but is lethal because of how widely spread it is in the community. In both instances, in the early phases, we didn’t know much about transmission and we didn’t know much about protection.

But what we learned was making ourselves available was not sufficient. We had to go out into the emergency room, into the ICU, into the respiratory care units, into the intensive medical units and make ourselves available to offer psychological support and an opportunity to learn about coping, to practice coping and to find ways of attributing meaning to people's experience.

What we learned with SARS that influenced our subsequent thinking about preparing for H1N1 and now, for COVID, is that healthcare workers, frontline workers, experience an enormous amount of distress in the face of these infectious diseases.

We don't know a lot about transmission. Even now, there's uncertainty about COVID. Early-on, there was concern about personal protective equipment and having adequate protection against exposure. Confronting in the face of shortages of supplies, moral distress, when our actions and behavior do not line up with our values.

It's a test of organizations. Some organizations respond in ways that elevate moral and other organizations respond in ways that diminish moral. We saw a great opportunity to bring group therapy principles and group psychological understanding to preparation and to support.

Always you want to do as much work as possible upstream rather than downstream. That's a basic public health principle, so we learned from SARS that for up to two years after SARS exposure—we were able to compare workers at different hospitals because SARS hit some hospitals more than others.

What we learned was that workers exposed to SARS suffered durable psychological stress. They didn't become necessarily manifestly ill with psychiatric illness, but quality of life was compromised by feelings of depression, anxiety, trauma and most importantly for the healthcare system as a whole, they were less likely to continue in healthcare.

So people left the field because they were so overwhelmed and they couldn't practice the way they wanted to. You can imagine families—we saw this with COVID, as well—were saying, "Don't go in," and the terrible dilemma healthcare workers faced in, "Do I go in? Do I abandon my family if I go in? That means I may not see my children for a month or two months or longer." We know many instances like this.

It's a big sacrifice and there's also the mortal danger. How many healthcare workers have died as a result of exposure in dealing with COVID? The psychological strain and stress is enormous.

Mental health professionals are not going to be providing frontline care to patients of COVID. But what we can do, I think uniquely and very effectively, is provide support for frontline workers. That's what we have done locally in our hospitals, at the University of Toronto. We've done a lot of training through AGPA, through webinars and ongoing groups to support group therapists in their work in leading groups, facilitating groups for healthcare workers.

Even before COVID, we were aware of the high rates of burnout and the risks, the emotional risks of healthcare in the contemporary environment. We saw this as both danger and an opportunity. I would say that doing this work—and I've led many groups over the years for frontline workers, nurses in the ICU, physicians, physician-leaders, the principles have stood true and I think we've been able to be effective and helpful and meet some of the requirements that our frontline workers need.

It's incredibly important work and we know that if we want to reduce a traumatic response, we have to help people cope early. We have to help people attribute meaning to their experience.

If your interest is not even about the people, if your interest is organizational, what is the most important resource that you have in a hospital? It's human capital and protecting the human capital and making sure you have reserves of human capital in terms of peoples' willingness and capacity to work, we know that proper training reduces the kind of feeling of being overwhelmed by pandemic exposure, proper support. Those are the kinds of things that we can bring to bear.

I'll say one other thing and then pause, and that is that we talk a lot about PPE. That was an abbreviation most people didn't know about eight months ago. Personal Protective Equipment. I would add that as important as that kind of PPE is psychological protective equipment; knowing how to cope with adversity.

**Dr. Diederich**

Absolutely. I do want to note for therapists out there who want to start running these types of groups that you're describing, you've done a number of trainings,

including at least a six-week one through AGPA that's available on their e-learning module. I do want to direct people to that.

You talk about coping. In your writing, you describe coping as having three foci: that problem focus grouping, so stress management, as you described "fix what can be fixed"; emotion-focused coping, so that social support and emotional ventilation; and the meaning-focused coping as you've been highlighting, that moral purpose and spirituality.

When you're working on training leaders, what area do you think they might struggle to incorporate in these support groups and what can they do to attend to that area more?

**Dr. Leszcz**

That's an excellent question. I think that understanding the importance of social support, social connection, reducing isolation, that makes sense to everyone. You have to recognize that in dealing with a pandemic, when we were dealing with SARS, we were meeting in groups with everyone wearing high-intensity PPE. People couldn't see one another. That adds another layer of isolation and dehumanization.

With COVID, a lot of the group work has been done by Zoom or online, but it still is incredibly valuable to go down into the front lines and help create reflective capacity, provide support.

A simple—a simple—intervention that relates to kind of emotion-focused coping is using a buddy system. You have somebody else in your organization who checks in with you, who you check in with. It makes people feel less alone, less isolated. That, I think, is readily accessible.

Problem-based coping involves identifying what are the issues, what are the challenges, how can we fix this? We would provide instruction about better nutrition, sleep, exercise, coping in the face of how do you manage inadequate supplies. Who else do you bring into the decision-making process so that you are not bearing the weight of that moral stress, that ethical decision by yourself.

I would say it is the meaning-based coping that is more difficult to access because it's a different level of abstraction. It's attuning to the moral purpose of the work that we do. We have seen and heard countless stories, especially with COVID, of

frontline workers who needed to comfort patients who are dying because family members weren't allowed to come in to see them.

That moral distress of being the only person holding the hand of a dying person, knowing that that person's heart is aching for their children and their children's hearts are aching for them, it's an incredible amount to contain. In conversations and groups with people who work on those frontlines, those are traumatizing experiences that they carry with them and influence their willingness and ability to care. On the one hand, they see it as the highest order of care and at the other, they see it, "How have we come to this?" and you hear kind of these beautiful stories about kind of housekeeping holding an iPad in front of a dying patient because there weren't staff around.

Helping people to see the moral purpose and take comfort from fighting the good battle, even if you are not ultimately successful in terms of victory—victory meaning survival—but victory meaning dignity, victory meaning decency, victory meaning someone not being alone. Those are traumatizing experiences for frontline workers and they need the opportunity to talk about it and attribute meaning to their experience and to be supported.

Normally, in the work that we do, we get a lot of support from our family and friends. But many healthcare workers will say, "Yeah. If I tell my husband or if I tell my wife what I'm going through day-to-day, they're going to say, 'Why do you do it? Stay home. You're putting yourself at-risk. You're putting me at-risk. You're putting our kids at-risk,'" and you're not being supported the way you need to be. That adds, that amplifies that kind of moral distress.

We were very much influenced in our early work by some of the people who did work post-9/11 and there's an organizational consultant by the name of Marc Maltz, who wrote about moral purpose and his experience in dealing with one of the big companies that had been decimated at 9/11.

The surviving lead of that organization said, "We have a moral obligation to get back to work, to support the families of our members and friends who were killed in 9/11. We will not be defeated," and he talked about how—and they were a big financial company. He talked about they would go to funerals and come back and make deals.

A lot of their former competitors—I find it very moving even to think about it now—a lot of their former competitors said, "We're going to help you," and so people

who were battling them on deals before became collaborators. They said, “We are going to take care of the families of our friends and colleagues who died,” and that kind of moral purpose, which echoes the existential philosophers like Nietzsche, that if you have—I’m going to paraphrase this—but if you have the why, you’ll find the how.

Much easier to do that, or much less hard to do that if you feel supported and valued. Some organizations do a really good job of that and other organizations do a terrible job.

My experience, the experience of others, of leading groups for COVID frontline workers is that in some instances, a whole unit will come and meet: the nurses, doctors, respiratory therapists, social workers. These are high moral, high cohesive units. In other units, staff are unwilling to meet on-site. They’ll go on Zoom, but they want to hide their picture because they’re afraid of retribution. They are afraid of calling out leadership. It illuminates, I think very powerful themes about organizational justice and organizational trust.

**Dr. Diederich**

Can you speak a bit more about those, particularly you’ve talked about organizational resilience. What are some of the goals that that organizational resilience can serve and then, link in organizational justice, as you’re just touching on here.

**Dr. Leszcz**

I think that you are more likely to be a resilient organization if you build upon organizational trust and you build upon organizational justice. What that means is that every decision you make—and I’ve found these principles to be enormously helpful in my roles as the chief of a large department of psychiatry, as a university vice-chair responsible for a large number of academic programs—is you’ve got to be principled in every decision that you make.

The principles have to be ones that support your human capital and enhance psychological safety. The hallmarks of an organization that is going to have resilient people and be a resilient organization, in my view—and there’s good literature to support this—number one is that if we look at organizational trust, there are three key dimensions. How is the leadership viewed? How is the organization viewed with regard to number one, their competence; number two, their integrity; number three, their benevolence? We want our leaders to be competent, benevolent and operate with integrity.

If you fall short on one of those, then you're going to have a less healthy environment. You're going to have less engagement with your staff and there are many studies that show quality-of-care is directly related to the quality of engagement that staff have with the organization.

Organizational justice falls into two similar kinds of domains: relational justice and decisional justice. Relational justice means people are treated fairly. That opens up the whole issue around culture, diversity, racism, anti-racism and that you as a leader in an organization—when I say you, I'm talking about the leadership structure—make decisions that are transparent and understandable and are based upon principles of equity and fairness. Decisional justice similarly is predicated upon those kinds of principles.

An example. With COVID, there was a great need for redeployment of staff because some areas of the hospitals were shutting down and others were overwhelmed. What are the principles that guide deployment, or how transparent are they?

If somebody resists deployment because they feel their health is at-risk—we saw a lot of this. Nurses, of course, are 70-80% of the hospital population in terms of employees. You're going to have a lot of young nurses who may be pregnant or expecting. Then, you have to deal with the decision of if we protect younger nurses, does that mean older nurses are being treated less fairly. These are incredibly complicated decisions. They are best made in a collaborative, flattened hierarchy way.

That's part of the problem that a lot of people have had with the kind of military analogies that have been used to deal with COVID, that we're going to war. This is an enemy. Even the word redeployment is a military term and again, if you're working in a high morale environment, good organizational trust and high levels of organizational justice, then people will feel they're in good hands and the decisions will be supported.

But if you're in a low morale environment, then what you experience is, "They just want to have authority to tell me what to do and they don't really care about putting me in harm's way."



You develop a resilient organization by having policies that help people to become resilient. People get worn down if they feel they're in an environment that feels unsafe, uncaring and disrespectful.

There's a lovely article by Tait Shanafelt which early-on in the COVID—he is a psychiatrist—I believe he's a psychiatrist at Stanford. He's at Stanford and he talked about what frontline workers want is they want to be seen, to be heard, to be cared for, to be protected, to be respected. It's not too much to ask, but we know in this environment, where burnout is so prominent, a lot of healthcare workers, a lot of nurses, a lot of physicians, are feeling higher and mounting degrees of burnout.

It is a real threat to care because if you're burnt out, you're going to provide less good care. Then, you get less reward from your work and it becomes a vicious circle. You don't protect yourself from burnout by giving out free coffee. It's a bigger structural, organizational issue. There are individual issues, individual activities that you can take on, but it's the organization as a whole that I think really needs to look at itself in order to be protective of its members.

That's where I think group therapy has a particular kind of advantage for leadership because we want our—if you think of the hospital as a larger group, or a unit as a larger group, you want leadership to be, to use the term socialized leadership, which means it's invested in securing the attachment and connection of every member to the team; that it's a safe place where people can feel supported and valued, creative, able to kind of come up with interesting ideas and not feel they're going to be thrown under the bus; where there is capacity for divergence of opinion and in different organizations, including the military, there are studies that show socialized leadership, attachment-informed leadership, reduces psychological casualties.

**Dr. Diederich**

I think as you're describing here, whenever group psychotherapy and group psychology can intersect, right? The entitativity of the group, the commitment to the group, those make it all that much more powerful, absolutely.

**Dr. Leszcz**

Absolutely.

**Dr. Diederich**

It's clear that you're passionate about this, that you're committed to this. Tell me a bit about what keeps you invested and running and training folks in leading these types of groups. What's keeping you doing this?

**Dr. Leszcz**

It's important work. It's meaningful work. One of the things that is always been a challenge in mental health is achieving that kind of multiplier effect. If you're a single practitioner, you see the people in front of you. If you do groups, you're able to treat more people. If you do groups that then facilitate other people being able to provide better care for their patients, their colleagues, then you have a real multiplier.

In addition to what you mentioned earlier, AGPA has had a webinar that I was able to provide on leading groups for healthcare workers. Then, we led a series of six sessions for people who had participated in that webinar. Then, there was sufficient interest that we led another four sessions because people were taking these ideas into their local communities and leading groups for frontline workers.

Sometimes they weren't able to get frontline worker groups off the ground because you need to have good administrative buy-in. You need to have a link inside the organization, but they found these principles to be very helpful in dealing with their colleagues and others because with COVID, if you're in healthcare, you're either front-frontline or you're frontline. If you're working, if you're seeing patients, you need to know how to manage COVID.

I also believe very strongly in the concept of psychological safety in the workplace. Every year, in order to be reappointed at my hospital—and I'm sure it's true across North America—you have to do a series of continuing education tests, how to manage a fire. That's important.

But every year, I kind of smirk at one of the ones that I have to do, which is how to handle workplace hazardous materials. I have never come near any workplace hazardous materials in 40 years, but what people should be taught instead is psychological first-aid. That should be de rigueur, standard for everyone and the more we're able to operationalize psychological safety in the workplace, the healthier our teams will be, the healthier individuals will be.

I use a very simple equation, that others who work in the domain of psychological safety have written about. And the equation goes like this. On one side of the equation, you have control and reward. On the other side of the equation, you have

demand and effort. What that means is that the more control individuals have, the more reward people have and reward is not just money. Reward is recognition and value. I pay attention to your input. Those are offsets against demand that is made organizationally and the effort that individuals have to put into it.

Generally those things are also mediated by the relationship with your supervisor. If you want to have a healthy organization, try to reduce peoples' sense of lack of control. Reward them in ways that are meaningful to them and make demands reasonable and transparent and fair and try to protect them from undue and exploitative efforts.

Again, keeping that as a kind of paradigm, I found very helpful in decision-making when you have to allocate resources or ask people to do things that are difficult and demanding. The more collaborative the decision-making, the more transparent the decision-making, the more humane and humanistic the decision-making, the more effective you will be.

If you lead in that kind of way, then you are able to reduce the risk of burnout. Burnout, we have to think about burnout as an organizational and structural issue in the same way that we talk about racism, for example; that racism is both something that happens between people, but more toxically, it happens at an organizational or systemic level. We have to find ways of being anti-racist and we have to find ways of being anti-burnout. For professional healthcare workers of-color, it's a double whammy.

### **Dr. Diederich**

When looking to support, say that population or other vulnerable populations within healthcare workers on the frontlines, or as you say, even if you're not the front-frontlines, you're on the frontlines regardless of where you are, what words of wisdom would you offer to therapists considering starting for the first time, these types of support groups? What words of wisdom would you offer them?

### **Dr. Leszcz**

Don't be discouraged if it's hard to get launched. Connect with someone in some authority who can help link you. Try to build on pre-existing relationships wherever possible because it's hard for people to talk about this. It's harder for them to talk about it if they don't know the person that they are going to be talking with. Lead boldly. Be transparent. Don't pathologize. Make the implicit more explicit.

I am sure, Leann, that there's nothing that we've talked about today so far that you wouldn't get completely right in a multiple choice exam. But we know that common sense dissipates with people are under strain. We lose reflective capacity when we're in a highly reactive mode. Part of this is creating reflective space. Recognize the enormous value of social connection. I think Judith Herman stated this well when she said, "The best response to trauma is the solidarity of a well-functioning group." Those are not just therapy groups. Those are team groups, unit groups, hospital groups.

**Dr. Diederich**

Absolutely. If we don't use the group lens to foster that resilience, what are we doing? Absolutely. Groups are so critical with that.

**Dr. Leszcz**

Exactly.

**Dr. Diederich**

In closing, what recommendations do you have for students right now at this point, as you're mentioning the racism that the world is grappling with at the structural level that's really gone unprocessed in terms of the COVID pandemic. Recommendations or words of wisdom for students in this environment right now?

**Dr. Leszcz**

That's a big question. The work that you do is important and don't be discouraged by it not going smoothly. Be prepared to lean in heavily and recognize that every crisis is an amalgam of danger and opportunity. In fact, I understand the Mandarin word for crisis is an amalgam of those two words. So seize the opportunity that comes with the danger.

Your clinical work is often about that. People come to you in crisis. There's danger and there's opportunity. Don't work in isolation. That's critically important. This is difficult work and you need support in order to maintain reflective space. Talk about your work. Talk about your work with trusted colleagues. It could be peers. Pursue mentorship if possible. Pursue supervision if possible. Most importantly, pursue good training.

One of the things that I and many others in AGPA are very excited about was the American Psychological Association recognition in 2018 of group psychotherapy as a designated specialty. We have a body of knowledge, of literature. We have an evidence base to our work. Get trained in it. Ask that your graduate programs teach

you how to do group therapy and if you don't get adequate training in your formal training, commit to it once you've launched your career.

The concept of deliberate practice is very important in our work. People don't get better just by experience alone. They get better by engaging a deep reflective process, learning from mistakes, reading about difficult cases, discussing cases and again, I'll say don't be isolated. Be part of a community of practice.

If you're interested in group psychotherapy, connect in AGPA. There are enormous opportunities for training, for mentorship, for professional development. I would encourage it strongly.

**Dr. Diederich**

Absolutely. I second that. On behalf of myself and the members of Division 49, the Society of Group Psychology and Group Psychotherapy, I want thank you very deeply for this interview today and wish you the best moving forward. Thank you for everything you do.

**Dr. Leszcz**

You're very welcome, Leann. Thank you. Good to be with you.

**Dr. Diederich**

Take care.