

Coaching employees with chronic illness: Supporting professional identities through biographical work

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Abstract

Chronic illness is a growing issue in the workplace, and can prompt employees to reconsider their professional and a coaching intervention to help develop personal resources to stay in the workforce. The analysis of data from exit interviews suggests that coaching supports coachees' identity work and behavioural strategies for integrating illness and work, increasing their confidence and improving their expectations for continuing to work.

Keywords: coaching, chronic illness, disability, identity, biographical work

Introduction

The population of employees with chronic illnesses and disabilities is large and is projected to increase. In the United States, chronic illnesses affect nearly 72 million, or 39% of working-age adults (Tu & Cohen, 2009). While the population of those actually working with chronic illnesses is difficult to identify, one estimate is that 15-20% of employees have a chronic illness (Munir, Yarker, Haslam, Long, Leka, Griffiths and Cox (2007). Chronic illnesses are defined as non-communicable illnesses that are prolonged in duration and slow in progression (World Health Organization, 2015). Typically, chronic illnesses do not resolve spontaneously and are rarely completely cured. Although chronic illnesses are the leading cause of disability in the U.S. (Centers for Disease Control and Prevention, 2015), many employees with chronic illness are not designated as disabled according to the U.S. Equal Employment Opportunity Commission (EEOC, n.d.). Still, according to the 2010 U.S. census, 7.2% of people age 16 to 64 years (14.4 million people) indicated difficulty finding or maintaining a job due to a physical or mental health condition (Brault, 2012).

In the workplace, people with chronic illnesses may experience challenges around adapting their professional and career identities to the realities of their illness (Charmaz, 1987), as well as developing new behaviours to manage performance, health, and stress at work (Munir et al., 2007). Chronic illnesses can have uncertain trajectories and variable symptoms, so on-going adaptations may be required as symptoms evolve (Register, 1987; Royer, 1998). Further, many illness symptoms are invisible or ambiguous, and workers may choose to conceal their illnesses at work (Vickers, 2000) due to potential stigmatisation (Clair, Beatty, & MacLean, 2002; McGonagle and Barnes-Farrell, 2014). Fear of

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disclosing an identity such as chronic illness can negatively influence individuals' work-related attitudes (Ragins, Singh, & Cornwall, 2007) and lead to feelings of isolation, lowered self-esteem (Frable, Platt, & Hoey, 1998), and an incongruent sense of self (Pachankis, 2007).

Concealing an illness can make it difficult or impossible for employees to attain needed workplace accommodations, and also hinders the identification of similar others who could be approached for advice and support (Scotch, 1988). Flexible organisational policies may be helpful; however, in organisations lacking flexibility, employees typically must develop their own illness and work management strategies with limited social and organisational support. Workers also have to plan for future career trajectories with potential illness-related limitations in mind.

Chronic illness career coaching is an alternative way to provide support to workers with chronic illnesses. This type of coaching has been found to be effective in reducing burnout and improving personal well-being and work ability perceptions in individuals who are working with chronic illnesses (McGonagle et al, 2014). The current study presents qualitative results of an examination of one important way in which coaching works to help employed individuals with chronic illness; specifically through supporting their professional identities through processes of biographical work.

Theory and research from Psychology and Career Development provide general frameworks for understanding why coaching may be helpful. Coaching is thought to be especially helpful when people are experiencing personal and career transitions (Bobek, Hanson, & Robbins, 2012) because it can help them clarify their life goals and values, and align their personal and professional decisions and behaviours. Grant, Curtayne, and Burton (2009) posit that social support attained through coaching can help relieve stress, and that setting and achieving goals during coaching can help to build self-efficacy. Accordingly, coaching can support employees with chronic illness by providing social support and social learning opportunities. A coach who understands the challenges of working with chronic illness can provide social support, such as emotional, informational, and appraisal-based support (i.e., providing specific feedback about a person's functioning: House, 1981; Schaefer, Coyne, & Lazarus, 1981). Coachees can practice social learning through social modelling, by interacting with a coach who knows appropriate and helpful behaviours. Expressions of support for one's abilities may also improve a coachee's self-efficacy (Evers, Brouwers, & Tomic, 2006). Coaching may help coachees through development of greater insight and self-awareness (Feldman & Lankau, 2005; Wasylyshyn, 2003), which can lead to seeing new perspectives and opportunities for improvement. Through some of these mechanisms, we posit in this paper that coaching can also help individuals with chronic illness maintain or adapt their professional identities, given their illness and its current or potential limiting factors.

Health and wellness coaching is well-established in the psychology, rehabilitation and medical fields. A systematic review by Wolever et al. (2013) found that in empirical medical literature, health and wellness coaching is usually patient-centred, with the patients determining their own goals. Goal-setting and accountability are essential elements of the coaching encounter. Coaches focus on patients' self-discovery and may provide them some educational materials so that patients can be self-directed, as opposed to giving them direct advice. Another systematic review of 190 studies of health and wellness interventions for people with chronic and disabling conditions (Stuifbergen, Morris, Jung, Pierini, & Morgan., 2010) found that 89.5% of the studies reported positive effects with respect to improving health behaviours and outcomes. While career issues may enter into health and wellness coaching, the primary foci of these kinds of coaching are symptom management and regimen compliance. Examples are achieving target cholesterol levels (Vale, Jelinek, Best, & Santamaria, 2002), coping with low back pain

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Angel, Jensen, Gonge, Maribo, Schiøttz-Christensen and Buus (2012) and learning Tai Chi to manage the stresses of illness (Galantino, Shepard, Krafft, Lapierre, Ducette, Sorbello., Barnich, Condoluci and Farrarr, 2005).

Although a focus on symptom management and regimen compliance are critically important for individuals with chronic illness, these types of interventions are not equipped to handle the unique challenges individuals with chronic illnesses face in the workplace (Munir et al., 2007). The issues at the intersection of career and illness management are unique, and merit a specialized focus, one that adopts more of a career perspective than a medical one. As mentioned, chronic illness career coaching has been found to be helpful for this working population (McGonagle, Beatty and Joffe, 2014). Our goal here is to understand specifically how this type of coaching may help these workers, with a specific focus on professional identity and biographical work.

The coaching described in this study addresses both the workplace and chronic illness domains. We discuss the complex issues facing people with chronic illness at work, and ask how coaching can support their adaptation to evolving and on-going illness symptoms. We aim to better understand specifically how coaching may work to help this population of workers through a lens of professional identity and biographical work. Practically, we aim to increase awareness among coaches and human resource professionals of the kinds of workplace issues employees with chronic illness experience, and to describe one way in which coaching “works” to help workers who are experiencing difficulties managing both career and illness.

Chronic illness requires biographical work

Chronic illness has been referred to as a “biographical disruption” (Bury, 1982), characterized by an assault on both the physical self and on the person’s sense of identity. Biographical disruption leads to anxiety and undermines assumptions about the body and life course, which are core assumptions by which people maintain their self-narrative (Reeve, Lloyd-Williams, Payne, & Dowrick, 2010). People aim to craft identity narratives that create a sense of coherence over time, and identity develops and evolves in response to life experiences (Savickas, 2002). Careers are one important venue for identity deployment (Super, 1957). A career identity represents an individual’s work-based self-concept, and gives a relatively coherent representation of an individual’s career experiences and aspirations. Therefore, a disruption such as illness can have a critical impact on one’s overall identity due to career disruptions or re-evaluations as people reconsider their career identities and goals.

Consider, for example, how chronic illness might influence vocational choice and career trajectories. Chronic illness and disability onset can happen across the lifespan. When individuals are diagnosed at a young age, they may face career barriers such as stigma, low self-esteem, and motivational issues that may shape their early career development (Feldman, 2004); yet, they can incorporate the limitations of their illness into their vocational choice, which can help them to avert some of the need for mid-career transitions. However, for many employees, illness and disability happen later in life after initial vocational choices and investments have been made, and personal and career identities have already been established. Chronic illnesses also have trajectories that can change over time, which can force on-going adaptations. Thus chronic illness can disrupt established identities and prompt a reconsideration of career plans (Beatty, 2012).

Biographical work

To repair the disruption to the self, Corbin and Strauss (1987) suggest that “biographical work” is required. They describe four kinds of biographical work that need to happen to “put the biography back together” (p. 252). The first is contextualising, in which the person incorporates the illness trajectory into their biographical ideational processes through reflection. The authors describe these as forward and backward reviews of the person’s life. The second is coming to terms with illness, arriving at some degree of understanding and acceptance of the biographical consequences of failed performances. The “failure” here is that the body is no longer performing as expected. The third is identity reconstitution, which is reintegrating the identity into a new concept of wholeness around their limitations. The final kind of work is biographical recasting, which gives new directions to the biography.

The authors and others such as Bury (1982) suggest that biographical work is accomplished through re-creations of personal narratives, requiring both independent self-reflection and discussion with trusted others. These ideas are consistent with self-verification and interpersonal congruence theories which state that confusion and uncertainty can result if an individual is not validated in his or her own self-view (Swann, 1983; Swann & Hill, 1982). Corbin and Strauss’ work focuses on managing illness at home, and does not directly address employment concerns and issues. In the context of the workplace, additional biographical work may be needed for one’s professional identity when one has a potentially-disabling chronic illness. This study therefore addresses an important gap in the literature by directly addressing biographical work related to employment issues that stem from chronic illness.

Professional identity is partially formed through life and work experiences that clarify one’s *individual* priorities and self-understanding (Schein, 1978), which can be accomplished alone – essentially the kind of biographical work described above by Corbin and Strauss (1987). But work identities are also developed through *social* processes involving other people. Walsh and Gordon (2008) suggest that individuals create work identities based upon social identities, by incorporating the identity offered by membership in various social groups. Identities must be affirmed by others in on-going, reflected social interaction (McCall & Simmons, 1978; Swann, 1983). Developing and maintaining a professional identity is a negotiated process that requires impression management. Chronic illness symptoms can present some impression management challenges in both personal and professional life. For example, the symptoms of chronic illness can be highly variable in their frequency and intrusiveness, and symptoms may not rise to the level of a formally recognised disability in the employment context (Beatty & Joffe, 2006). People with chronic illness may struggle with impression management issues such as knowing what to say, how much to say, when to say it, and to whom (Beatty, 2012; Ragins, 2008), and may fear work-related discrimination related to their chronic illness (McGonagle & Hamblin, 2014). Coaching can facilitate workers’ reconciliation of these self-presentation issues.

Summarising our literature review, we note that evidence supports the notion that the experience of illness is a biographical disruption that requires biographical work; and that coaching has been effective in helping people to cope with health and wellness issues. Our goal in this study is to investigate coaching and illness in the context of work. Specifically, we examine participants’ responses to a series of exit interview questions regarding their experiences in a coaching intervention designed to help currently employed people with chronic illness understand their career options and to develop strategies to remain in the workforce. Our intervention was previously found to be effective in McGonagle et al (2014). The coaching intervention incorporated life and career coaching that focused on specific issues of chronic illness, and was conducted by an independent coach with no connections to the coachees’ employers. The

specific research question we address is: How can chronic illness coaching facilitate coaches' biographical work?

Methodology

Participants and procedure

Participants were 34 individuals who completed coaching and exit interviews (following the sixth and final coaching session) from a larger sample of 59 individuals who participated in a study to determine the efficacy of a coaching intervention for workers with chronic illness; see McGonagle et al (2014) for details and results of the quantitative survey study. This current study uses associated qualitative data from participant exit interviews.

Our study was reviewed and approved by institutional review boards of both authors' institutions. The coach in this study is certified by the International Coach Federation, is well-trained on coaching ethics, and both researchers have up-to-date certifications on research ethics with human subjects from the Collaborative Institutional Training Initiative. Coaching was completed independently; the researchers were not involved in any way with coaching calls, coachee goal setting, or coachee assignments.

Participation was completely voluntary and participants were allowed to leave the study at any time, at their discretion and without penalty. One particular issue that was raised during the funding agency's review process was the notion that individuals with chronic illnesses are vulnerable to depression. Through discussions with the funding agency, we decided not to exclude anyone with depressive symptoms who was interested in and ready to start coaching. However, we did include an assessment of depressive symptoms in our baseline surveys. Participants who scored above a threshold for the scale were reminded that coaching is not a substitute for therapy or other psychological services, and were told that they may wish to seek further assistance from such services. Another issue related to this population is regarding confidentiality. It was of utmost importance that participants' involvement in this study be kept confidential from their employers. We never shared any information about who was in this study with any employing organisations and took utmost care to protect confidentiality in general (for example, assigning participants an ID and never using their names or other identifying information in all communications; and keeping a list of IDs and names on a password-protected computer).

Table 1 summarises the sample characteristics. All participants were working at least 30 hours per week at enrolment, all had at least one chronic illness or health condition, and none were planning to retire within two years of enrolment. Participants were largely recruited via social media, and worked in varied jobs in multiple organisations across the U.S. Most participants reported that their supervisor was aware of their illness, and 65% reported needing a workplace accommodation for their illness. Participants worked in healthcare and medical professions ($n = 7$), education and research ($n = 8$), information technology and software development ($n = 5$), accounting ($n = 4$), communications ($n = 3$), engineering ($n = 2$), and administration including managers ($n = 3$) and administrative assistants ($n = 2$) in unspecified industries. 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 were ankylosing spondylitis ($n = 3$), multiple sclerosis ($n = 3$), psoriatic arthritis ($n = 3$), and Sjögren's syndrome ($n = 3$).

Participants each received six one-hour phone-based coaching sessions (one every other week for 3 months). Coaching was provided free of charge, and no other incentives were provided except for one \$10 gift card upon completion of a final follow-up online survey three months after coaching ended. Coaching

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sessions followed a semi-structured and standardised format based on the GROW model of coaching (Alexander, 2006); the particular content was tailored to each individual's needs and goals. At the beginning of the coaching, the coach and coachee jointly established goals for the six-session set (the coachee stated his or her goal(s) in a pre-coaching worksheet and these were discussed in-depth with the coach and were revised during the first session). Individual session goals were also established at the beginning of each call, when the coach asked the client what he or she would like to work on for the day's call. Assignments were developed at the end of each call, with measurable action steps that the coachee could complete before the next coaching call. The GROW model encourages the coachee to be engaged in identifying their own issues and possible solutions. The coach's role is to listen, offer insights and observations, and to help increase awareness for the coachee. The coach may offer suggestions when appropriate, but the emphasis is on helping the coachee to surface and explore their own options. The coach's knowledge and expertise of chronic illness management is relevant and helpful for offering new alternatives to address the client's particular issues because the client may not be aware of resources.

Average age	38.8 years
Female	88%
Years since diagnosis of illness	
3 years or less	12
4 to 6 years	6
7 years or more	16
4-year college degree or higher	90%
Average work hours per week	41.9
Average tenure in current job	5.6 years

Table 1: Sample Characteristics

Exit interviews were conducted by the first author after the conclusion of the sixth and final coaching session. If the participant agreed, the exit interview was recorded and transcribed for later analysis. Interviews were semi-structured, asking questions about how coaching influenced the coachees' beliefs about continuing to work, their feelings and attitudes about work, and any new behaviours they may have tried at work based on their coaching sessions. If the coachee had changed employment since beginning the study, they were asked to describe how and why that came to pass. The final questions were about the coachee's perception of the main benefits of coaching, and for any suggestions on ways to improve the coaching experience.

Analysis

We used thematic analysis informed by prior research on identity and biographical work. Thematic analysis is a method for identifying, analysing and reporting patterns in data (Boyatzis, 1998; Braun & Clarke, 2006). This method is popular in health and wellness research because it gives rich detail of patients' experiences (Braun & Clarke, 2014).

Braun and Clarke (2006; p. 82) note that a theme "captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set." Themes should be prevalent in the whole dataset, but prevalence and centrality of a theme are not necessarily determined by quantifiable measures such as frequency (Braun & Clarke, 2006). The determination of central themes requires researcher judgment, after deep familiarisation with the entire

data set. We consider our approach to be a theoretical or deductive thematic analysis (Boyatzis, 1998) because the coding was driven by our analytic interest in biographical work.

The steps of thematic analysis are (1) familiarising oneself with the data, (2) generating initial codes, (3) searching for prominent themes, (4) reviewing the themes; and (5) defining and labelling the themes that seem to capture the essence of the phenomenon. Coding and analysis is a dynamic, iterative, and reflexive process, involving multiple readings of the transcripts, and revisiting the coding based on new understandings. We began with the major categorisations of internal and external identity to follow the distinctions in identity literature between individual and social processes. Subsequent coding then added more detailed themes. To test the reliability of the coding, the primary author took 54 excerpts from the transcribed interviews and coded them based on the identified themes. The second author then coded the excerpts using the same coding scheme. An excerpt could receive multiple codes. Percent initial agreement on codes applied (total agreed-upon codes/total number of codes) was 79%.

Results

Internal biographical work addresses the coachees' thoughts about self and identity, and behaviours they take to integrate illness into their lives. These are internal because they do not directly involve other people. External biographical work comprises the coachees' negotiations of their public image through impression management strategies and communication with other people. In the descriptions below, quotes indicate the coachee's age, gender, and whether they have been newly (N), mid-range (M), or long ago (L) diagnosed with illness.

Internal biographical work

Internal biographical work addresses how individuals make sense of their changing identities and integrate those changed identities into their lives. We found two categories of internal biographical work: identity work and behavioural strategies.

Identity Work. Identity work addresses how coaching helps coachees re-evaluate and think about themselves, with four themes:

1. Accepting illness. Both newly diagnosed and long-term diagnosed coachees reported that their coaching experience helped them to accept their illness. This theme displays two of the Corbin and Strauss (1987) elements of biographical work, contextualizing and coming to terms with illness. The comments suggest that acceptance can take time and requires some effort invested in reflection. For some, this was surprising since they thought that they had dealt with acceptance already, as this quote illustrates:

It was the hardest thing going through the process of accepting my illness. [...] I kind of felt like I was done with that and that I figured that all out, and the work that I did with [coach] helped me realize that I still had elements of that, both the sense of loss of that other identity, and a sense of trying to keep up with the previous identity. (age 43 female, L)

2. Realising value as an employee. Coaching helped coachees realise their value as an employee, taking stock and reflecting upon their job capabilities distinct from their illness. As one coachee described it:

[Coach] helped me to see that my value as an employee doesn't necessarily need to be lowered because I'm a person with a disability. [...] She started having me look at the things

I was accomplishing, and the value I was giving for the time that I was available, and to see that as an asset regardless of how you counted the hours. (age 44 female, N)

3. Developing confidence. Coaching helped coachees develop greater confidence to manage both their illness and career: “I am so much more confident in my ability to handle what comes my way with my health as it relates to my job, whereas before I would often find myself anxious and just feeling really out of sorts” (age 41 female, N). The greater confidence was reflected in a range of ways, such as applying for new job positions, using assistive devices that they had avoided in the past, and asking for time off for physical therapy.

One way that coachees gained confidence was by reframing their long-term beliefs about their ability to work, giving them a sense of control – especially valuable given the variability and uncertainty of chronic illnesses. As this coachee states:

I think coaching helps with my beliefs about continuing to be successful in the job position or career that I'm going to school for because it gives me control, it gives me a handle that I am taking charge of my life. (age 31 female, N)

Themes 3 and 4 relate to Corbin and Strauss’ (1987) biographical work of identity reconstitution, which is reintegrating the identity into a new concept of wholeness.

4. Establishing realistic expectations and goals. This theme is similar to the concept of biographical recasting (Corbin & Strauss, 1987), giving new direction to the biography. As they accepted the current limitations of their illness and the inherent uncertainty of their illness trajectory, they were prompted to think about their career goals in new ways: “The coaching I think afforded me the necessary insight in how to manage my own limitations and perhaps my own expectations for myself as it relates to my job” (age 41 female, N). This expectations piece is important because people with chronic illness may stay in bad jobs because they fear they cannot get another job, a situation that can lead to underemployment. Alternatively, they may have overly ambitious expectations that do not align with their physical reality.

Behavioural Strategies. The second kind of internal biographical work involved adopting behavioural strategies to integrate illness more effectively into their daily lives. Coaching helped them to understand their illness and illness management strategies, and prompted them to take actions that they may have avoided before. We identified three themes:

1. Understanding illness dynamics. Coaching helped coachees understand illness dynamics, such as the triggers for their illness symptoms, prompting them to pay attention to symptoms in a new way: “[Coach] helped me kind of realise that I wasn’t paying attention to my body as much as I needed to, and helped me learn how to cope with that” (age 30 female, L). Coachees learned about techniques to manage chronic pain and work through their pain, and developed a better awareness for managing their time and emotions.
2. Developing structures and processes. Coachees learned to develop specific structures and processes for integrating their illness and physical issues into their daily lives. This might include behaviours such as scheduling breaks during the day, asking for help, monitoring pain threshold and taking medications pre-emptively to avoid larger problems, accessing physical therapy, and performing stress-reduction techniques (for example, breathing exercises and journaling).
3. Adopting assistive devices. Some coachees reported that coaching helped them to adopt assistive devices that they had avoided in the past because they perceived them as a visible sign of their disability. They feared their use would reflect poorly on them.

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Identity work and behavioural strategies reinforced each other. For example, some coachees had avoided using assistive devices or asking for accommodation because they thought that it made them appear weak as employees. After they worked with the coach to reflect on their contributions as an employee and developed a sense of confidence and control (the identity work), they felt empowered to ask for the items that they had been avoiding (the behavioural strategies). In other examples, having a better understanding of illness triggers and stress management strategies (behavioural strategies) helped coachees to build confidence and a sense of control (identity work).

External biographical work

Coachees also discussed and learned ways to negotiate and manage their public image. This is external biographical work because it necessarily involves other people, and it includes two categories of impression management and communication about illness.

Impression management. Coachees said that coaching helped them to become more aware of the need to manage their public impressions. They came to realise that they could strategically manage the way that they presented themselves to appear in control of their illness: “[Coach] also gave me a few tips about how to feel, or appear in control, so that it doesn’t appear that chronic illness is all that I am to my co-workers, which had been one of my concerns.” (age 27 female, N)

Communicating about illness. This was a frequently mentioned issue and concern for coachees in the study, and we found three themes.

1. Communication skills. Coaching gave coachees knowledge and skills to help them discuss their chronic illnesses with their supervisors and co-workers. They were able to practice and obtain feedback on how to talk about it, and to consider both what to say and what not to say:

We talked about specific words that were more effective than others, which was really important ... At one point, she even helped me sort of draft a little speech for my boss, so it was helpful that way to sort of see how to approach and how to talk about it. (age 41 female, L)

2. Understanding disclosure. Coachees reported that the coach helped them to gain a better understanding of disclosure, including revealing the right amount of information about their illness. This was important for both protecting their privacy and building relationships.

[A main benefit was] Developing a capacity to know when and what I need to be able to tell somebody about my chronic illness, and we worked with a model. Now I have got it that I don’t need to disclose what the actual disease is. That is where I always got hung up. We talked about in certain situations providing less information, and in other situations providing more. (age 41 female, L)

3. How to ask for accommodation. As mentioned above, the internal work coachees did with the coach allowed them to realise the value of their work experiences and contributions, and gain confidence that they were worthy of good employment opportunities. Building on this in the external biographical work, they stated that coaching helped them with specific technical advice about how to ask for accommodation, and what to ask for:

It changed my view on what I should and could ask for, and how to go about it in the best way. [.....] Because of the coaching, I was more selective and in tune to what I want to ask my boss for. (age 49 female, N)

Coaching caveats

While the coachees' experiences with coaching were largely positive, they also mentioned some boundary conditions to consider that can influence the coaching experience. It is important that the coachee is ready and willing to engage in the reflection work required – they need to have high levels of change readiness: “You have to be open to it and you have to be willing to do the work associated with it” (age 39 female, M). Some coachees expected the coaching to be a more scripted program with defined tips and lessons for each session, and were surprised when the coach asked them in session one, “What do you want to work on?”. The coach in this study followed the coaching guidelines from the International Coaching Federation that states that coaches should not give direct advice, but rather help the coachee surface his or her own options and preferences. Some coachees mentioned that they would have preferred more directive advice from the coach.

An underlying assumption of our study is that *knowledgeable* social support helps coachees to cope with the biographical disruption and stress of chronic illness. For this population, specific knowledge about chronic illnesses, and working with chronic illness, is needed. The coach in our study has both professional and personal experience with chronic illness which gave her credibility to press coachees further. Coachees said they appreciated that she understood the full impact of illness on all life domains. This quote illustrates why this understanding is important:

What happens is we are frequently explaining ourselves to people who don't get it and who don't have a frame of reference for it, and that creates a lot of the internalised isolation and frustration. If you are talking to someone who has experienced that, there's no getting them up to speed, and there's a sense that their suggestions are worth trying because they use them to adapt to their life as well. (age 37 female, L)

Discussion

Our findings suggest that coaching can help individuals through the biographical work linked to working with chronic illness. Our major themes point to the centrality of acceptance of illness as a key aspect of adaptation, and are consistent with the second kind of biographical work identified by Corbin and Strauss (1987), highlighting the need for people with illness to arrive at some degree of understanding to reintegrate their lives. We see coaching as a resource to help coachees with practical support and guidance for all four kinds of biographical work: contextualising, coming to terms with illness, identity reconstitution, and biographical recasting (Corbin & Strauss, 1987). Our application looks particularly at these activities in the context of work, and efforts to restore and maintain one's professional identity.

Our concept of biographical work outlines both internal and external work. This is a useful addition to the concept of biographical work, which typically focuses only on internal work, because identities are reflected and socially constructed (McCall & Simmons, 1978). Organizations and careers are contexts for “realising the project of the self” (Grey, 1994; 482). Professional identity must also adapt to the changing physical body whilst maintaining the individual's desired image. Chronic illness does not always require immediate changes, and indeed, may not require any changes at all; however, the awareness of the *uncertainty* of chronic illness may prompt some reconsideration of future career goals and expectations.

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Focusing on the links between professional and personal identity offers another way to reintegrate an individual's identity as they adapt to illness. As coachees come to new understandings of how they can continue to work with chronic illness, they reframe both their personal and professional identities.

Our research contributes to coaching practice by showing how a special population can benefit from focused coaching. Similar benefits could occur for other employee populations with specific characteristics that influence their work performance or development of a professional identity. By branding it as “chronic illness career coaching,” our method emphasises the specific issues of illness. We have already noted examples of work-related maternity coaching (Bussell, 2008; Filsinger, 2012) and work coaching for mid-life women (Wright, 2005). Coaching could help other populations with specific issues or different kinds of stigma – for example, veterans, re-entrants from prison, and survivors of domestic abuse. Each of these groups may be a hidden population, making it more difficult for people to identify similar others with sufficient background knowledge to offer social support. As participants in our study said, it was helpful having a coach who understood the issues because they did not have to explain or justify their issues. Using our approach, these populations (and others) could be addressed with coaches that have specific knowledge and background of the kinds of challenges experienced. The benefit would be more immediate trust and relationship-forming between coach and coachee which can catalyse the coaching effectiveness.

Our study also has practical implications. It suggests that coaching can help workers with chronic illness do important biographical work that is needed to support their personal and professional well-being. Coaching can provide practical advice to help them perform better and to feel more confident. It may also provide employees with an understanding of how their abilities fit with their current job, which is an important aspect to establish a better fit with their working environment, say by making changes to their job duties or finding alternative employment.

From the organisation's perspective, coaching can be a resource to retain employees and decrease the occurrence of employees transitioning to disabled status. Unless the employee is receiving documented disability accommodations at work, employers may not know about the employee's illness situation. For a variety of reasons employees may not have asked for any accommodations, choosing instead to cope with their illness individually. A consideration for employers is that chronic illness career coaching focuses on the goals of the individual, not the organisation. Employees may realise in coaching that their career interests lie elsewhere, and decide to exit the organisation. Accordingly, chronic illness career coaching may be seen by employers as personal or life coaching, and outside their purview. If so, illness advocacy groups might sponsor this type of coaching for individuals, or employees may need to seek it out and pay on their own.

Our coaching was provided by an independent consultant with no connections to the coachees' employers. We think this is important for trust and confidentiality because some employees with chronic illness fear negative career consequences if supervisors find out about their illness. Thus, we are not advocating that chronic illness coaching be publicly offered within organisations (as, for example, executive coaching might be). However, it could be a service that is covered by organisational insurance policies, or offered as a component of employee assistance programmes.

Limitations and future research direction

A limitation of our study is that it relied on a single coach with experience in chronic illness career coaching. Future work should incorporate an expanded design with multiple coaches, and could also investigate whether and how the coach's personal characteristics influence the effectiveness of this kind of intervention. Our participants felt that the coach's personal experience with illness gave her added credibility, so additional work could explore whether this illness experience is a necessary prerequisite.

Further, the coach followed a standardised process with each coachee, but each coaching relationship had a unique situation and goals. We analysed common themes related to biographical work and identity, yet there are many other issues that were addressed during the sessions as well (e.g., stress management and coping). The results we report are based on self-reported benefits of a coaching program provided free-of-charge, based on discussions in the phone interviews with one of the authors. Coachees may have (consciously or subconsciously) felt obligated or otherwise motivated to provide positive feedback to the researcher. To partially address this, the researcher asked for suggestions the coachee might have to improve the coaching process to indicate that our process was open to feedback. Some of the coachee suggestions were noted above, such as preferring a more structured format with standardised content and more directive advice from the coach. Other suggestions included a request for the coach to prepare and provide summary notes after each coaching session, since one coachee felt it was difficult to keep their own notes, and requesting more time between coaching sessions to permit time for reflection and completing homework tasks.

Another limitation is that our sample was predominantly female. Coaching issues and effective coaching approaches could differ for men, so future research could investigate how gender shapes chronic illness coaching. Other working populations that have biographical disruptions, such as veterans, could also be relevant to study. Although we generally consider coaching to be about the interactions and relationship between the coachee and the coach, it could also be interesting to investigate factors related to organisational context. For example, is coaching more effective when the coachee's supervisor is aware of or involved in the coaching in some way, and does organisational culture influence the effectiveness of coaching interventions? Additionally, organisations may want to sponsor this type of coaching through health insurance plans or employee assistance programmes. A possible outcome of this may be increased feelings of support from the organisation, and possibly increased affective commitment to the organisation. Future studies could examine whether employer-sponsored coaching has such benefits.

Conclusion

Individuals who are working with chronic illnesses may experience disruptions to their professional identities due to health-related challenges. Chronic illness career coaching provides an outlet for these workers to maintain or renegotiate their professional identities in light of living with chronic, potentially-disabling illnesses. Workers reported a variety of benefits from coaching that aided their internal and external biographical work. Coaching helped them to accept their illness and to develop strategies for incorporating both the uncertainty and physical limitations of their illness into their work and personal lives. The positive results seen in this study indicate that contextualised coaching may also be beneficial to other worker populations who experience identity disruptions.

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