ORIGINAL ARTICLE

Coaching versus Psychotherapy in Health and Wellness: Overlap, Dissimilarities and the Potential for Collaboration

健康保健中的辅导与心理疗法：相同性、差异性以及潜在的合作性

Formación frente a psicoterapia en la salud y bienestar: coincidencias, diferencias y la posibilidad de colaboración

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INTRODUCTION

Health coaches and psychotherapists both work with the art and science of facilitating change in their patients and clients. While the evolving field of health coaching and the established disciplines of clinical or counseling psychology share major areas of overlap, there are also significant distinctions between the two fields. This article outlines those similarities and dissimilarities with the intention of fostering a cooperative and mutually enriching stance between the two helping professions for the benefit of the respective professionals and the countless clients and patients they serve.

As more psychotherapists add coaching skills to their practice and more health coaches work with complex medical patients wrestling with stress-related illness, the two disciplines bump up against each other, often times with salvos of accusations that coaches wrongly encroach upon psychotherapy or that therapists call themselves coaches without specific coach training. At the same time, a growing paradox exists that while the two fields can be rife with contention, they also move along a continuum of results-oriented, psychological skills for facilitating goal attainment while improving the mental and physical health of their clients.

DEFINING THE ROLES OF HEALTH COACHES AND PSYCHOTHERAPISTS

Though a handful of health and wellness coaches may have been in practice for over 25 years, the professional health coach training itself emerged in the last 10 to 15 years. As an emergent profession, health and wellness coaching still lacks nationally accepted educational standards and training benchmarks, as well as with agreed-upon levels of proficiency or core competencies.[1] However, efforts are underway by the National Consortium for Credentialing Health and Wellness Coaches (NCCHWC), formed in 2009, to define the profession, set educational standards, and influence practice guidelines.[2] Some healthcare professions, such as nursing and chiropractic, already have moved forward with initiatives or certifications to add coaching skills to their professional practice. The American Nursing Association recently recognized a new role (the nurse coach).[3]

Some health coaches are licensed healthcare professionals (nurses, psychologists, physicians, physician assistants) who assist their patients and clients in managing chronic medical conditions, such as heart disease, diabetes, arthritis, and cancer. Other health coaches have diverse backgrounds (health promotion, education, fitness training, wellness management). Though they differ significantly in their content knowledge bases, they both use coaching methodology to enhance the self-identified health and well-being goals of their clients. The field of health coaching has become increasingly sophisticated as it draws from a growing body of evidence-based coaching psychology, positive psychology, adult learning theory, motivational interviewing (MI), and new findings in neuroscience.

Psychotherapists, on the other hand, focus on mentally-based conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders V* (DSMV) and are trained in assessment, diagnosis, and treatment of mental disorders. Yet psychotherapists often work with issues related to chronic and acute somatic illness, postoperative states, recovery from injury and trauma, and also with more general health self-care and wellness-related issues. In so doing, the crossover with health coaching is apparent. The core of their professional relationships is to assist client growth through interpersonal interactions.[4]

Similar to health coaching, psychotherapy goals include behavior change, enhanced decision making, and better use of resources. In addition, goals may include mitigation of mind-mediated symptoms, increasing self-esteem, reduction in causal links between mental dynamics and somatic conditions, the impact of learning disorders, and relationship enhancement with adults and children.

In psychotherapy, the methods used to work on these issues are more vigorous versions of what health coaching may employ in a more limited and circumscribed way. Plus, the psychotherapist is trained to assess and diagnose myriad conditions (eg, serious eating dysfunction, affective dysregulation, personality-driven behavioral patterns, abuse experience, chronic pain problems). The field of consideration of affect and belief systems goes wider and deeper for psychotherapy than is prudent for health coaching. Effective psy-

chotherapy, of course, addresses mental aspects, but the overall care of the client/patient—especially by psychotherapists who are medically trained-nurses, physicians, some social workers—is holistic and includes health coaching and health educating. If the mental health professional is trained in both health coaching and health educating, per se, so much the better. Though both of these approaches are usually part of the educational process for health psychologists, they are not usually part of the primary education and professional training of physicians, clinical psychologists, and clinical social workers.

Health coaching, as understood by the public, is not viewed as a mental health service (psychiatric, clinical psychological, clinical social work, family therapy). Those workers making referrals of clients to health coaching, those marketing health coaching to industry, and the clients who use it do not view themselves as being in a mental health context. Although sometimes clients feel more comfortable starting with health coaching, they and their coaches may soon discover that the issues are best addressed by mental health diagnostic and therapeutic skills. For most people, however, health coaching may be the appropriate modality to meet their health-related needs.

Drawing from the Same Research

The conventional thinking was that changing one's habits took an ironclad will and nonstop motivation, or as fitness guru Jack LaLanne would yell at his television audience, "Pride and discipline—that's all you need!" Fortunately, for people who have tried and failed numerous times to quit smoking, lose weight, exercise, or improve their health, there are more effective strategies and well researched methodologies that underpin an expanding array of tools employed by both coaches and therapists. The research behind behavioral change now draws from scientifically observed methods for transformation and sustained action strategies.

Both health coaches and psychotherapists tap into theoretical frameworks and conceptual models including self-determination theory, adult development theory, learning theory, MI, transtheoretical model, social cognitive theory, internal family systems, locus of control, self-efficacy model, appreciative inquiry, and nonviolent communication techniques.

The training and education for health coaches tends to concentrate on more than 50 years of research in social psychology, health promotion, organizational leadership, behavioral and positive psychology, and the latest findings in neuroscience and the workings of the brain.

Psychotherapists, on the other hand, rely on a wider range of theories depending on their education and preferred modes of treatment. Those theories include cognitive-behavioral, psychodynamic or psychoanalytic theory, solution-focused therapy, humanistic-existential, transpersonal, rational emotive behavior, or an eclectic mix of theories. More marginally used theories or models include gestalt, reality therapy, body-oriented or somatic psychotherapy, object-relations, acceptance and commitment therapy, narrative, recovery model, and mindfulness-based therapy.

DRAWING FROM THE SAME APPROACHES

Positive Psychology

Both psychotherapists and coaches draw from the field of positive psychology with ample examples of applied findings.[5] For example, consider the research findings that suggest that three positive thoughts are needed to counter or quell the effect of one negative thought.[6] Emphasizing well-being, strengths-based thinking, and cultivating the approaches to happiness are part of the coach's toolkit. Coaches look at possibilities instead of problems and causes. Though both coaches and therapists rely on this foundational body of work in positive psychology, there may be a greater ease in which coaches access it. Coaches who are also psychologists may find it more difficult to depart from the medical model in which they were trained.[7]

Mindfulness

A rich field of exploration for both psychotherapists and health coaches is the burgeoning evidence behind mindfulness practices and related mind-body relaxation therapies such as guided imagery, medical hypnosis, and conscious breath work. While the psychotherapist may demonstrate a mindfulness practice to reduce stress, depression, anxiety or pain, the health coach facilitates the actual learning about mindfulness by the clients themselves. Coaches are committed to following the client's agenda, determining if some option is actually of interest, and helping the client to go about discovering it for himself. This follows the adage that it is far better to give a hungry man a fishing pole instead of a fish.

Motivational Interviewing

One approach used heavily by both therapists and health coaches is MI. MI is an evidence-based communication style, originally developed for patients struggling with substance abuse and addiction or who have ambivalence or significant resistance to change.[8] The number one rule in MI is to "roll with resistance," never telling the client what to do but instead empowering clients to discover their own reasons for change, discerning their own discrepancies about actions and intentions, resolving ambivalence at their own self-determined pace. This is accomplished through empathic listening and supporting the growth of self-efficacy. The MI approach delivers possibilities when nothing else works, and is one arena in which both the coach and the psychotherapist follow the lead from the client in committed fashion. The care and nurturing of nascent intrinsic motivation requires patience and a capacity for stepping back from what has been called the "righting reflex" on the part of psychotherapists

and health educators: supplying the right answer, the right reason, the right action just in the right time. Coaches are continually self-monitoring in an effort to allow the client to steer his or her course.

Strengths-based Focus

Both coaches and therapists embrace the arrival of the *Character Strengths and Virtues Handbook*, a departure from the more name-and-blame-and-treat paradigm posed by the DSM IV (and slightly less so in DSM V). Process-oriented coaches hold conversations in which clients identify their strengths and values and learn to anchor them in their imaginations, tapping into those strengths when challenges and difficulties arise. Seligman, a founding father of positive psychology and strengths-based interventions including learned optimism, posed an Authentic Happiness Coaching model in which scientific studies revealed that greater life satisfaction is largely a learned art.[9]

Professional Conduct and Ethics

Both health coaches and psychotherapists are expected to conduct themselves according to statutes, regulations, principles, values, ethics and standards of their professions. However, these are much more articulated in the field of psychology than in health coaching, as psychotherapists, psychologists, and other mental health professionals are highly regulated and licensed, with mandatory continuing education and governed by state boards of behavioral sciences. As stated earlier, professional practice guidelines and ethical conduct for health coaches is being addressed by the newly formed NCCHWC.

Solution-oriented Focus

In more recent decades, due in large part to a drastic reduction in insurance reimbursement from months of psychotherapy to merely three sessions, more mental health professionals have successfully employed goal-oriented treatment methods that are short-term, results-oriented, and similar in many ways to coaching methodologies.

In his blog in *Psychology Today*, psychoanalyst Michael Bader, DMH, writes that the difference between coaching and therapy is "greatly overstated," and that the customary demarcations between the two fields are simplistic and unrealistic.[10] Those myths include

- Therapists work with the past; coaches work with the present.
- Therapists focus on the *why*; coaches focus on *how*.
- Coaches stick with the conscious mind; therapists delve into the unconscious realms.

Bader points out that the timelines are false polemics as well, with therapists remaining in the open-ended inquiry, while coaches focus in the here and now. For any therapists trained in solution-oriented brief therapy, these claims must seem preposterous. Goal-oriented therapy, like goal-oriented coaching, is ideal for stress management, self-esteem enhancement, assertiveness training, marriage/divorce counseling, parenting skills, and a cornerstone of effective therapy and coaching.

DIFFERENCES

Training Differences

Besides the obvious differences in the years and intensity of education and training, there are more nuanced differences in *how* the training of psychotherapists and health coaches alters their perceptions of someone's capacity and journey to accomplishing meaningful change. Psychotherapists who have a master's degree in counseling psychology undergo 3 years of graduate education and approximately 3000 hours of clinical supervised internships. Clinical psychologists may take up to 6 or 7 years of graduate education and 5000 hours of clinical supervision. These figures vary from state to state.

Health coach training programs vary from 24 hours of online curricula to 6-month hybrid programs, to 2 to 2 years of university-level education. Again, there is no set standard, and efforts by the NCCHWC are underway to develop those standards, integrate basic coaching competencies into existing health professions, and advance collaborative health coaching research.

Training that is underpinned by evidence-based research, theoretical frameworks, monitored interactions, and ample time for development skills to mature is the ideal for both health coaches and psychotherapists. There is nothing quite as useful as a good theory (or in-depth experience) when the going gets tough, as when the novice psychotherapist or the newly trained health coach is confronted with a heightened emotional tension or intensely confrontational moment from the client—a moment that every healthcare provider encounters at some point in their professional lives. These are the times when a too simplistic "toolbox" of the coach (consisting of only skills such as reframing, clarification, or goal identification) may falter. Elementary tools may not help the client overcome an impasse. The psychotherapist has the advantage of drawing upon several years of education, training, extensive experiential dyad and triad practice, monitored practicums, and site internships. Psychotherapists are also trained to draw from a reliable theory whether it is psychodynamic or family systems models or cognitive-behavioral.

Another major difference between health coaching and psychotherapy in regard to training lies in how each discipline approaches difficulties in the therapeutic or supportive relationship and the expression of troubling obsessions, self-destructive thoughts, or charged emotional statements by clients. In this area, the health coach's toolbox is limited compared to that of the therapist. Coaches may have advanced skills through multimodal resource training refined methods for empathizing and affirming strengths and values in the face of a client falling into despair, self-sabotage, or heavy self-

judgment, especially when failing to achieve new healthful habits or lifestyle improvement goals.[11] However, the skills to help a client self-regulate and learn to manage their emotions effectively are the domain of therapy. Psychotherapists learn through years of practice how to recognize and deal with their own emotions in the intersubjective space that emerges in therapy.

Client Expectations of Therapy

Psychotherapy itself is more stigmatized than coaching by the general public. People are reluctant to think of themselves having a mental illness until they must deal with intense affect and/or dysfunctional behaviors. When meeting the skilled therapist, those initial hurdles are resolved as the clients are met with empathy, curiosity, exploration, and attempts to sort out causal factors and remedies. A high level of trust is sought so that any topic or any behavior can be revealed to the psychotherapist and will be met with empathy and with exploration of both intrapsychic and interpersonal factors.

A reasonable expectation these days is that any psychotherapy will explore intrapsychic connections among emotions, beliefs, past experience, behaviors, and bodily health. The depth of this exploration and the remedial processes are limitless in principle. If done well, they are guided by the evidence base of what works well for whom, by the therapist's sense of the client's tolerance for feeling vulnerable, and the need for control of maladaptive behavior between sessions. Posttraumatic stress is explored and processed, including that around illness. Finally, the therapist is sometimes expected to be available for urgent matters regarding the client's feelings and behaviors between sessions and in off-hours.

Client Expectations of Health Coaching

Individuals typically contact a health coach once they recognize they need assistance to accomplish goals involving health habits, wellness, exercise, weight, nutrition, stress management, or general health. The expectations clients have of health coaches often is unclear because they may regard them as health educators instead of coaches. In some training programs, the role of a health coach is expanding to include many more psychologically informed processes with limitations. Coaches are taught to understand what they are hearing, what they are not hearing, and how best to respond.

In health coaching, even when intrapsychic and interpersonal forces are noted, they are not the primary focus as they are in psychotherapy. Likewise, affect and behaviors are noticed, acknowledged, and appreciated with empathy but are *not* deeply explored. "Diagnoses" are not offered, but further evaluation elsewhere is invited as needed. The exploration of the patient's emotions and relationships should not be limitless, but only go as far as is needed to enhance awareness and provide the client some relief, for example, about their particular ambivalence in a health decision or medication adherence process.

If needed, a deeper exploration of their ambivalence could be met by a health coach experienced in models such as Internal Family Systems[12] or Motivational Interviewing.[13] These programs allow health coaches to master psychologically based skill sets that facilitate activation for behavior change on the client's part.

Sometimes affecting change is extremely difficult due to underlying emotional or relational problems. In those cases, a psychotherapy approach is essential, and the client should be referred. This is also true when the client experiences symptoms, somatic and/or psychological, driven by past experience and emotional/relational development that are being triggered by their current health situation. A good example is the coaching client and coaching professional who discover together that a significant psychological trauma has not been processed or that a significant ongoing abusive relationship needs attention.

It is possible for health coaches to talk with clients in a strategically constructed manner so that intense affects, backlash, and action-behaviors are *not* stimulated. For example, reports of a past trauma or abuse should be empathically acknowledged but not explored. The line between the health coaching process and psychotherapy needs to be clear for those doing coaching.

MAJOR DIFFERENCES BETWEEN HEALTH COACHING AND PSYCHOTHERAPY

General differences between health coaching and psychotherapy include the depth of the psychological self-awareness required of the professional, goals of the professional, and interviewing skills required. Other distinctions consist of the psychologically based processes used; the expectations of the client regarding focus; topics and depth of exploration; and relational experience, duration, and outcome.

Coaches Evoke and Inquire; Therapists Also Intervene

Psychotherapists clinically assess and diagnose and identify the issues to be addressed in therapy. Both psychotherapists and health coaches are capable of evoking agenda and strategies for change from the client; however, evoking from the client is a more consistent element in coaching. This evocative inquiry is an essential difference between coaching and psychotherapy or coaching and health education. Psychotherapists and health educators may be quicker to provide the client with information or interventions in the moment, since they are socially conditioned and educated to be expert resources and provide essential knowledge, as in working with trauma, sexual abuse, personality disorders, and attention deficit disorder/

attention deficit hyperactivity disorder.

Psychotherapists direct the course of therapy by planning treatment and case management. Coaches facilitate the client's accountability in authoring the goals and action steps. While some therapists would agree, most coaches follow the motto: it's far better to have someone happen upon an insight or solution from within, than to impose it from without. Facilitating a client's self-discovery and process of learning is central to coaching. Herein lies a conundrum for many health coaches, as they are expected to have advanced knowledge in health, exercise, nutrition, stress management, integrative health care, self-care, and many other aspects of wellness. However, they are trained to first ask permission of the client to share that information. The mere act of sharing the information takes the coach out of the coaching role and shifts him or her into the role of a consultant, which is an expert-driven, top-down authoritative position, the exact opposite of the coach approach. In practice, health coaches, especially nurse coaches, frequently jump back and forth between coaching and consultancy.

Provocative Questioning vs Safety

Another clear distinction between coaching and therapy points to the different thinking on creating the safe environment. When the health coach is working with mentally stable individuals and a relationship of trust and safety has been established, Williams and Menendez suggest inviting the client to stretch into new possibilities while a set of provocative, powerful questions are directed at the client.[14] Most coach trainers would argue that safety and trust have to be firmly established before coaches venture into this emotional territory that pushes clients outside of their comfort zone.

In a seminal coaching text, the *Evidence-Based Coaching Handbook*, Cavangaugh asserts that

> *One of the differentiation points between therapy and coaching is that in therapy, the level of instability, anxiety, or tension is so high as to be destructive of the person's ability to function effectively in his systems. They have slipped from the edge of chaos into chaos itself. Hence often one of the proximal goals of therapy is to help the person reduce distress so as to enable the emergency of a new order. In other words, therapy seeks to comfort the afflicted.*
>
> *In coaching, however, the coach is often called upon to afflict the comfortable! We often seek to increase information flow, energy, and diversity to a level that helps the person move out of stable mind-sets and behaviors so as to create new insights, understandings, and actions.*[15(p320)]

Because the therapist is working with someone who may have a fragile ego structure, may experience poor regulation with anger, or be burdened by paranoia, grief, terror, or depression, the establishment of safety is an ongoing commitment for a psychotherapist. Therapists are expected to attune to the inner world of the client, demonstrate empathetic sensitivity, and convey emotional presence while building trust and safety.[16]

Structured but Not Scripted

Health coaches, for the most part, rely on an established (yet flexible) structure for the coaching process as they co-create the coaching alliance with clients. While the education of health coaches varies among training programs of a few days to more extensive certificates and university-based degrees, most coaching sessions are fairly consistent with the steps outlined by the International Code Federation Core Coaching Competencies.[17] These include

- Set the foundation
  - meet ethical guidelines and establish the coaching agreement
- Co-create the coaching relationship
  - establish trust and intimacy and develop coaching presence
- Communicate effectively
  - Listen actively, ask powerful questions and directly communicate
- Facilitate learning and results
  - create awareness, design actions, plan and set goals, manage progress and accountability

Experienced health coaches will attest to the fact that there is no single way to respond or progress in the coaching conversation and the essential quality of being-in-the-moment with the client is part of the generative wellspring from which insightful moments and solutions arise.[18(p120)]

Traditional goal-setting techniques are the mother lode of all coaching programs, whether life purpose coaching or health coaching, as the essential process is results-oriented, with concrete strategies rooted in action and achievement. The acronym SMART for a goal is emblematic of the coaching process: smart, measureable, action-oriented, realistic, and time-framed.

Continuing Education

It has often been said that coaching is not just a career but a way of life. For health coaches, that way of life includes "walking the talk," practicing self-care and growth in all dimensions of wellness. For therapists, that commitment to continuously grow and learn is not only a professional ethic but a mandated requirement for licensure. Continuing education requirements of licensed therapists and psychologists require that they engage in scholarship, commit to lifelong learning while in practice, and have an ethical responsibility for the development of their profession. Health coaches as yet have no legal mandate for continuing their education, although professional ethics warrants continuous learning.

Diversity and Cultural Sensitivity

Both therapy and coaching have been criticized for embodying values that are representative of privileged, dominant culture and lacking in cultural competency or sensitivity toward differences in race, ethnicity, ability/disability, gender orientation, and culture.

While a coach may believe he or she can work with anyone by simply keeping the focus on validating the strengths and goals of the client, coaching as a profession has a long way to go to make significant inroads into uncovering the underlying privilege that is taken for granted in practices derived from white, privileged, executive business models. On the other hand, the profession of psychology has undergone significant reflective self-critique and acknowledges the need to revision therapy with greater cultural sensitivity. There is a need for both professions to build bridges into understanding difference and privilege and to direct therapy and coaching away from models that ascribe unquestioned values to "normal family life" or "non-disruptive behavior."[19]

Seeing Both a Health Coach and a Psychotherapist

There is no rule or general policy that clients who are seeing a psychotherapist can't also see a coach. They often work in tandem. These requests and negotiations should be handled carefully since privacy and confidentiality must be maintained. It is always up to the client to divulge whether or not they are seeing a psychotherapist. For example, a client taking anti-anxiety medications may have goals they wish to work on with coaches while the anxiety is managed. Studies on the reduction of anxiety through social support would confirm the strength of a coaching alliance.[20]

The call for interprofessional collaboration between health coaches and licensed health care providers underscores the crucial need for development of professional standards for the health coaching profession. As the NCCHWC progresses with its work in defining the scope and tasks of health coaches, leaders within the organization have called for the articulation of nationally accepted practice guidelines. For example, one such guideline would put forth ways for coaches to work cooperatively with health care providers and psychotherapists. Another guideline would assist health coaches in knowing just how and when to ask clients to inform their doctors that they are also seeing a health coach. Yet another would address how and when a coach should ask the client if they wish to have their physician or psychotherapist contacted by the coach.

What may seem common sense to practicing licensed providers is trickier for health coaches, since many operate independently of any health care setting. Some are well informed of HIPPA regulations, and adhere to standard ethics of professional practice when it comes to confidentiality and non-disclosure of patient (client) medical information. However, since the profession of health coaching remains unlicensed (in the United States) adherence to such guidelines is voluntary. Health coaches are not even required to maintain records on clients, although if they wish to maintain standing in other national organizations such as the International Coach Federation, such guidelines are customarily followed. In fact, most health coaches, in the absence of their own health coach standards at the present time, have adopted the professional code of conduct established by the ICF.

QUALITY OF RELATIONSHIPS WITH CLIENTS

Both health coaches and psychotherapists have a high regard for the quality of relationship that develops between client and practitioner, and both, in their own way, receive training in developing presence, a trait characterized by caring attention, empathy, connection, active listening, and mindfulness. Studies that examined practice models for psychotherapy and psychoanalysis found that the therapeutic relationship itself may be the most influential factor for changing behavior.[21-23]

The psychotherapist strives to establish the psychotherapist-patient alliance, and the coach works to bring presence into the coach-client relationship. Coaches investigate the elusive quality of presence as they co-create coaching relationships that reflect empathy, trust, and deep listening. Psychotherapists in training become alert to the development of intersubjective and intrapsychic space, which informs and enlivens the therapeutic exchange.

The relationship itself is a tool of the therapy, just as the coaching alliance can empower and provide a pathway to goal attainment in health coaching. One area in which pyschotherapists have advanced training is in understanding the subtle nuances and detours in the psychotherapist-patient alliance. An experienced psychotherapist employs these nuances as a means for enhancing the interpersonal effectiveness or psychosocial adjustment and increasing capacity for emotional self-regulation.

Because the brain is well organized to constantly make connections, just about anything can serve as a trigger to traumatic memories and elicit emotional reactions. It takes a healthy personality and egoic structure to not be set off by clients' transference, counter-transference, or projections. Psychotherapists train for many years to recognize and work with transference and countertransference. Transference occurs when the client makes the therapist the object of his or her issues. The client transfers some internalized idea of a person or event or thing onto the therapist, relating to the therapist as if she embodied that trait or "was being just like" that person. In therapy, this is an opportunity for breakthrough, but sometimes if ignored, it can be potentially destructive to the therapeutic relationship. In coaching, it presents nothing but problems as most health coaches have no training in dealing with transference.

Countertransference is the therapist's displacement of emotions directly back to the client or at least some degree of emotional involvement with the therapeutic

relationship. Projection occurs when clients deny some impulse, idea, motivation, or feeling as their own and unconsciously project it onto others as their impulses. Again, these common psychological defenses are grist for the therapist mill but can derail a coaching relationship. It takes experience to recognize that something is amiss and that therapy, not coaching, is appropriate.

In reviewing coaching case studies, one author (MJ) noted that a novice coach reported that his client who referred to herself as a "health nut," had identified an unrealistic weight goal. When the coaching agreement was ended, the client was seen by a therapist who diagnosed obsessive-compulsive traits, ruminative perfectionism, and a life-threatening eating disorder. Incidents of this kind may be rare but indicate the need to properly diagnose symptom emergence by psychological or psychiatric assessment.

Reflective Self-assessment, Self-care and Self-growth

The ability to engage in reflective practice, self-assessment, and self-care is valued in both psychotherapists and health coaches; however, the structure and process are firmly established in the training and education of psychotherapists but remain a non-mandated factor in the training of health coaches.

Reflective practice and self-assessment of psychotherapists (both master's and doctoral level) are extensive commitments demonstrated by the attainment of a set number of required hours in personal therapy prior to licensure. Required hours vary by degree and state mandate of behavioral science licensing boards. Therapists at a master's level often are required to obtain at least 50 hours of personal therapy with mental health professionals before being licensed. Clinical psychologists may be required to undergo 200 hours or more.

Entrepreneurs, Employers and Independent Clinicians

Health coaches can operate independently in solo practice, within networks of complementary practitioners, or for a wide variety of insurance companies or corporate wellness programs. If they are employed by health insurance or disease management firms, they often have established protocols for tracking client progress. There is no definite standard as yet for cooperating with other healthcare providers. Although therapists may be in private practice, as licensed professionals they are expected to have an intra-disciplinary commitment to communicate effectively with other health professionals for the dissemination of necessary patient information and to relate as needed with individuals, families, groups, and communities, assuming appropriate release of information is provided.

Between-session Communication

It is customary for health coaches to schedule and facilitate check-ins between sessions, something that therapists might do only if a client is in crisis. The expectation that changing habits for the better is hard work allows the health coach to deliver timely reminders (if agreed upon by the client) with email, phone/text messaging, or other web-based tools. Some of these newer technologies may appeal to therapists unless the patient's capacity for autonomous functioning is of concern and an expressed therapeutic goal. In that case, between-session "hovering" may be counterproductive, whereas in goal-setting, it is viewed as a friendly memory jogger. Therapists are generally expected to be somewhat available after hours and between sessions for clients in emotional turmoil or crisis.

RECOMMENDATIONS FOR PROFESSIONAL COLLABORATION

Interprofessional healthcare teams consisting of physicians, psychotherapists, health educators and health coaches can help societies prepare for futures in which the impact of behavior change on health outcomes is more important than ever. Cost-effective behavioral change strategies required to reduce healthcare spending are called for by every agency from the US Department of Health and Human Services (Healthy People 2020 Initiative) to the World Health Organization. Though many of those actions involve individual and community-based methods for addressing the social determinants of health, it remains to be seen which professionals (health coaches or psychotherapists) will take on the primary responsibility for facilitating behavior change. What is most likely is that the responsibilities will be shared by both professions.

The complex nature of social problems and health challenges that individuals and families confront calls for collaborative care models. The discussion of human behavior knows no boundaries. Something as innocuous as seeking exercise partners could head down a slippery slope into a discussion of why most of the relationships in one's life have been abusive or traumatic. An individual who is struggling with lifestyle changes to lower her blood pressure may also need to deal with domestic violence. An older adult may require better drug management for early dementia and also work

SUMMARY

- Health coaching and psychotherapy draw from theories and methodologies in behavior change and findings in neuroscience and positive psychology.
- While many practicing psychotherapists are adding coaching skills to their practice, health coaches must be careful to avoid encroaching upon therapy, unless specifically trained in psychologically based skill sets.
- Health coaches and psychotherapists should be able to make meaningful professional connections in ways that support the colossal challenges required for mass behavior change and lifestyle improvement.

Appropriate Referrals for Therapy Instead of Coaching

Most health coaching training programs alert trainees to the historical features and surface behaviors and symptoms ("red flags") that indicate that their client's underlying condition might be in a "no entry zone" and that a psychological/psychiatric assessment may be a best next step.

If clients exhibit, complain of, or express the following issues, health coaches should state that these topics are not appropriate for coaching and recommend that the client talk with a psychotherapist. Health coaches should maintain a network of healthcare providers, including psychologists and medical doctors and have psychotherapy referrals ready for the client.

- Hostile behavior; bullying
- Excessive anger
- Reckless, impulsive behavior
- Irrational, repetitive, compulsive, or obsessive actions
- Complaints of acute lack of sleep and somatic disorders
- Unresolved, prolonged grief (varies with type of loss and individuals)
- Unexplained absences; work becomes unmanageable; mounting absenteeism
- Unrelenting anger or resentment
- Signs of paranoia
- Signs of chronic anxiety
- Relentless fatigue
- Suicide ideation; any talk of suicide or self-harm
- Talk about harming others
- Problematic substance use or substance abuse
- Addiction
- Intrusive unpleasant thoughts, ruminative thinking
- Eating disorders (bulimia, anorexia, disordered eating, body dysmorphia)
- Depression; loss of experiencing any pleasure in life
- Neurotic tendencies
- Psychosis such as schizophrenia (departures from reality)
- Personality disorders
- Bipolar tendencies (manic to depressive states)
- Acts of violence, verbal or nonverbal, physical, domestic, to self or others
- Inability to reflect or gain insight into their own behavior; consistently blaming or shaming others
- Consistent lying, dishonesty
- Sexually inappropriate behavior; continuing sexual innuendo despite requests to stop
- Projections: one after another (We all project sometimes; relentless projection is a problem to be handled in therapy.)

with a health coach to end her social isolation.

In each of these cases, the optimal approach is an integrated one, a partnership between health coaches and psychotherapists who know and value coaching models.

REFERENCES

1. Wolever RQ, Eisenberg DM. What is health coaching anyway? Arch Intern Med. 2011;171(22):2017-8.
2. National Consortium for Credentialing Health & Wellness Coaches. http://www.ncchwc.org. Accessed June 19, 2013.
3. Hess D, Dossey, BM, Southard MB, Luck S, Schaub BG, Bark L. The art and science of nurse coaching: the provider's guide to coaching scope and competencies. Silver Spring, MD: American Nurses Association; 2013.
4. Biswas-Diener R. Personal coaching as a positive intervention. J Clin Psych. 2009;65(5):544-53.
5. Seligman M, Steen TA, Park N, Peterson C. Positive psychology progress: empirical validation of interventions. Am Psychol. 2005:60(5):410-21.
6. Fredrickson BL, Losado M. Positive affect and the complex dynamics of human flourishing. Am Psychol. 2005;60(7):678-86.
7. Williams P, Davis D. Therapist as life coach: transforming your practice. New York, NY: WW Norton; 2002.
8. Miller, WR, Rollnick S. Motivational interviewing: Preparing people for change. New York, NY: Guilford Press; 2002.
9. Seligman M, Csikszentmihalyi M. Positive psychology: An introduction. Am Psychol. 2000;55(1):5-14.
10. Bader M. Published blog in Psych Today. http://www.psychologytoday.com/experts/michael-bader-dmh. Accessed June 19, 2013.
11. Kauffman C. Pulling it all together: developing and organizing positive psychology interventions. Fourth Annual International Summit of Positive Psychology, Washington, DC; 2005.
12. Livingstone JB, Gaffney J. IFS and health coaching: A new model of behavior change and medical decision making. In: Internal family systems: new dimensions. Sweezy M, Ziskind E, editors. London: Routledge Publications; 2013. [Author: Please provide the page numbers of this chapter.]
13. Miller WR, Rollnick S. Motivational interviewing: preparing people for change. New York: Guilford Press; 2002.
14. Williams P, Menendez D. Becoming a professional life coach. New York, NY: WW Norton; 2007.
15. Cavanaugh M. Coaching from a systemic perspective: A complex adaptive conversation. In: Evidence-based coaching handbook: putting best practices to work for your clients. Hoboken, NJ: John Wiley & Sons; 2007:313-54.
16. Jordan M. Integrative wellness coaching: the art and science of facilitating lifestyle change. San Francisco, CA: CIIS Course publications/IW Coaching Course Manual; IHL 6060; 2012.
17. International Coach Federation. Code of core competencies. http://www.coachfederation.org/ethics/n.d. Accessed June 19, 2013.
18. Jackson E, Moore M, Tschannen-Moran B, Compton J. Generative moments in coaching. In: Moore M, Tchannen-Moran B. Coaching psychology manual. Philadelphia, PA: Wolters Kluwer/Lippincott; 2010:120-31.
19. Dolan-Del Vecchio K, Lockard J. Resistance to colonialism as the heart of family therapy practice. J Fem Fam Ther. 2004;16(2):43-66.
20. Reblin M, Uchino BN. Social and emotional support and its implications for health. Curr Opin Psychiatry. 2008;21(2):201-5.
21. Lambert MJ, Okiishi J. The effects of the individual psychotherapist and implications for future research. Clin Psychol Sci Practice. 2006;4(1):66-76.
22. Hubble M, Duncan B, Miller S. The heart & soul of change: delivering what works in therapy. Washington, DC: American Psychological Association; 1999.
23. Luborsky A, McLellan A, Woody G, Thompson L, Gallagher D, Zitrin C. Meta-analysis of therapist effects in psychotherapy outcome studies. Psychol Res. 1991;1(2):81-91.