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Life Coaching and Therapy: Possibilities in Dual Practice

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Life Coaching and Therapy: Possibilities in Dual Practice

by

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month timeframe to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

As life coaching grows in popularity, questions arise about its role in relation to therapy. Existing literature has explored theoretical similarities and differences between coaching and therapy and the potential benefits and drawbacks of separating and integrating the two. The current study sought to expand the limited base of literature on professionals' real-life experience in dual practice. Qualitative and exploratory in nature, the study involved semi-structured interviews with seven dual practicing professionals. Findings include perceived financial and emotional benefits of practicing coaching and therapy, practitioners' tendency to integrate rather than separate the two modalities, and participant concerns about the threat of untrained coaches, the hassles of health insurance, and unequal client access to services due to stigma and cost. Implications of this study include a need for educating the public on the realities of coaching and therapy, the potential adoption of more modern, less stigmatizing language to describe therapy and mental health, and changes to the healthcare system to promote proactive, accessible, and culturally-sensitive measures of early interventions to decrease the severity and costs associated with serious mental and physical health concerns that have become so common in our society.

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Introduction

As two similar client-helping modalities, life coaching and psychotherapy both involve a one-on-one relationship between client and practitioner. Both serve to support clients, raise client awareness, and create positive changes in clients' thoughts and behaviors (Hart, Blattner, & Leipsic, 2001; Davison & Gasiorowski; Williams, 2002). Both modalities require practitioner empathy toward clients, deep listening skills, and intentional questioning, all within a safe and trusting professional relationship (Bluckert, 2015; "Coaching versus therapy," 2006; Vallianatos, 2001). Both practices also include various specialties and niches that cater to particular client populations and issues, such as grief issues, couples counseling, cognitive-behavioral therapy, and trauma-focused therapies and executive coaching, relationship coaching, parent coaching, addiction coaching, and ADHD coaching.

Despite their similarities, many differences also exist between coaching and psychotherapy. For example, education, licensing, and supervision requirements are clear, extensive, and highly regulated in the practice of psychotherapy. Coaching, on the other hand, is an emerging and still unregulated field (George, 2013). While various education and certification programs exist, no state laws exist to mandate licensure or enforce codes of ethics. Individuals with any background or education level can claim to be a coach (George, 2013; Hart, Blattner, & Leipsic, 2001; Williams, 2002). The nature of the client-practitioner relationship, professional boundaries, confidentiality, and practitioner self-disclosure also vary greatly

between coaching and therapy. Psychotherapy's focus on mental health diagnoses, exploring the past, and healing emotional pain sets it apart from coaching's focus on articulating client goals and creating action steps toward change (Berglas, 2002; Caspi, 2005).

Authors in coaching and business journals suggest that coaching and psychotherapy are separate and distinct practices (Bluckert, 2005; Compone, 2014; Williams, 2002). To avoid potential ethical issues, some argue the practices should not be combined (Berglas, 2002; Reamer, 2008). Authors in the social sciences, on the other hand, argue that therapists' extensive training, supervision, and experience working with diverse client issues makes them well positioned to also act as coaches (Davison & Gasiorowski, 2006; Robb, 2010). Adding coaching to psychotherapy practice, they argue, allows practitioners to reap the benefits of increased profits, an expanded client base, and the morale-boosting satisfaction of guiding motivated clients to rapid achievement of their goals (Vallianatos, 2001; Williams, 2003).

While providing potential benefits to professionals, a separated approach to dual practice may serve to perpetuate stigma and undermine the strengths of some clients. Helping "healthy" and "higher functioning" clients reach their goals and full potential for success, life coaches often refer "lower functioning" and "pathological" clients to therapy (Bluckert, 2005; Hart, Blattner, & Leipsic, 2001). The traditional view of therapy—involving expert practitioners working to "fix" "damaged" clients—involves stigma and conjures images of personal weakness and dysfunction. In turn, this deters many individuals for whom therapy could be

beneficial (Chance, 2015; McKelley & Rochlen, 2007). To combat stigma and move toward a more integrated and inclusive practice, some mental health professionals have begun coaching with certain therapy-resistant groups and even those facing more traditionally therapeutic concerns like addiction and certain mental health conditions (Allen & Huff, 2014; Bora, Leaning, Moores, & Roberts, 2010; Shafer, Kiebzak & Dwoskin, 2003).

This research study focused on the perspectives of professionals practicing both life coaching and therapy. It explored their views on the similarities, differences, and overlaps between their coaching and therapy work with clients and their opinions on a separated or integrated approaches to dual practice. Issues of ethics, cost, and future directions in dual practice were also explored. The following pages include a literature review, conceptual framework, and a methods section that details the study's data collection and analysis procedures. A findings and discussion section detail major themes emerging from the study, implications for social work policy, practice, and research, and strengths and limitations of the study.

Literature Review

Therapy

History. Psychotherapy is defined as “the treatment of emotional or physical ills by psychological means” (Cautin, 2011). Born out of the moral treatment and mental hygiene movements of the early nineteenth hundreds, psychotherapy began as an alternative to harsh and inhumane treatments and physical punishments previously used to combat “deviant” behavior. Popularly associated with Sigmund Freud’s use of in-depth psychoanalysis and the assignment of often- sexualized meanings to client behavior, psychotherapy has evolved over time. Behaviorism, established by J.B. Watson, focused on modifying behavior through laboratory-tested conditioning. Carl Rogers’ client-centered therapy, on the other hand, emphasized the importance of the relationship between client and practitioner as foundations for positive client change. The Child Guidance Movement established interdisciplinary teams working together to collect client case histories, perform psychological testing and diagnosis, and provide psychotherapy (Cautin, 2011).

In recent decades, psychotherapy has become more diverse, inclusive, and integrated into the physical healthcare system. The notion of mental health parity advocates for equal treatment and funding of both mental and physical concerns. Continued de-stigmatization efforts attempt to normalize rather than ostracize individuals experiencing anxiety, depression, and other mental health conditions. Campaigns like “Make it OK” advocate for ending the silence and denial surrounding mental health. The view of a mental health as a spectrum and as part of a person’s

overall well-being has begun to replace the previous dichotomy of mental health or illness. No longer the predominant focus of psychiatrists, psychotherapy is now performed by a variety of mental health practitioners in a variety of settings (DeLeon, Kenkel, Garcia-Shelton, & Vandenbos, 2011). Alternative therapies—such as acupuncture, Ayurveda, nutrition, exercise, yoga, meditation, and spirituality—are also being employed more frequently in conjunction with psychotherapy (Emmons, 2006; Wang, Bai-song, Cui, Zhu, Rong, & Chen, 2008).

Regulation. Professionals that provide psychotherapy include licensed clinical social workers, psychologists, marriage and family therapists, licensed professional counselors, some psychiatrists, and psychiatric nurses (DeLeon et al., 2011). State boards regulate each of these professions and their educational requirements. Typical requirements include a master's degree in the particular discipline, the passing of a licensure test, and a certain number of supervised client practice hours. All licensed mental health professions have license requirements that include periodic recertification and yearly continuing education requirements. All licensed mental health professionals must follow an established code of ethics or face potential licensing sanctions, suspension, or revocation.

Practice. Psychotherapy sessions typically occur in a clinic, hospital, or a private practice office. Measures are taken to ensure confidentiality, including closed office doors, restrictions about discussing client information, and white noise machines near office doors. Measures are also taken to ensure the confidentiality of documents, including locked file cabinets, password protected computer records, and HIPAA protected client information (DeLeon, et al., 2011). All mental health

practitioners are mandated reporters and have a duty to warn, meaning they must immediately report the abuse or neglect of a child or vulnerable adult and any imminent threat of bodily harm to a client or by a client.

Psychotherapy services are often covered by insurance and require a mental health diagnosis for insurance reimbursement to the practitioner. Some practitioners choose not to work with insurance companies and instead charge on a fee-for-service basis. Many therapists offer a sliding fee, which allows clients of limited means to pay a lower rate. While office visits are the norm for psychotherapy, advances in technology are allowing practitioners to deliver services via telephone and Internet video (CITE). Ethical challenges exist in providing services remotely via technology. State-to-state licensing issues can occur when a therapist and client reside in separate states. There are also confidentiality concerns with transmitting sensitive personal information via text, email, and Internet video (Reamer, 2013).

Client relationship. The relationship between client and practitioner in therapy is professional in nature (Bluckert, 2015). Care is taken to attend to transference and countertransference, in which a client or practitioner may be responding and behaving in certain ways due to feelings or thoughts brought on by the particular topic or situation that arises. Self-disclosure by the practitioner is kept to a minimum in order to maintain a focus on the client's experience. According to the National Association of Social Workers Code of Ethics, dual relationships with clients are discouraged (2008). NASW code and state laws also prohibit sexual relationships between therapists and clients.

Life Coaching

History. Life coaching has its roots in humanistic psychology, the human potential movement of the 1960's, executive coaching, and cognitive behavioral psychology (Hart, Blattner, & Leipsic; Williams, 2002). As a newer field of practice, coaching lacks the professionalization and evidence-based effectiveness research that exists on psychotherapy. However, its popularity has increased over the past decades (George, 2013). Whether seen as a separate field of practice or a new specialty within therapy, its increasing popularity make it an area of interest for many practitioners (Caspi, J.; Shafer, Kiebzak, & Dwoskin, 2003).

Regulation. Currently, coaching is an unregulated field with no state licensing requirements (George, 2013). There are no mandated education or training requirements to become a coach. The International Coaching Federation (ICF), established in 1992, has created education and licensing standards, a code of ethics, and recommendations for supervision and continuing education for its members. However, law does not mandate these standards and only coaches certified by the ICF are required to adhere to them.

With several hundred ICF-certified coach training programs nationwide, and many more non-ICF-affiliated programs, would-be coaches are advised to do their research and make informed choices when deciding on certification. While some practicing coaches view mandatory regulation as limiting and unnecessary, others view them as a vital for the professionalization of the coaching field and for the protection of practitioners and clients (George, 2013; Caspi, 2005).

Practice. Life coaching may take place face-to-face, on the phone, via Internet video, and even through email and text message. While coaches may have an office, face-to-face coaching sessions may also take place at mutually convenient and locations such as a client's workplace, a restaurant, or a coffee shop. Because of its unregulated nature, no confidentiality laws exist to protect coaching client information. While the ICF Code of Ethics does suggest that coaches "maintain the strictest levels of confidentiality" with client information, the informal, public, and online settings in which coaching occur could jeopardize client privacy. Life coaching is not covered by insurance and clients may pay up to \$100, \$200 or more per session (George, 2013; Hart, Blattner, & Leipsic, 2001).

While little empirical evidence exists on the effectiveness of coaching, a handful of studies have shown improvements in physical and mental health, goal striving, hope, and wellbeing following coaching interventions (Grant, 2003; Green, Oades, & Grant, 2006; Spence & Grant, 2007; Butterworth, Linden, McClay, & Leo, 2006).

Client relationship. Due to its unregulated nature, no consensus exists in coaching on issues of confidentiality, dual client relationships, or self-disclosure in practice. However, existing coaching literature suggests that these issues are approached much less formally than in therapy (Caspi, 2015). Coaches are often invited to personal celebrations and events of their clients, and run-ins with clients are welcomed, both by clients and coaches (Robb, 2010). The length of coaching sessions may vary, cash payments are often made upfront, and coaching relationships may last from a few days to several months (Bluckert, 2005).

Similarities and Differences

Coaching and therapy are similar in several ways. Both involve the establishing of a trusting one-on-one relationship for the purpose of positive client change (Williams, 2002) Both also involve practitioner skills of empathy, deep listening, and powerful questioning (Bluckert, 2005). Both can involve processes of raising client awareness and modifying problematic thoughts, emotions, and behaviors (Caspi, 2005). Both fields also prohibit practitioners from engaging in sexual relationships with their clients.

In coaching literature, much attention is given to the ways that therapy and life coaching are different. This may be part of coaches' attempt at setting themselves part from other practitioners, protecting their client domain, and gaining elevated professional status (George, 2013). The classic differences between coaching and therapy that are cited in coaching literature are shown in Table 1. Frequently cited are those of past versus future focus, the diagnosis of pathology in therapy and focus on strengths in coaching, and the less formal nature of coaching versus therapy.

Another difference between the two fields—and one that is frequently cited in the social sciences as a problematic aspect of coaching—is that of regulation. Psychotherapists require a master's degree, the passing of a state-regulated licensing exam, completion of a several hundred hours of supervised client practice, and continued education. To practice as a coach, on the other hand, no formal training, education, licensing, or supervision is required (George, 2013). While the

coaching field continues to evolve and training and accreditation is common, it remains optional and unregulated.

Dual Practice

Coaching and business scholars view psychotherapy and coaching as distinct practices with unique techniques that serve separate purposes in clients' lives. They suggest that combining the two disciplines could be confusing, unethical, and potentially damaging to clients (Berglas, 2002). A coach without adequate mental health training, for example, could miss an underlying mental health condition and unknowingly engage in coaching practices that may worsen client symptoms.

Alternatively, a therapist acting as a coach could easily slip back into the therapeutic role of attending to emotions and focusing on past pain instead of helping clients identify goals and take swift action steps toward change (Williams, 2003).

Scholars from the social sciences suggest that therapists may be perfectly suited to act as coaches (Caspi, 2005; Davidson & Gasiorowski, 2006; Vallianatos, 2001). With an extensive knowledge of mental health conditions, therapist-coaches could avoid the pitfalls of less educated coaches. Able to recognize underlying pathology and refer coaching clients to therapy when needed, therapists could expand and diversify their practice through coaching (Davidson & Gasiorowski, 2006). As required by state licensing boards, therapists uphold high levels of confidentiality and professionalism that they could bring in to their work with coaching clients (Caspi, 2005; Hart, Blattner, & Leipsic). By expanding into the area of coaching, therapists may reap the benefits of increased profits, an expanded client

base, and the increased satisfaction of helping higher-functioning, more motivated clients define and quickly reach their goals (Caspi, 2005; Vallianatos, 2001).

No empirical studies exist to compare the effectiveness of coaching and therapy. One study, authored by Hart, Blattner, and Leipsic in 2001, explored dual practitioners' perspectives on the overlap and boundaries between coaching and therapy. The study involved interviews with 30 geographically dispersed practitioners explored the differing nature of relationships with coaching and therapy clients, confidentiality in each discipline, who's "in control" in therapy and coaching, and red flags for coaching clients in need of mental health interventions. Results from the study suggest that dual practitioners maintain a set of unwritten rules, expectations, and boundaries between their two practices. Practitioners tended to view therapy clients as lower functioning, "damaged," or in crisis. Coaching clients, on the other hand, were seen as less in need of "expert" intervention and more in control of the relationship. Red flags for coaching client referral to mental health interventions included depression, paranoia, anxiety attacks, and substance abuse (Hart, Blattner, & Leipsic, 2001).

Contrary to some scholars' and dual practitioners' beliefs on maintaining clear boundaries between therapy and coaching, other scholars and mental health professionals advocate for an integrated approach to dual practice. Instead of welcoming "healthy," "normal," and "non-clinical" clients into coaching while referring "broken," "dysfunctional," and "pathological" clients to therapy, a more inclusive model of coaching and therapy would view all clients—even those facing "clinical" issues of addiction and mental health conditions—as naturally creative,

resourceful, and whole (Bora, et al., 2010; Schafer, Kiebzak, & Dwoskin, 2003). This more integrated approach views clients and practitioners as equal partners working together to define client goals and take steps toward success. It also encourages clients and practitioners to find and build on client strengths and abilities rather than focusing on eliminating troubling symptoms.

Integrating coaching and mental health services, some argue, could simultaneously act to decrease stigma and increase client access to services (Chance, 2015; McKelley & Rochlen, 2007). By embracing coaching language and techniques, therapists could empower disenfranchised clients who are traditionally funneled into therapy while also expanding their client base to include more therapy-resistant groups. Men and particularly Asian men, who have been found to seek therapy at much lower rates than other groups, often associate help-seeking with personal weakness, deficiency, and dependence (Chance, 2015). Life coaching's collaborative, client-led, strengths- and success-focused skill-building process of setting goals and attaining control over one's life may prove a better fit with the rules of masculinity and cultural roles of men in Asian culture. Therefore, it is proposed, if marketed and practiced effectively, coaching could become a viable alternative, supplement, or introduction to therapy for these and other therapy-resistant groups (McKelley & Rochlen, 2007).

The current study set out to expand the limited existing knowledge on the dual practice of psychotherapy and life coaching. Specifically, the study explored the extent to which dual practitioners integrate or separate their coaching and therapy

practices. Ethical considerations in dual practice as well as client demographics, cost of service, access issues, and stigma were also explored.

Conceptual Framework

Strengths Perspective

The strengths perspective is a theory and practice centered on finding and utilizing client strengths and abilities to set and attain meaningful client goals. Considered an alternative to the traditional medical model, the strengths perspective views all clients as human beings possessing hopes, dreams, talents, and strengths, just like anyone else in the world. Instead of focusing on dysfunction, pathology, and limitations, the strengths perspective focuses on client potential and possibilities. The practitioner's job is to help clients to recognize their strengths and set small, meaningful, attainable goals. As small goals are attained, clients attain a greater sense of confidence and control in their lives. (Gray, Midgley, & Webb, 2012). The strengths perspective will be utilized throughout the proposed research study.

Methods

Research Design

The current study was qualitative and exploratory in nature. It utilized semi-structured interviews to gather a variety of information from study participants. This design was chosen in order to elicit rich and detailed narratives from participants as opposed to the more basic information collected through quantitative and more structured methods. The dual practice of life coaching and therapy has not been extensively studied. Therefore, a qualitative approach allowed participants the freedom to tell their story and enlighten the researcher to ideas not possible to discover through a more rigid research design.

Sample

Seven participants were selected based on the following target population criteria: healthy adults over the age of 18 with life coaching experience and a license to practice psychotherapy in the state of Minnesota. Four participants had been in practice for over 20 years. The remaining three had been in practice for between two and seven years (see Table 2). Three participants held licenses in clinical social work (LCSW), two held a marriage and family therapy licensure (LMFT), one was a licensed psychologist (LP), and one was a licensed professional counseling (LPC). Three participants—both of the LMFT participants and one LCSW participant—had undergone formal coaching education. The remaining four had not.

All participants worked in private practice. Two participants worked full time in private practice, while the other five worked part time in private practice and part time in a different role. Two of these participants provided part-time

contract coaching services to private companies, one provided intake services at a community mental health clinic, another was a member of the performing arts community, and one held a part-time accounting job. Four participants had offices in western suburbs of Minneapolis. Three had offices in the central Twin Cities area. One participant self-identified primarily as a coach, one identified as both a therapist and a coach, one identified as something broader than just a coach or a therapist and four identified as primarily therapists.

Protection of Human Subjects

Several steps were taken to protect human subjects in process of this research study. In addition to the steps outlined below, the researcher received approval to conduct the study from the St. Catherine University Institutional Review Board (IRB).

Recruitment of subjects. Subjects were recruited through convenience sampling techniques. The researcher conducted Google searches using the terms “life coach,” “life coaching,” “therapy,” “therapist,” “Minneapolis,” “Saint Paul,” “Twin Cities,” and “Minnesota.” Subjects were selected based on their current Minnesota licensure to practice psychotherapy and their advertised self-identification as a life coach. A total of 20 potential study participants were contacted through phone or email to inquire about their ability and willingness to participate in the study (see Appendices A and B). Of the twenty individuals contacted, six failed to respond to two attempts to make contact, seven declined to participate, and seven individuals agreed to participate in the research study. While potential participants were asked to provide the researcher’s information to other dual practitioners who may have

been qualified and interested in participating in the study, no additional research participants were gathered using the snowball sampling technique.

Informed consent. Upon meeting with the researcher, study participants received an informed consent agreement to read and review prior to the interview (see Appendix C). The agreement included contact information for the researcher, the Institutional Review Board, and the research committee chair. It also discussed the voluntary nature of the study and procedures for voluntarily withdrawing from the study at any time. It stated expectations of the participant, including their agreement to participate in an audio-recorded interview that would be destroyed at a later, designated date. Participants were given the chance to ask questions of the researcher before signing the agreement. The researcher maintained the signed copy of the agreement and participants retained an unsigned copy for their reference.

Confidentiality. Several measures were taken to preserve the confidentiality of research participants. The interviews all occurred in private locations, including the participants' home, private office, or a private meeting room at a local library. Participants' names were listed only on consent forms, which were kept in a locked file in the researcher's home office. Names were omitted from recorded interviews and interview transcripts.

Data Collection

Process. Following initial contact with study participants and their email or verbal agreement by to partake, the researcher scheduled an in-person meeting to review the informed consent agreement and conduct the interview. Upon meeting

with study participants, the researcher thanked participants for attending and presented the compensation of a five-dollar coffee shop gift card. Next, the researcher described the study's purpose and the voluntary nature of participation (see Appendix D). The researcher provided the participant with a copy of the informed consent form and allowed time to read and review it. The participant was then given time to ask questions about the consent form, the interview process, and the overall study. Once the consent form was read and all questions were answered, participants agreed to the interview and signed the consent form. The researcher then turned on the audio recording device and the interview began. Once all information was gathered, the audio recording device was turned off. Participants were again thanked for their participation and told they could receive a copy of the researcher's final project once completed. After the interviews, the audio recordings were transcribed to typed electronic form.

Instrument. A set of ten primary interview questions and five follow-up questions was used as a guide to gather information from study participants (see Appendix E). The first two primary questions served to gather basic information on participants' education, professional background, practice specialties, and primary identification as therapist or life coach. Answers to these questions helped inform the researcher's understanding of participants' answers to subsequent questions.

Some coaching literature argues that ethical issues require clear boundaries between coaching and therapy practice (Bluckert, 2005; Williams, 2002). A study of 30 dual practitioners revealed that practice separation is common and that practitioners view and relate differently with clients in therapy and coaching (Hart,

Blattner, & Leipsic, 2001). Other research discusses the inclusive, empowering, and de-stigmatizing potential of embracing a more integrated approach to dual practice. Family coaching, addictions coaching, and coaching for mental health recovery illustrate this ideological shift toward using coaching with more traditionally “clinical” issues and client populations (Allen & Huff, 2014; Bora, et al., 2010; Shafer, Kiebzak, & Dwoskin, 2003). Interview question three sought to reveal the extent to which participants embrace a separate or integrated model of practice. Questions four and five explored practitioners’ view and treatment of coaching and therapy clients and their issues.

Some research suggests that coaching may be a preferred modality for individuals resistant to therapy due to stigma and cultural factors (Chance, 2015; McKelley & Rochlen, 2007). Other research suggests that life coaching—while potentially desirable to individuals of a lower socioeconomic status—may prove inaccessible due to cost (George, 2013). To explore these issues, questions seven through ten inquired about per-session costs, client demographics, ethical issues in dual practice, and practitioner opinions on using coaching with therapy-averse clients and those with more traditionally clinical concerns.

Data Analysis

A grounded-theory approach to data analysis was used (Belgrave, 2014). Transcribed interviews were read line-by-line and a process of open coding identified prominent ideas, or codes. Following the identification of codes in interview transcripts, a process of focused coding began. At this point, transcripts

were re-read and codes were refined or eliminated based on the frequency of their repetition. Similar codes were then grouped and assigned to larger themes.

Results

Four main themes emerged from the analysis of participant interviews. These include the draws of coaching, benefits of integrated practice, problems in dual practice, and future solutions.

The Draws of Coaching

Participants described several benefits of being therapists who also practice coaching. Many of these benefits related specifically to the expanded clientele attracted to coaching.

More clients, less stigma. One practitioner explained that life coach is a “very disarming title.” She argued, “there’s less stigma, it’s cool, and it’s as if its educational, which is what I think therapy is. It’s a user-friendly term.” She did not separate her life coaching and therapy practice, but instead added the term “life coach” to her title to soften the stigma and appeal to a broader audience. Another practitioner explained about coaching, “there is definitely less stigma. Even if I do identical things. And sometimes I do.”

A third participant viewed coaching and therapy as two different areas of practice. Therapy, he believed, was for individuals with extreme suffering and the long-term need for regular in-person sessions with a trained professional. “Looking at the general population,” he said, “it’s really a small subset that really truly needs therapy.” Getting to therapy, however, takes an immense amount of effort.

Most people aren’t really motivated to go to therapy unless they’re suffering.

Pretty much, I'm not gonna go to all that hassle and work through any stigma—even though it's way less than ever—I'm probably not gonna go to therapy unless something's kinda wrong.

Coaching, he believes, fills a need and appeals to a group of people who may not be seeking therapy but who could benefit from a little help.

There's a lot of people that don't need that but they could benefit from somebody that really understands them and hears their goals and their determinations in life and can really give them a little push.

Engaging in coaching in addition to therapy allows him to “not be pigeon holed and limited.” To him, coaching is about “what does the world need now? I think more and more it's about where people are now, it is broader. Coaching appeals to a lot more people and it's more appropriate for their needs.”

More money, less hassle. Many participants described the financial benefits cash-only coaching clients. One practitioner—who had been leaning more toward coaching in recent years—explained, “A lot of my clients are out of pocket these days, which is great. I really love that.” Of receiving insurance reimbursements for therapy he said,

Not only was I not getting paid well, there was a huge hassle and delay with getting paid. So I would spend a lot of time on the phone or filling out paperwork to get maybe 50, maybe 60 percent of what I was worth.

Another echoed this statement saying,

I never know how much I'm getting paid for a therapy session. With life coaching you don't have to go through insurance billing, documentation.

Documentation and insurance companies have become unbearable. It has just become ridiculous. It's not quite as bad in private practice, but for agencies, its people spend at least as much time documenting as seeing people and they don't get paid for it. It's become unreasonable.

Another participant commented, "Occasionally, I will have the privilege of working with a client who is, the corporation is paying the bill. You get to charge a bit more, up to \$300 per session."

Healthier, more educated clients. In addition to increased profits and decreased insurance hassle, all participants reported having higher functioning clients in dual practice. "People who come into private practice setting," one participant suggested, "oftentimes are a little bit healthier, perhaps, have a little more means, perhaps." Others described their clients as educated and primarily white. One said her clients were "95 percent Caucasian, very high functioning people who live a pretty good life." Another referred to both her therapy and coaching clients as "educated, for sure middle to upper middle class, so pretty smart, fair amount of insight." One explained, "I would say that the people I see are more resilient. So they might have experienced horrendous things but they seem to have more resiliency than other people that I've seen in the past."

Decreased emotional burden. In addition to working with higher paying and higher functioning private practice therapy clients, seeing clients in just a coaching capacity appeared to pose less of an emotional burden for participants. Referring to the transference that often occurs in therapy, one participant said,

Often, that work isn't the fun work of therapy. Usually I'm getting attacked. The person thinks I'm awful. And again, I'm really super sensitive, really sensitive. So that's really hard work for me. For me I experience it as a bombardment, an attack. It triggers me into trauma, you know, "oh my God." So that's another reason that coaching's pretty appealing. I'm not expected to deal with that.

Another therapist who also does coaching explained, "For me, there's a lot more intensity doing therapy work. You're typically looking at a longer amount of time. There's more emotional stuff going on."

Engaging in coaching seemed to offer participants a way to help others without the drain and overwhelm they experienced at past jobs in agency settings. Most participants lamented the demands at past jobs in agency and clinical settings. One participant explained of his time at the VA,

About eight years in, I started feeling a little restless, started getting a little bored with the clientele. There's a lot of chronically mentally ill people there. It started feeling repetitive and a little monotonous.

Another participant described her past work in a clinical setting,

It was grueling. That was a system where you got a new client every day. You had to manage your caseload and you didn't have a client discharging every day. Soon your caseload was unmanageable. I was doing therapy 40 to 50 hours per week. I quickly hit a wall.

The same participant described her fifteen years as a school social worker,

The focus was on special ed. students. All three districts were underfunded. There were needs among general education students. We still attempted to meet needs among general education students. While a big job to work with all students, that was still doable with extra hours. What I found difficult was working with a very inflexible system and difficult administrators.

To many participants, operating in private, dual practice allowed them the flexibility to work with a broader range of clients in more flexible ways.

Leaning toward Integration

Separated Practice. Of seven interviewed participants, only one claimed to maintain very clear distinctions between her coaching and therapy practice. To her, coaching and therapy “are two very different roles. When I’m coaching, there’s just a definite bent to how I’m doing it different. And I’m very clear, in my head and with people when I’m doing therapy and when I’m doing coaching.” Additionally, “The difference with coaching is you’re not going into why a person developed patterns or what their family of origin might have contributed to those patterns developing.” Her role as a coach is “clearly delineated by the company” where she works doing contract work on a stress management program for employees.

In her private practice, she decides between coaching and therapy using input from her clients and her own professional judgment. She explained,

To a certain extent is client directed, so it’s what they prefer. Some people don’t want to use insurance, don’t want to be diagnosed with anything, that type of situation, so they self-identify “I want career coaching” or “I want life-balance [coaching].”

If clients present a higher level of distress, she is clear with her clients when therapy would be more appropriate.

I will say at the beginning, coaching isn't appropriate if I see there's a higher level—and frankly that's an ethical issue—if I see depression. Most people are amenable to what I say at the end, what my professional recommendation is.

Certain red flags alert her to a client's need for assistance that reaches beyond the scope of coaching practice.

When somebody isn't able to set goals, when they're not able to focus, when they appear very stuck,...if you can tell that there's a significant level of distress that's affecting their ability to develop insight, to develop steps, to process information.

Integrated practice. In contrast to a separated approach to coaching and therapy, three participants chose to fully integrate coaching and therapy in their practice. While their motivations for doing so, and their approaches to their work differ some, they all found it beneficial, both to their clients and to themselves as practitioners, to integrate rather than separate their coaching and therapy practices.

One participant described her use of therapy and coaching with clients by saying,

Right now I don't separate them at all. What I learned when I tried to establish a separate coaching practice is that it takes a lot of time and energy. I've always had three jobs. I just never felt like I had the time and energy to devote to marketing a sole life coaching practice. I did a little bit of that and

realized it didn't make sense to add a fourth job. So I found a way to integrate those skills into what I was doing. And what I found was that it enhanced my practice and enhanced the progress my clients were making.

Speaking to the way she integrates coaching and therapy, she explained,

Coaching, as a rule, has the philosophy that there's no reason to go back. And I don't fully subscribe to that. I think there usually is a reason to go back and rewrite what isn't right and to grieve things that need to be grieved, to acknowledge hurts and to process them, and then to move on. I think when we try to move on from before we've dealt with that part of it we're not really able to move on. I view it like a water pipe full of hair and gunk and grease and you're still trying to run water through and you're not able to until you get rid of the clog. And I think our past, when it's not dealt with, made conscious, enlightened, felt, processed, is that clogged pipe. That has to be cleared and then we can let the light shine, have the energy, insight, healing, to be in the present and move on. That's what coaching is about is being in the present and moving forward and that's where those skills are so powerful and helpful.

Discussing the ways that coaching enhances her therapy practice, she said,

Oftentimes when you are doing therapy with someone, they can't see the forest for the trees. Even using some coaching tools like future self or visualizing the future, their ideal life, can get them out of that stuckness to a place where, what would it be like if you didn't feel this way, if you weren't reenacting this, if you weren't stuck? So it starts to give them a sense that,

hmm, maybe it could be different. Without the ability to imagine that, for someone who is really stuck, there wouldn't be movement.

Another participant, who identified more as a coach than a therapist, explained, "I've done a lot of studying of solution-focused therapy...When that's done in its purest form, it looks exactly like coaching. It is coaching. So I think it's hard to separate it." She also said, "I feel like I almost do the same thing no matter what people are calling it." When clients "are using their insurance, I have to call it therapy. I'm still doing the same thing." During a one-hour session, she explained, "I'm probably [gesturing taking off and putting on hats] 'therapy hat, coaching hat.' There are times that I give advice as a coach. And there are other times when I am really digging for their wisdom. I have two hats."

A third participant identified herself a therapist who had recently added the term 'life coach' to her title. She explained,

What I think about the difference, therapist do life coach stuff and we have for 1000 years. Do you think that when I meet people I don't figure out what level of help they need and if they need the more simplistic stuff of life coaching that I don't offer that? Of course I do! We do life coach [expletive].

We've been doing it for decades. And then we do whatever else you need. We do the whole package.

She went on to say, "I think a therapist has 25 layers at least and one of them is the services provided by a life coach." When asked whether she had any specific training or certification in life coaching, she replied, "Hell no. I'm not going to do that. I already have ten times more, why would I ever do that?" Asked of any aspects of life

coaching she believed sets it apart from therapy she replied, "Not much. I don't put a lot of credibility in the techniques they use in life coaching." To her, therapy encompasses life coaching, while also offering trained expertise to deal with everything underneath. She believes that

Life coaching is more the presenting problem that people will come in seeking coaching for. For example, they've been looking for a job and just haven't been organized in their attempt; they're kind of spinning about. Or people have kind of a hoarding tendency, they're trying to juggle should they sell their house, should they move to a condo, they don't know how to make the next transition. They might be debating whether the relationship they're in is healthy or not. It's more like a little task they're unable to achieve at this point.

However, she added, "I think that when people have those seemingly simple presenting problems, are they ever really that simple of a presenting problem?" She went on to say, "It's all those layers. It's always layers and layers. Whatever you come in and talk about, it's not what you really need to talk about. It's always something deeper. It's everything underneath."

Blended practice. In addition to the one practitioner who clearly separated coaching and therapy and the three practitioners who fully integrated the two modalities, three remaining participants explained that while coaching and therapy can sometimes be separate, the two modalities sometimes blend into each other.

One such practitioner stated that, "I have a separate place I keep my coaching stuff. You know, it's sort of, in that sense, symbolically very separate" and "in a

practical sense they're very separate in that I do most of my coaching sessions by phone in my home," while "therapy is done in person." The lines can blur, however. He has, for example, "done Skype sessions in therapy." Asked to explain how he separates coaching and therapy in practice, he replied, "it's tricky because there's so much overlap and they both so inform the other." He went on to say, "it can't not be integrated," explaining,

It's just who I am now. How do I separate myself as a person out on the street from myself in the consulting office? It's just me both places. They inform each other. It's kind of the same with coaching and therapy.

Another participant described his challenges in defining his work with clients. "Some of it is probably just terminology. Some people are more comfortable with the idea of coaching than they are with therapy." He continued,

If the marriage is on the rocks and falling apart, it's probably more therapy. If it's about marriage enhancement, marriage enrichment, we're happy, been together a long time, but want to find what's next and what's meaningful, that's more of a coaching thing.

However, he admits, things aren't always that clear-cut.

I've had some referrals for leadership coaching, for example. And their agenda, it can be different things. Some of it can be wanting to figure out how to advance their careers and get to that next level. A lot of times they're also struggling with something. Something isn't working in their career; they have a difficult relationship with their boss. It always ends up with some kind of

overlap it seems. Sometimes they come in for therapy issues and it evolves into a coaching framework.

When asked whether the nature of the relationships he has with therapy clients in any way differs from the nature of relationship with coaching clients, he replied,

In theory, yes. In practice, I have to think about that. I would say, in theory, and probably in practice too, in therapy it becomes more personal, talking about their family of origin, their deeper emotional stuff, their relationships and all that. If it's a coaching focus, we typically don't go into that deeper stuff. We talk about their context, who's in their life, they're married, how are things going. Rarely we'll explore those deeper things. However, there is a place for talking about their life story.

Describing ethical issues he'd faced in dual practice he explained,

Perhaps the one gray area is around who's paying the bill. So they might start off where their insurance is paying the bill and it transitions into just coaching issues. Is it ok for the insurance company to still pay the bill for that?...But again, I think, if you're starting off, somebody's kind of anxious, then get pretty stable and then we start talking about and working on career issues, a little gray sometimes. You know, are we still working on your anxiety or have we transitioned over? The simplest thing to do is keep billing the way you are. Potentially unethical question or concern, I guess.

A final participant explained how her developing approach as a therapist made it difficult to maintain a separate coaching and therapy practice.

I find it hard to keep them separate. It's difficult. It's just hard to keep them separate. Because I'm such a therapist or counselor by nature, it's tough for me to—with clients who want coaching, it's hard for me to not want to do therapy. Because of that, actually, I've been sort of spending time recently thinking about eliminating coaching altogether. Because more often than not, the people who come to me, the issues they're presenting, it's just so clear to me that they're actually needing therapy.

To her, "it's much more productive to do the therapeutic relationship." She explained, "you're doing therapy to bring their functioning to a healthy level. And with that, you're able to make progress on these maybe specific pointed goals." In her view,

People who seek coaching are looking to have their needs met from external sources. They're more focused on what's happening in my life, how can I change this [pointing to space outside of her body] and in counseling it's how can I change this [pointing toward the body]. The orientation is different.

"My focus as a practitioner," she explained, "is to help people get more to the root of what their struggles are and that requires more than coaching." She argued that "in coaching, you're just not getting that deep into the person, their pattern, their family patterns, their own dysfunctions." Therefore, client changes made in coaching "might be good but they also might be very shallow. That's not to say that shallow is bad. But they're probably going to run into the same issue again down the road." She added, "do I think that [coaching] is going to lead to the most helpful change that needs to be made for long-term satisfaction in one's life and having a positive impact

on their children and a multigenerational impact? No. Because it's not changing dysfunctional real interpersonal patterns that are intergenerational."

Problems in Dual Practice

In addition to the multi-faceted dilemma of deciding between a separated, integrated, or blended approach to dual practice, study participants identified the following problem areas in dual practice: stigma, unequal access to services, and the dangers of untrained coaches.

Stigma associated with therapy. Every study participant explicitly discussed or alluded to the stigma associated with seeking therapy. Several practitioners described certain clients' desire to keep their information off the record. One clarified,

Some people come to me and just want to pay cash. They don't want records. So when I do life coaching the only record I have is financial. I don't have to do any case notes. And so there's obviously the advantage to have someone come in and they know that I'm a therapist but they aren't going to have a record of what we talked about or anything. So I think that's appealing to some people. Just to be able to call it life coaching. Some people find that title more palatable. That there's no stigma attached.

Another participant echoed this sentiment, explaining that in her previous coaching practice she "had a couple of people who wanted nothing to do with having a mental health condition. Not that they couldn't have had one, but they wanted nothing to do with that." Another stated, "not everybody wants to have stuff on their insurance health record." He then said,

If I'm treating somebody for depression, for example, it becomes part of their general health record. So, in theory, that's confidential. However, there could be a situation along the way where they want to sign up for life insurance and they sign a waiver and the life insurance company has a right to look at whatever they've been treated for and there it is. That might be one example. There could be divorce or custody issues that come up, similar kinds of things. So it becomes part of their healthcare records. Not my specific notes, but that they've been treated for that diagnostic code.

Misconceptions about therapy also contribute to clients' fears about seeking therapy. One participant explained,

If you haven't done anything like that in your whole life, people get really scared. What's the person gonna do to me? Literally, people ask that question. Literally. What are you going to do to me? Like I have a surgical knife, a psychological surgical knife.

Another participant said,

When I meet people and say I'm a psychologist or a therapist, they're like "whoa." They're like, "are you analyzing me?" And I'm like, "hell no, I'm just having a drink. You haven't booked a session with me, no." But people get like "whoa." So life coach is a very disarming title.

To her, the persistent "stigma from Sigmund Freud, the founding father of our field, working with people with schizophrenia and psychotic patients" leads people to believe that "in order to be in therapy you need to be profoundly [expletive]ed-up."

Unequal access to services. In addition to fear and stigma, practitioners cited cost, cultural issues, and the use of coaching as therapy by the affluent as reasons for unequal access to coaching and therapy services by some groups.

Prohibitive costs. One deterrent to seeking coaching and therapy services, said practitioners, was that of cost. Participants reported charging similar fees for both coaching and therapy with per-session costs ranging from \$70 to \$150. Of course, “coaching is not covered by insurance.” Therefore, clients must be able to pay these fees out of pocket. However, stated one participant, “the only people who can afford life coaching are those with disposable income.” Even individuals seeking therapy and using their insurance face struggles with cost.

It costs way too much money for people to afford premiums. In the richest country in the world we have so many working poor that can't afford their insurance. They're paying ridiculous premiums and have \$10,000 deductibles. They're not going to come in for help. They're gonna have to pay out of pocket. It's like they don't have insurance.

Coaching for the affluent. In addition to cost, the notion that “the affluent sometimes are more skilled at keeping things secret and hidden,” may explain one practitioner’s view that higher income, “more educated people are more familiar, more likely to have heard of coaching whereas some lower socioeconomic people have probably never even heard that term.” One practitioner explained,

I think trauma, issues of trauma, just by virtue of living in poverty, having experienced racial discrimination, living in violent neighborhoods, growing up with parents who engaged in domestic violence or substance abuse, or

who are in and out of jail, all of those demographics are the breeding ground for trauma and mental health issues....They're the ones that tend to come to the attention of law enforcement or the emergency room and the general community at large because of their need and their lack of skills and resources.

These individuals are more likely to be funneled into the mental health system and lack funds to access less stigmatizing forms of help such as coaching.

Cultural factors. Individuals from both higher and lower socioeconomic groups, participants suggested, are reluctant to seek help via therapy. One participant suggested,

You get teenagers who don't want to see a therapist. And even spouses. You see one spouse and they're like, "oh, they don't want to come in for therapy," but they'll come in if they're gonna see a life coach.

Another practitioner said,

There's stigma with help seeking, particularly among men and lower socioeconomics, culturally. There is a stigma that if you get therapy there's something wrong with you, whereas people can see coaching as, "oh yeah, I'm just getting support around this."

She went on to give an example,

I had a person who was pretty depressed...but there was no way he was going to do therapy. He was an inner-city former gang-banger. So I just worked with him on a level that was pretty, as comfortable as I could, doing just coaching with him.

To her, the “access gap is people that would not help-seek because of personal beliefs. Or people not being aware or not knowing how to access therapy.”

Reactive, symptom-focused healthcare system. The symptom-reduction focus of the American healthcare system can mean that interventions occur only after a problem has grown into something serious. One practitioner said, “Our insurance world is reactive not proactive, like child protection, special ed. People have to fail or get sick before something is done, rather than preventive care.” Another participant suggested there is a “big lack of acknowledgment” that, in reality, “it’s a lot of mental health and anxiety and stress and depression-related things that cause medical conditions.” In her view, the American healthcare system says to people, “here’s how we drive down your cholesterol and diabetes.” However, “if we don’t address the underlying issue, it’s not going to change.” Clients will continue to suffer and healthcare costs will remain high.

Untrained coaches. With some individuals turning to life coaching address their problems and avoid the stigma of therapy, three study participant expressed concern about the dangerous possibilities of untrained coaches engaging in therapeutic practice. One participant expressed the importance of “expertise and competency among practitioners” and of “having that baseline level of protection of the public.” Due to a lack of regulation and licensing requirements, however, “anyone can hang their shingle out as a life coach without any training.” Another practitioner clarified that “it’s less of an ethical dilemma for me to work on both sides of the fence with a client because I feel qualified on both sides of the fence.” However, he saw “more of an ethical dilemma if someone is trained as a

coach and they start dabbling in therapy. He believed “that’s inappropriate for them to do.”

Another went further by saying “I think life coaching should be illegal.” She added, “I think it’s malpractice. People come to you, they give you a superficial presenting problem and beneath it there’s usually very deep [expletive].” She illustrated her point with an example of a client family,

If you trigger, unconsciously those people are triggered about something—mom, for example, is triggered about something from her past—I need to find out about what that was. Then I need to go there with her. And so in order to go back to the trauma, neglect, whatever led the father to being absent, was he neglected? That’s deep [expletive]. And you can’t do it without knowledge of how to do it. It’s dangerous.

Further expressing her concern, she continued,

I literally left voice messages with the director of the Minnesota Board of Social Work and the Minnesota Board of Psychology and said, “Am I the only one that’s alarmed? There are all these people out there conducting malpractice.” And besides all of that, what you and I spend to get this...they’re slipping in under the tent and they’re stealing from me. And they’re malpracticing people and we should put a stop to it. And literally, neither one of them even called me back, which, I think, speaks volumes. So I wonder if I’m the only one that’s noticing this.

Future Solutions

Study participants suggested various future solutions to some of the issues they experience as dual practitioners. Two of the most extensively discussed solutions were those of rebranding therapy and changing the American healthcare system.

Rebranding therapy. One potential method for addressing stigma and access barriers is that of rebranding therapy. In one participant's opinion, "as Americans, we brag about our certificates and achievements and classes we're taking; education is cool." Therefore, she suggested,

We need to change the stigma—that it's continuing education; that it's about learning. That knowledge is power, ignorance is not bliss. Embrace that whole American education thing. That being a psychologist or a mental health professional and seeking mental health professional help is cool. Instead, what we're doing is we're dumbing it down by calling ourselves coaches so that people will play with us, which is very sad.

Another practitioner suggested,

I think if people could look at therapy as life-changing, life-enhancing, how to be in your life fully, live your life more fully, be happier in life, be able to live the life you want, anything that could give therapy that identity for people, would be more likely to invite people to come in and work on the things that are preventing them from having the life they want.

She went on,

I hate the term behavioral health. I don't like the term mental health. But I've never thought about what might work better. Maybe life health, or, I like life by design. Living life by design...those kinds of things. Coaching for the life you want. I think that would be so much more inviting to people. It's not, "you're sick, you need help, you're defective." Anything that could say "you have the power to do something to create the life you want. Anything that could switch that paradigm from you're defective, you're sick, you need help, to you have the power within you to design and change your life to be the way you want it would be so awesome.

Health insurance changes. Along with changing the stigma surrounding therapy and mental health, practitioners suggested making changes to America's health insurance system. Lamenting low reimbursement rates, one participant commented, "meanwhile, the insurance companies are the richest, beside banks, they're the richest conglomerate in the country." Another suggested, "I would like to see the entire insurance industry change. I would like to see it be blown up. It has become, it's so out of control. The CEOs make way too much money. There's way too much bureaucracy." Results include low reimbursement rates to practitioners and high costs to She went on to say, "things like coaching, massage, chiropractic care could prevent more serious issues. More early intervention. Those things make sense if people had the freedom to use their benefits in those ways." In an effort to drive down costs, one participant predicted that, "some of those, what are traditional wellness programs...will start to include some of those populations that are missed."

Discussion

Connection to the Literature

Many themes emerging from study participant interviews tied directly back to existing literature on the topics of coaching, therapy, and dual practice.

Draws to dual practice. As the article title, “Coaching Can Bolster Social Work Career” suggests, social workers and other therapy practitioners may look to enhance their practice through coaching. While no specifics are given on how or whether therapy and coaching should be combined, the article suggests that coaching services tend to attract higher income, higher functioning clients.

Providing services out of pocket services, practitioners enjoy freedom from the requirements of managed care. (Vallianatos, 2001). The draw of higher functioning, higher paying clients was clearly expressed by this study’s respondents. Most agreed that serving higher functioning cash-only clients reduced their financial, emotional, and administrative burden.

Different dual practice models. In his 2002 article, “Coaching vs. Psychotherapy: The Great Debate,” psychotherapist and coach Patrick Williams discussed the question, “Is it coaching—or merely a new-fangled therapy in disguise?” While acknowledging that coaching and therapy have similar roots and can appear very similar, he argued that each serves a distinct role and the two should remain separate in practice. Separation, say many coaching scholars, lends credibility and professionalism to the coaching field while offering protections and clarity for clients and practitioners (Berglas, 2002; Williams, 2003). Only one

participant in this study stated that she clearly distinguished her role as coach from her role as a therapist.

While a few participants cited specific settings or client circumstances that would warrant the use of either a clearly defined coaching or therapeutic approach, most reported integrating or switching off between a coaching and a therapeutic approach with clients. Some participants discussed theoretical differences between coaching and therapy discussed in previous literature. These issues included the future-focused nature of coaching and the past-focused nature of therapy, the emotional and transference issues attended to in therapy, and the out-of-pocket nature of purely coaching cases versus the possibility of insurance reimbursement in therapy (Bluckert, 2005; Caspi, 2005). Many times, however, how they classified their work with clients depended less on what they were doing in a session and more on the title and payment method that clients preferred.

Problems in dual practice. The real danger of combining coaching and therapy, scholars and this study's participants agree, lies in coaches engaging in therapy when untrained and unlicensed to do so (Berglas, 2002). The threat could affect clients and therapists alike. Due to the unregulated nature of the coaching industry, no protections exist for clients to ensure that coaching practitioners uphold ethical standards of codes of practice. Untrained coaches could, therefore, unknowingly trigger, worsen, or fail to recognize clients' serious mental health issues (Berglas, 2002; Williams, 2003). Additionally, trained mental health professionals, who have undergone extensive education, supervision, and licensing requirements, could face competition from life coaches appealing to certain groups.

Problems of stigma and client access issues arose both in this study and in the literature. Participants reported encountering male clients who preferred the lighter and less stigmatized title of “life coaching” to the more stigmatized, deficiency-focused title of “therapy.” Regardless of the actual methods used by practitioners, the title used to describe the work, particularly with men, certain cultural groups the affluent, and those in lower socioeconomic groups. This echoes previous research that suggests coaching may be a viable supplement or alternative to therapy for men, and particularly Asian-American men (Chance, 2015; McKelley & Rochlen, 2007). Individuals with greater means may be more likely to take advantage of coaching, however, due to cost barriers and a lack of knowledge among lower socioeconomic groups. High copays and deductibles may also prevent access to therapy services, even by those with insurance.

Future solutions. In a 2002 article, author, psychologist, and coach, Patrick Williams opined,

As more people in the public sector begin to realize the great differences between therapy and coaching, and see more and more value in having a partner to promote self-discovery and design for better living or better working, the shadow of the therapy stigma will disappear.

Study participants, however, suggested that bolder and progressive moves be made to de-stigmatize therapy. Educating the public on the realities of therapy and the modern approaches that exist could help change misconceptions about the field. Integrating coaching and therapy in practice, some suggested, could also attract individuals who are otherwise reluctant to seek help.

Social Work Practice Implications

Rebranding therapy. People continue to view therapy as mysterious, frightening, and only appropriate for extreme cases or severe disorders. Coaching, on the other hand, is seen as a lighter, more success-oriented, and less stigmatizing form of help. Widespread efforts to modernize and rebrand therapy could start to include some of the positive, strengths-based, and non-stigmatized language of coaching to increase therapy's relevance to people's everyday lives. As many study participants suggested, therapy could be framed as a relevant, valuable, and "cool," a form of continuing education, and a way to design one's life and invest in long-term health and success.

Educating the public. In addition to redesigning the language surrounding therapy and mental health, public education about coaching, therapy, and dual practice should be considered. Helping people understand the realities of each could help them decide which approach might be best for them. It could also shed light on the similar and often-overlapping nature of coaching and therapy and the potential risks of hiring a coach who is not also trained as a mental health professional. Culturally relevant outreach education could be geared toward men, higher and lower socioeconomic groups, teenagers, and other therapy-resistant groups. Education efforts could increase awareness, understanding, and access while decreasing stigma associated with seeking help.

Social Work Policy Implications

Focus on prevention. To cut down on costs associated with untreated mental health conditions and the resulting physical symptoms and diseases, policy

changes should focus on parity for early interventions in mental health. By emphasizing the link between stress, depression, anxiety, and many pervasive physical conditions like obesity, diabetes, and heart disease, policy advocates could demonstrate the life-enhancing and cost-saving potential of addressing problems early on. Just as yearly preventive medical visits are covered by most health plans, free regular mental health check-ups could also be offered and encouraged. Employers could also begin to offer and expand mental health components of employee wellness plans. On-site or remote options for therapy, coaching, and stress management could be considered.

Decreased costs. To address one of the barriers people face in accessing therapy, policies should be devised to decrease or subsidize its cost. While regular preventive visits could help reduce clients' financial burden, a focus on decreased deductibles and lower premiums could be of equal or greater benefit. In order to achieve this, insurance company conglomerates would likely need to be restructured. A transition to true universal healthcare could also be considered.

Future Research Directions

Attitudes towards coaching and therapy. Anecdotal evidence suggests that many people hold a stigmatized view of therapy and a general favorable or uncertain view of coaching. Further research should investigate the extent and quality of people's knowledge and attitudes towards therapy and coaching. If culturally sensitive de-stigmatization efforts are to occur, research should be done to identify specific language and terminology that attracts or drives away specific groups. Preference for or aversion to specific coaching and therapy techniques,

labels, diagnoses, and the use of insurance benefits to pay for services could also be investigated.

Adding effective coaching techniques to therapy. To attract and retain a broad base of clients and protect and expand the professional reach of therapy, practitioners should consider adopting and integrating effective coaching practices into their work. To ensure high-quality, evidence-based service to clients, research should explore the effectiveness of specific coaching techniques with certain populations and concerns. Studies could compare the effectiveness of coaching and therapy techniques and evaluate outcomes when integrating both.

Strengths and Limitations

Strengths. A main strength of this study was the richness of participant responses to open-ended, qualitative questions. Unlike a quantitative survey, the semi-structured, in-person interviews provided an open and personal setting in which study participants were encouraged to freely share their perspectives. Another strength of the study was the unique perspective gathered from individuals practicing both therapy and life coaching. While much existing literature described similarities and differences between life coaching and therapy, little prior research had involved the dual practitioner perspective. The study illuminated these professionals' first-hand experience with the overlap, conflict, and potential benefits of integrating life coaching and therapy through real-life experiences and practice examples.

Limitations. A major drawback of this study was the relatively small sample size. Due to the scope and time limitations of the research project, it was not feasible

to include more participants. An increased sample size could, however, have improved the quality and accuracy of aggregated responses. Additionally, participants were gathered through a convenience sample that was not controlled or randomized. Participants who did not participate in the study—either due to unavailability, unwillingness, or being unknown to the researcher—may have had distinct characteristics and perspectives to those represented in the data gathered from the study. Similarly, no effort was made to specify the type of therapists or life coaches recruited for this study. While this openness may have provided a diversity of responses, it may not have clearly accounted for the differences among responses due to a particular educational or professional bent.

Conclusion

The current study sought to explore professionals' real-life experience with coaching and therapy in dual practice. Specifically, it sought to determine the extent to which dual practitioners separate or integrate their therapy and coaching work with clients. Overall, participants agreed with existing literature that suggests fundamental differences between the two modalities. Unlike the only existing study examining dual practitioners' perceptions of dual practice, however, this study's participants emphasized a tendency toward integrating coaching and therapy rather than keeping them separate. Underlying this approach, however, was not a strong social justice focus or the passionate belief in expanding strengths-based practice to all. Instead, coaching and therapy appeared to have been combined to afford practitioners the benefits of a more positive, balanced, and flexible workload

without the hassles, stress, and low pay traditionally associated with agency and clinical social work settings.

Client benefits of dual practice include getting to the root of negative, subconsciously repeated behavior patterns, imagining and working toward a more positive future, and seeking help without the stigma traditionally associated with therapy and mental health diagnoses. While gray area exists—regarding who pays the bill and which type of service is actually being offered—participants tended to agree that they were “qualified to practice on both sides of the fence.” Therefore, the benefits of combined therapy and coaching far outweighed the potential risks.

Many groups, argued participants, are averse to seeing a therapist and yet open to seeing a life coach. Only those with means, however, can afford the less stigmatizing services of a life coach, executive coach, or a no-insurance, no-record therapy arrangement. Lower income groups—particularly those who are teenagers, men, and of certain cultural backgrounds—decide between the heavy stigma of therapy, the high costs of coaching, and the potential dangers of seeking no help at all. Combining coaching and therapy, it appears, can serve to soften stigma, appeal to broader audiences, and help clients and practitioners to focus on the importance of both the past and future, client patterns and possibilities, and people’s symptoms and their strengths.

Future research could expand on this study’s focus on dual practitioner integration of coaching and therapy. Studies could also explore the extent to which certain coaching- and therapy-specific language and techniques may repel or appeal to particular client groups. Finally, additional research on the effectiveness of

coaching techniques with specific client issues and populations could help to more clearly define its role in relation to therapy.

References

- Allen, K., & Huff, N. (2014). Family coaching: An emerging family science field. *Family Relations Interdisciplinary Journal of Applied Family Studies, 63*(5), 569-582.
- Belgrave, L. L. (2014). Grounded theory. In D. Coghlan, & Brydon-Miller (Eds.), *The SAGE encyclopedia of action research*. (Vol. 7, pp. 388-390). London: SAGE Publications Ltd.
- Berglas, S. (2002). The very real dangers of executive coaching. *Harvard Business Review, 80*(6), 86-92.
- Bluckert, P. (2005). The similarities and differences between coaching and therapy. *Industrial and Commercial Training, 37*, 91-96.
- Bora, R., Leaning, S., Moores, A., & Roberts, G. (2010). Life coaching for mental health recovery: The emerging practice of recovery coaching. *Advances in Psychiatric Treatment, 16*(6), 459-467.
- Butterworth, S., Linden, A., McClay, W., & Leo, M. C. (2006). Effect of motivational interviewing-based health coaching on employees' physical and mental health status. *Journal of Occupational Health Psychology, 11*(4), 358-365.
- Camponi, F. (2014). At the border: Coaching a client with dissociative identity disorder. *International Journal of Evidence Based Coaching and Mentoring, 12* (1), 1-13.
- Caspi, J. (2005). Coaching and social work: Challenges and concerns. *Social Work, 50*(4), 359-362.

- Cautin, R. L. (2011). A century of psychotherapy: 1860-1960. In J. C. Norcross, G. R. VanderBos. & D. K. Freedheim, (2nd ed.), *History of psychotherapy: Continuity and change* (3-38). Washington, D.C.: American Psychological Association.
- Chance, R. D. (2015). *Coaching as a therapeutic approach for Asian-American men: Toward a culturally-indicated and gender-specific therapeutic modality* (Doctoral dissertation). Accessed from ProQuest.
- Davidson, M., & Gasiorowski, F. (2006). The trend of coaching: Adler, the literature, and marketplace would agree. *The Journal of Individual Psychology, 62*(2), 188-201.
- DeLeon, P.H., Kenkel, M.B., Garcia-Shelton, L., Vandenbos, G. R. (2011). A century of psychotherapy: 1860-1960. In J. C. Norcross, G. R. VanderBos. & D. K. Freedheim, (2nd ed.), *History of psychotherapy: Continuity and change* (3-38). Washington, D.C.: American Psychological Association.
- Emmons, H. (2006). *The chemistry of joy: A three-step program for overcoming depression through western science*. New York, NY: Fireside.
- George, M. (2013). Seeking legitimacy: The professionalization of life coaching. *Sociological Inquiry, 83*(2), 179-208.
- Grant, A. M. (2003). The impact of life coaching on goal attainment, metacognition and mental health. *Social Behavior and Personality, 31*(3), 253-264.
- Gray, M., Midgley, J., & Webb, S. (2012). *The sage handbook of social work*. Boston, Massachusetts: SAGE.

- Green, L. S., Oades, L. G., & Grant, A. M. (2006). Cognitive-behavioral, solution-focused life coaching: Enhancing goal-striving, well-being, and hope. *The Journal of Positive Psychology, 1*(3), 142-149.
- Hart, V., Blattner, J., & Leipsic, S. (2001). Coaching versus therapy: A perspective. *Consulting Psychology Journal: Practice and Research, 53*(4), 229-237.
- McKelley, R. A., & Rochlen, A. B. (2007). The practice of coaching: Exploring alternatives to therapy for counseling-resistant men. *Psychology of Men & Masculinity, 8*(1), 53-65.
- Reamer, F. G. (2013). Ethics and values. *Encyclopedia of Social Work*.
- Robb, M. (2010). 7 secrets of highly successful coaches. *Social Work Today, 10*(3), 22.
- Shafer, K. C., Kiebzak, L., & Dwoskin, J. (2003). Coaching: A new role for addictions social workers? *Journal of Social Work Practice in the Addictions, 3*(2), 105-112.
- Spence, G. B., & Grant, A. M. (2007). Professional and peer life coaching and the enhancement of goal striving and well-being: An exploratory study. *The Journal of Positive Psychology, 2*(3), 185-194.
- Vallianatos, C. Coaching can bolster social work career. (2001, February) *NASW News*.
- Wang, H., Bai-snog, H. Q., Cui, Y., Zhu, Z. R., Rong, Z., & Chen, H. (2008). Is acupuncture beneficial in depression: A meta-analysis of 8 randomized controlled trials? *Journal of Affective Disorders, 125*-134.

Williams, P. (2003). The potential perils of personal issues in coaching. The continuing debate: Therapy or coaching? What every coach must know! *International Journal of Coaching in Organizations*, 2(2), 21-30.

Table 1

<i>Distinctions Between Therapy and Coaching as Presented in Coaching Literature</i>	
<u>Therapy</u>	<u>Coaching</u>
Explores past events	Explores future goals
Emphasis on emotions	Emphasis on actions
Diagnosing dysfunction	Finding client strengths
Practitioner as expert	Practitioner as partner
Long-term (months to years)	Short-term (days to months)
Slow client change	Rapid client change
Professional relationship with client	More relaxed relationship with client
Dual-relationships discouraged	Dual relationships acceptable
Limited practitioner self-disclosure	Frequent practitioner self-disclosure
Meetings mainly in person	Meetings in person, by phone, online
Limited contact between sessions	Frequent phone and email contact
Clients often have limited income	Clients often have higher income
Sometimes unmotivated clients	Often highly motivated clients
Clients with clinical concerns	Non-clinical clients
Stigmatized	Not stigmatized
Associated with weakness	Associated with success
(Berglas, 2002; Bluckert, 2005; Caspi, 2005; Davison & Gasiorowski, 2006; Hart, Blattner, & Leipsic, 2001; Williams, 2003)	

Table 2

<i>Participant Demographics</i>					
<u>Participant</u>	<u>Gender</u>	<u>Licensure</u>	<u>Years in practice</u>	<u>Coach Education</u>	<u>Practice Model Used</u>
1	F	LICSW	20+	Yes	Integrated
2	F	LICSW	20+	No	Integrated
3	M	LICSW	20+	No	Both
4	M	LP	20+	No	Both
5	F	LMFT	7	Yes	Integrated
6	F	LPC	4	No	Both
7	F	LMFT	2	Yes	Separated

Appendix A

Phone Script

“Hello. My name is Jessie Martinez. I’m an MSW student at the University of St. Catherine and St. Thomas. I am conducting my clinical research project on the separation and integration of coaching and therapy in dual practice. I’m wondering if you would be willing to share your perspectives on this subject in a one-on-one, in-person interview lasting approximately 60 to 75 minutes. The interview can take place at your office or another private location of your choice at a time that is convenient for you. The interview will be audio-recorded and later transcribed; your identity will be kept confidential and any identifying information will be removed from your interview data. As compensation for your time and participation, you will receive a five-dollar coffee shop gift card.”

Appendix B

Email Script

“Hello. My name is Jessica Martinez. I am a current MSW student at the University of St. Thomas/St. Catherine University. I am conducting my clinical research project on the separation and integration of life coaching and therapy in dual practice.

I am interested in conducting a one-on-one 60- to 75-minute in-person interview with you to gather your professional perspectives on this topic. I can meet you at your office or another private location of your choice at a time that is convenient for you. The interview will be audio-recorded and later transcribed; your identity will be kept confidential and any identifying information will be removed from your interview data.

As compensation for your time and participation in the study, you will receive a five-dollar coffee shop gift card.

Please reply at your earliest convenience. Please also share this information with other dual practitioners you are aware of in the Twin Cities area.

Sincerely,

Jessica Martinez”

Appendix C

Informed Consent Form

Life Coaching and Therapy: Possibilities in Dual Practice INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating the integration and separation of coaching and therapy in dual practice. The study is being conducted by Jessica Martinez, a graduate student at St. Catherine University under the supervision of Rajean Moone, a faculty member in the Department of Social Work. You were selected as a possible participant in this research because you are licensed to conduct psychotherapy and you also practice life coaching. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to gather professionals' perspectives on the separation and integration of coaching and therapy in dual practice. Approximately 8-10 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to engage in an audio-recorded, face-to-face interview with the researcher. This study will take approximately 60-75 minute over 1 session.

Risks and Benefits of being in the study:

The study has minimal risk.

There are no direct benefits to participants. Indirect benefits include adding to the knowledge of the burgeoning field of coaching and its relationship with the field of therapy.

Compensation:

If you participate, you will receive a five-dollar coffee shop gift card.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the research results in password-protected folder on my personal laptop computer and/or a locked file cabinet in Minnesota and only my advisor and I will have access to the records while I work on this project. Audio recordings will be stored on a password-protected mobile telephone and only a transcriptionist and I will have access to them. The transcriptionist will sign a statement of confidentiality, agreeing to keep all information private. I will finish analyzing the data by May 1, 2015. I will then destroy all original reports and identifying information that can be linked back to you by August 31, 2016.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships. Your compensation will not be affected by your decision to stop participation. Any information provided up to the point of withdrawal from the study will be destroyed immediately and will not be used in the study.

New Information:

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

Contacts and questions:

If you have any questions, please feel free to contact me, Jessica Martinez, at 651-497-6029 or mart8138@stthomas.edu. You may ask questions now, or if you have any additional questions later, the faculty advisor (Rajeon Moone at 651-235-0346 or moon9451@stthomas.edu), will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study.

I consent to participate in the study and I agree to be audio taped.

Signature of Participant

Date

Signature of Researcher

Date

Appendix D
Interview Introduction Script

“Hello. Thank you for meeting with me today. I am conducting interviews for my MSW clinical research project. I am seeking to understand how dual practitioners integrate or separate coaching and therapy in their practice with clients and how they view ethical issues in practice. Before beginning the interview, I will have you read and review an informed consent form (consent form given to participant). Please read it and I can clarify any information and answer any questions you have. Then you can decide whether you would like to sign it and continue with the interview.”

Appendix E

Interview Questions

1. What are your educational and professional backgrounds?
 - a. Do you specialize in any particular client populations or issues?
2. Do you identify more as a life coach or a therapist?
3. To what extent do you integrate or separate your therapy and coaching practices?
4. How do you decide whether to use coaching or therapy with clients?
5. How does your relationships with therapy and coaching clients differ?
 - a. Do you view coaching and therapy clients differently? How?
6. What are the per-session costs for therapy and coaching?
 - a. How do clients typically pay for sessions?
 - b. Are sliding fees available for either modality?
7. How do client demographics (age, gender, cultural background, socioeconomic status) differ among your coaching and therapy clients?
8. What ethical issues arise for you as a dual practitioner?
 - a. How do you navigate these issues?
9. Some research suggests that coaching could be an alternate intervention for individuals who are reluctant to seek therapy due to stigma or cultural factors. What is your opinion about this?
10. Some mental health practitioners have begun to engage in family coaching, coaching for mental health recovery, and substance abuse coaching. What is your opinion on coaching with populations with more clinical concerns?