

## **The mental health boundary in relationship to coaching and other activities**

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### **Abstract**

This article explores the relationship between coaching and mental health issues. Coaching functions in a world that is dominated by the medical model of mental health, where problems are viewed as illnesses to be diagnosed and treated. The coaching industry also functions alongside many other helping by talking activities, such as counselling and psychotherapy. The relative mental health of individuals is often quoted as a difference between coaching and other “helping by talking” activities but this is, at best, a marketing tool and does not stand up to scrutiny in view of the diverse range of activities and viewpoints of psychological therapies. It is suggested here that a different approach to the mental health/mental ill health boundary is necessary and that by focussing on answering the question “what to do?” rather than the question “what is wrong?” the differences between coaching and other helping by talking activities can be acknowledged. The approach suggested allows for the professional and ethical management of boundary issues without the need for in-depth training in psychological dysfunction and diagnosis.

**Key words:** Mental health, boundaries, coaching counselling, therapy, coach training

### **Introduction**

As a still-developing “helping by talking” activity coaching interacts with other, more established, activities and with the general society in which it takes place. From the viewpoint of mental health, mental ill health, mental illness and psychology the dominant paradigm is the medical model, certainly in the westernised world. Despite alternative views, such as the positive psychology movement (Snyder and Lopez 2005), a potentiality model as suggested by counselling psychology (Woolfe and Dryden 1996) and the anti-psychiatry movement (Glasser 2003, Lynch 2001, Szasz 1974) whenever someone becomes poorly due to a possible mental health issue it is most commonly a doctor who is turned to. The use of such terms as depression, stress and even complex medical definitions such as post traumatic stress disorder (PTSD) in general language, again, points to the dominance of the medical or illness model.

The development of coaching as a separate and distinct activity to counselling, counseling, psychotherapy and other psychological therapies is a continuing process. To further add to the complexity of this subject it is difficult to find clear and unambiguous definitions of any of the psychological therapies. During the 1990’s the British Association for Counselling undertook an extensive consultation to try to define a workable difference between counselling and psychotherapy. It was not successful and the decision was taken to rename the organisation The British Association for Counselling and Psychotherapy. This change, however, was not universally accepted. The British Government is in the process of legislating for a licensing process for counsellors, psychologists, psychotherapists and others. The term being used is

“psychological therapist” to cover all the different activities. No attempt has been made to separate the counsellor from the psychotherapist or the psychologist.

The difficulty in providing a generally agreed definition is further complicated by national variations. The term used in the USA is ‘counselor’, with one ‘l’, and they are state licensed mental health professionals. In parts of Europe, Germany for example, the psychotherapist is medically qualified. In contrast the United Kingdom, at present, operates a system where there are no barriers to anyone using the term psychotherapist or counsellor.

Throughout this article the term counsellor will be used and should be assumed to cover a range of activities that fall under the general heading of the psychological therapies.

### **Coaching and Mental Health – an overview**

Most published works about coaching have a description of what coaching is not, or the difference between coaching and counselling or therapy. Many of these descriptions seem very simplistic and more of an aid to marketing than informing the reader in any real sense. Fairley and Stout (2004, p. 32) describe the difference as, primarily, in the people who are served and say; “In counseling, the person is seen as broken, bruised, and in need of healing. In coaching, people are viewed as creative, resourceful, and whole”. As an accredited counsellor and psychotherapist in the United Kingdom this statement does not reflect my views on whom I am talking to, nor does it reflect my self-view as someone who has had many hours of therapy for personal development. Interestingly Fairley and Stout include this definition in a section titled “Distinguishing Coaching from Other Fields for Marketing Purposes”.

One often seen example of the differences between coaching and therapy is the table produced by Patrick Williams (2003, p. 5). This table lists therapy as a medical model, a Doctor-patient relationship, dealing with dysfunction, the therapist diagnoses, assumes emotions are a symptom of something wrong and that the therapy patient usually has difficulty functioning. The table lists the characteristics of coaching as about: learning and development; the client’s desire to move to a higher level; creating the future; assuming emotions are natural and that the coaching style is a catalyst to change with a healthy client.

The idea that the coaching client is mentally healthy, or at least “normal” is a recurring theme in the literature when talking about the differences between the coaching client and the therapy client. Fairley and Stout use a –10 to 0 to +10 scale with –10 being high psychopathology, 0 being “normal” and +10 being exceptional, highly skilled and fully functioning suggesting that the realms of coaching lie from 0 to +10 and the province of therapy as 0 to –10.

The coaching industry often uses the “dysfunction” of the therapy client as a key differentiator to the coaching client. There have been attempts to bring a more credible voice to this debate, notably Bachkirova and Cox in their article ‘A bridge over troubled water: bringing together coaching and counselling’ (Bachkirova and Cox, 2004) and Bluckert with ‘The similarities and differences between coaching and therapy’ (Bluckert 2004).

There seems to be one clear statement that most coaching literature subscribes to and that is that the coach works with a mentally healthy person. Many codes of ethics and good practice and statements of “what is coaching” back this up. There appears to be a general view that coaching is

not aiming to help people with psychological dysfunction, mental health problems or psychopathology. In some countries to suggest this would be illegal. Codes of ethics and good practice talk of the competence of the coach and the need to refer to an appropriate professional those clients who need something other than coaching.

The Ethical Code of the European Mentoring and Coaching Council states, under boundary management, that the coach/mentor will “at all times operate within the limits of their own competence, recognise where that competence has the potential to be exceeded and where necessary refer the client either to a more experienced coach/mentor, or, support the client in seeking the help of another professional, such as a counsellor, psychotherapist or business/financial advisor.” (European Mentoring and Coaching Council). There are many coaches who are also trained and experienced counsellors, but the need to consider a referral is just as valid. The question for the coach/counsellor is not “can I help?” but “can coaching help?” (Buckley and Buckley, 2006, p. 73). This subtle difference helps the coach/counsellor with boundary management and reduces the possibility of inadvertently moving into a counselling mode.

In contrast the counsellor, by definition, deals both with clients with a psychological problem and those wishing for personal growth and “wellness”. The American Counseling Association defines counselling as “The application of mental health, psychological, or human development principles, through cognitive, affective, behavioural or systematic intervention strategies, that address wellness, personal growth, or career development, as well as pathology.” (American Counseling Association, 1997).

Using the model suggested by Fairley and Stout of –10 to +10 the therapist is equipped to see clients ranging from –10 to +10 whilst the coach is limited to those from 0 to +10. There is a need within those countries that have a regulated and licensed profession of counsellor or psychotherapist for the coaching industry to clearly define who their client base is in the terms of the dominant medical model of health care.

The importance of this distinction is highlighted by statements such as “Personal coaching practiced for the purpose of promoting self-discovery, understanding and coping with various life issues, and setting personal goals or engaging in any self-improvement counseling is most likely considered the practice of psychotherapy by the Regulatory Boards.” by the Mental Health Licensing Section of the State of Colorado (Martinez 2004). This article ends with a summary of the legal consequences for the coach who is found to have transgressed into protected territory and “These are rather severe consequences for coaches who are offering to provide clients with “the opportunity to create the most wonderful life possible.” These legal differences between the counsellor and coach and their client groups and activities are likely to become increasingly relevant as the activity of coaching becomes ever more popular.

There is a central theme through this discussion on the attempts to differentiate coaching and counselling with reference to the relative psychological health/ill-health of a person, with therapy being portrayed as “deals with healing pain, dysfunction and conflict within an individual or a relationship” and coaching “is forward moving and future focused” (International Coach Federation, 2006).

I believe that this differentiator may be an effective marketing tool but it does not stand up to academic scrutiny. So, the best that a mental health professional is likely to be able to say is;

“No signs of psychological dysfunction were evident.” This is not the same as saying someone is healthy. The logical end result of defining the coaching client as a “healthy client” is that no coaching could ever take place. No coaching could take place because of the impossibility of defining mental health as a distinct ‘have or have not’. I acknowledge that this is pushing definitions to the extreme, but does highlight the difficulties that the mental health of a client brings to the activity of coaching.

I think that one of the more important tasks facing the coaching industry is to develop a realistic and positive approach to the mental health/mental ill health boundary. Continuing to rely on a forced definition based on coaching being about human potential with therapy, counselling and other “helping by talking” approaches being about dealing with deficit, does not stand up to examination and is in essence a defensive approach. Counselling is as much about human potential as coaching. As Woolfe and Dryden maintain (1996 , p.8), “Counselling psychology arose from a concern with the fulfilment of potential rather than the curing of sickness.”

### **Approaching mental health from the coaching viewpoint**

‘Is coaching appropriate?’, as a question, has several dimensions that encompass both the ethics of coaching as well as the practical intent. De Jong explores this from a philosophical perspective and says “What is needed is a deeper connection to one’s own sense of new ethics” (in Passmore, 2006, p. 200). Buckley and Buckley (2006, p. 57-74) take a more practical approach to the consequences of the choices a coach must make when working with any client.

Dr. Mike Nowers, consultant psychiatrist (quoted in Buckley and Buckley, 2006) says, “most mental illnesses lie on a spectrum between health and illness and an individual may slide from health into illness over a period of time and in a way that may be hard to identify.” Quite serious mental health problems can, and do, appear without warning in seemingly healthy, successful and intelligent people. Mental illness is no respecter of gender, wealth or position. This highlights the need for the coach to have the ability to recognise when a client’s behaviour suggests a referral to a suitable mental health specialist.

Unfortunately the coaching boundary with respect to mental illness is not as straightforward as, ‘Does this client have a diagnosable mental illness?’ To use this as the criteria, would need backing up by an evaluation of mental health, as suggested by Berglas (2002, p. 92), who recommends that every executive who receives coaching should be psychologically assessed. For the coach attempting to evaluate the suitability of a client based on the medical model and the question ‘does this client have a mental illness?’ would require considerable training in history taking and a mental health examination and the ability to recognise symptoms and behaviours that are by their nature complex and often difficult to define, even for the most experienced psychiatrist or mental health practitioner.

The coach does not need this level of skill and the coaching client would not benefit. But the coach does need the ability to be able to judge when not to coach both with new clients or existing clients who exhibit unusual behaviour.

### **The Mental Health Boundary – an alternative way**

The coaching industry and individual practitioners have an opportunity to define the relationship between mental health, mental ill health and the activity of coaching in a way that does not rely

on the illness definitions taken from the medical model. An alternative model is one that offers a solution to boundary management, appropriate care, the skills of individual practitioners and the place of the medical practitioner or psychological therapist in a way that acknowledges that there will be some individuals who ask for coaching when the activity of coaching is inappropriate.

What the coach needs is an ability to recognise when coaching may not be an appropriate solution to an individual client's needs and to know how to proceed in a way that covers the best interest of the client and legal and ethical issues in place locally.

One way would be for every coach to be well trained in the recognition of the symptoms of mental illness so that they could make an informed decision as to the appropriateness of coaching when a client behaves in an unusual way. The coach would need to acquire the knowledge, experience and skills of differential diagnosis to aid in the decision making process. The length of training needed for the coach to become competent in the recognition of mental illness seems unreasonable when the majority of coaching clients do not ask for coaching with any expectation of "cure" of dysfunction.

What the coach does need, however, are four key skills to be able to effectively manage those client's where for some other form of help may be indicated.

1. Awareness that some people will have temporary, or more permanent, mental health issues that will prove to be barriers to effective coaching. For the coach to know that an inability to be able to offer help is no reflection on competence as a coach but an acceptance of the range of people likely to be seen.
2. An ability to recognise the signs that may suggest a possible mental health issue. The capacity to explore these signs with the client so that premature judgements are not taken.
3. Thorough knowledge of legalities and ethics at a national level as well as an ability to make informed judgements in view of the coach's own level of training and experience and any specific contractual arrangements that may be in place.
4. A willingness to make choices around coaching as an appropriate solution and to be able to offer alternatives to those client's in need. Choice of the best course of action may not be straightforward and all the factors need to be considered before a decision is made.

These four key skills will aid the coach in answering the question 'What to do?' when a client behaves in any way that is unusual, worrying or that may indicate any of the behaviours that a trained medical professional would classify as mental illness. The four skills do not try to help the coach with an answer to the question 'What is wrong?'

Avoiding any attempt to think about what is wrong removes the need for the coach to be trained and become competent in the recognition of mental illness. It also avoids any temptation on behalf of the coach to try and diagnose or worse "help". Equally, there is no longer any need or pressure to understand the complex world of differential diagnosis.

All the coach needs is an ability to make clear, effective, ethical and legal judgements as to the efficacy of coaching with this particular client.

## Conclusion

This paper has argued that there is a clear difference between the counsellor and coach in their ability to help people across the whole spectrum of mental health/mental ill health. The goal of counselling is to be able to help those who have problems as well as those who desire a better quality of life. The goal of coaching is to help those who desire a better quality of life.

By emphasising the place of coaching as one of working with mentally healthy and fully functioning human beings there is the presupposition that someone is able to make an informed judgement as to the relative health of this potential client. In a practical sense the judgement of the suitability of a client for coaching and the advisability of coaching as an intervention is most likely to be taken by the coach. Therefore the coach needs an ability to recognise psychological issues and the ability to make sensible decisions around the question "Is coaching appropriate?"

The coach, in contrast to the counsellor, does not need to receive training in how to help someone with a psychological problem or mental health issue, only to recognise and assess the impact of the issue on the delivery and likely efficacy of the coaching that can be offered. By using a model linked to non-medical and non-diagnostic terms the coach can start to explore the issues with their client and make choices without the need to receive training in diagnosis.

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