

At the Border: Coaching a Client with Dissociative Identity Disorder

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Abstract

Coaching/psychotherapy boundaries have been explored theoretically and through surveys. The confidential nature of coaching has precluded direct observation of how they are operationalized. The case presented here was initiated at the invitation of a client who has a clinical diagnosis of Dissociative Identity Disorder and her coach. Their journals, interviews and observed sessions enabled the author to construct a case study that offers insight into how an individual coach and client navigate the coaching/psychotherapy boundaries in practice. The case provides evidence of specific coach and client characteristics and coaching strategies employed in these circumstances.

Key words: Coaching and psychotherapy, boundaries in coaching, life coaching, coach qualifications, mental health and coaching

Introduction

What are the boundaries between coaching and psychotherapy? How are these boundaries navigated in a coaching session? Coaching/psychotherapy boundaries have been explored theoretically (Cavanagh, 2005; Price, 2009; Allen, 2010) and through studies of coaches' perceptions (Hart *et al.* 2001, Maxwell, 2009). The literature has explored questions of client suitability and coach qualifications as well as the constraints of professional standards and ethical concerns. However, the confidential nature of a coaching engagement has presented an obstacle to examining how these boundaries are enacted in actual coaching sessions. The case presented here offers an unusual opportunity to engage in that examination, as well as to investigate client and coach perceptions of the experience of negotiating and navigating those boundaries in the moment. The purpose of the study is to present a real world exploration of coaching and psychotherapy boundaries in practice. It is not the author's intention to provide a manual for coaching clients with mental disorders or to advise that all such clients are suitable for coaching. It is also not the author's intention to suggest that all coaches are equally suited to coaching these clients.

Documentation of the case was initiated at the request of the coach and client and material for the case was generated through their journals, interviews and observations of the author. Specific "checkpoints" in the coaching/therapy boundary emerged through analyzing the patterns in the qualitative data. In particular, the case offers insights into the participants' perspectives and experiences of establishing roles, boundaries and goals; maintaining trust and safety; fostering a client-centered partnership; and the use of coaching processes and strategies.

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Navigating the Borders in the Literature

While there have been a number of articles in recent coaching literature seeking to provide evidence for the boundaries between coaching and psychotherapy, the results remain inconclusive. Early studies have suggested key aspects of the boundary but have not provided definitive answers. Respondents to Hart, Blattner and Leipsic's (2001) study, for example, noted differences in the relationships, the goals and purposes of engagement and underlying assumptions about the client. They also acknowledged overlap in methods of coaching inquiry, with a "propensity for advice-giving, boundaries issues and potential for power differentials." (p. 235).

More recently, Bachkirova's (2007) discussion of counseling and coaching boundaries points out the challenges of drawing solid boundary lines. These include assumptions about uniformity of process and disagreement about the definitions of coaching. She also discusses the potential fallacies in distinguishing the coaching suitability of clinical and non-clinical populations. She argues "there is a serious ethical issue bound up with identifying people as belonging to a clinical population only on the basis that they have decided to improve the quality of their emotional life with the help of a professional counselor." (p. 353). In comparing coaching and counseling, Bachkirova (2007) notes that one area of distinction is the initial motivation of the client. In the case of counseling, it is "eliminating psychological problems and dysfunction"; in coaching, the motivation is "enhancing life, improving performance." (p.357) While both interventions have increased well-being as possible goals, client's expectations for coaching include shifting from relative to higher satisfaction, compared with the expectation of counseling to shift from high dissatisfaction to relative satisfaction.(p.357)

While studies cited by Griffiths and Campbell (2008) recognize overlap, they also note differences, albeit stating that "the distinctions presented...remain largely unsubstantiated." (p.165) Similarities include using some methods such as listening, questioning, and a non-judgmental stance to uncover and address the client's challenges. Differences include client's focus and intention and the client's baseline from both the client and coach's perspective.

Boundaries and distinctions between coaching and psychotherapy were the focus of a World Café session at the Special Interest Group in Coaching Psychology's Second European Conference (Allen *et al.* 2010). The discussion participants raised several useful questions but did not reach definitive conclusions. As Buckley notes (2007), "the development of coaching as a separate and distinct activity to counseling, psychotherapy and other psychological therapies is a continuing process." (p.17) Rather than focus on the client characteristics and draw a line based on the client's mental health, he argues that the boundaries should take into account the coach's expertise and knowledge of mental health issues; legal and ethical considerations; the ability to recognize the signs of mental illness; and a willingness and ability to make appropriate choices of action.

Preparing and Documenting the Case

In 2009, a life coach working with a client with Dissociative Identity Disorder (DID) contacted the author, a colleague from his coach training. Intrigued, I agreed to meet with the coach and client. As a coach educator, I am sometimes challenged to help students integrate coaching theory and coaching practice. The case offered an opportunity to observe and learn from such an intersection by constructing a case study from participants' journals and interviews, observation and reference to peer-reviewed literature.

Dissociative Identity Disorder and related dissociative disorders may be found in between 1% and 5% of patients participating in psychiatric programs (International Society for the Study of Trauma and

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Dissociation, 2011). Over 20% of the general population will suffer from some diagnosable mental-health problem at some point in their life and 10% to 15% of the population suffers from some form of personality disorder (Cavanagh, 2005). Thus, there is a possibility that a coach may encounter a client who has experienced significant trauma or suffer from a mental health problem.

Nonetheless, the phenomenon of coaching clients with mental disorders has not been documented in practice. Case study can be useful in addressing descriptive questions that may help refine the understanding of people and events in this context (Yin, 2006). The literature supports the use of anomalous cases to illustrate or explore a phenomenon under investigation. A case study may be viewed as a “heuristic that involves the careful delineation of the phenomenon for which evidence is being collected” (Van Wynsberghe and Khan, 2007). Insights gained from such cases “may lead to the development of hypotheses that can be tested using other methods” (Cozby, 2009, p.116). This case offered an unusual opportunity to study the phenomenon of the coaching-therapy boundary in a real life context, representing both the emic and etic perspectives (Gall, Borg and Borg, 2007). This approach seeks to integrate participants’ views and understanding of their social reality (the emic perspective) and the researcher’s conceptual and theoretical understanding of the participants’ reality (the etic perspective).

In an initial meeting with the coach, client and the client’s husband, the participants asked the author to help them document and analyze their collaborative coaching process in order to better explore three sets of questions:

- What are the coaching/therapy boundaries in practice? To what extent do the boundaries in practice align with those proposed in the coaching literature?
- Can life coaching help a client with a significant, identified psychological disorder?
- What specific aspects of the coaching process did the client find most helpful?

Given the nature and characteristics of client’s disorder, trust was a critical factor in developing this project. The process for gathering information and documentation for this study was designed to respect the client’s boundaries and to minimize the researcher’s presence in the coaching process. The initial meeting was followed up with a written communication from the author to the coach and client, summarizing her understanding of the purpose and goals of the project, defining participant roles and the standards of confidentiality. The coach and client were asked to give their consent and advised that they might chose to end the project at any time they chose. The follow up memo also outlined the elements of the study process including all forms of documentation, follow on interviews, and three-way reviews of drafts of resulting papers with the coach and client providing feedback, correction and any supplemental material needed. All parties would agree to the final paper before it would be submitted for consideration for publication.

The researcher developed a semi-structured journal format for both coach and client to complete after each session. The journal asked the participants to record the behaviors they recalled (i.e. what each said and/or did) and any thoughts or feelings they recall having at that time. They were also invited to record comments or afterthoughts. Recognizing that the nature of DID would prevent the client from full recollection, the coach’s notes were considered a complementary source to the client’s in documenting process and outcomes, as well as providing insight into the coach’s own reasoning in boundary-setting. The author was responsible for researching the professional literature and analysis of the documents and interview data. For reasons of trust and confidentiality, recording and transcribing the sessions was not an

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option. The agreed upon documentation and process included six months of journals prepared by the coach and client; the author's notes from two observed coaching sessions; notes from follow up interviews and supplemental material provided by the participants; and reviews and feedback from the coach and client of each iteration of the resulting paper. Initially, the client and coach requested that their own names be used. However, on reconsideration they chose the pseudonyms which are used here.

This interplay of perspectives aligns with recommended strategies to ensure quality in case study (Gall, Borg & Borg, 2007). The process uses data provided by participants, including their reviews, corrections and amendments to researcher interpretations; inclusion of all documents and materials; and cross-referencing coach and client category patterns and comparisons with patterns in the literature. Using this case as a means of investigating a complex phenomenon allowed the author to gain an understanding of the critical elements which emerged at the intersection of theory and practice.

The author reviewed and conducted an analysis of the documents. Notes were segmented and typed into a database. Each segment was assigned a category of referent-i.e. about therapy/coaching boundaries; coach processes or actions; client reactions or responses. Items within categories were grouped and analyzed for patterns using reflective analysis (Gall, Borg and Borg, 2007). Initial drafts were reviewed by the coach and client and supplemental data added. After a final supplemental interview and review, a matrix of key patterns was constructed to support the observations and discussion at the conclusion of this paper.

The Case

In August of 2007, Jennifer, a married, 54 year-old female social worker employed at a residential treatment facility for at-risk teenage girls, contacted Paul regarding the possibility of life coaching. Jennifer had been referred to Paul by his wife, who was taking a yoga class with Jennifer. At the time, she had no experience with life coaching and did not know what to expect. Jennifer struggled with stress-related headaches and Paul's wife suggested that he might be able to help.

Paul is an experienced life coach. After receiving a M.Ed. in 1978, he was a school counselor for three years and a personal and professional life coach with a business corporation for 12 years. He has been in private practice as a counselor and life coach for over 19 years. Paul is certified by the National Board for Certified Counselors and maintains his credential as a Licensed Professional Counselor in his current state of residence. His counseling orientation is strongly Rogerian and client-centered. This orientation is a primary influence on his coaching, along with the cognitive orientation of Albert Ellis' work. Life coaching has been Paul's primary practice for the past several years.

Paul and Jennifer established initial goals for their coaching work with a focus on assisting the client to manage her stress related headaches and to help her develop strong social/interpersonal skills. In particular, Jennifer wanted to expand her understanding and experiences of friendship. After several conversations, Jennifer felt safe enough to share with Paul that she had been working with psychologists and psychiatrists in the mental health system for decades, receiving a variety of diagnoses including severe clinical depression, major anxiety, post-traumatic stress disorder and , at one point, borderline personality disorder. In April of 2006, after seeing her current psychotherapist for eight years, she revealed information to him that led to her diagnosis of Dissociative Identity Disorder (DID). As their coaching work continued and evolved, Jennifer added the goals of wanting to write a book and be able to speak to groups of college students about her experiences. Her social interaction goals clarified into wanting to "do some normal things with other people, having conversations that don't revolve around (the) disorder."

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The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) characterizes Dissociative Identity Disorder (DID) as “the presence of two or more distinct identities or personality states that recurrently take control of the individual’s behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness” (p.477). These manifestations may be the result of severe physical or sexual abuse in childhood. The disorder is highly complex and the guidelines for therapy (International Society for the Study of Trauma and Dissociation, 2011) highlight the complexity of treatment which is undertaken in several phases. The goal of psychotherapeutic treatment is integrated functioning. The clinician is advised to recognize all identities equally as adaptations by the patient to master challenging situations. While the therapeutic alliance is a key element of each phase of treatment, clinicians are advised that they should take care to not underestimate the difficulties that clients with this disorder experience in establishing and maintaining the alliance. The deep distrust engendered by childhood abuse experiences may manifest as a complex of shifting transference roles in the relationship. Initial phases of treatment emphasize safety, stabilization and symptom reduction. Subsequent phases involve confronting, working through and integrating traumatic memories.

A survey of practices and recommended interventions in the treatment of dissociative identity disorder (Brande *et al.* 2011) offers a variety of perspectives and orientations among clinicians who treat the disorder. The outcome of clinical interventions may be integration (i.e. all dissociated states fuse together) or resolution (some states remain unfused within a cooperative system). Nonetheless, there is high agreement among clinicians regarding the value of a relationally focused intervention throughout all phases of treatment, specifically in establishing and repairing the therapeutic alliance. Intervention proceeds through various stages with emphasis in the early stages on establishing the therapeutic alliance. Subsequent stages involve working directly with the dissociated identities using a variety of strategies. Later stages focus on daily functioning skills, emotional regulation and future life goals.

As a consequence of her childhood experiences, Jennifer told Paul that her life was restricted by her internal “rules” which did not allow her to have feelings or self-expression and which had a profound impact on her sense of self-worth. Jennifer had been in therapy with clinical psychologists since 1998 and was continuing in treatment with her current therapist in twice weekly-sessions. The therapy focused on recovery using strategies consistent with the guidelines for treatment of Dissociative Identity Disorder. She was also taking anti-depressant and anti-anxiety medications under the supervision of a psychiatrist.

The coach and client co-constructed an agreement to work on a variety of life skills to improve her overall quality of life, including stress management and skills for developing friendships. Paul explained the distinctions between coaching and therapy and was clear that he did not want to interfere with the work she was doing with her psychotherapist. He defined his role as her thought partner and supporter to acquire the identified life skills. They clearly specified and agreed that trauma work was “out of bounds” in coaching and that she would continue her therapeutic work with the clinical psychologist. Coach and client began meeting weekly at Paul’s office. Initial coaching goals focused on the core life skills of stress management and learning basic interpersonal social skills. Later, these initial goals were expanded to include the goal of writing a book and speaking to college students about her experiences. The coach honored the client’s request that she serve as the liaison between coach and therapist. She felt strongly that she would be very uncomfortable about their discussing her if she was not a part of the conversation. Paul chose to respect the client’s request for confidentiality with the understanding that she would keep the therapist apprised of her work with the coach. She did so consistently, often sharing specific details of the coaching with the therapist and conveying feedback from the therapist

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The coach and client worked together for three years prior to contacting the author and documenting this case. During the course of this study, they met weekly for approximately two hours per session. The case documentation took place over a period of six months with subsequent interviews and information provided over another year in the preparation of this article. During this time, Jennifer continued her twice weekly sessions with her psychotherapist and her weekly coaching sessions with Paul.

Paul initiated a self-directed course of learning more about DID and invited Jennifer to share her own extensive clinical and personal knowledge of the disorder. In addition to studying the material contained in the Diagnostic and Statistical Manual of Mental Disorders, he used on-line search resources to find and read articles from a variety of professional sources. The coach reports that he also engaged in reflective learning from his experiences with the client. For example, he kept a record of the different identities and their roles in Jennifer's construct. He tracked shifts in the client's boundaries and degrees of risk-taking, noting the circumstances that supported such changes. He took a research in action approach to identifying the strategies he used and the impact on the client's boundaries and her feedback.

Paul sought to establish and maintain a safe environment for Jennifer as well as cultivating a deeply trusting relationship. Responding to the client's hyper-vigilance and safety issues, the coach took care to ensure that the physical surroundings of the office were consistent. The coach was aware of his gender as a factor in ensuring safety and trust in the relationship, given the client's history of abuse. He was transparent in advising Jennifer when he was about to stand or move about the room. He did not initiate physical contact. When Jennifer arrived for each session, Paul welcomed her at the door. The coach was highly attentive in listening, maintaining appropriate and non-challenging eye contact and a relaxed body language, regardless of the client's affect. He smiled naturally, spoke in a soft voice and maintained a calm and even tone.

When Jennifer first arrived at each session, Paul assessed her initial condition and continued his close observations throughout each of their sessions. If she had a headache or was consumed by another distracting issue, that directed the conversation. The coach partnered with the client to co-create the agenda for each coaching session within the constraints of her mental models. At the outset, because it was against the "rules" for Jennifer to choose or express a desire, the coach offered the client options for how she wanted to think through setting the agenda, suggesting one or two topics and asking for her partnership. Over the course of the coaching, he sought to use different strategies to encourage client expression in ways that maintained her safely while allowing her to experience self-direction. For example, creating a third-person space allowed Jennifer to express preferences. The coach might share a story about friends and invite Jennifer's reaction. When laughter occurred, Paul named the experience as a normal part of friendship and social interaction. Using a process of naming without pressing the client to own an unfamiliar experience introduced new concepts and experiences within the boundaries of her safe zone. Agenda topics included those that might be raised in any life coaching engagement: work and life-related stress, a new dog in the home, every day family issues, time management. Conversations covered a variety of subjects including art, music, coping skills, spirituality, and social conventions. In the course of coaching together, the participants used imagery such as a Quiet Forest that would help them center or ground as needed. They also developed specific metaphors that they could use as "shorthand" for recurring aspects of the client's challenge. The coach sometimes supported the client to role play or rehearses a new behavior. To cultivate Jennifer's awareness of her skills and internal resources, the coach helped her create a "strengths box" in which they collected notes about successful experiences and attributes she shared in their conversation. As the client started to bring her writings to the sessions, the coach first read the notes aloud to her. A shift occurred as Jennifer started to read her own work and Paul listened attentively and appreciatively as she read aloud.

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Several significant challenges emerged during the course of their coaching engagement. In particular, Jennifer's lethality (she often carried blades and had access to lethal doses of medication) was cause for concern. Asked about this by the author, Jennifer stated that this was one way for her to feel she retained control over her life. Her psychotherapist was very aware of the issue and they had an agreement about intention and notification. Jennifer's lethality was one of the issues addressed in their on-going therapy sessions. Jennifer and Paul both noted in their journals other challenges which arose in coaching sessions that were related to her history and disorder: the concept of secrets (she had been brainwashed by her abusers into believing that "If you tell, you die."); her sincere belief in her internal "reality; and significant abandonment issues, which had an impact on her ability to trust. Paul worked to maintain a balance of safety while encouraging Jennifer to comprehend and experience the world in ways that were often novel and challenging for her. Paul constantly monitored Jennifer's verbal and nonverbal cues and managed an appropriate transition process to end the coaching session. He took care to ensure she felt in control of herself and managed the trajectory of the session so that she could comfortably return to the outside world. On occasion, after particularly difficult conversations, the transition could take up to 30 minutes.

Periodically, the coach and client discussed the impact of the coaching work. Both felt strongly that the life coaching was assisting the client to improve in aspects of her life which were not addressed in her concurrent work with a psychotherapist. The coaching sessions addressed the client's social and interpersonal skills in meeting and making friends and engaging in what Jennifer described as "ordinary social experiences". As the goal of writing a book about her experiences evolved, they spent a number of sessions on time and task-management related to writing. Discussing this goal in particular, Jennifer refers to Paul as her "dream-maker". His belief in her and encouragement has "allowed me to continue working on the book." This project is progressing with outlines, content, and graphics and she is maintaining forward momentum on this process. Jennifer has established a connection with a professor of psychology at a local university and is speaking to graduate students in counseling programs about DID and her experience. She reported gaining a better definition of friendship, and found herself able to laugh and to talk about her life goals, especially of being a voice for people who suffer from DID. In particular, she wrote that coaching helped her to see "my dreams are possible...I can come out of the closet and speak to classes about this". Jennifer has made new friends, including the male professor to whose classes she speaks. The coach offers Jennifer strategies to help her organize, carry through, and rehearse assignments from her psychotherapist which, in turn, supports her continued progress in the therapeutic work.

In their respective journals, both client and coach recorded changes which they attributed to the life coaching. In particular, the client reported several shifts in her thinking and behavior. She noted that the relationship with the coach had helped her learn to trust men other than her therapist or husband. She attributes this trust to the coach's nonverbal communication, especially his eye contact; to his transparency; and to his openness and natural presentation, including his use of humor. Jennifer writes that she "figured out not everybody in the whole world is dangerous"; relieving her of the tension of feeling she needed to be continually on guard. The coach indicated that his awareness of gender and power dynamics in the client's history were critical in informing his self-presentation and affect with the client. He reports being consciously authentic and transparent in his self-presentation and extremely attentive to her particular safety concerns throughout. This included attention to the smallest physical detail (such as ensuring that all items in his office remained in the same placement from session to session). The coach noted that Jennifer was starting to have experiences that were beyond what her "rules" had initially allowed, moving from a carefully preserved physical distance to spontaneously

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initiating a hug with her coach. He observed that the coaching environment allowed her to be more authentic, take risks and mildly challenge her “script”, gaining a measure of self-confidence. For example, she stood up and effectively spoke to a local class of graduate students about her experiences. The act of inviting this author to document the case and allowing the author to sit in and observe two coaching sessions constituted a risk Jennifer was willing to take in furtherance of her goal of speaking on behalf of herself and others. Jennifer spoke up on her own behalf and clearly stated her opinion and positions to the author in the course of preparing and reviewing this paper. I observed a shift in her willingness to self-express from being very reserved at our initial meeting to a very clear, articulate and emphatic presentation of feedback in our penultimate interview.

Both participants report being changed by their work together. Coach and client noted that the coach also gained a new level of confidence, including the coach’s ability to acknowledge those areas where he needed to grow his knowledge and skills. He also gained confidence in his willingness and ability to stretch the client. The coach’s ability to hold a safe space and accept all of the client’s states with equanimity noticeably deepened over the course of the engagement. As the coach became familiar with each of the “alters” who might present, he addressed them by name and interacted with a conversational style appropriate to that identity. In a session which I observed, when a very young girl identity presented, he was careful to ensure that his vocabulary and tone of voice were appropriate to conversation with a child. His self-management also evolved, along with a heightened self-awareness. In a follow-up interview, Paul noted that he had a very “deep, strong emotional reaction” to Jennifer’s history and felt “strong anger”. He intentionally focused on maintaining strong empathy without betraying his own emotions and noted that he sometimes moved to a state he described as “non-attachment”, a framework of intellectual curiosity without personal involvement.

Observations

Through a reflective analysis of coach and client journals, the author identified key patterns in the coach and client experiences which point to five “checkpoints” (see Table 1) along the coaching/psychotherapy border where the participants established themselves within a coaching framework. These checkpoints identify actions in this case which address principles raised in the literature.

Both the coach and client in the case were aware of the existence of a border between coaching and therapy. The coaching agreement specifically formulated boundaries of coaching content and clarified differences in coaching and therapy processes. The coach clearly explained his role as a support and thinking partner for the client’s acquisition of the specific agreed upon life skills. Trauma work was clearly and explicitly excluded. Their journals reflect this awareness as well, documenting several instances of defining and making appropriate choices in the course of a session to ensure that the coaching remained within the agreed upon boundaries. For example, the coach attended closely to the client’s body language, particularly noting cues of an impending change in personality through her eye movements and focus. At several junctures over the sessions documented for this study, the coach noticed key cues and engaged in an internal debate about how to best proceed knowing that his choice might engender sufficient anxiety to catalyze a personality switch. His reflections identify the risks he might be taking and the process of weighing the possible consequences, along with a self-assessment of his ability to respond appropriately if a switch were to take place. As Hart, Battner & Leipsic (2001) and Buckley (2007) point out, it is essential that coaches have the ability to identify boundaries and make informed choices in the moment.

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<i>Checkpoint</i>	<i>Coach's Perspective</i>	<i>Client's Perspective</i>
Establishing the relationship, roles and boundaries	Ensuring safety; presenting self authentically; defining coaching and content and process distinctions from therapy; defining client-centered approach; articulating partner/support to role; maintaining coach stance	Presenting a life management focus; clearly distinguishing coach and therapist roles; defining communication patterns; articulating boundaries and internalized rules
Establishing goals	Life skills focus and language; defining social and communication skills; term "friendship"; planning and implementing book writing and public speaking specific activities	Initial goals defined as relief from stress headaches and learning about friendship; subsequent focus on life purpose in speaking and writing about experiences with disorder
Maintaining trust and safety	Transparent in all aspects from establishing role to moment to moment movements; attentive and responsive to client's need for environmental consistency; gentle, authentic presentation of self; use of body language; respectful of all of the client's "alters"; strong empathy with clear boundaries; continual observation and assessment, decision protocols for response	Pattern of "hyper vigilance" on her own behalf; attentive to all details of environment and coach behaviors (verbal and non-verbal); "alters" emerging when stressed; seeks to maintain control of self, environment; continuing work with psychotherapist
Fostering client-centered partnership	Attentive and responsive to client cues; maintaining focus on life skills goals; safe strategies for inviting client self-expression; client-specific language and metaphors	Willing to engage in some degree of risk-taking and self-expression; commitment to carry through between sessions; clearly articulating focus, needs and boundaries
Coaching processes	Empathetic presence; use of metaphors and imagery to foster safe space; maintaining silence; deep and attentive listening; constant self-awareness of strategy and attention to impact; moment to moment decision-making; emotional self-management; patience managing pacing and expectations	Felt truly heard and understood; strong eye contact shows "genuine caring"; reminded of strengths and successes; direct expression by coach fosters trust

Table 1: Border "Checkpoints": Key Patterns in the Coaching Framework

The approaches to establish coaching specific goals are consistent with Bachkirova's (2007) observation about coaching goals which enhance life satisfaction. As Paul defined his role with Jennifer, he served as a partner in the acquisition of life skills. In a communication from the coach in the case, Paul states that while coaching and psychotherapy "... both teach life skills...my theory is that coaches engage only in conversations regarding life skills and counselors engage in conversations of life skills plus more." He further notes that "conversations of life skills can be used to help people deal with mental disorders but life skills conversations don't include the psychodynamics of what is going on." The client and coach focused on the development of skills and behaviors: strategies for managing stress-related headaches, strategies for making new friends, strategies for planning and writing a book, public speaking activities, and skills for the client to engage in self-reflection. As the client noted in her reflections, a therapist "constantly challenges my reality in order to do the tough work of trauma", whereas the life coach "offers options, other possibilities and allows client (sic) to draw own conclusions."

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The coach's focus on establishing and maintaining safety and trust in a client-centered partnership speaks to Hart, Battner & Leipsic's (2001) position on ensuring equity and addressing the power dynamic. Several of the coaching strategies used by the client draw on the coach's Rogerian-oriented training. His training as a counselor also provided a knowledge and skill base to underpin his learning about the disorder and on-going assessment of the client's state throughout the sessions. Paul's reflections note his consideration of language, tone and affect alternatives and optimal strategies: for example, "I think if I make this more of an academic conversation, she can remain distant and not so personally involved. This will make it safer." The coach would occasionally engage in a mental rehearsal of the alternatives before speaking. He noted the responses that his coaching interventions elicited from the client and changed course as needed.

The coach recorded several instances where he used deep listening skills learned in his counselor and coach training. He noted he was "speaking into the listening, choosing the words and communicating strategically" (to maintain safety and focus on the session goals). The coach's journal indicated his awareness that he was "speaking to a host of disorders" and thus chose specific responses according to the client present at the time. He paid particular attention to word choice, for example characterizing self-expression as a life skill rather than a psychological need or a right. Similarly, aware that the client's "rules" would not allow her to hear compliments, the coach reframed affirming feedback to allow its acceptance. Rotenberg (2000) offers a comparison of how a professional understanding of unconscious motivation influences coaches and therapists. He notes that psychotherapists explore unconscious motivation to understand underlying conflict. Coaches use their understanding of unconscious motivation processes to inform a technical modification in their coaching strategies, seeking an approach which minimizes disruption of the client's psychological constructs. To illustrate the principle in this case, the coach intentionally uses the language of performance (e.g. "that is a good example of how friends communicate") rather than the language of psychologists (i.e. making a statement about her limiting construct around self-expression) in response to a client's self-expression.

The coach's training as a counselor also supported his ability to self-manage. Some of the client's personalities were aggressively protective of Jennifer. The client would sometimes discuss parts of the violent and brutal traumas she had experienced. The coach was able to maintain calm, accepting and even tone regardless of the client's presentation. The coach's understanding of psychodynamics was implicit in his interpretation of the client's body language, enabling him to recognize when their work was moving into territory best addressed in her work with her psychotherapist. On those occasions, he interrupted the coaching process to focus on the present moment and check in with the client. Allowing the client to discharge intensive thoughts, feelings and struggles allowed her to become more fully available to the task they had agreed to work on in the coaching session.

While the client had the self-awareness to recognize when she was "disappearing into the empty place", she could also acknowledge her trust in the relationship and feel that the dissociative state would be accepted by the coach. Her notes mention several times how important the coach's clinical knowledge and understanding are to her: "I know if I am in real trouble (he can) find ways in which he can be helpful". She also felt that his clinical knowledge allowed him to understand and accept her reality. The client reports she was always attentive to the coach's body language as well, especially the expression in his eyes, characterizing them as "genuine and caring". She was attuned to his listening – "he listens with his whole self" -and this allowed her to be more open. She also noted that he appears to stop and consider carefully, "testing how far he can push me before he loses the opportunity."

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As these patterns suggest, there were many points in this case where the practice aligned with recommendations and guidelines in the literature. Two key recommendations in the literature, however, are not present in this case. The guidelines for treatment (The International Association for the Study of Trauma and Dissociation, 2011) specify that treatment of an individual with DID may involve professionals other than the psychotherapist; however, it is essential that all involved professionals work as a team with coordination and agreed upon role definitions. The client's expressly stated that she needed the coaching work and psychotherapy work to remain separate and wished to serve as the liaison. The recommendation that coaches receive supervision (cite, cite) was also absent in this case. Paul's coach training and his entry into the field predated the use of formal coach supervision as a standard in the field. He has been a sole practitioner for almost 20 years. This pattern, coupled with the client's strong concern about confidentiality led the coach to self-direct without supervision. Both of these recommendations may have served the coach and client well, particularly in ensuring management of the boundaries and in the coach's reflective learning processes.

Discussion

Like many borders, the present boundary between coaching and psychotherapy is a somewhat theoretical construct: signposts rather than a high brick wall. There remains a high degree of ambiguity and fluidity in defining and navigating this border. As this case demonstrates, the characteristics of the coach and of the client and the goals of the engagement are key determinants. Nonetheless, this glimpse into a real-world experience with those boundaries points to key markers of the territory.

Both Cavanagh (2005) and Bachkirova (2007) underscore the importance of a coach's clinical knowledge. Coaches without mental health training may fail to notice subtle signs of mental disorder in their clients (Cavanagh 2005, p.23). He also warns that coaches may cause harm by encouraging depressed clients to set goals which are beyond their current capacity. Comparing the types of coaching goals and processes and measuring these against the knowledge and skill sets of different groups of coaching practitioners, Bachkirova concludes that coaches must be aware of the limitations of their skill set and apply the skills they have appropriately with respect to psychological issues in their practice. In this case, Paul's clinical education and his behavioral skills were critical to gaining and maintaining the client's trust. His professional education helped him to research and understand the specific mental disorder and to work within the parameters indicated by the particular condition. Both his counseling and coach training provided the tools to establish a deeply trusting relationship and to inspire the client's confidence in the coach's ability to manage the process. Understanding of transference and countertransference phenomena, a standard element of training for psychotherapists helped Paul to maintain appropriate boundaries. Given this client's history of abusive relationships with men, this knowledge was especially important in the case. The coach's skill in managing his own emotions reinforced these aspects of the coach-client dynamic (Cremona, 2010). The coach was able to attend to nuances of the client's presentation and adjust coaching interventions as seemed appropriate. The client aptly notes "all issues are not the same and those that are cannot be dealt with the same way."

The case also has implications for the types of clients with mental disorders who may be suitable for coaching. In this case, Jennifer has a very high degree of functioning as evidenced by a stable marriage and job. She has held a responsible position as a social worker with her organization for over 30 years. She has been in a stable marriage for 34 years. Her journals were highly detailed and reflected both her internal dialogues as well as close observation of the coach and environment. Jennifer came to coaching with an ability to make constructive use of the high degree of vigilance and need for safety which characterizes individuals who have experienced severe trauma. This includes an acute sense of self-

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awareness and the ability to objectively reflect on her self-observation. Her goals for the coaching engagement were consistent with life coaching goals: specific, measurable, outcome-oriented and future directed (Price, 2009; Maxwell, 2009). Price (2009) found that coach respondents to his study most frequently cited a future vs. past orientation as a key differentiator of coaching and therapy, followed by aspects of the processes used and the goals. Respondents also noted that clients play a “much more important role in determining what makes a coaching or therapeutic interaction than the coach/therapist” (p.140). Coach qualifications, training or personal competence were mentioned by only 11% of Price’s respondents. Maxwell’s (2009) interviews with coaches identified coaching issues which coaches perceived to be “at the boundary” and found that – as with Price’s respondents- the boundary was co-created by the client and the coach.

While this paper represents only one case- and an admittedly rare one- there is a strong possibility that at some time an individual with a mental disorder will seek coaching. This case suggests that the presence of a disorder which has been diagnosed by a qualified mental health professional need not preclude an individual from coaching or the benefits of coaching. As with all coaching clients, those with a clinical disorder have unique needs as well as unique capabilities. Rather than an exclusionary principle, a more nuanced model for considering the suitability of a client for coaching may emerge as more data are gathered in the continued investigation of the coaching/therapy boundary.

Limitations

This case study represents only a single, possibly anomalous case and observations made on the basis of this case may not be generally applicable. While the author sought to provide a measure of validity through cross-referencing multiple data sources and iterative feedback from participants, all data other than references from peer-reviewed journals are drawn from participant self-reports and author interpretation. Conclusions are drawn solely from information available in this case. It is hoped, however, that the identified “checkpoints” might serve as a point of reference for further study and verification using more empirical methods. In particular, further study is warranted to determine the essential knowledge and competencies required of coaches and the most appropriate strategies for educating coaches in these areas. Understanding transference-countertransference processes in coaching may also warrant additional study.

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