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Integrative Health Coaching: An Organizational Case Study

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Abstract: **OBJECTIVE:** The aim of this study was to describe integrative health (IH) coaching as developed in three different interventions offered through a major medical center, as a step toward further defining the field of health coaching.

STUDY DESIGN: An organizational case study was conducted with document analysis and interviews.

SETTING/PARTICIPANTS: Interviewees were the first six IH coaches at Duke Integrative Medicine who provided 360 clients with individual and/or group coaching (two to 28 sessions) in a randomized clinical study and two work-site wellness programs.

ANALYSIS: Qualitative analysis using the constant comparative method was conducted.

RESULTS: Integrative health coaching is characterized by a process of self-discovery that informs goal setting and builds internal motivation by linking clients' goals to their values and sense of purpose. Time, commitment, and motivation are necessary in the IH coaching process.

CONCLUSIONS: The underpinnings of IH coaching are distinct from the medical model, and the process is distinct from health education, executive coaching, and psychotherapy. Integrative health coaching fits well with the assumptions of integrative medicine and has a role in supporting behavior change.

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INTEGRATIVE HEALTH COACHING: AN ORGANIZATIONAL CASE STUDY

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Key words: Health coaching, integrative medicine, wellness, health promotion, disease prevention, work-site/community intervention

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INTRODUCTION

The definition and boundaries of health coaching are still being shaped. As defined by the International Coach Federation, coaching itself is "partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential."¹ Coaching clients are usually very functional but may not be achieving their full potential. Coaches generally work with clients to define goals, formulate a plan that will use the client's abilities, hold the client accountable for progress, and provide structure, encouragement, and support.

Integrative health coaching at Duke Integrative Medicine (Duke IM) began in 2002 with a study funded by the Centers for Medicare and Medicaid (CMS) called Strategic Health Planning (Table 1). When this randomized clinical trial found that the health coaching intervention reduced the 10-year prospective risk of coronary heart disease,² variations on the program were extended to employees at private companies through a program called Charter Partners, and to the employees of the medical center in the Duke Prospective Health program. Although ran-

domized controlled trials and qualitative studies of various face-to-face and tele-coaching interventions have been published,³⁻¹⁶ we could find no studies that describe the process we use. We have entitled this process "integrative health coaching" to clarify the distinctions. The purpose of this qualitative study was to clearly describe IH coaching and identify ongoing questions and lessons learned by IH coaches through service provision in the randomized controlled study and two work-site-based wellness programs.

METHOD

We used a qualitative case study design that included a document analysis and individual and group interviews of health coaches. A qualitative researcher (K.L.C.) who had not been involved in delivery of any of the health coaching services conducted an extensive document review. This included review of the following: (1) treatment session descriptions, (2) the coach's manual, (3) written program evaluations by participants, (4) notes from telephone interviews of participant feedback on the programs, (5) participant stories written by their health coaches, (6) forms used in the coaching process, (7) legal and fiscal contracts establishing the parameters of the programs, (8) meeting minutes from both operational and strategic planning meetings, and (9) notes from supervision. Based on the document review, the external reviewer developed questions for interviews with the health coaches. Six coaches who had been involved in the provision of coaching services in the three programs were available for interviews (J.M.K., J.P.W., L.V.D., J.G., K.J.L., A.S.), as well as the leader of the health coaching team (R.Q.W.). These coaches were interviewed in one focus group (n = 3) and seven

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Table 1. Program Characteristics of Three Integrative Health Coaching Programs at Duke Integrative Medicine, 2002-2005

Program Characteristic	CMS-Funded Strategic Health Plan Study, 2002-2004	Duke Prospective Health Coaching, 2004-2005	Charter Partners Experience, 2004-2005
Target population	Those at elevated risk for heart disease	Employees at increased health risk	Employees from 12 different companies who were members of Charter Partner
Length of coaching	10 months	Year 1: 3 months Year 2: 2 sessions	6 months
Number and spacing of coaching sessions	28 in-person groups of 8-12 participants, provided weekly for 4 months, biweekly for 5 months, then monthly Individual coaching provided biweekly by telephone	Year 1: 9 coaching groups of 5-9 participants provided in person or telephonically at participants' choice Year 2: individual or group, telephone format Included Web-based information and monthly educational sessions	Weekend retreat, initial individual coaching session plus 6 months group coaching provided weekly for 3 months and then biweekly for 3 months Retreat was in person, with 14-24 participants; group coaching delivered via telephone bridge lines for 6-8 participants at a time
Length of coaching sessions	2 hours for group sessions; 20-30 minutes for individual coaching sessions	Year 1: 60 minutes, groups Year 2: 60 minutes, groups or 20-30 minutes, individual calls	60-90 minutes, depending on group size
Number of participants	77	229	54
Integrative health coaches	Gresko, Little, Shaw, Wakefield	Gresko, Duda, Little, Wakefield	Frey, Kosey, Little, Shaw

CMS, Centers for Medicare and Medicaid Services.

individual interviews. The interviews were subsequently audio-taped and transcribed.

Data collected through the document analysis and interviews were managed with the assistance of NVivo7 computer software (QSR International, Doncaster, Victoria, Australia). The external reviewer (K.L.C.) developed an open coding system during the document review and interview process. Using a constant comparative method of analysis, additional hypotheses and questions were developed, which then formed the basis of additional interviews. Using the coding function of the NVivo software, passages with the same coding could be gathered, and based on patterns within each code, an axial coding scheme was developed. Another researcher (R.Q.W.) reviewed and revised the developing thematic coding scheme. When no new themes emerged in the interview process, a thematic narrative was developed by K.L.C. and then revised by the health coaches. We also developed an audit trail that included the following: (1) a methodological journal; (2) interview transcripts; (3) a list of documents reviewed; (4) coding definitions; and (5) data reduction, reconstruction, and synthesis products.

RESULTS

The five most frequently used codes in the transcripts referred to the following: (1) the process of IH coaching, (2) training to be a health coach, (3) fit with integrative medicine, (4) defining coaching, (5) and lessons learned. After examining the overlap between coding segments, these codes were simplified to two

main themes: defining coaching (which included codes two and four) and the process of IH coaching (which included codes one, three, and five).

Ongoing questions and lessons learned by each coach reflect the unique background of each coach. These reflections demonstrate the unique approach to coaching that resulted from the interplay of the skills of each coach and the requirements of the research studies and work-site wellness programs through which they provided coaching. Together, the coaches created detailed treatment manuals for group and individual coaching processes based on the following: (1) their clinical skills; (2) coaching supervision they received from a nationally known coaching supervisor and author; (3) the supervision they received from a clinical health psychologist trained in solution-focused, cognitive-behavioral, and strength-based approaches, as well as motivational interviewing (R.Q.W.); and (4) the training and emphasis on mindfulness that characterizes the integrative medicine approach at Duke. Four members of the team were or had been licensed psychotherapists from distinct backgrounds. One had doctoral level training in marriage and family therapy (A.S.), one had master's level training in health psychology (J.P.W.), one in clinical social work (L.V.D.), and one in rehabilitation counseling (J.G.). Two members had master's level training in health behavior change (J.M.K. and K.J.L.). Four began the work with minimal life coaching training, one with substantial life coaching training, and another with extensive experience as a life coach. All six continued to obtain additional

training through various life coaching schools across the three programs. All felt the holistic emphasis of integrative medicine was a good fit with their own preferences for client interaction, solution-focused theories, and positive psychology.

What to Call It? Defining IH Coaching

Because the field of health coaching is relatively new, the term *coaching* can refer to many different kinds of practices. The International Coach Federation has put together standards for the field of coaching, including a code of ethics and credentialing. However, a bachelor's degree is not even required for entry into the field. The knowledge base of coaching at this point is not unique to coaching but comes from many areas, including the following: human development, humanistic psychology, positive psychology, motivational interviewing, organizational psychology, leadership development, and solution-focused therapy.

In the process of trying to name the service they were providing, coaches involved in the Duke programs felt it important to distinguish their approach from seemingly similar approaches, such as case management, health promotion, psychotherapy, executive coaching, or life coaching.

Distinct from medical model. Integrative health coaching philosophically differs from the conventional medical model, and thus from systems that are based upon it such as case management and disease management. The primary philosophical difference is that IH coaches, like most coaches, believe that their clients have or can obtain the internal resources to meet their goals. They see their clients as partners that may need support, challenge, or guidance, but do not need an expert to “fix” the client's problems. Having worked with traditionally trained physicians in conventional medical settings prior to her involvement at integrative medicine, one coach commented, “It's a whole different paradigm. Two worlds collide. And they don't have to collide, they could actually find a way to dance together.” However, healthcare centered on the client's values, sense of purpose, and personal health goals is a radical shift from the current model that focuses on symptoms and diagnosis.

Distinct from health education. One manifestation of this philosophical difference is seen in the process of goal setting. In most case management and health education programs, the coaching agenda is driven by the goals of the disease management or insurance company (eg, lower costs by helping clients to lose weight—the goal for the company is weight loss). Although IH coaches do work with clients who are actively managing disease processes, the coaching agenda in IH coaching and the specific behavioral goals developed are clearly those of the client rather than a third party (eg, the disease management entity or insurance company). One coach described the difference between health educators or case managers and IH coaching by referring to the type of questions persons in these two positions would ask. Case managers are more likely to ask questions focused on the disease management process such as, “Have you (eg,

gotten your HbA1c, pap smear, etc.?” or “Are you on top of this (prescription refills or sugar levels)?” The questions an IH coach would ask focus on the client's agenda: “Let's look at what's important to you. Where do you want to take this?” This distinction is important for two reasons. First, IH coaching is centered on clients' values, sense of purpose, and personal vision for their lives. This represents a radical shift from the current medical model and related systems (eg, health insurance and disease management industries) that focus on diagnosis and treatment of symptoms. Second, there may be cost implications for these distinct approaches. For example, in the third year of the Duke Prospective Health program, IH coaches were replaced with care managers and programmatic offerings because these were seen as less costly in the short term. The question of whether IH coaching is more cost effective in the long run than case management remains to be tested.

IH coaching fits well with integrative medicine. Integrative health coaching is philosophically aligned with integrative medicine. Although each of the IH coaches comes from a distinct professional background, they each expressed appreciation for the good fit between coaching and integrative medicine. When asked to describe the fit, coaches referred to four main areas: (1) focus on mindfulness, (2) partnership approach, (3) holistic approach to address a wide range of issues, and (4) using an evidence base to integrate modes of care not traditionally associated with medical practice (eg, mindfulness, guided visualization). One coach acknowledged that many health coaching approaches use a “wheel of health” to ask about different parts of people's lives, but the “main difference with integrative medicine is the mindfulness. A lot of other wheels don't have mindfulness at the center.”¹⁷ Mindful awareness is cultivated by intentionally paying attention without judgment to whatever arises in the present moment.¹⁸ By deliberately paying attention, we create the opportunity to be more fully and skillfully present in our lives. This appears to increase our ability to make better choices and fewer habitual ones.

Distinct from psychotherapy, executive coaching, and life coaching. Integrative health coaching requires a unique skill set that is distinct from psychotherapeutic and other coaching approaches. Although coaching is based on a number of psychological principles, and the field of coaching began in the executive arena, the IH coaches are acutely aware of how IH coaching is distinct from psychotherapy, executive coaching, and life coaching. Because of their experience as psychotherapists (L.V.D., J.P.W., A.S., J.G.) and an executive coach (A.S.), the IH coaches described the distinctions: Traditionally, psychotherapists and their clients approach the helping process from the position of “I have a problem,” whereas executive, life, and health coaches approach the helping process from the position, “I have a goal I want to obtain.” Another coach described the distinctions in this way: “As a coach, you're not really ‘providing,’ the same way that a therapist would; you're not providing the clarification and insight. You're really allowing your clients to provide it for

themselves; you're asking the questions that allow them to have the insights." However, in executive and life coaching, the issues presented by clients are around leadership and professional development or personal development, respectively, and clients are generally high functioning. So what happens when a client needs health coaching for a health problem; is that therapy or coaching? What happens if clients are not as high functioning as traditional coaching clients?

Integrative health coaching clients can include those with serious health concerns who are facing life-threatening and existential challenges, those with personality disorders, or those whose primary concern is intense affect or a psychological disorder. In a private coaching practice, coaches can readily refer out clients who are not able to initially focus on reaching specific goals. The situation can be different with IH coaching because clients often present with more complex situations. The IH coaches agreed that a clinical background is useful in this medical setting.

Client fragility is also relevant in determining the extent to which the client can make good use of coaching. Coaching is a process based on honest feedback, open communication, and conveyance of the belief that the client has (or can build) the internal resources to change. The coach must be able to directly, but with kindness, point out discrepancies in clients' stated goals and their behavior. When clients are more vulnerable, they may be less able to tolerate honest feedback and less likely to openly talk with their coaches about how they feel about the feedback.

Client vulnerability also can be characterized in terms of physical health (eg, how physiologically compromised they are and what resources are available to them to support change). Although life coaches may have some understanding of physical health and how to promote health behavior changes, IH coaches need specific training to work with high-risk populations they are likely to encounter. For example, when a client with diabetes complained of frequent disorientation, the IH coach knew to support her in taking her blood sugar regularly and contacting her physician to get updated treatment recommendations. Another IH coach worked with a participant who had avoided contacting her physician for three years because she feared that her partner had given her HIV. The IH coach helped her to manage her fear, communicate with her physician, and obtain the much needed HIV testing. In addition to general training about relevant medical conditions and screenings, IH coaches need to recognize the signs that indicate need for medical referral. One participant in a group focused on cardiovascular risk reduction was having left jaw and arm pain. Fortunately, the coach recognized these symptoms as potential signs of a cardiac emergency and sent him to the emergency room.

The team of physicians and therapists available at Duke IM provide strong support for dealing with complicated situations. As one coach phrased it, "Especially in the health arena, vulnerable people are coming to you for help. You can suddenly be in way over your head and not know it. And that's what scares me. So for our team, we've done a lot of trying to help each other understand what are the flags [that indicate when to refer]. We

have a couple of staff who are both a coach and therapist. That helps."

Lessons Learned

Developing an IH coaching program within an academic medical center requires skillful management of complexity.

First, the philosophical models are distinct, and second, definitions of the approach are still evolving. Since IH coaching is philosophically distinct from the conventional medical model, IH program leadership must be able to communicate effectively to help other leaders understand the work and co-create opportunities to test its utility. Successful work-site wellness initiatives that utilize IH coaching require collaboration between the work-site wellness leaders and the IH coaching leadership. This collaborative process requires a high level of negotiation skill by all parties and strongly benefits from determining clear measures of success at the beginning of the initiative.

The establishment of job titles and job descriptions along with determining the optimal level of training and background for coaches adds to the complexity of management. One coach commented, "In a health care system, often the assumption is that you just take a health care provider and teach them minimal coaching skills and then they'll be a health coach." But the coaches and IH leadership have learned that the process is actually considerably more complex. Getting human resources at a large institution to understand this, however, has been quite challenging. Duke IH coaches had previously held job titles such as *lifestyle maintenance counselor* and *health educator*, but they felt strongly that the practice of IH coaching required a unique set of skills and a wider knowledge base than what they had used in these positions. One coach echoed the challenges in defining IH coaching by saying, "Different people have different ideas about what it takes to do a health coaching job well—how much of it is skill? How much formal academic training do you need? If so, what particular kind is needed? Who are we hiring?" Another coach who had had significant previous management responsibilities said, "In a large health care system, people want to fit into something they already know and they have structures and categories for . . . We prepared all our job descriptions [for IH coaches] and submitted it to human resources and the position came back as lower than a health educator when we were in fact trying to say that you need to have everything a health educator has plus additional skills."

Because the skill set of IH coaches is unique, the whole issue of whether coaches should have liability insurance is unresolved. When a coach is considered to have an educational and/or motivational role and not a clinical role, then liability insurance is not clearly needed. When the role is considered to be clinical, then liability insurance is indicated. Which is it? This remains an ongoing question. One coach described this situation: "Different arms of a major academic medical center are looking at us through different lens; it's immensely complicated trying to figure out how you fit."

Program format lessons. Establishing the role of the IH coach required multiple trials of program formats to clarify which formats made the most sense logistically. The formats varied in the

amount of coaching, whether they included individual and/or group coaching, and the spacing of coaching sessions. Two lessons were learned. First, although group coaching is the most economical and provides an additional level of social support, it is also the most logistically challenging to coordinate. Second, although individual participants find it helpful to obtain more attention at the start of programs, the logistics of offering sessions weekly, then biweekly, then monthly, are outweighed by the complex task of matching coaching staff availability with times of intense need and times of minimal need for various programs. One IH coach advised, "When you have busy people (coaches and participants) with packed schedules it is very challenging to find a time that's going to work consistently for participants over an extended period of time. Programmatically, we've learned that it's better to keep coaching participants on a consistent rhythm rather than kicking off with more intense coaching at the beginning of programs and tapering off as you go. Looking at it from a management perspective rather than a client's perspective, staffing for large fluctuations is just too difficult. It's easier to work staff schedules out if the coaching schedule is consistent rather than tapering off the amount of coaching."

The Process of IH Coaching

Integrative health coaching is characterized by a client-centered process of self-discovery that informs goal setting and builds internal motivation by linking the goals to a client's values and sense of purpose.

Linking goals to values and sense of purpose. All coaching approaches share a process whereby clients identify goals, create action steps to reach goals, and develop strategies to stay accountable. Our coaches described this aspect of their work as "being an ally, a confidant, a teacher." Various health coaching approaches differ, however, in terms of the amount of education the coach provides, as well as the degree to which the process is truly client centric: whose goals are being addressed? Integrative health coaching is further unique in the depth and breadth of self-discovery, the linking of behavioral goals to an individual's larger vision and sense of purpose. Integrative health coaches describe this aspect of the process as "engaging clients in self-discovery," being "an explorer," and "teaching clients how to use the process [of linking goals and vision]." The IH coaches also used a number of metaphors to describe their work: "finding a way to dance together," "an art," "an exploration," "coaching a rich sauce or a rich meal," and "using language in a way that brings a kind of energy into people's lives."

Reliance on self-discovery. The reliance of IH coaching on self-discovery is perhaps the primary distinction between IH coaching and more traditional health education or medical model approaches. The depth and breadth of this self-discovery process and the amount of time coaches spend supporting their clients in self-discovery may also distinguish IH coaching from other coaching approaches. Integrative health coaching also uses some of the skills of motivational interviewing to help participants sort out ambivalence but involves many additional skills

in building motivation based on helping participants gain clarity on their personal values and create a holistic vision of their health as they would like it to be. Coaches then help participants connect specific desired health behaviors to this sense of meaning. One coach said, "The connection to values happens early in coaching. I like to start mining for values in the first call." This focus on values and purpose can happen in a number of ways. One coach gave an example of this coaching skill as "listening for what has deep meaning" for participants and then punctuating this by saying something like, "It seems like this is very important to you." Another coach mentioned asking questions such as, "How do you imagine your life would be different if you lost weight? What would be possible for you if you quit smoking?" This motivational process also involves pointing to the "bigger picture." One coach used the metaphor of "feeling like a huge tree with a lot of branches, and people kind of hang out on the branches and swing, and look over the roof tops and catch a glimpse of what's before them. Knowing that my roots are pretty deeply planted, so they can feel safe swinging, or changing or whatever they choose to do." Another coach mentioned that for some clients, this involves getting in touch with spiritual resources. She referred to one of her clients who had quit smoking, and when asked what had helped him, his response was, "I asked God for help."

Another way to discover what has deep meaning for participants is doing a future self-visualization, which as one coach said, "not only helps them visualize their future but, for some people, speak about where they are and what's with them . . . So that also speaks to values." Other approaches could be asking questions like, "If your house is burning down and you have five minutes to take out the most important items, what would you take?" or "Remember a day or a time that was very important and special for you." These are other ways to "mine" for values, but techniques are not necessary, according to one of the coaches: "When people start talking about what's going on in their life you can really get a sense [of what is important to them]. But I do check it out and confirm. So what I talk with them about is connecting wherever they want to make a change in their life, making sure that we keep that connected to values. If it has meaning to them, there's a greater likelihood that it will happen. There will be commitment."

Meeting clients where they are. Like other coaching approaches, IH coaches constantly balance participant accountability and permission to change at one's own pace. Each IH coach referred to the importance of meeting clients where they are. One coach recalled learning this lesson from one of her male clients with whom she struggled in the beginning because she was trying to help him shift into a behavior that wasn't right for him. He was obese, but he really wanted to focus on some communication in his life. "We had focused on exercise and some nutrition changes, but what was most valuable to him was when we started working on how to better communicate with people in his life." In the conventional medical model, healthcare providers are the experts whose education and training allows them to "know what is best for patients." However, IH coaches have become sensitized to the risks of undermining the

provider-client relationship when pushing clients for a health behavior change they are not ready to make. There is an additional risk for clients to attempt changes when they are not ready. If clients are unable to continue the changes, they often feel like failures, which can reduce the chance that they will try again in the future.

When the partnership between client and coach allows for free give and take, then clients can create or discover strategies for change that are uniquely fitted to their particular situations. For example, one overweight participant had set as one of her goals to eat more vegetables. She mentioned to her coach that although she often bought vegetables, they usually rotted because she forgot about them. The coach asked, “How could you not forget about them?” The client thought of putting them in a bowl in the middle of the refrigerator rather than keeping them in the drawer at the bottom of the refrigerator, and this change led to a shift in eating behavior that eventually translated into a large reduction in weight. When this same client was facing joint surgery, she wrote to her coach about her plan to use the skills she had learned in the coaching relationship to prepare for and recover from the surgery. Having learned a process to solve her own problems, she planned to reuse that process in a new situation. Had the coach just told her how to “not forget” the vegetables, she would not have learned this process.

As participants accomplish their goals, their self-confidence increases. As they recognize their ability and competence in achieving small steps toward goals, they are more confident about taking the next steps needed. For example, a coach remembered one participant who made a number of successful behavioral changes in the six months that he participated in group coaching, although he did not choose to stop smoking during the intervention. A year after the coaching program had finished, his coach received an unsolicited e-mail from him saying that he had quit smoking. This was a powerful indicator of the way in which he had internally shifted; he learned to make small changes and stay accountable. This increased his confidence until he had enough pieces in place in his life that he was ready to take on the really big step of smoking cessation.

Time, commitment, and motivation are required for success in the IH coaching process. The three projects central to this case study (Table 1) involve various structural formats, such as individual and group coaching both in person and telephonically, as well as distinct amounts of time spent with clients, ranging from two sessions to 10 months of biweekly contact. These varying formats required different amounts of commitment from participants and created the context for different types of coaching relationships.

How much time is needed for clients to affect change? Although this must be answered empirically, this qualitative study identified the necessary steps in the IH coaching process (Table 2). Time is needed in IH coaching for clients to accomplish the following: (1) to build trust, (2) to experience support, (3) to gain knowledge of their health risks, (4) to create a personal vision of their health based on their own values and sense of purpose, (5) to connect this vision to specific health behaviors, (6) to learn the process of goal setting and creating do-

Table 2. Essential Components of Integrative Health Coaching That Require Time to Develop

- 1 Trust is built with the individual coach and if group coaching occurs, with the group members.
- 2 Clients experience support from the coach and the group (if relevant), as this is one of the key generative aspects of the change process.
- 3 Clients acquire enough knowledge of their health risks to be able to set realistic goals.
- 4 Participants create a vision of their health as they would like it to be, gain clarity on their personal values, reflect on the meaning of their life or their purpose, and connect specific desired health behaviors to this sense of meaning.
- 5 Participants learn to use the coaching process to create SMART goals and develop small, doable action steps.
- 6 Participants experience success in forming new habits which can, in turn, create changes in motivation and physiology.
- 7 Participants maintain new health behaviors and receive support for this.

SMART, Smart, Measurable, Action-oriented, Realistic, Time-bound.

able action steps, (7) to form new habits, and then (8) to maintain new health behaviors. For example, in the 10-month CMS program, changes in biomarkers mostly occurred by the five-month time point. When asked how she explained these results, a coach responded, “it (5 months) gives people enough chance to form a habit and feel successful and feel supported . . . longer is better for the maintenance phase.” Another coach commented, “with CMS we knew we were going to be in a relationship because we committed to 10 months together . . . versus, Charter Partners was a work culture, so, although people really knew each other and had support, it was different because at work you want to be careful how much personal information you divulge to someone you’re going to see every day.” Referring to the difference between the first year of the Duke Prospective Health program with nine coaching sessions and the second year with only two coaching sessions, one coach said, “I really felt the difference. You feel like you’re just starting the relationship [in two sessions], just starting the coaching process, then you had to end.”

Internal versus external motivation factors also differed across the various program formats. One coach explained, “People in the CMS study were extremely motivated to commit to 10 months of effort. They chose for themselves. They signed themselves up. With Charter Partners, [management] wanted everybody to participate, so there was more pressure to join. And then what was really different with Duke Prospective Health, they had case managers signing them up, with pressure from the case managers. So we got a lot of no shows in our orientations, about half of those that signed up . . . I found that to be a real difference in the commitment level of the participants.”

Future directions for research include the need to compare or distinguish ways in which IH coaching may differ from other coaching approaches.

CONCLUSION: SO WHAT?

In summary, one consistent piece of advice offered by Duke IM coaches was to get life coaching training from a reputable site approved by the International Coach Federation. To then address the need for professional education in this specific IH coaching model, Duke has created and currently offers professional training in IH coaching. The field of health coaching is still being defined, but IH coaches identified a good fit between the assumptions of life coaching and integrative medicine. Duke IM coaches developed their unique skill set in a number of ways. Those in leadership positions negotiating Duke IM coaching programs need a strong tolerance for complexity. As developed at Duke, the Duke IM coaching process requires time, commitment, and motivation on the part of clients to develop individualized health visions, goals, and plans. When the relationship between client and coach allows for free give and take in a partnership, clients can create or discover strategies for change that are uniquely fitted to the particular situations.

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