IT IS OFTEN SAID that coaching is not therapy and that coaching does not aim to treat psychological problems, mental illness or other issues of pathology. Rather, coaching clients are looking for ways to better attain their goals, improve their performance and enhance their quality of life (see, for example, Whitworth et al., 1998). Are these mantras in fact true? If not, how can we integrate issues related to mental health and goal striving within a coaching-related model?

As the practice of coaching develops and as research into coaching advances, our understanding of the parameters of the coaching industry and demographics of coaching clients has become more sophisticated. As this knowledge has developed, it has become increasingly clear that there is a discrepancy between espoused ideas about what coaching 'should' be and the reality of what happens in real-life coaching practice. In reality, the boundaries between coaching practice and therapeutic practice are somewhat blurred.

That there has been little theoretical or empirical research exploring the boundaries between coaching and therapy is a serious shortcoming in the coaching literature. Clearly, the coaching industry and coaching psychology would benefit from coaching-related models that delineate issues of goal striving, mental health/mental illness and psychopathology.

In this paper past approaches to distinguishing coaching from therapy are discussed. The key foci of coaching; goal striving, well-being enhancement and goal attainment, are distinguished from the foci of therapeutic interventions which are identified as the treatment of psycho-

A model of goal striving and mental health for coaching populations

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Coaching focuses both on facilitating goal attainment and enhancing well-being. Yet there has been little work on developing models that integrate mental health/illness issues with goal striving. This is important because many distinctions between coaching and therapy have been based on the supposed differing levels of psychopathology in clinical, counselling and coaching populations. However, research suggests that some coaching clients have high levels of depression, anxiety or stress, and there is recent evidence that coaching clients who voluntarily seek life coaching tend to have higher levels of psychopathology than individuals who undertake coaching as part of a workplace coaching program. These findings underscore the importance of coaches having a sophisticated understanding of the issues related to coaching and mental health. Drawing on recent languishing-flourishing work in the area of positive psychology this paper presents a new provisional model of goal striving and mental health/mental illness with two key dimensions: (i) mental health-illness; and (ii) intentional goal striving (high or low). The languishing section of the model represents individuals who are have low levels of psychological or subjective well-being but do not have elevated levels of depression, anxiety or stress. The acquiescent section is where individuals have good levels of mental health and but have low levels of intentional goal striving. The flourishing section is where individuals have high levels of mental health and are actively engaging in high levels of intentional goal striving. The model also delineates a distressed but functional client group who have high levels of intentional goal striving, but significant levels of psychopathology, and distinguishes those from clients with major psychopathology but very low levels of intentional goal striving. Recommendations are made for future coaching research and practice.
pathology. Drawing on recent languishing-flourishing work in the area of positive psychology (Keyes, 2003), this paper then presents a new provisional model of goal striving and mental health/mental illness for use in coaching research and practice. Recent comparative research, presented in this paper, suggests that coaching clients who voluntarily seek life coaching have higher levels of psycho-pathology than individuals who undertake coaching as part of a workplace coaching programme. These findings underscore the importance of coaches having a sophisticated understanding of the issues related to coaching and mental health.

Coach or couch?
A wide range of factors have been used to differentiate coaching from therapy. Coaching is said to have a greater emphasis on structured conversations and goal attainment (Hart et al., 2001), and greater variation in modes of delivery, with coaching being conducted in short sessions, by face-to-face, by phone or e-mail (Richard, 1999). Coaching is also said to be more focused on solution construction rather than problem analysis, and focuses on the present rather than on the past (Berg & Szabo, 2005) or unconscious facets of behaviour (Levinson, 1996).

However, for each distinction offered, alternative viewpoints have been presented. For example, it has been proposed that coaching is developmental rather than goal focused (Kilburg, 2000), should incorporate the past as well as the present (Kemp, 2005), should focus on emotions rather than actions (Schlegelmich & Fresco, 2005), and should prioritise the delivery of expert skills-based knowledge rather than focusing on self-directed learning (Fox, 1983).

Such distinctions centre on how coaching is conducted, rather than who the coaching client is, or the specific focus or goals of the coaching intervention. Whilst distinctions based on how coaching is conducted give a useful overview of what coaches do with their clients, they give an incomplete picture of the differences between coaching and therapeutic modalities, and they give little guidance to coaches about how to deal with psychopathology within a coaching engagement (for further discussion see Bluckert, 2005).

The normal curve: Distinguishing the abnormal pollution?
Another way that coaching has been differentiated from therapy considers the different levels of degree of psychopathology seen in coaching, counselling and clinical populations. This somewhat simplistic approach is based on the distribution of psychopathology in the general population which is represented as lying on the normal distribution (Krabbendam et al., 2004). In such approaches the extreme end of the normal distribution of psychopathology (say, approximately three to four standard deviations below the mean) can be deemed to be a psychiatric population, with less extreme sections of the distribution being deemed clinical, counselling and coaching populations respectively (see Figure 1; see Cavanagh (2005) and Sperry (2004) for detailed discussions of this issue).

This approach to delineating coaching from therapeutic modalities is based on two fundamental assumptions. First, that coaching clients do not present clinically significant problems for treatment or are from a ‘non-clinical’ section of the population. Second, that coaching is primarily about enhancing goal striving and well-being rather than treating mental illness or distress. This is an important and central philosophical assumption about coaching and coaching psychology, and reflects the espoused viewpoint of a large number organisations including the Association of Coaching (AC), the European Mentoring and Coaching Council (EMCC), the International Coach Federation (ICF), the Worldwide Association of Business Coaches (WABC), and a wide range of individual commentators such as Parkes (1955), Whitmore (1992), and Williams and Thomas (2004).
The notion that a range of client groups *per se* can be distinguished by reference to varying degrees of psychopathology is central to the Australian Psychological Society (APS) distinctions between coaching, counselling and clinical psychology. The APS Interest Group in Coaching Psychology (IGCP) defines coaching psychology as ‘the systematic application of behavioural science, which is focused on the enhancement of life experience, work performance and well-being for individuals, groups and organisations with *no clinically significant mental health issues or abnormal levels of distress*’ (italics added; APS IGCP, 2003).

The APS distinguishes counselling psychology as being predominantly focused on the use of ‘therapeutic techniques’ in the amelioration of distress. Thus ‘individuals may seek assistance from a counselling psychologist to help them to … ‘manage stress and conflict at home and work, deal with grief, loss and trauma, [and] overcome feelings of anxiety and fear’ (APS, 2007a).

In contrast, ‘clinical psychologists are specialists in the assessment, diagnosis and treatment of psychological problems and *mental illness*’ (italics added; APS, 2007b), with the majority of the training of clinical psychologists primarily focusing on the identification and treatment of psychopathological states.

The focus of coaching psychology then is subtly different to that of clinical and counselling practice. As can be seen from the above APS definitions, the primary focus of clinical and counselling practitioners is the alleviation of psychopathology or distress and addresses such issues directly. In contrast, the primary focus of coaching is not explicitly on alleviating psychopathology or primarily dealing with distress, rather it is about assisting clients in articulating goals and helping them systematically strive toward goal attainment. These goals may be developmental or focused on enhancing performance or acquiring a specific skill set.

**The psychopathology of coaching clients: Three recent studies**

There has been very little empirical research into the levels of psychopathology found in coaching clients. Although there have been concerns that coaching is being used as a de facto form of therapy (Berglas, 2002), and various authors have reported anecdotal concerns about the overlap between coaching and therapy (Naughton, 2002), to the present author’s best knowledge only...
three studies have quantitatively collected data on the extent to coaching populations manifest psychopathology.

As part of a study of the effectiveness of life coaching, Green et al. (2005), surveyed a total of 107 potential life coaching clients from a community sample and found 52 per cent had clinically elevated scores (a score of two standard deviations above the mean) on the Brief Symptom Inventory (BSI: Derogatis & Melisaratos, 1983). The BSI is a well-validated self-report health screening instrument designed to be used with both clinical and non-clinical populations (Preston & Harrison, 2003).

Reflecting Green et al.’s (2005) finding, and using another community sample and the same BSI screening criteria, Spence and Grant (2007) found that 25 per cent of 84 participants in a life coaching programme had clinically elevated BSI scores. It worth noting that whilst Green et al. (2005) drew their sample from a regional centre with a relatively low socio-economic status, Spence and Grant (2007) drew their sample from a capital city with a relatively higher socio-economic status. The comparative results of these two studies suggest that individuals who seek life coaching may have higher than average levels of psychopathology, and such levels may be reflective of the specific population from which the sample is drawn.

A third study examined the extent of psychopathology in 43 participants who took part in a workplace coaching programme in an Australian high school. Using the Depression, Anxiety and Stress Scales (DASS; Lovibond & Lovibond, 1995) Grant et al. (2007) found that 4.6 per cent of participants had levels of depression at the 90th percentile or above, 21.9 per cent had levels of anxiety at the 90th percentile or above, and 18.6 per cent had stress levels at the 90th percentile or above (note: percentiles used follow recommendations of Crawford & Henry, 2003). These levels of depression, anxiety and stress appear to be in accord with the general levels found in the teaching profession (see van Dick & Wanger, 2001).

The DASS is a well-validated self-report measure of depression, anxiety and stress suitable for use in both clinical and non-clinical populations (Clara et al., 2001; Henry & Crawford, 2005)

The sample sizes in these three studies are not large enough to draw definitive conclusions. However, they provide useful preliminary empirical evidence about psychopathology in coaching populations, and indicate that these levels can vary considerably depending on the specific population. This point is further reinforced by recent Australian research examining the mental health of 7500 individuals from a number of professions which found that 15 per cent of lawyers, 10 per cent of accountants and nine per cent of information technology professionals had symptoms indicative of moderate or severe depression (Australian Financial Review, 2007). Together these findings illustrate the inadequacy of differentiating coaching from counselling or clinical populations merely by means of levels of population psycho-pathology, and emphasise that coaches need more sophisticated theoretical frameworks.

**Psychopathology: A languishing-flourishing distinction**

Given that a proportion of clients presenting for coaching will have mental health problems, do such issues exclude them from coaching? Can a professional coach ethically coach someone with an anxiety disorder, when the goals of the coaching engagement are about a work or leadership development-related issue, or if the client who becomes depressed during the coaching engagement? How are we to understand such mental health issues in relation to goal attainment within a coaching context?

Recent theorising from within the positive psychology area may be useful here. Keyes (2003) has proposed a model for use in the study of mental health and mental illness within the positive psychology framework. Keyes conceptualises mental health and mental illness as being separate constructs.
with two orthogonal dimensions: the mental health continuum and the mental illness continuum (see Figure 2). In brief, within Keyes’s model the mental health dimension is represented by high or low levels of psychological well-being, for example, self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery and autonomy (Ryff & Keyes, 1996). The mental illness dimension is represented by a presence or absence of symptoms indicative of depression, for example, anhedonia, insomnia or hypersomnia.

For Keyes, mental health is far more than the mere absence of mental illness symptoms. Individuals high in mental health and low in mental illness are designated as flourishing in life, whereas those low in mental health and low in mental illness symptoms are designated as languishing. Those with low mental health and high mental illness are designated as both languishing and depressed (for details, see Keyes, 2003). Keyes estimates that only approximately 25 per cent of the population can be considered to be flourishing.

Languishing has been defined as ‘a state in which an individual is devoid of positive emotions toward life, is not functioning well psychologically or socially, and has not been depressed within the past year’, whereas flourishing can be understood as ‘a state in which an individual feels positive emotions towards life and is functioning well psychologically and socially’ (Keyes, 2003, p.294).

The languishing–flourishing delineation may have considerable utility for coaching. However, Keyes’s approach as it stands does not explicitly incorporate the elements of goal striving and goal attainment so central to coaching practice. Coaching is after all primarily focused on facilitating intentional goal striving and goal attainment (Whitmore, 1992). Thus, a useful adaptation of Keyes’s

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**Figure 2: Keyes’s Model of Mental Health and Diagnostic Categories**

(Keyes, 2003; reproduced with permission).
approach for use in coaching would need to explicitly incorporate both a mental health/illness dimension and a goal striving dimension.

**Goal striving and coaching**

Goal striving sits at the very heart of coaching. Implicit in the notion of goal striving is the concept of intentionality; the purposeful pursuit of the goal. It is thus important to distinguish between ‘strivings’ and ‘aspirational goals’. The concept of striving implies that the individual has somehow invested in the intentional pursuit of a goal, and is actually engaged in its pursuit. This can be contrasted with the notion of aspirational goals.

The notion of aspirational goals has traditionally referred to higher order, values-based goals that an individual hopes to achieve (see, for example, Zimmerman & Bandura, 1994). However, the contemporary meaning of term ‘aspirational goal’ has taken a new direction and reflects recent political rhetoric (Milbank, 2007). In line with recent usage ‘aspirational goals’ can be understood as goals that an individual expresses interest in achieving, but in reality is unwilling or unable or to work towards or make a commit to. For example, political leaders may have a aspirational goal of reducing global greenhouse gas emissions and global warming, but not have actually begun the striving process by setting specific pollution reduction benchmarks or enacting legislation.

Of course, not all goals are created equal. Different types of goals differently impact on individuals’ performance and their subjective experience of the goal striving process. For example, Coats et al. (1996) found that people who tended to set avoidance goals had higher levels of depression and lower levels of well-being. Other studies have found that approach goals are associated with both higher levels of academic performance and increased well-being (Elliot & McGregor, 2001). Performance goals tend to focus individual’s attention on issues of personal ability (Gresham et al., 1988), and such attentional focus can actually impede performance when the task is complex or the goal is perceived as highly challenging, and the individual is not skilled or is low in self-efficacy. In such cases learning (or mastery) goals may better facilitate task performance (Seijts & Latham, 2001).

**Self-concordance, goal striving and mental health**

Sheldon and Elliot (1998) noted that not all personal goals are personal. Individuals can pursue specific goals for a wide range of reasons, and the specific motivations underpinning goal striving can have an important impact on well-being. For example, the degree to which a specific goal is self-concordant has an important impact on the emotions associated with the goal (Koestner et al., 2002). Self-concordance refers to the degree to which a goal is perceived by the individual as being autonomous, that is emanating from the self (a internal perceived locus of causality indicating greater self-concordance), as compared with a goal that is perceived by the individual as being controlled by factors outside of the self or by the introjected ideas of others (external perceived locus of control indicating less self-concordance) (Sheldon & Elliot, 1998). It is important to remember that goals are nearly always motivated by a complex combination of internal and external factors (Spence et al., 2004). Thus a dimensional rather than categorical approach is appropriate here.

Goals that are self-concordant and in alignment with the coachee’s core personal values or developing interests are more likely to be engaging, and self-concordant goals are associated with higher levels of goal attainment, greater goal satisfaction and well-being (Sheldon & Elliot, 1999; Sheldon & Kasser, 1995). Further, both goal content (intrinsic or external) and goal motivation (autonomous or controlled) make significant contributions to psychological well-being or lack of well-being (Sheldon et al., 2004).
As can be seen from the above discussion, goal striving and goal attainment may not necessarily be associated with mental health or well-being. Indeed, individuals may have high levels of goal striving and goal attainment, yet have low levels of well-being and mental health. These observations have important implications for a coaching-related model of mental health and goal striving.

A languishing-flourishing model of goal striving and mental health
The proposed model of goal striving and mental health presented in Figure 3 has two key dimensions: (i) the mental health-illness spectrum; and (ii) intentional goal striving (high or low).

There has been considerable discussion attempting to define the differences between mental health and mental illness. One approach argues that mental health is more than the mere absence of mental illness (e.g. Keyes & Lopez, 2002; Seligman & Csikszentmihalyi, 2000). This view posits that the presence of mental health is best indicated by high levels of psychological and subjective well-being, rather than the mere absence of depression, anxiety or stress, whereas mental illness is indicated by the presence of high levels of depression, anxiety or stress.

Measures of well-being and life satisfaction tend to correlate between –.40 and –.55 with measures of psychopathology such as depression, indicating a shared variance of about 25 per cent (Keyes, 2003). Given the degree of shared variance, one useful way of visually representing the relationship between mental health and mental illness is in a Venn diagram with separate but overlapping dimensions representing mental health and mental illness (following the work of Grünbaum (2003) this is represented as a quadratic polygon in Figure 3).

Flourishing
The concept of flourishing used in this model extends Keyes’s construct. Where Keyes defines flourishing by primary reference to the presence of mental health and the absence of mental illness, flourishing in the present proposed model is defined also by explicit reference to the intentional pursuit of goals. The far top right-hand area of this figure is where individuals have high levels of mental health and are engaging in high levels of intentional goal striving. This is the area of flourishing. Many would consider this area to be the ultimate goal of the coaching process. Goals in this area can be expected to be highly self-concordant because the long-term pursuit of self-concordant goals are associated with higher levels of well-being (Sheldon et al., 2004). The relationship of levels of self-concordance to this area is of course is an empirical issue, and further research is needed here.

In relation to workplace coaching, clients in this area can be expected to be fully engaged in their work, find meaning and purpose in their work lives, and have positive relations with others in the workplace. However, it is important to note that high levels of intentional goal striving are not necessarily equivalent to ‘getting things
done’, ‘upward and onward’ or ‘high performance’. An individual may be intentionally striving to achieve less, for example, increasing the quality rather than quantity of their work performance, or redefining their career path based on personal values, rather than corporate or social definitions of success. Indeed, increasing numbers of executives are engaging in such career plateauing (The Families and Work Institute, 2004). Individuals in this area may also be engaging in practices of intentional non-striving as in Buddhist and some mediative traditions. Paradoxically, such mindful or mediative activities can be also understood as being strivings in the pursuit of acceptance goals. Such acceptance goals may be articulated as ‘My goal is to unconditionally accept whatever I experience, by bring my attention back to my breathing whenever my attention wonders.’ Although the concept of strivings in the pursuit of acceptance goals may appear contradictory, such attitudes of purposeful awareness and intentional acceptance is central to mindfulness meditation (Kabat-Zinn, 1995).

**Acquiescence**
The top left-hand section of Figure 3 is where individuals have good mental health but have low levels of intentional goal striving, although they may well hold aspirational goals. This is the area of acquiescence. Here individuals enjoy psychological and subjective well-being, but are not actively engaged in an intentional goal striving process characteristic of the flourishing domain. To be acquiescent is to assent tacitly, to consent, to agree with other’s wishes, and is the act or process of accepting. In this quadrant goals are likely to be only moderately self-concordant, as individuals may well show a greater tendency to accept decisions made for them by others or by setting aside the pursuit of their own goals in preference for the goals of others.

The notion that individuals can have good levels of mental health, and yet not be intentionally pursuing goals of their choice may at first glance appear to be incongruent. However, many parents will be familiar with the experience of having to set aside their own personal career goals so that their partner or...
children have the opportunity of pursuing their goals. Paradoxically, setting aside their own goals may still result in parents experiencing psychological well-being, on dimensions such as positive relations with others and purpose in life (Ryff, 1989).

In the workplace, individuals in this area are the ‘happy but disengaged’. It can be expected that individuals in this quadrant would be physically and emotionally present, but not actively engaged with the goals of the organisation. Although some individuals may well purposefully choose the kind of work that does not demand engagement, it may be that individuals in this area over time will become increasingly bored with the daily work routine, and may well drift into the area of languishing.

**Languishing**

The overlapping area between points B and C represents individuals who have low levels of psychological or subjective well-being without elevated levels of depression, anxiety or stress. This is the area of languishing. Whilst individuals who are languishing may be intentionally striving towards goals (possibly with the assistance of a coach), in general their lives are likely to be devoid of the pleasure often associated with intentional goal striving (Street, 2002). Such individuals may well be engaged in the pursuit of conditional goals.

Conditional goals are goals that are pursued because the individual believes that that its attainment will bring happiness and well-being (Street, 2002). For example, an individual may be striving to acquire a specific sum of money in the belief that ‘everything will be fine’ once that sum is in the bank. Such goals are likely have a relatively low level of self-concordance. The languishing state at the higher end of the goal striving dimension thus encompasses the notion of ‘deferred happiness syndrome’ in which individuals persist in the long term with life situations that are difficult, stressful and exhausting in the belief that this sacrifice will pay off in the long term (Breakspear & Hamilton, 2004).

**Distressed but functional**

The bottom right-hand area is the area of distressed but functional clients. Here we find individuals presenting for coaching who have high levels of intentional goal striving. They may highly functional, in terms of work performance, social status and earning capacity, yet still be dysthymic or even clinically depressed, anxious or stressed. Issues of mental health or mental illness here can range from moderately dysthymic or distressed (as represented by the areas aligned with point C) to more serious levels of mental illness (as represented by the areas aligned with point D).

This area is an area of significant challenge for coaches who do not have clinical or counselling training (Cavanagh, 2005). This is because, contrary to popular belief, it is not always easy to recognise depression or anxiety, particularly for those who are untrained in such diagnostics (Leimkuhler et al., 2007; Preville et al., 2004). Indeed, coachees in this area are unlikely to present for treatment for mental illness, and may not even be aware that they have such problems. The coachee is far more likely to present with issues related to time management, interpersonal communication difficulties or workplace disengagement.

**Major psychopathology**

The bottom far left-hand area in the model is the area of major psychopathology. Here we find clients with high levels of mental illness, which might include illness such as major depression, major anxiety disorders, serious chemical dependencies, self-defeating behaviour patterns or major personality disorders. In addition, clients in this area have low to very low levels of intentional goal striving and low to very low levels of functionality.

The term functionality in this context refers to the degree to which an individual is capable of carrying out the activities of daily living in occupational, social, or personal domains (see Roper et al., 1980). According to the Global Assessment of Functioning...
Scale as presented in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) very low functioning might be characterised by a danger of harm to self or others, a failure to maintain personal hygiene, serious impairment in judgment, serious impairment either occupational or school functioning, interpersonal relationships, judgment, thinking, and/or mood.

Although it may appear self-evident that individuals in the bottom far left-hand area are not suitable candidates for coaching, some commentators have suggested that coaching might be a more acceptable alternative to therapy, especially for those who are resistant to therapy (Filippi, 1968; McKelley & Rochlen, 2007). Coaching methodologies have been found to be effective in enhancing skills generalisation in social skills training programmes for schizophrenia (Gottlieb et al., 2005) and for improving adherence to antidepressant treatment among primary care patients (Brook et al., 2005). Further, some have suggested that life coaching might be a suitable therapeutic intervention for disorders such as Adult Attention Deficit Disorder (Ratey, 2002).

It is in this quadrant that the boundaries between coaching and therapy become dangerously blurred. Whilst a solid argument can be made in favour of trained mental health professionals using coaching methods to treat some forms of psychological disorder (e.g. schizophrenia, depression), this would be ethically unacceptable for coaches who are not trained mental health professionals (Spence et al., 2006). This is because overconfident, poorly trained coaches may not recognise the limits of their competency and inadvertently do harm to their clients (for further discussion on these issues see Buckley & Buckley, 2006; Cavanagh, 2005; Sperry, 2004).

Can inappropriate coaching interventions do harm?
There has been very little discussion within the coaching literature as to whether coaching interventions can be harmful (Berglas, 2002). This is an important question particularly for coaching clients in the lower section of the model between points C and D, where individuals have increased vulnerabilities. The somewhat limited coaching outcome literature to date suggests that coaching interventions per se tend to be effective (for a recent review, see Grant & Cavanagh, 2007), but to date there has been little or no work examining the possible negative effects of coaching in vulnerable populations.

Support for the notion that, under certain conditions, coaching may be harmful for vulnerable populations comes from the clinical literature. First, it has been shown that not all interventions are equally effective. For example, cognitive behavioural interventions tend to be more effective than non cognitive-behavioural therapies for generalised anxiety, social phobia and obsessive-compulsive disorders (Chambless & Ollendick, 2001), and this suggests that some coaching interventions will be more effective than others.

Second, and more worryingly, the inappropriate use of psychological treatments can result in enduring psychological or physical damage. Lilienfeld (2007) lists a number of therapies that can be explicitly harmful through inappropriate usage. For example, expressive-experiential therapies can be harmful for some clients, confrontational ‘boot-camp’ style interventions for conduct disorder, recovered memory therapy and critical stress debriefing.

Additionally, whilst some interventions might be ineffective and not directly harmful, they may carry indirect harm (such as elongated periods of suffering) and various ‘opportunity costs’ (such as lost time). Lilienfeld (2007) cautions that the costs of indirect harm should not be underestimated. This warning may be particularly
salient for organisational and executive coaching clients, where both personal and business costs should be taken into account. For example, failure to address clinical levels of stress or depression in a senior executive who is receiving coaching could result in an escalation of mental health problems, burnout and eventual executive derailment, and this could have serious consequences for the coachee, their family, and for organisational stakeholders as a whole. Coaches who are highly skilled and well-informed about mental health issues are ideally placed to help prevent such unfortunate occurrences.

**Ethical issues**

If a coach is not qualified as a mental health professional they still have a legal and ethical duty of care to address the issue by making a preliminary assessment and considering referral options (Spence et al., 2006). Even in the face of obvious symptomology, many clients are reluctant to accept a mental illness diagnosis or preliminary assessment, and are often reluctant to accept a referral to a qualified mental health professional (Bluckert, 2005).

Thus a key challenge for the coach is to determine if and how to work with the coachee. If the coachee is not prepared to take a referral to a qualified mental health practitioner for treatment, the coach needs to make a decision about whether or not to continue coaching. Ethically this is problematic because the focus of therapy is the explicit treatment of psychopathology. Coaches offer coaching services not therapy. Thus, most coaches would be acting unethically if they engaged in therapy with clients, as they would be acting beyond the boundaries of their competence (AC, 2006; ICF, 2005; WABC, 2003). In line with the understandings of coaching outlined above, a coach who is not a trained mental health professional may ethically work with a coachee from the distressed but functional population as long as the goal of coaching is not intended to primarily address psychopathology or serious intrapersonal or interpersonal distress, and as long as the coaching does not impede recovery from such distress.

However, for coachees in the far lower right hand area, their distress may be of such a magnitude that it significantly impedes their progress towards their coaching goals. Such clients are the ones where, despite robust goal setting at the beginning of each session the coaching conversation keeps returning to therapeutic issues, and the coach finds themselves repeatedly acting as a supportive counsellor. At some point the coach may have to take a firm stand and insist that the coachee seeks treatment. One way to deal with this is for the coach to highlight how the presenting symptoms are preventing goal attainment, and how appropriate treatment will help the attainment of the goals of coaching. Supervision for the coach is essential here and ideally from a supervisor or mentor with extensive experience in such issues.

If on the other hand the coachee is willing and prepared to accept a referral to a qualified mental health practitioner, the challenge for the coach then becomes one of how to establish a working relationship with a suitability trained therapist. This is about managing the possible three, four or even five-way relationship between (for example) the therapist, the coachee, the sponsoring organisation, family members and the coach themselves. This is not an endeavour for the unskilled or fainthearted. Managing the boundaries and interests of multiple stakeholders takes tact and a considerable investment in time and effort. Done poorly it can have a considerable negative influence on outcomes. Conversely, done well, there may be considerable potential to foster growth and recovery.

**Future directions in research and practice**

This paper has presented an initial theoretical model that integrates goal striving and mental health-illness and has discussed ethical issues related to coaching and mental
This has begun the process of developing a framework that situates the concepts of languishing, acquiescence and flourishing within the coaching and goal striving process. The model presented in this paper has utility for individual coaching and in organisational contexts. Future research should seek to empirically validate this model, for example, by developing screening tools that map on to this model and which cover the full mental health-illness spectrum. We also need to discover the relative percentages of coaching clients in each area. This model also has potential in organisational context in terms of mapping well-being and workplace engagement, and when coupled with validated assessments may prove to be a useful framework for coaching for well-being in the workplace.

The main focus of coaching is on helping clients move from languishing or acquiescence to flourishing. It is the energising sense of fulfilment inherent in helping clients move from ‘good to great’ that attracts many individuals to work in the coaching industry. But just because we are solution-focused and positively-orientated does not mean we should be problem-phobic. It is all too easy to avoid the difficult issues of mental health and mental illness in coaching clients. In the past the coaching industry has side-stepped this issue with the mantra of ‘it’s coaching, not therapy’. This is no longer good enough.

Given that a significant number of coaching clients will have problems related to mental illness, it may high time for the major coaching bodies to make basic training in mental health issues, understanding of mood disorders and referral procedures a compulsory part of any coach certification process. In addressing this issue with coaches who are not psychologists, organisations such as the AC, ECMC, ICF and WABC should take a proactive position on this issue. Indeed, not to take such action is to fail to meet basic ethical duty of care requirements for our coaching clients, the coaching industry and society at large.

The proposed model presented in this paper is meant to be a starting point for future discussion and research about the integration of mental health, mental illness and goal striving within a coaching context. A sophisticated understanding of the issues related to coaching, goal striving and mental health can only help the coaching industry further flourish.

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