ROUNDTABLE DISCUSSION

Health Coaching Education: A Conversation With Pioneers in the Field

健康辅导教育：与该领域领先者的对话

Educación de la formación sanitaria: diálogo con unos pioneros en este campo

Interview by Suzanne Snyder

In February 2013, Global Advances in Health and Medicine (GAHMJ) interviewed eight pioneers in the field of health coaching education: Michael Arloski, PhD, PCC CWP; Linda Bark, PhD, RN, MCC, NC-BC; Georgianna Donadio, MSc, DC, PhD; Meg Jordan, PhD, RN; Sam Magill, MBA, MCC; Margaret Moore, MBA; Linda Smith, PA, MS; and Cheryl Walker, ML, MCC. This article features biographies of the participants and their perspectives on the evolution and value of health coaching education and the keys to its success.

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Linda Bark, PhD, RN, MCC, NC-BC, is founder and president of Bark Coaching Institute and a faculty member/mentor at John F. Kennedy University, California, and National Institute of Whole Health, Boston.

Georgianna Donadio, MSc, DC, PhD, is one of six American Florence Nightingale Scholars, an MNA (Massachusetts Nurses Association) award–winning nurse advocate, integrative health practitioner, and behavioral health expert. She is the author of *Changing Behavior: Immediately Transform Your Relationships with Easy to Learn, Proven Communication Skills*, based on 33 years of hospital research.

Meg Jordan, PhD, RN, Meg Jordan, PhD, RN, CWP, is professor and chair of Integrative Health Studies and Somatic Psychology at California Institute of Integral Studies (CIIS), San Francisco, and a clinical medical anthropologist specializing in behavioral and integrative health. Editor and founder of *American Fitness Magazine*, she serves on numerous boards, including the National Wellness Institute and the Leadership Team for the National Consortium for Credentialing Health & Wellness Coaches.

Sam Magill, MBA, MCC, is a master certified coach with the International Coach Federation and a certified supervisor of coaches through the Coaching Supervision Academy in the United Kingdom. He teaches coaching supervision in both France and the United States and works with coaches in the United States, Canada, France, the United Kingdom, Brazil, Australia, Singapore, and China. He also coaches executives in a variety of health-related settings and continues to teach coaching skills for Wellcoaches Corporation, Wellesley, Massachusetts.

Margaret Moore, MBA, is chairman and chief executive officer of Wellcoaches Corporation, Wellesley, Massachusetts, and co-director of the Institute of Coaching, McLean Hospital, a Harvard Medical School affiliate, Belmont, Massachusetts.

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GAHMJ: Professional coaching is used in two ways in health and wellness. One is the scenario in which health professionals add coaching skills to expand their effectiveness in their regular roles, and the other is the scenario in which people function as full-time professional coaches in health and wellness. Please comment on these approaches.

Linda Smith: I am a trainer and the founder of Duke's Integrative Health Coach Professional Training. We train people in both of these scenarios—those from a healthcare or allied health background who wish to become full-time coaches and change their professional orientation to that of a coach as opposed to a nurse or a physician or a psychologist, for example. We also train those who want to use the skill sets of coaching in their existing professions.

Cheryl Walker: I am not a healthcare professional. My training and experience is as a coach. I do, however, work with people around health and wellness goals. At Maryland University of Integrative Health, we work with both people who are healthcare professionals, educating them to be coaches, as well as people who are non-healthcare professionals.

I think one of the benefits of having a healthcare background is that if you have a client who has more serious health challenges, a healthcare professional can address those needs and make recommendations. Having said that, though, I've been involved in educating healthcare professionals, both in the program at Maryland University of Integrative Health and teaching pharmacy students. The challenge with this group is helping them move out of the expert role during a coaching session. Being able to put the client at the center and empower the client to be his or her own expert can be challenging when you've been trained to be the expert. There's room for both and a need for both.

Linda Bark: In the Bark Coaching Institute, about 80% of our students are nurses and the rest are mostly other healthcare professionals like nutritionists, pharmacists, doctors, physical therapists, social workers, and the like. I have had a private practice in coaching since the early 90s. I began teaching coaching out of necessity when I was starting holistic healing centers and needed coaches who had licenses in healthcare to work as part of a healing team.

Sam Magill: My situation is parallel to Cheryl's. I'm an executive coach, not a healthcare professional, and I train health professionals to become coaches. A big part of my business for more than 25 years has been coaching executives, often in healthcare contexts. While generally I'm referred to clients more on leadership issues than health, health concerns show up. For example, I'm working with a human resources executive in a large healthcare system, and as we've looked at leadership behaviors that are working and not working so well, my client is realizing that stress is right at the center. We're now working on things to help her manage her stress so that she performs better as a leader.

I agree with what Cheryl said about how important it is to help health professionals move out of the expert role. New coaches quickly learn to appreciate the value of a facilitative coaching approach, helping clients tackle things that are their own responsibility. All the domain expert knowledge in the world does not often help clients change what is under their control. Under normal circumstances, for example, registered nurses aren't successful in changing patients' lifestyles and behaviors, but with coaching they are able to powerfully support them in behavioral change.

Georgianna Donadio: We developed and began research on our model of behavior health change, now called health coaching, back in the late 1970s. I think the challenge for coaching over the next few years is for it to find its place as, one, a set of skills to facilitate client discernment and action and, two, a new modality that becomes incorporated into professional trainings. With the American Nurses Association embracing coaching into the scope of nursing practice, other professions are sure to follow. Most of our learners are advanced practice nurses, dieticians, physicians, social workers—people who have an excellent health education and training and credentials, along with a scope of practice and professional liability. They have training in the integrity and responsibility of healthcare, the psychology of working with those who are ill or suffering, and training in the multiple aspects of serving others. At our program, we "re-train" these professionals in the patient health information and coaching knowledge they need to be a whole-person practitioner—not just a health expert or not just a coach—but a whole-person health facilitator who invites others into the center of their health and wellness.

Linda Smith: I would say this about coaching as used in health and wellness: We all know that 70% or more of healthcare dollars are being spent on chronic disease and the sequelae of those diseases and that the primary things that we can change in terms of that trajectory are self-care and

the choices of health behaviors. We have no one in healthcare today whose primary responsibility is to be a partner and a collaborator with patients so that they're able to take these very complex choices they face and turn them into long-term transformative health behaviors, particularly the things that we eat, the way that we move or don't move our bodies, the substance use that we do or do not engage in, and the ways that stress affects us.

The health coach is that person who is the expert in health behavior change. What's the neuroscience behind that? What have we learned from the different systems of change? And how can we partner effectively so that these changes are not just New Year's resolutions but permanent, transformative changes in someone's day-to-day and lifelong experience. That's the role of a coach. A coach is the bridge between the healthcare recommendations and the patient's activation and engagement on his or her own behalf.

Michael Arloski: As a psychologist, I saw all of this develop out of what we were calling behavioral health, which was mostly the psychologist helping patients with stress-related disorders and very clinical application issues. And what we overlooked was the opportunity for lifestyle behavior change. Linda really nailed it: We want coaches to be the behavioral change expert rather than a content expert who tells people how to eat and how to exercise, etc. We're more about developing a methodology that helps people be successful at lasting lifestyle change.

Cheryl Walker: Yes. The reason that coaching has been proven so successful is because it's sustainable. It's not really about getting people to change their behavior overnight but to change it over the long-term and sustain it. What we know as coaches, and research studies support this, is that the sustainable results come when the change comes from the person's own inner motivation.

When we teach coaching students, or when we coach, we are tapping into the sweet spot where the person has his or her own realization of, "Oh, this is what's going on for me. This is what's meaningful to me." You're working with the person's values, with what's important to them. We're looking at their behavior in the context of their whole life, not just the behavior in isolation. No one method or approach is going to work for every person.

Margaret Moore: I think it's vital to train and support a large cadre of professional health and wellness coaches who are highly skilled at working with clients who find life and lifestyle change difficult, to design and lead individual and group coaching programs, and to train and mentor the next generation of health and wellness coaches as well as peer coaches. Just as important is the wide dissemination of coaching skills to the roles of health professionals—particularly those who already have a protocol that involves multiple sessions where they're helping people over time engage in their own self-coaching in some way. Anytime a health or allied health professional has one or more conversations with clients or patients about what they're doing to take good care of their health, basic coaching skills apply. It's a skill set that's designed to help people make sustainable changes, which has been elusive in the health field. In even a few moments, health professionals can be catalysts for change, improving awareness and insights, motivation, or confidence and unleashing people's innate desire to thrive.

***GAHMJ:* How do you define health coaching?**

Michael Arloski: Many of us are part of the National Consortium for Credentialing Health and Wellness Coaches. We hammered out a great definition of what health and wellness coaches are. First of all, I want to say that the distinction between the terms *health coach* and *wellness coach* is very arbitrary. Wellness coaches end up working with people with health-related concerns all the time. Somewhere else, they're going to be called a health coach.

Our definition is as follows—I'm going to read this—"Health and wellness coaches are professionals from diverse backgrounds and education who work with individuals and groups in a client-centered process to facilitate and empower the client to achieve self-determined goals related to health and wellness. Successful coaching takes place when coaches apply clearly defined knowledge and skills so the clients mobilize internal strengths and external resources for sustainable change."

Linda Bark: I'd like to share another definition from a newly published book called *The Art and Science of Nurse Coaching: The Provider's Guide to Coaching Scope and Competencies*. It was written by six nurses, myself included, and was published recently by the American Nurses Association. This definition says that nurse coaching "is a skilled, purposeful, results-oriented and structured relationship–centered interaction with clients provided by registered nurses for the purpose of promoting achievement in client goals."

Key to both of these definitions is that the client is leading the process. Having worked on both definitions, I can say that that's the part that we really wanted to underline.

Margaret Moore: The International Coach Federation is involved in assisting with the National Consortium's effort because our dream for the whole industry is ultimately that there is a common core across all domains of coaching, from health and wellness, life, and executive to all the specialties like ADHD and parenting and relationships and so on. There's a common core, and then there's a core set that would fit in with each domain. And in fact, the purpose of our National Consortium is to embark on a process, an organic, ground-up, best practices process to define what those competencies are as well as the knowledge and skills required to become a competent coach. The leaders in this endeavor have been building science-based curricula and training and mentoring coaches in addition to coaching clients over a long period of time.

Georgianna Donadio: Medicine is changing and redirecting itself back to Marcus Welby, MD, back to Florence Nightingale, back to our origins, our beginnings. This is not new. We're returning to what has been lost in nursing, what has been lost in medicine, what has been lost in healthcare: the kind of compassion and respect and integrity that human beings deserve to be met with. From a vocational perspective, we're here to serve. We're not here to have big egos, and we're not here to be important. We're here to serve other people.

And I think that what's beautiful about the coaching component is that we are returning to that value. The most important thing, in my opinion, about the coaching movement is that we're recognizing that nobody wants to be told what to do. Nobody wants to be treated as though they're not an equal. I celebrate that.

GAHMJ: Please talk a bit about the difference between training health professionals to become coaches and training people outside of the medical profession to become coaches. Is there a difference?

Meg Jordan: I work with that difference all the time: graduate students. We first insisted that they had a health background as they go into a master's program in integrative health and learn coaching. But then we found that students coming in wanted a career shift. They were in the marketing or business or high-tech industry, and they were so adept at learning the client-centered process, at mobilizing strengths, at helping empower people to determine and evoke goals from within that sometimes they just passed up the healthcare professional who was so burdened by years of learning how to be a health educator.

I think we've all worked with that difference: Linda Smith, Linda Bark, all of us, in trying to say, "Well, that wasn't really a coaching sentence. Here's a coaching sentence versus what you just said." It's fun to tease out the difference. I think that we've all had experience in training health professionals become coaches and training people from other walks of life as well. And we have found that the people from other walks of life sometimes do just as well if not better.

Michael Arloski: I second what Meg said. Unless something's emerged that we on the Consortium haven't caught yet, there is no evidence that a healthcare background makes you a better health coach.

At one organization where I train people who work as diabetes coaches, their preference was for well-trained coaches who came out of an International Coach Federation (ICF)–approved coach training program who also got wellness coach training but had no medical background. They preferred coaches who were not healthcare professionals because they didn't have that expert tool bag to habitually reach into; they could stay in the coach role. There is a diversity of backgrounds, and that's one of the reasons we put that phrase in the Consortium definition.

Linda Bark: I've had the same experience in terms of training people who are not in the healthcare profession. One of the reasons I stopped doing that was because they couldn't find jobs. Especially in the earlier years, if you didn't have a license, you couldn't get into any kind of healthcare system. So I would train people, but then they couldn't find jobs unless they went into private practice. And even that was a little tricky. I think the times are changing, and there are and will be more opportunities for people who do not have a clinical healthcare license to join the coaching ranks, especially as competencies become established and more education programs respond to the need and to those standards.

Margaret Moore: The knowledge and skills that apply to health and wellness is considerably different from those needed by executive and life coaches because they operate in different worlds and address different client needs. Hence I think it is important that health and wellness coaches have a basic foundation of knowledge and referral sources in areas such as science-based health behaviors and relevant medical practices.

Linda Smith: Who makes the best coach? It really does seem to be independent of previous background. But at the same time, it's critical that we bridge this gap between really well thought through healthcare recommendations and guidance and the implementation of that according to the

individual's own personal goals, lifestyle, situation, etc—what we would call their vision for their own health. Their vision, their values for their own health and well-being. Bridging that gap is critical.

Will a healthcare professional bridge that gap most effectively? Or does it really matter? We know that the medical-centered home is something that is being really thought through, particularly with the Veteran's Administration and other healthcare organizations. Having a coach as part of the team, integrated within the team, so that the physician and the highest-paid medical professionals can perform their roles effectively and turn over their recommendations to someone who can partner in a different way with the client is critical.

Meg Jordan: And it's a low-cost means, too, for reaching those seven out of 10 who have preventable stress-related degenerative lifestyle illness. We've got this medical ascendency, a medical hierarchy: higher costs, better technology, better skills and training. Health coaches operate on the bottom rungs of that pyramid. They are a lower-cost means for helping people partner into changing health behavior. That as an emerging profession is probably the most promising player on the medical landscape.

Linda Smith: The fact that coaching can be done as effectively from a distance, by phone or Skype, as it can be in person and that it is powerfully effective in groups means that it can be very cost-effective.

Michael Arloski: What Linda Bark was saying earlier was quite true: If the only jobs are out there were for someone in a disease-management company, for example, where the model was pretty much around medical compliance, and it was necessary for a registered nurse, for example, to be the health coach who could advise people on medication and things like that, then people without that kind of background have no job opportunities.

But that has really been changing. And now those disease-management companies, the insurance companies providing a lot of the big-scale services, are hiring health educators. They're hiring people with other backgrounds and putting them in the role of coach and having someone else on the team serve as the medical expert.

Meg Jordan: I think this is the next frontier. That together with what Linda just said about group coaching. I have a graduate student now who was asked by a primary care physician's office to put together a 12-week health education model. She said, "'ll do that, but only if you'll let me tag on 20 minutes at the end of the hour of health coaching in a group." They said, "What's that?" She did a before-and-after qualitative and quantitative analysis. They were stunned by what the additional 20 minutes of group coaching at the end of their 90-minute health education session provided for those patients. They all said, "This is the first time I've ever been heard in this practice."

Linda Smith: Since we've been doing our program, the two professions that are most highly represented volume-wise are nursing and social work/psychology, which is interesting because they bring different points of view. One has a medical focus; the other has an understanding of the mind and how people work to make change. I find them equally valuable and equally dynamic as coaching backgrounds.

Meg Jordan: Right on the heels of psychologists and nurses entering coaching, we have so many yoga instructors. Something about yoga and the practice of yoga leads people to want a health career ladder. They say, "I feel the personal transformations, my own strengths and values change toward my own health approach. And I want to learn how to take this to the next level."

Linda Bark: As a nurse, I want to talk a little bit about how to expand our roles as nurses. I too have trained people who are not in the health profession, and they can do great coaching. Speaking personally, there is a way that my training as a nurse does help me, for one thing, know boundaries. Also, sometimes my powerful questions can be informed by my knowledge of healthcare.

There are 3.2 million nurses who might be interested in expanding their role. The American Nurses Association has taken a very strong stand on coaching for nurses. My book, which is on health and wellness life coaching, has been selected as first place in professional development by *The American Journal of Nursing.* Nursing is stepping up and recognizing coaching when as little as 9 months or a year ago it wasn't even on the mainstream's horizon. The idea that a nurse at the bedside can ask a 5-second question of their patients such as, "What's your goal for today?" that can empower patients in a step-by-step process can change the healthcare system.

Michael Arloski: Since the very beginning, when I started doing training back in the late '90s, it's been nurses more than anybody else whom I've been training, and what I have seen is that a wellness program for employees at a hospital or at a corporation typically take whoever they've got on staff who's a nurse, and they say, "Okay, start coaching

people." They kind of throw them into the deep end of the pool with no training. The nurses do their very best, but what's wonderful is when we come along with good training and supply them with the methodology and skills and they become dynamite coaches.

They are often the ones in the lead in the employee wellness programs. They're often the ones with all the responsibility, and they've been doing it for many years in a lot of different settings. I think the recognition that Linda's talking about at the higher professional level now is only going to facilitate this.

Cheryl Walker: People from all different kinds of backgrounds can do this work. It has more to do with temperament. A successful coach has a temperament that is empathic and humble, the ability to get out of the way and be a partner. They have the ability to collaborate and have a high measure of maturity and self-awareness. And then, you need quality training where students are receiving good feedback from experienced coaches.

GAHMJ: Earlier, one of you mentioned that one of the keys to successful coaching is applying a methodology for lasting lifestyle changes as opposed to simply telling clients or patients what they need to do. Is the methodology that you develop for your own coaching practice or to train coaches client-specific, or are there tried and true, more general strategies that you use?

Sam Magill: Some research done about 10 years ago suggested that the most important factor in a helping kind of relationship, including coaching, is the quality of the relationship between the coach and the client. The second most important factor was the character of the coach. The third factor was that the coach was grounded in a coaching theory and approach and had studied it and practiced it. The fact that you had studied and taken it seriously was an important factor in effective helping relationships.

Having training in a coaching framework helps practitioners understand that coaching is not simply a warm and friendly conversation that you might have with a good friend. It has elements of that in terms of the empathy and the warmth that are expressed. But there also is a progression of growth-oriented conversations that is necessary for coaching to be effective. Good coaching begins with a person who very much wants to support his or her clients or patients. And the training is to give coaches a framework in which to coach change and growth.

Margaret Moore: The big leap forward with the arrival of coaching was to move from an authoritative top-down, expert-led, prescriptive, directive model where you tell people what to do, which has been the model used throughout human history in most organizations. Certainly medicine is top-down, prescriptive. The authority figure knows the answers, and you're dependent on that authority figure.

In the broader context, the role of the coach is to help people build autonomy, self-sufficiency, self-efficacy, self-management, self-mastery—whatever self-authored term you want to call it. Being responsible for one's own destiny, being responsible for one's own self-sufficiency. If you think about human history, it's really only in the last few decades that we live long enough that we are required to manage our health for a whole lifespan. Up until now, developmentally, humans were very much dependent upon their tribes, their cultures to give them the recipe. We really didn't need the self-sufficiency.

So the first order of business here is to help people stand on their own feet. Adult life doesn't come with an instruction manual. We're now learning a lot more about how the brain works and how to create the optimal conditions for the brain to change.

Ed Deci and Rich Ryan's self-determination theory has identified core human drives and the nature of motivation. Positive psychologists have identified the ideal conditions for resilience and well-being. Neuroscientists are teaching us how to organize our brains for creativity and learning. The transtheoretical model has been one of the foundation stones. There's a new book out by John Norcross called *Changeology* that is an up-to-date process based upon a large body of new research on the transtheoretical model around how to change health behaviors. It is relevant to any life habit. There are all these fields of endeavor that are now being put together to help coaches help clients become self-sufficient, learn the skills, develop the habits of life that lead to mastery in a specific area. In our case, it happens to be health.

Georgianna Donadio: When we created our model, we started with a model of peer interaction. Everything that we do, everything that we teach, and everything that I do in my private practice is peer-based. It's all based on treating the other person with complete equity and respect. You're not an expert in that role, you are a person who has knowledge and skills and a license, and most importantly, you also have professional liability, which may not seem necessary, but there are plenty of horror stories about what can happen even when you're not advising someone.

As a coach-oriented professional, you're not advising, recommending, telling, treating, or directing people. The role of the coach—which is different from the role of nurse, the role of doctor, the role of dietician or social worker—is to bring out the best in another, to facilitate the very best in another person. And the only way we can do that effectively is to meet each other in a peer relationship. Everything that we teach is all about peer engagement. I'm not an expert. I'm not talking down at you. You're the expert of yourself. This is very much aligned with New Thought philosophy.

Michael Arloski: There are definitely tried and true strategies. Each training program is going to have a combination of theoretical resources that they base their program on, but we're all coming from the same roots, the same origins. Really good coaching has a client-centered base. Regular life coaching evolved partly out of the field of psychology, and there it was sort of a combination of Carl Rogers and client-centered therapy.

Margaret is right: Good coaching has integrated the transtheoretical model of change, the readiness for change theory that Prochaska and his team developed. I think health and wellness coaches are on top of that because the whole health-promotion field has been more aware of it. Those backgrounds form a lot of our theoretical model that the methodology comes out of.

And the methodology goes way beyond just goal setting. It starts with an overview of someone's life, taking stock of their wellness, and then developing an effective, integrated plan for taking the lifestyle change forward. That combined with the traditional coaching foundational work around accountability and support, working through internal and external barriers—with that roadmap to follow, we get clear, measurable results.

Linda Bark: I agree and would add that coaching also came out of a consulting background, as well as the psychological one. There's a way of looking at deliverables and setting goals. I ask a question of my clients: "Between now and a week from now, what small, fun, and easy step would you like to take?" That's really part of coaching. It's about having homework and moving forward.

I come from an integral, holistic conceptual framework, so I ask people if they're interested in tuning into body wisdom and looking at sense of purpose. I've found that adding those aspects helps people move faster and more easily and more authentically toward their goals. It's as if they're flying a plane and they have more instruments to refer to. They become much more aligned with deeper levels of themselves, saving time, energy, and false starts.

Margaret Moore: The role of a coach and the competencies of a coach emerged about 20 years ago and became agreed upon by the ICF, which was founded in 1995. The ICF competencies are the best known and well-disseminated. They're not the only set. There are several other organizations defining competencies.

When Michael and I came along, what was lacking in that competency set was any kind of grounding in a theoretical or scientific foundation. To date, there isn't a lot of evidence for coaching, but there are now four textbooks—and I'm the coauthor of one of them—around the theoretical foundations for coaching competencies. I've just written a chapter on coaching for the second edition of the six-volume *Lifestyle Medicine* textbook, the first chapter on coaching in a medical textbook. I'm also writing a chapter on health coaching for a coaching handbook that comes out of the United Kingdom. So today the coaching field has four textbooks and a pretty robust theoretical foundation.

Linda Smith: We have the same passion and a very similar understanding of what health coaching is and what it can do. I would like to mention the work in neuroscience in our program at Duke. There's been exciting developmental study of how the brain works and what we can learn from that to help to make behavior change more effective. What is the effectiveness of small steps? How do our neurons respond to habits over time? How do we break habits?

It's very important to stay abreast of the newest science that's coming out. What coaching does not do is grab onto a single theory. At least, I know none of our programs does. We are learning from the wisdom that's coming out in the research and from all of these developmental theories that Michael and Linda Bark were articulating so well, so that we bring all of it to bear on the client with an attitude of mindful awareness.

The sense of mindfulness is a very important part of our program. It enables us to pay attention to all of the cues that a client is giving us: verbal clues, body language, affect, etc, so that we're responsive to where they're going and where they're needing to go in a way that is less didactic than it is exploratory and engaging. That might be the reason they tell us things that they don't necessarily tell other healthcare professionals.

Linda Bark: When I was at the annual conference of the ACTO, the Association of Coach Training Organizations, last year, neuroscience was one of the areas that was emphasized and that coaching schools wanted to learn more about.

Sam Magill: It's clear that we're understanding what makes coaching work better and better. The neuroscience research coming out shows that there is physiological change happening throughout our bodies when good questions are asked and when empathy is present. The more we know about the science of coaching, the more acceptable this kind of work is to, for example, hard-headed engineers. That's good for everybody.

Meg Jordan: I worked in behavioral medicine, and I ran cardiac rehab. When I was working cardiac rehab, there was a great deal of research on nonadherence, or what we called noncompliance. We were always asking, "Why is this patient

jeopardizing his health and persisting in high-risk behaviors?" There was research on nonadherence showing that although its prevalence might vary, it just varied with the type of regimen prescribed. We were always wondering, "What are we doing right? What are we doing wrong?" I never looked at it through the eyes of the patient.

I left that field shaking my head and ran across a business coach in the '80s who trained me in coaching, and I never wanted to go back to the early biomedical models of nonadherence. When positive psychology and health psychology arrived on the scene, it was a breath of fresh air. And now I believe neuroscience, just as my colleagues have said, is adding to the strategy for how to make behavior change more effective.

Each time we do this, we take another step toward more compassionate collaboration with the patient or the client and work more toward an informed collaboration with other healthcare practitioners. We're able to provide much deeper emotional and practical support as well. It's fun to see the field grow up, and it's growing up by becoming more humble.

Linda Bark: And more whole.

Michael Arloski: It's validating what we've been doing for a long time. Today's positive psychology is simply good research studies that validate all of this. It's been validating everything that coaching has been since day one. Coaching has always been a positive, "What's working? What's possible?" approach rather than a "What's wrong? And how can we fix it?" approach.

Cheryl Walker: Reframing things to a positive frame from a negative frame is the key. That's what we do as coaches. We look at the client's strengths, where the client thrives, where in their life they are most satisfied. We build upon that. We build on assets.

Sam Magill: We've been talking about training for coaches and I'd like to add a note about what happens after coach training. We need to consider the well-being and long-term effectiveness of the people doing the coaching. Just as in other professions that require some form of supervision, coaches in some parts of the world are now required to have a coaching supervisor. As I listen to emerging health coaches, it's becoming clear that many are under a great deal of pressure. When that happens, coaching can quickly become mechanical and effectiveness can decline. Just think of the essential relational aspect of coaching—the keen awareness and presence required in back-to-back sessions depletes energy and gets frayed around the edges. So having a supportive resource for them in the guise of coaching supervision can help coaches stay sharp and find ways to recharge their own batteries.

GAHMJ: In each of your programs, how do you teach the self-awareness and personal growth that are required for good coaching? Are those qualities teachable?

Georgianna Donadio: We teach it every day. We teach it in a way that we believe and we know is based on an evidence-based approach. There's a science to how you invite people into making changes for themselves. There's a science to how we can invite each other into learning, care, and compassion. People are looking at coaching as a career. I think that we need to look at this as a calling—a vocation or a service to other people. If we look at it as a career, we can become ego-centered.

Cheryl Walker: I do think those qualities are teachable. At our school, we have a signature course in all of our programs called, "Becoming a Healing Presence." It starts with self-awareness. We teach the students how to pay attention to their own bodies, to notice when they are becoming reactive, when they are becoming tense, when they feel relaxed. Good coaches have a high level of self-awareness.

We teach techniques that come from mindfulness meditation that enable students to recover a sense of calm when they are reactive. We teach people to become aware of their own stories or the assessments they make about themselves, about situations, about other people, and to learn to reframe these to improve a sense of well-being and improve relationships.

Sam Magill: I'm sitting here smiling because I share some background with Cheryl, having attended programs a long time ago at Tai Sophia. The part that was standing out for me, which we also use in Wellcoaches, is self-observation without evaluation. One of the most powerful activities was to observe a little group of people having a conversation on any topic in the world, and to learn to monitor whether one is truly observing the conversation or if one is interpreting, judging, equating with one's own experience. And hearing you talk, Cheryl, I'm reminded of how much that is the core of how I teach coaching now.

One of the other things that we use at Wellcoaches is positive psychology, including the Values-In-Action Signature Strengths Questionnaire. It's a self-assessment which points out 24 core character strengths that we share as human beings. We use it because knowing yourself and what your strengths are as a human being, hence as a coach, really provides a foundation. We're not all alike. We don't have to be the same. But it's especially

important, for example, in a critical moment in coaching, to be able to rely on one's own core strengths. It is such a helpful factor in staying centered, not getting distracted by one's own imperfections. I love the statement, "Who you are is how you coach."

Linda Smith: We teach mindfulness in our program as well. We also have an interesting dynamic that is probably somewhat similar to that in many of the programs: In order to train to be a coach, you need to be coached. In other words, this is not an academic experience. This is an experiential experience. When people come to our training program, they go through the whole coaching process. They choose their own goals. They are coached through the whole experience. The process of coaching, the partnership of coaching, the skills needed in coaching—they're both experiencing it for themselves and they're being coached in it.

They run into the same kind of barriers that their clients are going to run into. I tell them at the beginning that they will learn as much from the not-so-great coaching as the great coaching. The not-so-great coaching that they will experience from their peers will be part of the training process. They get feedback from each other every step along the way. They practice when they're together onsite, and they practice when they're at a distance in triads, so they learn how to do group coaching, distance-based coaching, and in-person coaching.

At the end of even the very first module, people tell us that they have had a transformation in how they interact and communicate with others in their world—not just the people they're coaching, but their families, their coworkers. Coaching is a specific kind of communication. People see how they've been communicating and what is possible for them. The shift is necessary for someone to become the coach that they can be.

Margaret Moore: At its essence, coaching is about facilitating change and learning and growth, not about imparting information. To become a coach, you need to put yourself on a good, healthy learning trajectory, which means you're walking the walk through continually challenging yourself to grow. You really want to have experienced your own transformation, and even better, to have transformed something that's not easy via a coaching process that makes the journey of change lighter and more interesting and fun.

Most people who are stuck in a lifestyle that's not producing great health have low levels of confidence. If coaches are not also working on the things that are hard for them, they won't have the compassion and patience and insight they need to be good coaches, and they won't appreciate the value of an adventurous path of creative experiments and learning. Most of us have been taught how to tell people what to do. Humans love to tell our kids, our spouses, our colleagues what to do. To move out of that mode, which is a human modus operandi, to a mode where we're asking and listening and prodding and probing with mindful warmth and curiosity and getting people to come up with their own ideas and their own insights, basically have their brains light up and change, is a really different way of relating to people.

Linda Bark: I agree that the coaching experience is instrumental in the learning process. I had a student who was about three-quarters of the way through the 60-hour program, which is about a 9-month program. She called me during a break between the different modules, and I didn't know who she was. She had changed so much that I couldn't recognize her voice. She had moved, and she had a new job, both of which she credited to the coaching training process. My faculty and I love to teach because we get to be part of supporting that transformation.

Michael Arloski: I think we all, in various ways, build into our curricula an emphasis on personal growth. If you look at the roots of wellness, it is all about personal growth. Something we talk about in our curriculum at the Wellness Coach Training Institute is creating the alliance with our clients, and it all starts with you, the coach. We talk about developing your own personal wellness foundation. How are you consciously working on your own health and wellness? Do you have your own wellness plan? How are you engaged in it? What does that self-awareness look like?

Another key question is how do we continue to support that personal growth after they've become graduates of our program? We have to provide resources that our clients can continue to use. We set up online forums where people interact and communicate with each other. I do free monthly webinars every month on various coaching topics. I write an in-depth coaching blog that's all about wellness coaching topics.

And we all have curricula that offer more advanced classes. We are all developing more resources for our students so that they can continue to grow.

Meg Jordan: Growing is what wellness is all about. I echo everything my colleagues have said. Our wellness program certificate is embedded within the master's program, and it's a bit unfair to compare a master's program with other training programs. Number one, we've got the students for longer and we can require a lot more of them because they're going for that golden prize: their master's degree.

At CIIS, the students have to adopt a holistic self-care

practice. They have required courses in human flourishing. They have to cultivate mindfulness meditation practices, and they have to maintain reflection journals through the 2 or 3 years, writing about their growth, their inner development. They're expected to grow in buddy coaching practice, peer mentoring. They have extensive internships in which they have to do community service and take their coaching to public-housing residents.

It's a full-blown master's program, and it's loaded with multicultural sensitivity and social justice, and because it's in San Francisco, it's also loaded with LGBQT sensitivity training. But I would not expect that of a typical health coaching training.

Linda Bark: Looking at yourself and learning the process first yourself so you can understand what others are going through is pretty typical of coaching. We nurses are not great at taking care of ourselves. This is another reason that I have spent time on the nurse coaching credential looking at how we can help nurses address their own self-care. It's part of the scope, and it's reinforced. And although it's not a requirement for the certification, it's recommended that nurses have their own coaching to sit for the Nurse Coach examination.

Margaret Moore: We can't be our best if we're not well, if we're not really accessing our own personal vibrancy, vitality, health, wellbeing, thriving, flourishing, etc. That's got to be in place for coaches to radiate wellbeing. That's a big part of what clients pick up on. Coaching is, in part, a modeling of wellbeing.

Meg Jordan: Nurses already are pretty steeped in professional practice ethics. They know how to not make the story about themselves. When you're taking others through a coaching, there's something about focusing on the patient—I call it the sacred covenant. It's not about you. It's about them. That's where nurses tend to fall into a trap of eclipsing their own self-care.

But it's a real fine balancing act when you're dealing with somebody who says, "I've left my marketing high-tech job, and I want to be a health coach." It takes a lot to say, "Okay. Do you know how to be with other people in a way that the story is not about you and your lengthy bio and your incredible successes in life?"

That's steeping them. I tell them, "You're a tea bag. I'm going to put you in hot water now. We're going to steep some of that nonsense out of you so you can be with somebody." I talk to them in very confrontational ways sometimes if they've overstepped that balance that Linda said nurses learn in the early days of their nurse training and first days on the floor.

Linda Smith: I want to build on that. One of the biggest transformations is people finally realizing that my brilliant solution for your problem is simply not as effective as your brilliant solution for your problem. My job is to help you come up with yours. My story and my solutions are actually in the way.

Michael Arloski: What's so wonderful is when these very caring professionals understand the process that can help them work effectively with people. I did a training a long time ago for a great big disease management company in two different cities. They had nurses and registered dieticians in these big call centers working with people. Their idea of coaching was to ask, "Do you have any questions about your medication? Is there anything else you want to talk about?" People would bring up their issues, and the so-called coach would say, "Well, have you tried this? Have you tried that? Why don't you do this? Why don't you do that?" What we've all been able to do is equip people with not just skills but with real ways of working with people that are all about a behavioral change process and a process to help the change last. That's why my book is called *Wellness Coaching for Lasting Lifestyle Change*.

GAHMJ: How long are the courses, and how do you assess the level of skills in your program?

Cheryl Walker: We have three programs. We offer a 12-month Post Baccalaureate Certificate in Health and Wellness Coaching. We also offer two master's degree programs. One program is a Master of Science in Health Promotion with an area of concentration in health coaching. In this 2-year program, students get an in depth understanding of the field of integrative health along with coaching skills. We also offer a Master of Arts in Health and Wellness Coaching with areas of concentration in nutrition and herbal medicine. In this 2-year program, students study coaching skills plus an area of concentration in nutrition or herbal medicine. In all three programs, students are required to complete a coaching internship.

Early in these programs, students take a self-assessment and then take it again at the end of the program. They are assessing their own coaching competencies. They also get feedback on a number of different markers including the International Coach Federation Competencies.

Linda Bark: We have a 60-hour telecourse that is voice to voice over a 9 to 10–month period. Our classes are high-touch and have 12 to 15 students in each class so the faculty has plenty of chance to assess and grow their skill level.

Because we are accredited by ICF, there is a requirement for observed sessions and feedback for students. During the last 15 hours of our course, which is a practicum, I like to have about 8 students per class so faculty can listen closely to students coach individuals and groups and offer upgrades. We also include one-to-one sessions in that last module so unique individual learning needs can be addressed.

Sam Magill: I taught for 6 years at the Hudson Institute of Santa Barbara in the coaching certification program. That and the other coaching schools I'm aware of are also almost a year long. At Wellcoaches, there is a basic coaching skills course that lasts 18 weeks, one live class per week, followed by a 3 to 6–month certification process. And then there's the full professional coach certification, which is also approximately 1 year long.

Regarding assessment, one of the things that I think is very helpful is to observe the future coach being coached. Someone said a long time ago, the best coach is the one who can be coached. If a person is resistant to coaching, it's hard for him or her to do coaching. So that's part of the assessment. And the other is live observation using, for example, the ICF Competencies, and observing the relationship between the coach and the client.

Georgianna Donadio: We have an excellent process. First of all, you can only be accepted into our program once your credentials have been independently verified. So you have to be trained and licensed or certified. We don't accept anyone into the program who doesn't have a professional credential.

Once in the program, participants take 24 whole health foundational courses, which are all approved for professional contact hours. After that, they take a 4-hour proctored exam, wherever they live, at a testing site or a library or some acceptable site.

Once they pass that, they take the skills courses. These are coaching courses. These are peer-counseling courses. These are behavioral engagement courses. These are mindful listening courses. Everybody has an advisor whom they work with in their particular professional area.

From there, they have to submit three case studies with video to their advisor, and there's another board that looks at it.

After that, participants have to write a fairly significant summary paper about their understanding of the principle of what they're doing, the skills of what they're doing. They have to provide a thorough evaluation of each of their clients: what the client brought to them, what they brought to the client, what the outcome was.

And so in our program, there is an academic component, a skills component, which some people call the clinical component, the case studies component, and the capstone project. By the time they complete their 18 months or so with us—they could finish it in a year, but we give them 18 months—by the time they're done with our program, they've undergone a very comprehensive training.

Linda Smith: We assess skills all along the way. People are mentored, observed as they're coaching, given feedback. To graduate as certified health coaches, the participants have to take both a written exam and an oral exam. The exam is evaluated with a matrix that we've created. They have that matrix ahead of time and know exactly how we're going to be scoring it. If they fail the exam, they get an hour of in-depth feedback and recommendations about what they need to work on, and they can retake it. The oral exam is simply a demonstration of coaching someone. The skills and the process and the partnership of coaching need to be clearly demonstrated.

Margaret Moore: The Wellcoaches certification process has four pieces that add up to a score of one hundred percent. Two-thirds of the grade is based on an oral skills assessment, which is a 30-minute coaching session where the examiner is the client, and the coach is the coach. There is a very specific set of behaviors that we're expecting, and people know what those are ahead of time. They even get to listen to a sample so they know what an excellent session sounds like. When someone is right on the pass-fail line, we have two people assess it, and we never have a disagreement on pass-fail.

The second is a knowledge exam. It's a computer exam that been validated with all the psychometric stuff. It's a one hundred–question, multiple-choice exam based on our textbook.

Third is the data from coaching sessions that the person has done with clients so we can see that they know how to help people create a vision and define their motivation and their confidence and all those things that go into thinking about, "Where am I going?" We look at the behavioral goals at 3 months, and what they are each week, make sure that's all internally consistent. We have to have a sense that the coach knows how to help a client craft a workable plan that's going to get them where they want to go.

The fourth piece is the coach's own personal wellness plan.

Then, posttraining, we have a membership program, and we offer matching of coaches to coaches so they can continue to coach each other, so that if they can't afford to hire a coach themselves, they can find a fellow coach and vice versa.

GAHMJ: How would a national credential affect your training program, and what it would do for you? Do you think a national credential is necessary?

Linda Bark: I'm having that experience right now—the nurse coach credential, which is national and is just starting. I've worked with nurses for so long, and many of them want to change what they're doing. Some have said, "I've been looking at your website for 5 years, and now I think it's time to do it." I have a waiting list. I'm starting new classes. I'm training more faculty. Having the credential has really made a difference for me.

Meg Jordan: A credential like this is important for many reasons. It gives the public something that they know and can trust. One troubling thing happening in the healthcare landscape is that there are websites out there saying, "Make more money by calling yourself a coach as well as a chiropractor," for example. And "There's a good chance you're already coaching clients, and you're just not calling it that." Or, "Coaching is easy." We see an easy adoption of coaching titles. What we're trying to do at the National Consortium is say, "Halt. Where's are the educational standards that determine who can call themselves a health coach or wellness coach? What benchmarks can we look at?"

I've seen professionalization of other industries. I worked in the early days with the professionalization of the fitness industry as it came into designing theoretical and practical examinations for fitness instructors and personal trainers. It's all about the maturation of a profession, when you can put aside minute, micro-differences and have a better understanding of the macro-view, the process of what it takes to educate and train a coach.

And that's the beauty of our seventy-plus stakeholders and the educational leadership team that's looking at laying out the approach of educational standards and, eventually, national certification. As a medical anthropologist, I witness the professionalization of emergent professions. And sometimes there's a coopting that exists. Sometimes there's a sequestering and a mystification of language that can happen. I'm going to be the medical anthropologist on the team who's going to guard against that, who's going to keep coaching true to its foundational roots of the democratized, peer de-stigmatized, supportive relationship with someone so that we don't escalate it into the land of medical ascendency. Professions do get compromised in their original goals sometimes, but I think we're all really cognizant of why we want these professional standards and a national credential.

Cheryl Walker: I'm really excited about it. I think it's going to add a level of credibility and professionalism to the field. It can only be good for all of us. It will give us additional guidelines for program development, assessment, and scope of practice. Right now, in our programs, we use the ICF Competencies as our primary guideline, along with other evidence-based coaching models, such as Motivational Interviewing.

Sam Magill: In general, I think credentialing is a good idea. For example, if there is national credentialing, some standards around maintenance of certification, as it's called in the medical world, can also be attached to it. In the United Kingdom, for example, in many situations, coaches are required to have supervisors who help them keep their coaching tuned up. That's just beginning to occur here in North America.

The little bit of hesitation I have is that I would not like for coaching to be regulated. Something strange happens when things are regulated. When people have to pass exams, they tend to begin to perform to a test, and tests don't necessarily indicate whether you're a good practitioner. The focus can get lost. And let me borrow from my experiences with medical practitioners. I was involved with the John Fetzer Institute for quite a number of years in a project to explore the importance of relationships in healing. It was called the Relationship-Centered Care Network.

As I facilitated those conversations, I heard about the paucity of positive healing relationships in a variety of settings. People passed all the qualifying exams, met the requirements to be a licensed practitioner, but the training didn't include anything on relationships. To borrow from a recent personal experience, my son had broken his left leg very badly, and a lot of surgeons who were technically praised by their peers were terrible at patient relationships. They were downright rude, but they certainly were at the top of the game in terms of their training and credentialing. I am certain the absence of relational skills, such as those good coaches have, adversely affected his healing.

Coaching is so dependent on the quality of rapport and resonance between the coach and the client that if that ever got lost in the name of credentialing and regulation, coaching would be done. It's not all about coaching knowledge that can be tested in a multiple-choice test. It's about profound levels of awareness and emergent navigation of what's happening while one is coaching.

Georgianna Donadio: If we're talking about life coaching, you don't need any prerequisite. You don't need to be trained and licensed and educated and have professional liability insurance. You don't need those things. When we're talking about health coaching, I think we're stepping into a different venue. I can tell you a classic story about something that happened right here in the Boston area.

There was a person who was trained in a "health coaching" program that had no prerequisites. She came out of that program and had a client who was in his

fifties. This was a very passionate and enthusiastic health coach who worked with this client and said, "If you eat your greens and exercise and meditate, you're not going to have high blood pressure. Your high blood pressure is coming from your lifestyle."

While she did not say to the man, "Stop taking your medication," she did say, "If you do this, you won't have high blood pressure, and you won't need to be medicated." About nine months later, the man did stop taking his blood pressure medication, and he had a stroke. His wife sued her, and the coach lost everything.

Cheryl Walker: Those are very important points. We need to always remember the spirit of what we're doing. The reason I feel so strongly about credentialing is because I see many people out there calling themselves coaches—health coaches, wellness coaches, executive coaches, life coaches, leadership coaches—and they're not coaching. What many are doing is advising, which is very different.

Margaret Moore: The discussion among all of us has arrived at something like the following: The best practices around developing any national credential, unfortunately I think, have moved away from practical skills assessments. If you want to become a child psychiatrist when you take your specialty exams, there's no relational skills test. It's all focused on a test of knowledge.

That's pretty much standard because there are all sorts of lawsuits and legal problems with practical assessments. Almost universally now, national tests, such as the bar exam and medical exams, are computerized multiple-choice exams. We'll need to follow in those footsteps.

But knowledge does not predict practical skill level. If someone who weighs 300 pounds sits down in front of you with a lifelong history of challenges and difficulties, the multiple-choice exam isn't going to tell anybody whether you can coach that person effectively or not. The skills really matter.

What will likely happen is that the schools will be required to test practical skills, oral skills to determine whether you can really coach another human being to change for good. The schools will likely be responsible for the oral exams, and the national credential will be a knowledge test.

Georgianna Donadio: No professional liability insurance company is going to just give you malpractice insurance or professional liability insurance unless you've demonstrated competencies. If you've demonstrated competencies in an accredited program that's either professionally accredited or academically accredited, the insurance company can then say, "Okay, you've demonstrated competencies." There's no doubt that the Medicare/Medicaid insurance providers will want, in some capacity, to provide coverage for these services. There is no responsible insurance network that is going to accept as a provider into their network someone who has not demonstrated that they in fact have been evaluated to insure against liability and injury. Can you imagine the liability? The government says, "We're going to open wellness centers and we're going to offer wellness and health coaching." How could they be expected to hire someone or to credential someone who could later turn out to cause not only great injury to the individual, but a tremendous liability to the government?

Michael Arloski: Something I love about what we're doing is that it is specific to health and wellness coaching. It is not the same profession as life coaching and business coaching and so forth. Our program is completely ICF-certified and approved. That's a good thing, but wellness coaching is something more. To have something specifically addressing that is what we want to be aligned with.

Linda Smith: I think we're all very intent on the transformation of healthcare in this country, if not the world. A huge piece of that is to dramatically change the trajectory of chronic disease. I want to see the reduction of diabetes and of the childhood obesity and adult obesity that are leading to diabetes. It's leading to arthritis. It's leading to cardiovascular disease, and it is an epidemic in this country.

National credentialing, I hope, would allow us to step forward in having everyone in this country have access to a healthcare professional who is capable of partnering with them to shift the complex behaviors that lead to these disease states. It is imperative for us, as a country, to shift the financials as well as the healthcare of this nation. The health coach has an important role in it.

Credentialing would allow individuals to have jobs within healthcare and outside of healthcare that would make that shift possible and make the partnering within the healthcare system itself possible so that we could be more effective with what we had gone into healthcare to do to begin with. And hopefully, the incredible burnout that we're seeing among our physicians and nurses would also be reduced by having someone who has these core skills to help patients change their behaviors.