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John Price

fstscoaching, The Retreat, Ketton Road, Hambleton, Oakham, LE15 8TH, United Kingdom


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The coaching/therapy boundary in organizational coaching

John Price*

fstscoaching, The Retreat, Ketton Road, Hambleton, Oakham, LE15 8TH, United Kingdom

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A literature search revealed diverse descriptions of the coaching/therapy boundary. In an attempt to gain greater definition, organizational coaches were surveyed to discover how they made decisions about the boundary in their practice. Responses indicated that practising coaches viewed coaching as differing from therapy in being future-orientated, short-term, less deep, goal-orientated, appropriate for clients who are mentally healthy, and organizationally focused. But, under such a definition, much of their practice appeared to be therapeutic. In addition, it was found hard to find a theoretical justification for the process and client elements of this definition. It is proposed that, rather than attempting to define a coaching/therapy boundary, it might be preferable to accept the indications from the research that coaching has a significant overlap with therapy, and that coaches would benefit from therapeutic training. Coaching could be differentiated from therapy by the specific competences of coaches and some contextual parameters.

Keywords: organizational; coaching; therapy; boundary; practice

Introduction

The impetus for this study stemmed from a statement in a book on coaching that read simply: ‘remember that coaching is not therapy’. The author gave no further explanation of what this implied. It seemed to the researcher that he should know how to differentiate coaching from therapy, but a quick literature search produced a wide dispersion of answers. Few of them included a cogent expression not only of the characteristics of the boundary, but also their implications for coaching practice. There is an accepted assumption that coaches should not provide therapy; those who provide therapy should be therapeutically qualified, and ideally professionally registered. Although the reverse is not as strongly supported, it would seem that there is an interest and shared responsibility for both the coaching and therapeutic communities to explore the boundary between them.

The core idea behind this study was that, although coaching literature can afford to entertain a variety of possible ways of describing the coaching/therapy boundary, practising coaches have to have a view. This view can be conceptual, or implied from their practice. But in either case, they cannot escape a decision; they either coach or they decide that they need to stop. Thus there seemed to be the possibility of deriving a more deterministic picture of the boundary from the aggregated experiences of practising coaches.

*Email: johnprice@fstscoaching.com

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Coaching, for the purposes of this study, was limited to organizational coaching, thereby excluding life coaching. In the literature the two types of coaching are often treated separately, and for some writers coaching is presumed to have an organizational focus. In order to minimise any intra-coaching variations that might confuse the coaching/therapy relationship, the research concentrated on organizational coaching. This has the added advantage of enabling the research to consider the question of whether it is coaching’s primary focus on effectiveness at work, rather than personal development, that differentiates it from therapy, the only dimension that Bluckert (2005) viewed as providing clear light between coaching and therapy.

**Literature review**

Coaching and therapy are defined in the literature in such varied and general terms that it is difficult to differentiate between them. Bachkirova (2007) made the point that, in response to this dilemma, more prescriptive concepts of coaching and therapy have been introduced (Bluckert, 2005; Peltier, 2001; Zeus & Skiffington, 2000), through which qualities could be attributed to each in a way that enabled differentiation. The difficulty with this approach was that they were not satisfactory in describing the scope of the two practices. As an example, Peltier’s (2001, p. xxvi) definition of coaching as ‘action oriented, data driven, present-moment focused and designed for a high-functioning client’ is too narrow to categorise current coaching practice.

Consideration of the literature on the relationship between coaching and therapy provided four dimensions of relational helping that might be useful in describing the boundary between them: the client; the coach/therapist; the process; and the purpose. These are now reviewed in turn.

The two main ways proposed for evaluating the suitability of a client for coaching appeared to be the degree of mental health and level of performance. Grant (2001) and Cavanagh (2005) proposed a normal distribution of mental health, with coaching likely to benefit the healthier part of the spectrum, and therapy the lower, with an overlap described as challenging coaching clients. Sperry (2004) was more prescriptive, suggesting that clients who were resistant, damaged, needy, dependent, or not ready to change, were not suitable for coaching. However, Bachkirova (2007, p. 353) argued that ‘the proposition of dividing the population into “clinical” and “normal” is continuously disputed and rejected’. And it would seem likely that many clients seek coaching or therapy to meet different requirements, rather than that their nature determines only one as suitable. Some writers differentiated clients on performance grounds. Zeus and Skiffington (2000) and Stone (2007) contrasted workplace counselling for problem employees with coaching being a process of continual development aimed at improving performance. This suggested that coaching should not be remedial, but only applied to people at least already performing at least adequately.

The European Mentoring and Coaching Council Code of Ethics (2009) states that:

The coach/mentor will at all times operate within the limits of their own competence, recognise where that competence has the potential to be exceeded and where necessary refer the client either to a more experienced coach/mentor, or support the client in
seeking the help of another professional, such as a counsellor, psychotherapist or business/financial advisor.

In practice it may be that the wider the psychological knowledge and experience of coaches, the greater the spread of mental health with which they feel comfortable, and therefore the wider they consider their coaching remit. On the other hand, how coaches detect the boundary might be judged more on a theoretical view of where coaching stops than from a feeling related to their personal comfort zone (Buckley & Buckley, 2006).

Another way that coaching could be seen to be moving into therapeutic territory is in the process of the work. There are many possible directional indicators of how this judgement might be made. Zeus and Skiffington (2000, p. 12) gave several examples of which two are:

- traditional counselling focuses on exploring reactive problems and behaviours, whereas coaching is proactive and looks to recognise and avert problems before they arise;
- therapists tend to focus on the resolution of old pains and old issues, whereas coaches acknowledge their historical impact but do not explore these in depth.

Greene and Grant (2003, p. 16) added that ‘coaching is less about unravelling problems and difficulties and more about building solutions and improving performance’. The Association for Coaching (2009) code of ethics and good practice includes:

- In particular, coaches are required to be sensitive to the possibility that some clients will require more psychological support than is normally available within the coaching remit. In these cases, referral should be made to an appropriate source of care.

Kilburg (2000) commented on the relatively deeper way in which issues are pursued and processed in therapy compared to coaching. All of these provide some guidance to coaches of warning signs that might suggest that the work is turning into therapy. Equally it could be argued that they all require judgments that depend more on the coach, the client and their relationship than on any objective differences between coaching and therapy.

Some definitions of coaching prescribed the scope of what coaching can address. The most common of these was that coaching concerns goals, and that work outside the achievement of agreed objectives should be set aside, either for future work or for referring on for another type of help. Writers on organizational coaching expected that coaching goals would relate to improved satisfaction or performance at work. Bluckert (2005) remarked that therapy also deals with history and relationships that may be only tangentially related to business; clients repeatedly focusing on their private life would indicate that a non-coaching issue needed to be addressed before coaching could resume.

In summary, it has been found difficult to use definitional comparisons of coaching and therapy to lay out a framework for a coaching/therapy boundary. However, differences between the two discussed in the literature could be combined to suggest a conceptual framework for structuring further inquiry. The four themes of the client, the coach/therapist, the process and the purpose provided a framework for thinking about the coaching/therapy boundary, and within these the literature
suggested several parameters that might be useful in calibrating the coaching/therapy boundary.

**Research methodology**

The research approach adopted was to question coaches practising in organizations to find out if there was any commonality about what they thought about the boundary or how they managed it in their practice. The literature review provided some parameters that were offered to respondents in order for them to be rated as differentiators, in the expectation that practising coaches’ views would overlap with at least some of the views expressed in the literature. By discovering how each coach has experienced the boundary, individual points of difference between coaching and therapy could be identified. If common themes were to emerge from clustering of these points of difference, it might be possible to produce inductively a generalised, if partial, description of the boundary.

Given the diversity of opinions evident from the literature review, it was thought that there was a risk that a limited number of in-depth interviews might present the researcher with multiple interpretations and an insufficient range of data to establish patterns. Thus an email survey strategy was adopted, which offered the potential to access a wide range of coaches, and a short and easy-to-use web-based questionnaire was employed to encourage response. On the other hand this approach would not allow any in-depth discussion of views or experiences, and increased the chance of misinterpretation of responses. This is a significant limitation to the validity of the research findings, particularly as the main finding was an apparent lack of consistency in individual responses. Thus the survey results are perhaps best regarded as highlighting a potential issue that requires further investigation, where in-depth discussions could identify the reasoning behind individual answers.

The questionnaire was structured firstly to find out the backgrounds and experience of respondents to see if there were any relationships between these and their subsequent answers. Next respondents had the opportunity to express their views of the boundary in their own words. Thirdly they were asked about their experience of declining potential clients as more suited to therapy than coaching, and of terminating coaching when it seemed to be turning into therapy. To understand better why they made the choices they did, respondents were asked how well the potential dimensions of the boundary selected from the literature described their reasons for declining or finishing coaching. Only a selection of the questions and responses from the questionnaire is covered in this paper, but it captures the main messages from the research.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Parameter</th>
</tr>
</thead>
<tbody>
<tr>
<td>The client</td>
<td>Mental Health; Level of performance; Commitment/resistance to change</td>
</tr>
<tr>
<td>The coach/therapist</td>
<td>Competence</td>
</tr>
<tr>
<td>The process</td>
<td>Depth Specific therapies; Level of psychological support; Past/future orientated</td>
</tr>
<tr>
<td>The purpose</td>
<td>Goals Personal/work issues</td>
</tr>
</tbody>
</table>
Email questionnaire invitations were sent out mainly through third parties, augmented by direct approaches to organizational coaches accessible on the internet. For this reason, and because the questionnaire was designed to keep responses anonymous unless respondents volunteered their details, response rates and any specific organizational biases were not known. 192 coaches practising in organizations answered the questionnaire. Of these there was a 49:51 split between respondents from a psychological or therapeutic background and those from management or HR with no psychological or therapeutic experience. 48% of all respondents had received coaching training. Neither of these dimensions, nor length of experience of coaching, proved to be significant discriminators of responses to later questions. Although the results presented below are aggregates, the questionnaire response database allowed for analysis of individual responses, and the segmentation of one type of response by the results of others. Thus checks could be carried out to ensure that patterns suggested by aggregate responses reflected individual answers rather than being fortuitous.

**Analysis of data**

*Differences between coaching and therapy*

The open question ‘When you think about how your coaching is different to therapy, the things that come to mind are:’ was asked early on in the questionnaire. Respondents wrote in their own words their answers to this question, and responses have been grouped into themes, guided by the four dimensions of the client, the coach, the process and the purpose identified in the literature. Three other groupings emerged that warranted their own categories: future/present versus past; organizational; and no difference. It should be recognised that ‘process’ is a very wide category, and one would expect a high response count.

The outstanding feature of respondents’ first thought about coaching was that the concept that coaching addresses the future had the highest mention. Sometimes this was linked to a reference such as ‘rather than the past’, but the most common expressions were just ‘forward looking’ or ‘future focused’. Interestingly, of those who chose this as their first thought, later on in the questionnaire only 37% agreed

<table>
<thead>
<tr>
<th>When you think about how your coaching is different to therapy, the things that come to mind are: [192 Respondents]</th>
<th>Firstly</th>
<th>Secondly</th>
<th>Thirdly</th>
<th>Fourthly</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future/present vs. past</td>
<td>47</td>
<td>14</td>
<td>8</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Process</td>
<td>44</td>
<td>86</td>
<td>89</td>
<td>56</td>
<td>21</td>
</tr>
<tr>
<td>Purpose</td>
<td>42</td>
<td>31</td>
<td>19</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Client</td>
<td>34</td>
<td>25</td>
<td>25</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Organizational</td>
<td>15</td>
<td>18</td>
<td>13</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Coach</td>
<td>7</td>
<td>4</td>
<td>9</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>There is no difference</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>192</td>
<td>179</td>
<td>165</td>
<td>104</td>
<td>29</td>
</tr>
</tbody>
</table>
that ‘the work became past- rather than future-orientated’ fitted very well as a reason to finish coaching. This suggests that 63% of coaches whose first thought about coaching was its future orientation were not thinking in terms of its process. The likely alternative is that their replies referred to coaching’s purpose being a focus on a future goal. In this coaching seems no different to therapy. It may be that dealing with the past is more of a therapeutic process, but therapy’s purpose is obviously to help the client to feel better now and in the future.

There was good support for the two dimensions of process and purpose being important in differentiating coaching from therapy. A review of the process comments showed, however, that they were a wide-ranging collection, with the only two identifiable themes being that coaching is more short-term and less deep. The key purposes highlighted by respondents were expressed in terms of goals or performance. There was also support for the view that coaching is organizational. This theme may well have been biased by the questionnaire invitation having been focused on coaches with organizational experience. But it is still interesting that an organizational focus was regarded by some coaches as differentiating coaching from therapy, not just as a general description of what they did. It would be fascinating to know how they regarded, for example, life coaching.

Clients were thought to play a much more important role in determining what makes a coaching or therapeutic interaction than the coach/therapist. Even so, at 17% of first thoughts, this was lower than might have been expected from the literature review, where for many writers the mental state of clients was the predominant differentiator.

Only 11% of respondents mentioned in any of their responses anything to do with qualifications, training or personal competence being a differentiating factor. Given that 51% of respondents came from management/HR with no psychological or therapeutic experience, this apparent lack of sensitivity to what seems to be an obvious differentiator for those who are not qualified to provide therapy was surprising. A matching argument for organizational skills could be made for those from a therapeutic background with no managerial experience. There did seem to be a majority view that the coaching/therapy boundary exists outside the personal qualities of the coach/therapist.

Whatever differences there might be in how coaching is viewed as different to therapy, the proportion of respondents believing that the two are indistinguishable was very low.

**Reasons for deciding not to start coaching**

The next question addressed the reasons why coaches might decline to coach a potential client (see Table 3 below).

Only 8% of respondents regarded ‘significant performance issues’ as a good reason for declining to coach, the word significant having been used to try to differentiate from ‘any performance issue’ which in many cases would be precisely the reason why people came to coaching. The view that significant performance issues often arise from psychological problems was not shared. There was certainly little support for the, mainly US, literature in which coaching was viewed as only appropriate for those performing at least adequately. ‘Apparent mental health issues’ and ‘psychological problems rather than well-being or performance at work’ both
received good support as reasons for declining potential clients, while the answers on commitment were ambiguous.

All of these issues rely on coaches making assessments about other people. This is not so when evaluating their own competence, and it is hard to see how ‘the work was likely to be outside my field of competence’ would not be an excellent prima facie reason for deciding not to take on a client. It is possible that many coaches felt that they could stay within their competence by constraining the scope of their work. But the limits they put on themselves did not appear to be sufficiently restrictive to secure this; of the 52% of coaches who responded that the work being likely to be outside their field of competence was not necessarily a very good reason for deciding not to coach, 86% were at least sometimes prepared to coach clients with mental health issues, or where psychological problems needed to be addressed, or where clients seemed uncommitted to change.

### Reasons for terminating coaching

The final question considered here asked coaches to give their views on reasons why they might terminate the coaching of an existing client (see Table 4 below).

There was a general sense from the data that many coaches were reasonably confident in their ability to manage quite substantial client difficulties. ‘Mental health problems’, ‘psychological dysfunctions’, and ‘needing more than normal levels of psychological support’ were generally regarded as strong reasons to end coaching, but not overwhelmingly so. It is interesting to analyze the responses of the 139 (73%) coaches who did not answer ‘very well’ to all three questions, as they demonstrated quite a wide view of the coaching remit. Of these 139 coaches, 94 (68%) did not have therapeutic experience, and of these 42 (30%) did not regard ‘moving out of my field of competence’ as a very good reason to stop coaching. In other words, 22% (42/190) of the coaches who answered this question were not therapeutically trained, not particularly concerned about their competence, but were prepared to coach clients seemingly showing therapeutic need.

‘Persistent performance issues’, ‘resistance to change’ and ‘inability to focus on coaching goals’ (6%, 12%, and 13% respectively) were not seen as very good reasons
to stop coaching. It is perhaps surprising that the support for ‘persistent performance issues’ and ‘resistant to change’ in this question were lower than in the previous question (8% and 35% respectively). It might be expected that, if after a period of coaching clients still had performance problems and difficulty in embracing change, these would indicate either a problem more deep-seated than could be assessed before coaching began, or that the coaching was at best not yet effective.

‘Work becoming past- rather than future-orientated’ and ‘personal rather than relating to work’ had intermediate scores (29% and 21%). From a competency perspective these might be regarded as easier to deal with than those in the last paragraph, so it is likely the purpose of the work rather than client issues that was regarded as important in determining the coaching boundary.

Discussion of results

The analysis of results showed that coaches have a variety of views on the boundary between coaching and therapy, reflective of the diversity in the literature. One of the main features of the research was the apparent inconsistency between coaches’ general theoretical perspective on the boundary and how they thought about and managed it in their practice. The findings of the analysis of practice are now reviewed within the structure of the overall themes of the coaching/therapy boundary shown in Table 2.

Table 4. Reasons for finishing or renegotiating a coaching contract.

<table>
<thead>
<tr>
<th>How well would the following possibilities describe the reasons you decided or might decide to finish coaching or to negotiate a therapeutic contract? [190 Respondents]</th>
<th>Dimension</th>
<th>Very well %</th>
<th>Possibly %</th>
<th>Not at all well %</th>
</tr>
</thead>
<tbody>
<tr>
<td>The client appeared to have mental health problems</td>
<td>Client</td>
<td>66</td>
<td>27</td>
<td>7</td>
</tr>
<tr>
<td>Goal achievement required addressing psychological dysfunctions in some depth</td>
<td>Process</td>
<td>55</td>
<td>36</td>
<td>9</td>
</tr>
<tr>
<td>The client needed more psychological support than is normal in coaching</td>
<td>Process/Client</td>
<td>51</td>
<td>40</td>
<td>9</td>
</tr>
<tr>
<td>I felt I was moving out of my field of competence (in the case of finishing coaching)</td>
<td>Coach</td>
<td>56</td>
<td>28</td>
<td>16</td>
</tr>
<tr>
<td>The client had persistent performance issues</td>
<td>Client</td>
<td>6</td>
<td>42</td>
<td>51</td>
</tr>
<tr>
<td>The client was resistant to change</td>
<td>Client</td>
<td>12</td>
<td>47</td>
<td>42</td>
</tr>
<tr>
<td>The client needed more psychological support than is normal in coaching</td>
<td>Process/Client</td>
<td>13</td>
<td>47</td>
<td>40</td>
</tr>
<tr>
<td>The client was unable to maintain focus on the agreed coaching goals</td>
<td>Process/Client</td>
<td>13</td>
<td>47</td>
<td>40</td>
</tr>
<tr>
<td>The work became past- rather than future-orientated</td>
<td>Purpose</td>
<td>29</td>
<td>53</td>
<td>19</td>
</tr>
<tr>
<td>The work became personal rather than relating to improved satisfaction or performance at work</td>
<td>Purpose</td>
<td>21</td>
<td>38</td>
<td>41</td>
</tr>
</tbody>
</table>
It was notable that one of the most popular concepts that first came to coaches’ minds when considering the boundary was the idea of coaching being future/present-focused. It can be argued that psychotherapy as defined in the Encyclopaedia Britannica (2009) as ‘modifying existing symptoms and promoting personality growth’ is equally future/present-focused. It is unlikely that therapists would regard their work as past-focused (Spinelli, 2008); they may consider that delving into the past is a useful, or even a necessary, part of the process, but the therapeutic aim would still be to change the current and future happiness or coping ability of the client. When coaches chose a future orientation as differentiating coaching from therapy, one would expect this to be a statement about its purpose, not just a comment on its process. This interpretation was supported by the fact that only 37% of those choosing this also believed that the process becoming past-orientated was a very good reason to finish coaching. However, as such it can be seen not to stand up to much scrutiny as a key differentiator. ‘Coaching is about the future’ is a plausible phrase, but one that captures only a very small part of the difference between coaching and therapy.

There is another aspect of ‘future/present-focused’ that is probably better communicated by talking about objectives, and in this sense responses about the future/present could have been grouped within goals. 40% of respondents wrote as one of their unprompted inputs that coaching is differentiated from therapy by the fact that it is solution-focused, goals are agreed, or performance improvement is targeted. The descriptions of goals were by far the clearest of all the survey inputs, and they do seem to offer a potential dimension of the coaching/therapy boundary.

It might be assumed that if coaching is about goals, particularly if combined with the view that coaching should not go into great psychological depth, that there would be a strong reason to decline potential clients if they seemed uncommitted to change, whereas this received only limited support. Equally one might expect a coach to be wary of potential clients with significant performance issues, as goals connected to these might be difficult to achieve. Certainly if these symptoms were to persist in coaching sessions, then it would appear that coaching was not achieving its core aim and finishing would be a consideration, whereas there was similarly little support for this view among coaches. Neither was there agreement that the client being unable to maintain focus on agreed coaching goals was a good reason for finishing coaching, although this clearly demonstrates that the coaching was struggling to be effective.

These inconsistencies give the impression that as long as goals are agreed, or it is performance that is being addressed, the work is coaching, even if the process is indistinguishable from therapy. This positions coaching more as therapy in a particular context, rather than as a separate discipline. What would be required to underpin goal-orientation as a discriminator would be a positive statement on the particular expertise of coaches in helping clients to set, work towards and attain goals, linked to a restrictive statement that clients unable to follow this path would be referred for therapy.

Respondents cumulatively input almost 300 statements that have been loosely grouped under ‘process’. This was a broad category, and the only common themes differentiating coaching from therapy were that coaching has less depth and is more short-term than therapy. The concern about depth was supported by most coaches agreeing that ‘goal achievement required addressing psychological dysfunctions in some depth’ was a good reason to finish coaching. However there was very little
agreement that the client having ‘persistent performance issues’, being ‘resistant to change’, or unable to ‘maintain focus on agreed goals’ were valid reasons to stop coaching. It can be argued that all these issues would probably require working at some depth with the client, and were unlikely to be solved by short-term intervention.

It appeared that coaches gave reasons why coaching is different from therapy, based on a genuine belief that the two are different, yet their implications for deciding which issues that arise during the work require therapeutic handling do not seem to have been thought through. There was a sense that the process of coaching was perceived as a sort of therapy-lite, without coaches having determined in their own minds what they needed to be light on.

The input of those respondents who focused on the client was typified by one answer: ‘The clients I work with are not ill’. As was discussed in the literature review, the view that coaching is for ‘healthy’ clients has significant support in the literature, and perhaps it is surprising that only 17% of respondents included it in their first thoughts about how coaching and therapy differ. However, its importance was demonstrated elsewhere in the survey, with ‘clients appearing to have mental health problems’ the most favoured reason for declining or terminating coaching. The implications of coaching being for the well, and therapy for the ill, can be interpreted in two ways: it could mean that the two processes are very similar, but the clients are different; or it could be that the sort of work that is effective with healthy people is inherently different from that undertaken with the mentally ill.

The difficulty raised by the first alternative is that segmentation of the population into ill and healthy is at best problematic and at worst discriminatory (Bachkirova, 2007). It is a position that could be helpful in determining skills requirements for coaches, such as the need for them to be trained in client assessment. But, on further consideration, this concept does not move coaching much further forward. Those capable of assessment would likely be therapeutically competent, and could simply provide therapeutic support rather than limiting themselves to coaching the mentally healthy. And without an agreed delineation between healthy and ill, which has hitherto been problematic even for mental health professionals, assessment has no meaning.

The second possibility, of the process of helping the healthy being different from that undertaken with the mentally ill, is quite radical given that coaching leans heavily on psychological theories developed for therapeutic populations. Newer developments such as positive psychology are starting to address the psychology of the ‘healthy’, but there is very little evidence that a fundamentally different approach would be more effective. Indeed the analysis of Wampold (2001), that demonstrated that in therapy the precise type of intervention was not a significant differentiating factor, would tend to suggest that the effectiveness of coaching is unlikely to be based on specific methodologies that differ from therapy.

Those coaches whose first choice was to stress the organizational aspect of coaching either saw coaching as what happens in a business environment, or as addressing the work side of a client’s life. As with the discussion above about goals, there is nothing about either of these that would lead to coaching being inherently different to therapy. Coaching could be seen as simply that part of therapy that is carried out in organizations or addresses work issues. This is a perfectly feasible way
of determining the coaching/therapy boundary, but it does suggest that coaching is more a branch of therapy than an independent profession.

Given that 71% of respondents did not have therapeutic experience, perhaps the most surprising finding in the survey was that so few coaches saw the boundary as in any way related to coaches’ qualifications, training or personal competence. This was evident not only in the mere 4% of respondents including them in their first thoughts, but in the fact that only 11% of coaches, unprompted, mentioned these at all. This was affirmed by the responses to other questions; 52% and 44% respectively of respondents did not view moving out of their field of competence as a very good reason to decline or stop coaching. At first sight this is in line with the response to several other equally good reasons, and does not stand out. But the difference is that views of the client are only assessments, and views on the process are interpretations for which responsibility could be shared with the client. But coaches should know their own limitations, and hold sole responsibility for staying within them. The International Association of Coaching ethical code (2009) states: ‘Coaches will represent themselves in an honest and fair manner, being cognisant of their particular competencies and limitations’.

A possible reason for the low level of support for competence as a discriminator could be that the way the question was asked might have included the possibility that coaches in practice just never found themselves stretched enough for them to feel they were moving outside their field of competence. But given that coaches were clearly prepared to work with a wide range of psychological issues, and that so many did not have therapeutic experience or training, it would appear unlikely that questions of competence would not arise and require answering either individually or in supervision. The fact that, of those with therapeutic backgrounds, 29% thought that ‘moving outside their field of competence’ was a very good reason not to start coaching, and 40% to end coaching, showed that even those qualified to move coaching through into therapy were aware that their competence might still be tested.

The number of coaches that believed that coaching and therapy were one and the same was very limited. Despite all the difficulties that are apparent in determining the boundary between the two, there was a general belief that, nevertheless, the two were different. Based on the research, this view seemed more an article of faith than a reasoned conclusion, perhaps simply reflecting the anxiety of a new profession about the potential dangers of appearing to encroach on established therapeutic territory.

In summary, the research has indicated that practising coaches overwhelmingly believed that coaching is different to therapy, but their practice did not seem to be in line with their beliefs that coaching differs from therapy in being future-orientated, short-term, less deep, goal-orientated, appropriate for clients who were mentally healthy, and organizationally focused. It can reasonably be inferred from the survey results that against this definition many coaches were engaging in therapy. The limitations of the research methodology meant that the reasons behind this apparent inconsistency could not be properly explored, but it could be that it was the result of coaches holding on to an embedded view of coaching that does not reflect the realities of current practice. Spinelli’s (2008) suggestion that the differentiation between coaching and therapy be thought of as a ‘fuzzy space’ reflected and addressed this inconsistency. But it did so on the basis of probabilistic definitions of coaching and therapy, an approach that inherently excluded the proposition that coaching and therapy could be simply separated.
Potential ways forward

From the perspective of this study, there seem to be two alternative routes forward for coaching: one is to develop coaching as a profession differentiable from therapy; the second is to accept that coaching significantly overlaps therapy. In the first case a boundary with therapy needs to be established, but in the second no such boundary is required.

The first alternative would require the coaching community to develop a description of a context, purpose and process for coaching. The choice of an organizational context, and a purpose that emphasizes goals and performance, might be regarded as overly limiting, but, unlike other parameters that have proven to be difficult to justify theoretically, they do seem to provide a supportable way forward. The process element of this alternative is much less easily managed. It would need to exclude therapeutic situations of types that can be clearly articulated. But the review of the literature and the practical experience evidenced in the survey have shown that this is probably unachievable. Thus it does not appear that there is any obvious way of satisfactorily defining a coaching/therapy boundary, unless it is limited to context and purpose. And, as such, coaching would appear to be more a bounded type of therapy than a separate discipline.

The questionnaire indicated that coaches were currently straddling both the alternatives above; they thought of coaching as different to therapy, but much of their practice seemed therapeutic. It can be surmised that many coaches would feel unnecessarily constrained by being limited to, say, organizations and goals, and to having to avoid clients and situations that they currently include in their practice. So it is worthwhile trying to justify current flexibility.

It can be argued that helping adults to develop is not the sole province of trained therapists. Parents, teachers, managers, trainers and so on are all involved in adult development of a general population which can be assumed to include the full spectrum of mental health. Coaches are certainly no less capable or trained than most of them. Particularly in organizations it can be argued that coaches take on developmental tasks that would otherwise be carried out by less-qualified managers. It would be a great loss to sponsoring organizations if coaching’s remit were to be narrowed, as many executives would not want to be seen to require therapy and would therefore forego help.

But, realistically, there would be intense pressure on coaching in this instance to give up its psychological heritage, as it would be hard to keep this and at the same time argue that it is fundamentally different to therapy. Unfortunately, what would then be left might feel more like training than coaching. There does not appear to be a simple way out of the present dilemma: creating a coaching structure that is independent of therapy seems overly limiting; accepting that coaching is a form of therapy is not what coaches believe, nor a way forward that it appears they want to countenance.

In any of the alternatives discussed above there is a need for coaches to become clearer about what they are qualified for. The codes of ethics of coaching bodies (for example the Association for Coaching (2009), and the European Mentoring and Coaching Council (2009)) specify that coaches should only coach within their
fields of competence, a concept developed further by Bachkirova (2007). As a first step it seems unarguable that coaches should either receive therapeutic training, or work within a boundary that precludes them from carrying out therapeutic work, however that might be defined. Given the difficulty in narrowing down such a definition, being absolutely sure of working within it would severely limit practice, and the option of avoiding this through therapeutic training becomes more attractive. One of the surprising findings of the questionnaire was the limited interest coaches showed in their own competence. It seems to the researcher that one of the preferable ways of transforming the coaching/therapy boundary is to focus on the differing skill sets of individual coaches, requiring them to be specific on their individual boundaries in a way that reflects their focus, training and experience. This may lead to a wide variety of coaching practices, with no unified field of coaching (Drake, 2008), but within each piece of coaching the work and boundaries would match the competence.

Coaches could categorise themselves as experts on goal achievement in an organizational context who use therapeutic techniques in appropriate circumstances. This would not be substantively different from the position of most therapists who equally regard themselves as competent in only a particular aspect of therapy. And coaches have more than just therapeutic skills to offer. Although the focus of this research was on the coaching/therapy interaction, it is worth remembering that there is a great deal about goals and organizations that has nothing to do with therapy, all of which would need to be part of the competence of coaches. Coaches coming from a management background would need training in adult learning and therapeutic skills; equally those from a therapeutic background would need to take on adult learning and organizational skills. It does not seem that coaching would find it hard to establish its own credentials.

**Conclusion**

On balance, the researcher believes that organizational coaching would maximise its potential by accepting that it includes therapy, and coaches would benefit themselves and their clients by being therapeutically trained. Coaching educators and governing bodies might consider what could be deemed core therapeutic competences for coaches. But the key lesson that the researcher takes from this study is that it is not the general definition of coaching that is important; it is that each coach should consider his or her personal competences, make them explicit to customers and clients, and work within them. In this event the coaching/therapy boundary, as currently construed, would cease to be important. It would be replaced by definitions of coaching practice characterised by the competences of individual coaches and some contextual parameters.

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References


Notes on contributors

John Price is an organizational coach working in the UK.