

Reflections from the Field

End-of-life coaching: A qualitative study

 Iain McCormick 

Abstract

Death involves the destruction of the mortal body and the consciousness it contains. The coaching psychology literature covers related topics such as grief and loss however much of this focuses on the individuals left behind rather than the person facing death. Despite this gap, coaching psychology offers several relevant approaches which include existential, phenomenological and narrative coaching. In addition, there is a wealth of important knowledge from the research on the effectiveness of grief counselling, recommended end-of-life client communications, and the value of palliative care. This paper uses four case studies on end-of-life coaching to explore these issues.

Keywords

end of life, coaching psychology, coaching techniques, client experience, case study

Article history

Accepted for publication: 01 July 2025

Published online: 01 August 2025



© the Author(s)

Published by Oxford Brookes University

Introduction

Dying involves the inevitable head-on collision between the mortal body and the essence of human consciousness that the body contains. The news of a terminal illness is typically devastating both for the individual and their loved ones. All involved can feel distraught by the thought of pain, suffering and the destruction of the flesh (Singh, 2000).

The coaching psychology literature does cover topics such as ways to coach and supervise through bereavement, grief and loss (Menaul & João, 2022) however much of this focuses on those left behind rather than the individual facing death. The coaching psychology literature does however advocate a range of approaches that address issues that are very important in working with clients at the end-of-life. One example is existential coaching that is based on existential philosophy and aims to assist clients to explore profound questions about life, authenticity, relatedness, freedom, values, death and meaning (Hanaway, 2020). The major themes in existential coaching are relatedness or how we connect with others, uncertainty or dealing with the multiple and critical unknowns in life, and existential anxiety which refers to the uneasy awareness of knowing the ultimate incompleteness of all of our actions and meanings (Spinelli, 2010). It is noted that human beings typically sustain hopes, plans and expectations within the uncertainty and

insecurity of the inevitable movement towards death. End-of-life coaching can be greatly enriched from these powerful approaches.

In a closely related method, the phenomenological approach encourages coaches to step back from their initial models and preferences to suspend assumptions and expectations when working with clients. It challenges coaches to explore the client's actual experience of the fear of death or the frightening awareness of leaving their loved ones behind or of facing the permanent end of consciousness. It is about examining the dynamics of consciousness as seen inside the client's world view. Spinelli (2010) outlines three steps that highlight the process:

1. *Bracketing* challenges coaching psychologists to put aside their logical process driven approach to working with clients and to *bracket* all assumptions regarding the client or their situation. This enables coaches to become attuned to what the client is presenting without the frame of the coaches worldview.
2. *Description* encourages clients to 'describe but not explain'. Rather than trying to understand a client's presenting issues on the basis of the coach's theories or hypothesis, the step involves focusing solely on the information that arises when exploring the client's worldview. The step includes feeding back to the client the 'what and how' of their experience but not the 'why'. The aim is to use the client's words, perspective and mindset to build understanding.
3. *Horizontalization*, or avoiding drawing or imposing assumptions, is about what is important to the client and seeing all the issues they raise as of equal value or on the same horizon. The aim of the phenomenological approach is to understand and describe the client's consciousness in their own language, using their own perspective without judgement or inference. The approach also encourages descriptive questioning (Spinelli, 2007). This involves exploring the clients presenting issues and challenges in depth. For example the statement 'I desperately want to see my grandchildren grow up and go to school' can be explored in a number of different ways. Using what the author calls *embodiment* the coaching psychologist can ask about the physical sensations associated with the desperation – do they have an ache in the chest or a tightness of the throat? From a *metaphorical* perspective the coaching psychologist can ask about what shape, object, sound, colour and so forth the desperation looks like - a black hole, a song of longing or a pool of quicksand? Using a *narrative* perspective the coaching psychologist may ask the client to tell a story about their own life or a fictional account exploring the desperation. This builds up an more unbiased understanding of the client's consciousness that enables this individual to start to explore the profound challenges of life such as authenticity, relatedness, freedom, values, death and meaning.

Exploring the latter approach further, Drake (2018) suggests that narrative coaching can utilise contextual storytelling to better understand the client's journey in life and to provide a powerful vehicle for them to express and even reshape this. It involves working with the client on three levels. Firstly, drawing on the individual's narrative to better understand and connect with them. Then, using the story telling structure, such as setting, rising action, climax, problem solving and resolution, to help the client gain perspective and meaning from their life. Lastly, exploring the dynamic nature of storytelling to enable the client to re-tell their story from a different and more meaningful frame. For example, starting with the story of being the powerless victim of cancer and moving to retell it as a story about leaving a legacy of resilience and devotion that will profoundly impact the loved ones left behind. This may move death from being a time of anxiety and dread to being a time of curiosity and profound significance as well as of uncertainty and angst; from death being the opposite of life to being the most powerful stage in personal growth; from death being a failure of the body to it being the successful completion of the life journey.

Kredentser and Chochinov (2020) suggest that there are a range of psychotherapeutic options for clients with terminal illness and these are directly relevant to coaching the dying. They suggest that the key challenges at the end-of-life are anxiety, anticipatory grief, depression,

pain management, and dignity-related concerns. They suggest that traditional therapeutic approaches need to be adapted to the unique needs of these clients including care in scheduling, goals of care, greater therapist flexibility, inclusion of family or health care team members, and the shortened duration of therapy. They recommend a range of evidence-based approaches including Acceptance and Commitment Therapy (Feros et al., 2013), Cognitive-behavioural Therapy (Greer et al., 2012), Dignity Therapy (Vuksanovic et al., 2017) and Meaning-centred Psychotherapy (Rosenfeld, et al. 2017) to address end-of-life psychological, social, spiritual, and existential issues.

So while little is written within coaching psychology specifically about working with dying individuals there are a number of relevant approaches that can greatly help the coaching psychologist to assist the client at this time.

Literature review

Not only is there little literature on coaching clients at the end-of-life there is even less exploratory or evaluative research in the area. However there is a wealth of material in the medical, nursing, counselling and palliative care literature which is relevant and important. Several areas of review are considered below: the effectiveness of grief counselling, end-of-life client communication, and the value and duration of palliative care.

A range of literature on the effectiveness of grief counselling is set out here. This is relevant to the present study as there is considerable overlap between the approach adopted in grief counselling and in end-of-life coaching.

Bagheri et al. (2020) undertook a systematic review and meta-analysis of the effectiveness of healing counselling interventions for post-abortion grief. They reviewed seven relevant studies with 918 subjects and found that psychotherapy-based interventions were effective in post-abortion grief treatment but also found these interventions were only somewhat effective in assisting with short-term grief but were more effective with long-term grief.

Ngesa et. al. (2020) undertook an assessment of the efficacy of a modified form of complicated grief therapy in treating orphaned children. A total of 426 such children aged 10-15 years were screened using the Brief Grief Questionnaire: 263 met the complicated grief criteria, with 241 subjects fully participating in the study, with 123 in treatment and 118 in the control group. The treatment group had a short 12 week version of the grief therapy and the controls had no treatment. This shorter therapy was effective in reducing grief symptoms and the control group showed no such reduction. The authors concluded that this shorter and less stringent therapy in a school environment did not interfere with its effectiveness.

Akbari and Arefi (2021) studied the effectiveness of Rational Emotive Behaviour Therapy, Logotherapy-based Group Counselling, and their combination, on the treatment of grief caused by adolescent girls' love trauma. They recruited 50 adolescent girls of which 36 were diagnosed using the Ross Love Trauma Scale. The subjects were assigned to four groups with the first receiving Rational Emotive Behaviour Therapy, the second receiving Logotherapy-Based Group Counselling, the next a combination of both methods, and the last no treatment. The results indicated that all three treatments were effective in the reduction of love trauma for adolescent girls, however the combination method was the most effective.

Zuelke et al. (2021) conducted a systematic review and meta-analysis on the effectiveness of internet and mobile-based treatment for grief after bereavement. They examined seven studies and significant improvements were found for symptoms of grief, depression, and posttraumatic stress. The overall quality of reviewed research was graded as low for grief and depression, to moderate for posttraumatic stress. However client satisfaction with the interventions was high, as was the

quality of the treatments assessed using objective quality criteria. They concluded that these types of treatments might constitute an effective approach for the symptoms of grief in bereaved adults.

Panahi et al. (2022) undertook a comparison of the effectiveness of grief counselling and God-orientated spiritual counselling on depression and suicidal ideation in clients with COVID-19 grief. A total of 51 individuals were used in the study and they were randomly assigned to the two different treatment groups and one control group. Data was collected using the Beck Depression Inventory and the Beck Scale for Suicidal Ideation. The results showed that both interventions were effective in reducing depression symptoms and suicidal thoughts. However, the God-orientated counselling had the greater impact. These authors concluded that this spiritual counselling was the most effective in reducing depression symptoms and suicidal thoughts in this Iranian sample.

Neimeyer et al. (2023) conducted a range of meta-analytic research which demonstrated that professional grief therapy is effective especially for groups of individuals with severe protracted and functionally impaired grief. Client age, gender, cause of death and duration of bereavement were not consistently predictive of the effectiveness of grief therapy. Cognitive behaviour therapy interventions were commonly seen amongst effective therapy types but there was little evidence that these types outperform the alternative treatments. Telehealth and writing based intervention offered promise for geographically dispersed and low cost interventions.

Saladino et al. (2024) undertook a systematic review of the effectiveness of Cognitive Behaviour Therapy for prolonged grief symptoms in children and adolescents. A total of 20 studies were reviewed and the results highlighted the improvements in prolonged grief symptoms and global functioning that were achieved using cognitive behaviour therapy. No significant age, gender or ethnic differences were found in most of the reviewed papers. The Inventory of Prolonged Grief for Children/Adolescents and the Inventory of Complicated Grief–Revised for Children were identified as the most sensitive prolonged grief measures. The authors concluded that Cognitive Behaviour Therapy was effective for prolonged grief symptoms in children and adolescents.

This brief review of the effectiveness of grief counselling can give coaching psychologists some confidence in the evidence-base for utilising this type of approach.

A range of research on end-of-life client communication is set out below. This is relevant to the present study as end-of-life coaching can usefully adopt a similar communication approach used by other professionals such as oncologists, intensive care specialists and so on.

Rodenbach et al. (2017) built on an initial randomized controlled trial of a combined patient-oncologist process to improve communication in advanced cancer by undertaking a post hoc analysis of patient coaching sessions that used a question prompt list. The authors hypothesized that the intervention-group would use more prompt questions related to topics, such as prognosis during the visit, than the control group. They recruited 170 patients with advanced cancer. Twelve intervention-group oncologists undertook individualized communication training and up to 10 of their patients ($n = 84$) received a pre-visit an individual coaching session that incorporated prompt list questions. Twelve control-groups and 86 patients received no interventions. The authors concluded that combined coaching and question prompt lists were effective in assisting these advanced cancer patients and their caregivers to bring up topics of concern, including prognosis, during their subsequent visits.

Levin et al. (2010) summarised the research and recommendations for intensive care unit end-of-life communication. They found that family-centred communication was key to end-of-life intensive care unit palliative care. The main forum for this was found to be the family meeting, which was important for shared decision making. They also found that better communication improved patient outcomes such as reducing psychological trauma, depression and anxiety, shortening the intensive care stay, and improving the quality of death and dying. Effective communication involved

addressing family emotions empathically and discussing death and dying in an open and meaningful way.

In an integrative literature review on the topic Kennedy et al. (2014) explored three issues: diagnosing the dying, medically futile interventions and the importance of communication in dealing with terminal clients. The authors screened 331 titles and abstracts, reviewed 42 papers and included 23 articles in their final work. These studies outlined the physical, social, spiritual and psychological decline towards death. Pain, loss of appetite and increased dependency were frequently part of the physical decline seen in clients before death. Other physical symptoms such as difficult or laboured breathing were correlated with shorter survival and often indicated the final phase in dying. Aspiration pneumonia or cardiac failure were major contributors to death in 78% of the clients in the reviewed papers. Several of the reviewed studies on both cancer and non-cancer clients indicated that psychosocial issues were present at the end-of-life but these received less attention in the studies. These psychosocial issues included grappling with the purpose of life and its meaning as well as impaired cognition and consciousness levels. In one reviewed UK study of clients with either heart failure or lung cancer, the meaning and purpose of life was often seen as more important than physical well-being, symptoms or support at this stage. Other studies suggested that that medically futile interventions may be persisted with even at the final stages of life. Medical staff recognised and documented both poor prognosis and the dying phases but there was little evidence of planning for end-of-life care so in many cases unnecessary interventions continued. These results were reported in both German and Italian studies despite the use of established care pathways for the dying patient. Kennedy et al. (2014) also reviewed a phenomenological study of hospice doctors and nurses, and illustrated the importance of understanding the individual's history and the views of family and carers at the end of life. They suggested that staff felt anxious about the timing of implementing the final care plan and thus possibly causing additional distress for both clients and families. Clinicians may then avoid problematic discussions with families who were struggling to accept the reality of the upcoming death. Kennedy et al. (2014) concluded that there was only a limited understanding of what constituted a 'good death' and that professionals too often avoided or postponed difficult communications with clients and their families.

Brighton and Bristowe (2016) suggested that early end-of-life care discussions with clients and their families often did not occur despite the demonstrated benefits of this. This review paper examined the barriers faced by clinicians in relation to these discussions including fear of causing distress, prognostic uncertainty, assessing client readiness and feeling unprepared for these conversations. They recommended that clinicians offer the patients and their families the chance to discuss these end-of-life issues in a way that meets the clinicians' decision making preferences.

Walczak et al. (2016) undertook a systematic review of evidence on the effectiveness of end-of-life communications. They assessed 45 studies that examined interventions that targeted patients (n = 6), caregivers (n = 3), healthcare professionals (n = 24) and other stakeholders (n = 12). Interventions included advance care planning, education, communication skills training, and structured practice changes. They found that some of these studies provided evidence of effectiveness in well-designed random control trials, however most studies in this area were not robust.

Attempts to better understand the communication needs of the dying patient were explored by Ekberg et al. (2021) and these are all relevant in the coaching context. The authors identified the following communication patterns that were recommended in discussions about the progression of the illness and the end-of-life:

1. Where possible, create opportunities for clients or family members to bring up issues they want to discuss as this indicates their readiness to deal with them.

2. Try to understand the client's or family member's perspective before providing your own view, as this will enable you to take their views into account.
3. If a client or family member discusses the future, try to mirror this approach but being careful not to increase ambiguity or concealing outcomes. In different societies, dying and death can be discussed indirectly, and this approach needs to be appreciated.
4. Where relevant try to use phrases or concepts that the client or family member has already used to describe death or the process of dying, as this can facilitate the discussion of end-of-life plans.
5. If appropriate, use hypothetical scenarios to discuss topics that could be important as many clients and family members may find this type of discussion more comfortable than the direct expression of reality.
6. If it is helpful refer to the illness, its progress and end-of-life in general terms, if it is unclear how the client or family member will react. For example, the phrase "when people are very ill..." may be useful as it does not mention the individual by name.
7. Even when the client's future and the progression of the illness is clear, it may be useful to express issues such as the timeframe for expected death in less concrete terms if this seems more easily accepted.
8. Display verbal and non-verbal signs of sensitivity when discussing illness progression and end of life. Explicit comments can be confronting for delicate individuals for example "there is now nothing more that we can do ...".
9. Recognise the positives, but not in an insensitive way, such as the age of the individual or the quality of life they have led.

Pun et al. (2024) undertook a systematic review of studies examining the Chinese perspective on end-of-life communication in a western context. The paper used 13 studies that met the quality criteria. From these, six themes emerged: the importance of Chinese philosophies on the meaning of 'a good death', the general negative attitude towards communication on dying, the taboo nature of end-of-life communication, the importance of clinician centred approaches to treatment decision-making, the family expectations about patient self-autonomy in prognosis discussions, and the caregivers frequent confusion over cultural preferences regarding end-of-life communication in this group. The authors concluded that western palliative care providers serving Chinese patients lacked a culture-specific model of communication and that this was needed.

Latham et al. (2024) examined the emotional experiences of physicians undertaking end-of-life conversations and decision making. They reviewed 17 studies from a total of 8,429 identified. Two themes emerged, firstly, a tension between the desire and the ability to communicate end-of-life news, and secondly the conflict of hiding versus revealing self across a range of different practical and emotional contexts.

Jackson and Emanuel (2024) identified a range of key clinical suggestions in relation to navigating and communicating about serious illness and end-of-life. These included the following recommendations.

1. Partnering with patients which requires the effective communication of prognostic information while responding empathetically to the emotions produced during these conversations.
2. Clinicians needing to have the skill to engage in a range of discussions about prognostic information and allowing patients time to integrate this both cognitively and emotionally.
3. Expecting that patients normally oscillate between intense hopefulness and more realistic aspirations.
4. Clinicians ability to facilitate discussion about patient hopes and worries, to understand patient priorities and build coping skills for living with serious illness.
5. Finally the ability of patients to integrate prognostic information and for clinicians to discuss what is most important for patients given the likely illness arc.

Gerber et al. (2024) undertook a scoping review of end-of-life care for older first generation immigrants. They found 15 studies which met their quality criteria and identified several themes for dealing with these patients.

1. The hesitancy of older immigrants and their families to talk about death and dying and the resulting problematic patient–client communication.
2. The contrast between individualistic and collectivist cultural norms and the end-of-life preferences.
3. The limited healthcare knowledge of older migrant adults.
4. The nature of barriers such as time pressure, lack of cultural sensitivity and inflexible service provision when dealing with these clients.
5. The need for caregivers to appreciate the migrants ‘double home’ experience and what this means for end-of-life decision-making.
6. The authors recommended that healthcare staff research and policy makers invest in cultural sensitivity issues related to end-of-life care.

This brief review of the research on end-of-life communication has much to offer the coaching psychologist wanting guidance in this area.

Several papers on palliative care are set out below. These are relevant to the present study as all the case study clients were in some form of palliative care at the time of coaching.

The World Health Organisation (2019) suggests that palliative care aims to improve the quality of life of patients with terminal illnesses by the prevention and relief of suffering. However Quinn et. al. (2020) undertook a systematic review and meta-analysis of 28 randomised clinical trials of noncancer patients receiving palliative care and compared the results with care as usual. They found a statistically significant relationship between less acute care and lower symptom levels, but there was no significant difference in quality of life between the two groups.

Jordan et al. (2020) undertook a systematic review and meta-analysis of 169 studies from 23 countries with 11,996,479 patients. The median length of palliative care was 18.9 days. They found significant differences between length of care by disease type with 15 days for cancer compared to 6 days for non-cancer conditions, with 19 days for specialist palliative care compared to 20 days for community/home care, and 6 days for a general hospital ward. There were also considerable variations across different countries. They concluded that the length of palliative care was typically much shorter than the 3-4 months which is needed to achieve the full patient benefit. The studies also highlighted the inequity across different types of clients, services and countries.

Jiang et al. (2024) undertook a systematic review of the effectiveness and cost-effectiveness of palliative care. The authors reviewed 17 studies which assessed a variety of interventions and populations. They found that the quality of the research was variable but by using natural experiments most studies reported that lower costs and improved outcomes were associated for those in palliative care when compared to other settings . However one third of the studies suggested that the use of palliative care had no impact on a variety of relevant measures.

This brief review of palliative care has some useful ideas that will be of benefit to the coaching psychologist wanting relevant information in this area.

Methodology

Yin (2009), in the book *Case study research: Design and methods*, makes a number of relevant methodological recommendations. These include ensuring that case study research has clear study questions to clarify the purpose and scope of the work; also that several collection methods

are used to ensure validated data and that the data analysis method is clear, for example, cross case comparisons or pattern matching between cases.

Any type of research method into the coaching with end-of-life clients' needs to be tempered with great concern for the circumstances these individuals are going through. In the present paper the following case study questions were asked.

Table 1: Case study questions

1. At what point in the end-of-life process did the clients come to coaching?
2. What issues did clients bring to this coaching?
3. Where clients used defence mechanisms during coaching, were they useful?
4. What were clients' view of the palliative care they received?
5. What were clients' views of new medical advances in their disease field?
6. What were the clients' attitudes towards their oncologists?
7. What issues did the coach face when dealing with end-of-life clients?

Case study data was collected using direct observation of client verbal and non-verbal behaviour and participant observation techniques made during the coaching with data recorded as case notes and self-reflective practice observations. Data analysis included identifying the common themes or patterns seen in the sessions and also comparing the differences between them.

The present study used four coaching clients all of whom had been given a terminal cancer diagnosis before entering coaching. There were two males and two females with an average age of 62 years. Two had graduate degrees and two had post graduate qualifications.

Table 2: Characteristics of the participants

Client ID	Age group	Gender	Qualification level
Client A	60 - 70	Male	Post graduate
Client B	60 - 70	Female	Post graduate
Client C	50 - 60	Female	Graduate
Client D	60 - 70	Male	Graduate

McCormick (2023) argues that reflective practice is an area of importance in coaching psychology, and there is also preliminary evidence supporting its effectiveness (McCormick & Forsyth, 2024). While the present study used direct observation of client verbal and non-verbal behaviour, the reflective observations by the coach proved to be particularly important in this case study approach. These reflective practice notes included coverage of the nature of the impact that the session had on the coach, the self-care approach used after sessions and the challenges that arose during the coaching and at the end of it, particularly when the coach was informed about the death of the client.

In preparation for this article the coach also undertook an additional reflection period and focused on the range of questions set out in Table 1.

Limitations

The current study has several limitations. The sample size is very small and all lived in the one geographical location, that is in New Zealand. There is a need for larger and more diverse sample groups so that the generalisability of the findings can be established. If possible future research should include a control condition. In addition the coaching and data collection was undertaken by the author of this paper which has risks of bias. Independent data collection would reduce this.

Results

The results are set out in the order of the case study questions identified in the method section. They are either drawn from case notes or are direct quotes from the reflective practice exercise (set out in *italic* below). As part of presenting the material anonymously all clients are referred with the pronouns 'she' or 'her'.

At what point in the end-of-life process did the clients come to coaching?

All clients entered coaching after they had received their terminal cancer diagnosis and between three and six months before dying. At this point three of the four clients had largely accepted the reality of their rapidly approaching death. All clients were referred directly to the coach, with one being referred by her partner who had previously worked with the coach.

What issues did clients bring to end-of-life coaching?

Dealing with the time between the present moment and death was a common coaching topic. For several clients returning to work after an initial period of temporary recovery was helpful.

She was at the stage where she was still angry but accepted that she would die in the next few months. The biggest problem she now had was that she did not know what to do with her time between now and then.

She repeatedly said she didn't know how to spend her time. Initially she felt she wanted to take the family away on a grand long overseas tour. However, it soon became apparent that she was much too sick to even contemplate this. In the end she decided that the best thing she could do was to enjoy long early morning walks with her partner on the beach and the occasional short trip away with her sons and daughters. These small simple steps came to mean a great deal to her because of the intensity of the human connection.

In the next session she said that when she received the diagnosis she went on sick leave as work was out of the question. However, when she had been off work for a month or so, she was utterly bored and felt like she was on death row counting down the days. By the end of the coaching session, she had decided that she would go back to work for as long as she could. Work gave her meaning and she desperately needed this.

Anger was a common theme that was brought to coaching.

She said she was angry that she had been unwell for many months, but her doctor had not been able to find anything wrong. Then when she was very insistent the doctor sent her for an MRI scan, and the specialist said it was inoperable cancer. She said it felt like being hit with a sledgehammer.

Day to day choices were brought to coaching as they took on a totally different significance for the dying client.

She needed a new mobile phone and would have previously purchased a top-of-the-line model. But given her prognosis what was the point? After some considerable discussion she decided on a full function but midrange model. She appreciated being able to talk about this in coaching as she felt that talking about it at home would be too distressing for the family.

Where clients used defence mechanisms during coaching, were they useful?

She came to coaching with a very matter-of-fact approach to her diagnosis and prognosis. The coaching sessions were filled with her telling stories of the past and reminiscing about good times and she indirectly made it clear she didn't want to talk about death. As a coach I was very happy to listen and enjoy the stories but did initially wonder if this was a cover for a great deal of underlying sadness. However, as the coaching went on I saw little sign of the reminiscing being unhelpful and was touched when she said the coaching was so helpful because it focused on her own agenda as it was often difficult to talk to others about this. She said she got the impression that her friends and family felt she ought to be miserable but all she wanted to do was celebrate her life. It seemed that her 'denial defence mechanism' was a positive psychological strategy that was used to help protect her from unhelpful death anxiety.

What were clients' views of the palliative care they received?

All the clients spoke highly of their palliative care. Generally, they felt that the professionals involved were concerned, sensitive and realistic. All were receiving some type of chemotherapy or radiation therapy during the coaching to reduce their discomfort and temporarily improve their quality of life.

What were clients' views of new medical advances in their disease field?

The promise of medical science and new advances proved to be a great source of torment for her. She was offered the opportunity to participate in a large international genomic study of cancer which had the promise of identifying an individualised genetically tailored treatment. After several difficult days trying to decide, she went ahead with the trial only to find some weeks later that her form of cancer was not in the international database and therefore the trial offered no hope. She felt crushed, once again!

What were the clients' attitudes towards their oncologists?

Generally the clients felt that their oncologists were helpful and objective about their diagnosis and prognosis. However not all interaction was useful. In one case the palliative chemotherapy treatment proved to be effective in reducing her discomfort and level of cancer markers. However, she told me that her oncologist had said that she was doing so well that her markers were now lower than his (the oncologist's). She had a rare moment of hope until the oncologist casually added "but your condition is still terminal".

What issues did the coach face when dealing with end-of-life clients?

This was my first coaching session with a dying client, and I felt awkward at the start of it and not sure what to say. I knew perfectly well that I just needed to be there with her and listen but still felt very uncomfortable. She was so extremely pleased to see me and so happy to talk that my discomfort evaporated.

After the first session and when the client had left, I immediately was overcome with sadness and wept bitterly for some time. I then felt utterly exhausted and was very pleased that I had no further appointments that day. I experienced the reality of my own mortality with frightening force. I knew with total certainty that I too would need to stare death in the face one day and was totally unsure how I would cope when tested.

After the coaching session I felt drained, fatigued and alone. I sat down to do some mindfulness meditation and immediately fell asleep. For much of the rest of the day I felt a vague sense of sadness and longing but for what I did not know.

I felt a strong need to be prepared for the upcoming session but also frustrated that there was no way to know what was going to happen. I later learned that preparation was both painful and futile. Mindful contemplation did however help at this time and did reduce my anxiety and apprehension.

Perhaps the greatest challenge for me as coach was a total absence of closure in almost all cases. I worked hard in sessions to connect deeply with my clients and help them to find some meaning in despair. Afterwards I longed to know what had happened to them and how they felt after the sessions. But the typical finish was a short phone call or text to say they had passed away. I found this acutely painful. With my latter clients I was very careful to avoid ever suggesting a follow up appointment or being too encouraging about an action plan. I found some solace in telling myself as I watched them being driven away from my office after every session that this could well be the last time I saw them, and I had done my utmost to be with them on their final journey.

Soon after agreeing to see the first dying client, I decided that I would do all this work on a pro bono basis. The idea of sending an invoice to someone who was dying was an anathema. I have never had a second thought about this issue. I consider it a privilege to work with these people and to share some of this precious and sacred time with them. I have learned so much about 'a good death'.

Discussion

This study explored coaching with terminally ill clients all of whom died shortly after the end of coaching. The paper used four case studies and the reflective writing of the coach to explore the types of issues brought to coaching and the experiences of both the clients and the coach as the illness progressed. All clients reported finding having an independent emphatic coach to be valuable in helping them find meaning and face death.

The value of coaching psychology for clients at the end of life

There are also several coaching approaches, set out below, that are beneficial for coaching psychologists in this context (McCormick, 2023).

1. The supportive approach in which the coaching aims to confirm, strengthen and validate the client's insights, strengths and actions.
2. The cathartic method where the client can talk in depth and openly about their feelings such as sadness, frustration or anxiety and so release their negative emotions.
3. The catalytic approach in which the goal is to inspire the client's self-discovery by exploring important areas and helping them understand their feelings and thoughts in a way that enables them to gain insight and meaning.

Coaching psychology also encourages the development of a humble mindset in the coach (Roxburgh & Queen, 2020). These authors suggest a humble approach is linked to a genuine respect for the client's experience, expertise and understanding. It strengthens the likelihood of serious dialogue and genuine exchange. It also allows the coaching to create a safe environment and helps to build trust in the relationship.

The relevance of existential coaching

Existential coaching has several elements which were found to be very helpful in this context. This approach helps clients to explore the fundamental elements of their lives such as the meaning of their existence and the responsibilities and choices that they have in order to achieve a good death. It assisted the coach to work with the clients to find their authentic values and beliefs, to help them find or create purpose in their lives, to address the uncertainty, isolation and existential anxiety that is so frequently a part of dying.

The importance of the phenomenological approach

This approach had great value as it challenged the coach to explore in depth the client's reality about the fear of death, the frightening awareness of leaving their loved ones behind and with facing the permanent end of consciousness. It enabled the coach to put aside the logical process driven approach of working with clients and to let go of assumptions regarding the client or their situation. It assisted the coach to 'describe but not explain' and focus solely on the client's worldview. Lastly it helped to avoid drawing or imposing assumptions about what is important to the coach and seeing all the issues they raise as of equal value. Overall it enabled a better understanding of the client's consciousness in their own language, using their own perspective without judgement or inference.

The effectiveness of end-of-life coaching

While the coaching psychology literature has little coverage of end-of-life coaching, much can be learned about what is effective in grief therapy and the research on end-of-life client communication. This suggests that it is important to create opportunities for clients to bring up issues they want to discuss as this indicates their readiness to deal with them. To understand the client's perspective before providing your own as this will enable the coach to take their views into account. To mirror the language and approach of the client in exploring their world view. To be sensitive and refer to the illness, its progress and end-of-life generally, in a way that will not shock or offend the client. To sensitively emphasise the positives in the life of the client such as their achievements or the quality of life they have led.

The need for self-care

Corrie and Kovacs (2021) suggest that if coaches are to deliver their best work they must be emotionally and psychologically well-resourced. This can only be achieved if coaches are aware of the importance of self-care and act accordingly. In the present case the coach found it essential to have time after each coaching session to openly express grief and sadness as well as to reflect and write about the session.

Conclusion

The coaching psychology literature covers topics such as bereavement, grief and loss however much of this focuses on those left behind rather than the individual facing death. Nevertheless coaching psychology has a great deal to offer in helping clients at the end of life. Useful approaches include existential, phenomenological and narrative coaching. Much can be learned from grief therapy and counselling as well as from ways to communicate effectively with the dying client. Coaching psychologists embarking on this type of work are advised to understand the importance of self-care and how to implement this.

Coaching at the end-of-life is an important topic which deserves further research to explore its generalisability and utility. Further studies are needed with more diverse client groups, larger

sample sizes and future research could replicate the findings from this study in different countries, cultures and economic groups.

References

- Akbari, F., & Arefi, M. (2021). Effectiveness of rational emotive behavior therapy, logotherapy-based group counseling, and their combination on the treatment of grief caused by adolescent girls' love trauma. *Pajouhan Scientific Journal*, 19(2), 1-9.
- Bagheri, L., Nazari, A. M., Chaman, R., et al. (2020). The effectiveness of healing interventions for post-abortion grief: a systematic review and meta-analysis. *Iranian Journal of Public Health*. 49(3) 426-436. DOI: [10.18502/ijph.v49i3.3123](https://doi.org/10.18502/ijph.v49i3.3123).
- Brighton, L. J., & Bristowe, K. (2016). Communication in palliative care: talking about the end of life, before the end of life. *Postgraduate Medical Journal*, 92(1090), 466-470. DOI: [10.1136/postgradmedj-2015-133368](https://doi.org/10.1136/postgradmedj-2015-133368).
- Corrie, S., & Kovacs, L. (2021). Addressing the self-care needs of coaches through the use of formulation. *Coaching: An International Journal of Theory, Research and Practice*, 15(1), 117–130. DOI: [10.1080/17521882.2021.1926523](https://doi.org/10.1080/17521882.2021.1926523).
- Drake, D. (2018). Narrative coaching. In E. Cox, D.A. Clutterbuck, & T. Bachkirova. *The Complete Handbook of Coaching*. 109-123. London: Sage.
- Ekberg, S., Parry, R., Land, V., et al. (2021). Communicating with clients and families about illness progression and end of life: a review of studies using direct observation of clinical practice. *BMC Palliative Care*, 20, 1-12. DOI: [10.1186/s12904-021-00876-2](https://doi.org/10.1186/s12904-021-00876-2).
- Feros, D. L., Lane, L., Ciarrochi, J., & Blackledge, J. T. (2013). Acceptance and Commitment Therapy (ACT) for improving the lives of cancer patients: a preliminary study. *Psycho-oncology*, 22(2), 459-464. DOI: [10.1002/pon.2083](https://doi.org/10.1002/pon.2083).
- Gerber, K., Maharaj, E., Brijnath, B., & Antoniadis, J. (2024). End-of-life care for older first-generation migrants: A scoping review. *BMJ Supportive & Palliative Care*, 14(e1), e211-e219. DOI: [10.1136/bmjspcare-2020-002617](https://doi.org/10.1136/bmjspcare-2020-002617).
- Greer, J. A., Traeger, L., Bemis, H., et al. (2012). A pilot randomized controlled trial of brief cognitive-behavioral therapy for anxiety in patients with terminal cancer. *The Oncologist*, 17(10), 1337-1345. DOI: [10.1634/theoncologist.2012-0041](https://doi.org/10.1634/theoncologist.2012-0041).
- Hanaway, M. (2020). *The Handbook of Existential Coaching Practice*. Routledge.
- Jackson, V. A., & Emanuel, L. (2024). Navigating and communicating about serious illness and end of life. *New England Journal of Medicine*, 390(1), 63-69. DOI: [10.1056/NEJMc2304436](https://doi.org/10.1056/NEJMc2304436).
- Jiang, J., Kim, N., Garrido, M. M., et al. (2024). Effectiveness and cost-effectiveness of palliative care in natural experiments: a systematic review. *BMJ Supportive & Palliative Care*, 14(e1), e150-e161. DOI: [10.1136/spcare-2022-003993](https://doi.org/10.1136/spcare-2022-003993).
- Jordan, R. I., Allsop, M. J., ElMokhallalati, Y., et al. (2020). Duration of palliative care before death in international routine practice: a systematic review and meta-analysis. *BMC medicine*, 18, 1-25. DOI: [10.1186/s12916-020-01829-x](https://doi.org/10.1186/s12916-020-01829-x).
- Kennedy, C., Brooks-Young, P., Gray, C. B., et al. (2014). Diagnosing dying: an integrative literature review. *BMJ Supportive & Palliative Care*, 4(3), 263-270. DOI: [10.1136/bmjspcare-2013-000621](https://doi.org/10.1136/bmjspcare-2013-000621).
- Kredentser, M. S., & Chochinov, H. M. (2020). Psychotherapeutic considerations for patients with terminal illness. *American Journal of Psychotherapy*, 73(4), 137-143. DOI: [10.1176/appi.psychotherapy.20190048](https://doi.org/10.1176/appi.psychotherapy.20190048).
- Latham, J. S., Butchard, S., & Mason, S. R. (2024). Physician emotional experience of communication and decision making with end-of-life patients: qualitative studies systematic review. *BMJ Supportive & Palliative Care*, 14(e1), e99-e119. DOI: [10.1136/bmjspcare-2021-003446](https://doi.org/10.1136/bmjspcare-2021-003446).
- Levin, T. T., Moreno, B., Silvester, W., & Kissane, D. W. (2010). End-of-life communication in the intensive care unit. *General Hospital Psychiatry*, 32(4), 433-442. DOI: [10.1016/j.genhosppsych.2010.04.007](https://doi.org/10.1016/j.genhosppsych.2010.04.007).
- McCormick, I. (2023). *Reflective practice for coaches: A guidebook for advanced professional development*. Routledge.
- McCormick, I., & Forsyth, S. (2024). Assessing the effectiveness of group based reflective practice for coaches. *International Journal of Evidence Based Coaching & Mentoring*, 22(1), 293-302. DOI: [10.24384/rhbp-8660](https://doi.org/10.24384/rhbp-8660).
- Menaul, J., & João, M. (2022). *Coaching and supervising through bereavement: A practical guide to working with grief and loss*. Routledge.
- Neimeyer, R. A., Breen, L. J., & Milman, E. (2023). The effectiveness of grief therapy: A meta-analytic perspective. *The Handbook of Grief Therapies*, 29-40.
- Ngesa, M. O., Tui-Kong, S., & Ongaro, K. (2020). Treating complicated grief among orphaned children in Kenya: Effectiveness of complicated grief therapy. *Open Journal of Social Sciences*. 8, 461-478. DOI: [10.4236/jss.2020.84034](https://doi.org/10.4236/jss.2020.84034).
- Panahi, S., Ataefar, R., Bahrami-Heideji, M., et al. (2022). Comparison of the effectiveness of grief counseling and God-oriented spiritual counseling on depression symptoms and suicidal ideation in people with COVID-19 Grief.

International Journal of Body, Mind & Culture (2345-5802), 9(4), 309. DOI: [10.22122/ijbmc.v9i4.433](https://doi.org/10.22122/ijbmc.v9i4.433).

- Pun, J. K., Cheung, K. M., Chow, J. C., & Chan, W. L. (2024). Chinese perspective on end-of-life communication: a systematic review. *BMJ Supportive & Palliative Care*, 14(e1), e30-e37. DOI: [10.1136/bmjspcare-2019-002166](https://doi.org/10.1136/bmjspcare-2019-002166).
- Quinn, K. L., Shurrab, M., Gitau, K., et al. (2020). Association of receipt of palliative care interventions with health care use, quality of life, and symptom burden among adults with chronic noncancer illness: a systematic review and meta-analysis. *Jama*, 324(14), 1439-1450. DOI: [10.1001/jama.2020.14205](https://doi.org/10.1001/jama.2020.14205).
- Rodenbach, R. A., Brandes, K., Fiscella, K., et al. (2017). Promoting end-of-life discussions in advanced cancer: effects of patient coaching and question prompt lists. *Journal of Clinical Oncology*, 35(8), 842-851. DOI: [10.1200/JCO.2016.68.5651](https://doi.org/10.1200/JCO.2016.68.5651).
- Rosenfeld, B., Saracino, R., Tobias, K., et al. (2017). Adapting meaning-centered psychotherapy for the palliative care setting: results of a pilot study. *Palliative medicine*, 31(2), 140-146. DOI: [10.1177/0269216316651570](https://doi.org/10.1177/0269216316651570).
- Roxburgh, R., & Queen's, I. R. C. (2020). *A humble mindset: A coaching differentiator*. Available at: https://irc.queensu.ca/wp-content/uploads/2020/01/articles_a-humble-mindset-a-coaching-differentiator.pdf.
- Saladino, V., Verrastro, V., Calaresi, D., & Barberis, N. (2024). The effectiveness of cognitive behavioral therapy for prolonged grief symptoms in children and adolescents: A systematic review. *International Journal of Stress Management*, 31(1), 66. DOI: [10.1037/str0000301](https://doi.org/10.1037/str0000301).
- Singh, K. D. (2000). *The grace in dying: A message of hope, comfort and spiritual transformation*. HarperCollins Publishers.
- Spinelli, E. (2007). *Practising Existential Psychotherapy: The Relational World*. London: Sage.
- Spinelli, E. (2010). Existential Coaching. In E. Cox, D.A. Clutterbuck, & T. Bachkirova. *The Complete Handbook of Coaching*. 94-106. London: Sage.
- Vuksanovic, D., Green, H. J., Dyck, M., & Morrissey, S. A. (2017). Dignity therapy and life review for palliative care patients: a randomized controlled trial. *Journal of Pain And Symptom Management*, 53(2), 162-170. DOI: [10.1016/j.jpainsymman.2016.09.005](https://doi.org/10.1016/j.jpainsymman.2016.09.005).
- Walczak, A., Butow, P. N., Bu, S., & Clayton, J. M. (2016). A systematic review of evidence for end-of-life communication interventions: who do they target, how are they structured and do they work? *Patient Education And Counseling*, 99(1), 3-16. DOI: [10.1016/j.pec.2015.08.017](https://doi.org/10.1016/j.pec.2015.08.017).
- World Health Organisation. (2019). *Palliative Care*. Available at: <https://www.who.int/cancer/palliative/definition/en/>.
- Yin, R. K. (2009). *Case study research: Design and methods* (4th ed). London: Sage.
- Zuelke, A. E., Luppá, M., Löbner, M., et al. (2021). Effectiveness and feasibility of internet-based interventions for grief after bereavement: systematic review and meta-analysis. *Journal of Medical Internet Research Mental Health*, 8(12), e29661. DOI: [10.2196/29661](https://doi.org/10.2196/29661).

About the author

Iain McCormick PhD, an executive coach, trained initially in clinical psychology, then completing a PhD in work stress. His research and practice interests include existential coaching, reflective practice and schema coaching.