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Academic Paper

The Decision Bridge: A Model for Coaching Distressed Physicians

Pamela Nemecek

Abstract

How do coaches make decisions when they become concerned about a client's mental health needs? Using a Grounded Theory approach, this U.S. based study explored key decisions made by 12 experienced coaches of physicians; a group of highly stressed professionals more likely to engage in coaching than therapy. Findings included a theory describing how coaches recognise mental health needs and make decisions about how to respond, without attempting to diagnose or treat any psychological condition. This theory, called the Decision Bridge, has general coaching implications, as well as practical application for coaching distressed physicians.

Article history

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Introduction

Coaches often face decisions about how to respond when clients experience distress. They need strategies to recognise and respond to mental health needs in a coaching context, without attempting to diagnose or treat any psychological condition. This is especially important if the client is open to coaching but not therapy. Physicians comprise a highly stressed professional group who are more likely to engage in coaching than therapy, therefore coaches of physicians must prepare to recognise and respond effectively to physician distress in a coaching context.

Literature offers guidance on how mental health concerns *should* be handled in coaching, but the phenomenon of how coaches *actually* recognise and respond to client distress is an under-researched area, especially in physician coaching. This study is a window into that phenomenon.

The following sections will review literature on physician distress and the effects of coaching, describe unanswered questions, and outline the methodology chosen to investigate those answers in this study. Key findings will show how participants recognised and responded to physician distress, followed by a discussion of the Decision Bridge Theory, which emerged from this research as a model for decision-making to address mental health needs of clients. The conclusion highlights practical implications of the Decision Bridge as a tool for general coaching practice, and offers recommendations for future research.

Literature Review

Physician distress and coaching

Physicians are experiencing unprecedented levels of stress, moral injury, and exhaustion (Murthy, 2022; Mong & Noguchi, 2022). Some studies reveal deeper suffering, including self-harm and suicide (Shanafelt et al, 2021; Moutier, Myers, Feist, Feist & Zisook, 2021).

Doctors are conditioned to ignore their own suffering, and are excellent at hiding their distress (Moutier, 2018; Wong, 2020). Despite their need for support, however, physicians are significantly less likely than the general population to seek therapy, due to concerns about their reputation and license if perceived as being mentally unhealthy (Weiner, 2020; Clough, March, Leane & Ireland 2018; Gold, Andrew, Goldman & Schwenk, 2016). Fortunately, doctors are often willing to accept coaching, which carries less stigma (Gazelle, Liebschutz & Reiss, 2015).

Evidence shows that coaching interventions are effective to reduce distress and improve well-being in physicians (Boet, Etherington, Andreas & Denis-LeBlanc 2022; McGonagle et al, 2020; Dyrbye, Shanafelt, Gill, Satele & West 2019) but questions arise about the processes being used by coaches of physicians.

Diagnose and Treat or Recognise and Respond?

Coaching is not intended to ***diagnose or treat*** any mental health condition. These terms carry legal meaning in the U.S., and are used to clarify roles and responsibilities when speaking with clients and sponsors. Coaches do, however, need skills and competencies to ***recognise and respond*** to mental health needs of clients. This raises the question of how coaches make decisions when working with distressed clients who decline therapy, but wish to continue coaching.

Navigating boundaries between coaching and therapy is a richly debated topic. Some argue that "crossover" must be avoided (Williams, 2003). Others maintain that some overlap is unavoidable, and can even be useful in the context of appropriate training (Bachkirova and Baker, 2018).

Psychologists debate using the client's level of mental health as a guide for who should be coached, based on the problem of defining what a *"mentally healthy"* coaching client is (Buckley, 2007; Cavanagh and Buckley, 2018). While there are concerns that coaching may be used by some clients as a way of bypassing the clinical help they need, it has been noted that, for clients with *"subclinical symptoms"* coaching may serve as *"early preventative intervention"* that can help clients avoid *"sliding into frank clinical symptomology"* (Aboujaoude, 2020).

Legal codes define the licensure, education, and scope of practice for a U.S. psychologist or psychiatrist. However, coaching activity is restricted because no licensure or education mandate currently exists. (Jasper & Griffin, 2022).

Confusion can occur for clients or sponsors, since coaching and therapy share a toolkit of psychology-based techniques, like ACT-based Coaching (Blonna & Antiss, 2018) or Cognitive Behavioral Coaching (Williams, Edgerton & Palmer, 2010). Coaching applications of these and other techniques are not intended as mental health treatment, but they do sit on a continuum with clinical psychology interventions, which work at a deeper level (Bradwejn, 2020; Bluckert, 2005).

Recommendations from coaching literature

Coaching literature makes recommendations for recognising and responding to mental health needs of clients. Buckley (2007) says all coaches should learn to identify key signals that a client needs referral for psychotherapy, providing a detailed book as a guide (Buckley & Buckley, 2012). Hullinger and DiGirolamo (2018) outline recommendations for when and how to make this referral with a coaching client, and Cavanagh (2005) points out that it is important to have *"a process for deciding"* what to do, proposing questions to assess a client's suitability for coaching if a concern arises.

These valuable resources support a coach's understanding of what *should* be done. Questions remain, however, about what coaches *actually* do, and why. Descriptive studies are needed to answer these questions and to shed further light on effective practices.

Methodology

An interpretivist philosophy informed this qualitative research, based on the premise that humans create meanings that can be studied (Saunders, Lewis & Thornhill, 2016). The research design was based on Grounded Theory (GT) (Glaser & Strauss, 1967) using a constructivist perspective to gain insight about participants' data through *"the logic of their experience"* (Charmaz, 2006:35).

Data collection took a phenomenologist approach, focusing on participants' lived experience, to provide richer understanding of the context as unique to the circumstances of participants (Alharahsheh & Pius, 2020). Some maintain that within participants' stories may be an interwoven story of the researcher as they gain insight about themselves (Creswell, Hanson, Clark Plano & Morales, 2007). With this in mind, I took care to reflect on my own values and experiences as a physician coach, maintaining awareness of personal assumptions during data interpretation.

Participant Selection

Purposeful sampling guided selection of 12 participants who could provide information-rich descriptions of multiple cases (Neuman, 2005; Saunders et al, 2016:301; Patton, 2002) resulting in a sample size based on number of incidents discussed (24) not just number of people interviewed (Woolsey, 1986).

Participants were given information about the study, and were recruited in three categories, defined by their background in 1) full-time coaching; 2) coaching + medicine; 3) coaching + psychology/psychiatry. (Table 1.) Recruitment was done through professional coaching organizations, physician support groups, and outreach to experienced colleagues. Approval was granted and research conducted under the ethical guidelines of York St. John University regarding confidentiality, data security, and informed consent.

Table 1: Professional Profile of Participants

Professional Category	Coaching Experience	Interview Hours
4 Non-Physician/Non-Therapist Coaches	39 years total	4.5 hours total
4 Physician/Non-Therapist Coaches	32 years total	4.5 hours total
4 Therapist or Psychiatrist Coaches	20 years total	6 hours total

Segmented Interviews

Interviews were divided into two segments. The first segment employed Critical Incident Technique (CIT) (Flanagan, 1954) using self-report of incidents to understand cognitive, affective and behavioural elements of the participants' perspective. (Chell, 1998; Butterfield, Amundson & Maglio, 2005).

An advantage of using CIT method in GT research is that it does not involve a preconceived idea on the part of the researcher about what the respondent will find important, allowing the incident to be understood subjectively from the perspective of the respondent (Gremler, 2004:66). In behavioural interviews, Klemp & McClelland (1986) caution against letting interviewees generalize about what they *usually* do in typical situations and why, which does not yield much accurate information about their actual behaviour. Beginning with the CIT segment helped participants stay 'in the story', focused on narrative details of what happened, knowing they could comment later on what they *usually* do and why.

During the second segment, general questions elicited participants' perspective on boundaries and overlaps between coaching and therapy, and on competencies and strategies for coaching distressed physicians. During the general interview segment, additional themes and sub-themes were identified, revealing a decision process that occurs *between* recognition and response. This developed into the core variable and Decision Bridge theory, which will be described in Findings and Discussion.

Analysis and Coding

Interviews of 60-90 minutes were conducted over Zoom, recorded using transcription software from Otter.ai, and coded manually from transcripts corrected by hand during audio playback.

The CIT segment enabled the speaker to recall accounts freely, rather than answering specific questions (Gremler, 2004). During analysis of early interviews, this facilitated identification of primary themes based on patterns in the narratives about what was going on (thoughts, feelings, behaviors) when the coach "recognised" distress, and what was going on when they "responded" to it (Chell, 1998).

Quotes were disassembled and reassembled in categories relevant to "Recognised" or "Responded", and sub-categorised according to the "thoughts" "feelings" and "behavior" of the coach during that part of the story. These categories led to major themes identified in each area. Subsequent interviews contributed to the support or adaptation of that theme, and in some cases sub-themes became evident. (Braun & Clarke, 2006, 2021; Boyatzis, 1998).

An abductive approach to theory development was used, moving between induction (observing patterns to develop a theory) and deduction (testing of the theoretical proposition) to arrive at the "*most plausible interpretation of the observed data"* (Charmaz, 2006:186). Through memoing, constant comparison of data, and contrasting with activities coded differently, a stable set of themes and subthemes were created (Denscombe, 2007). Thematic saturation was reached at the *"new information threshold",* when data from new interviews contributed no new information to the theory (Guest, Namey & Chen, 2020).

Findings

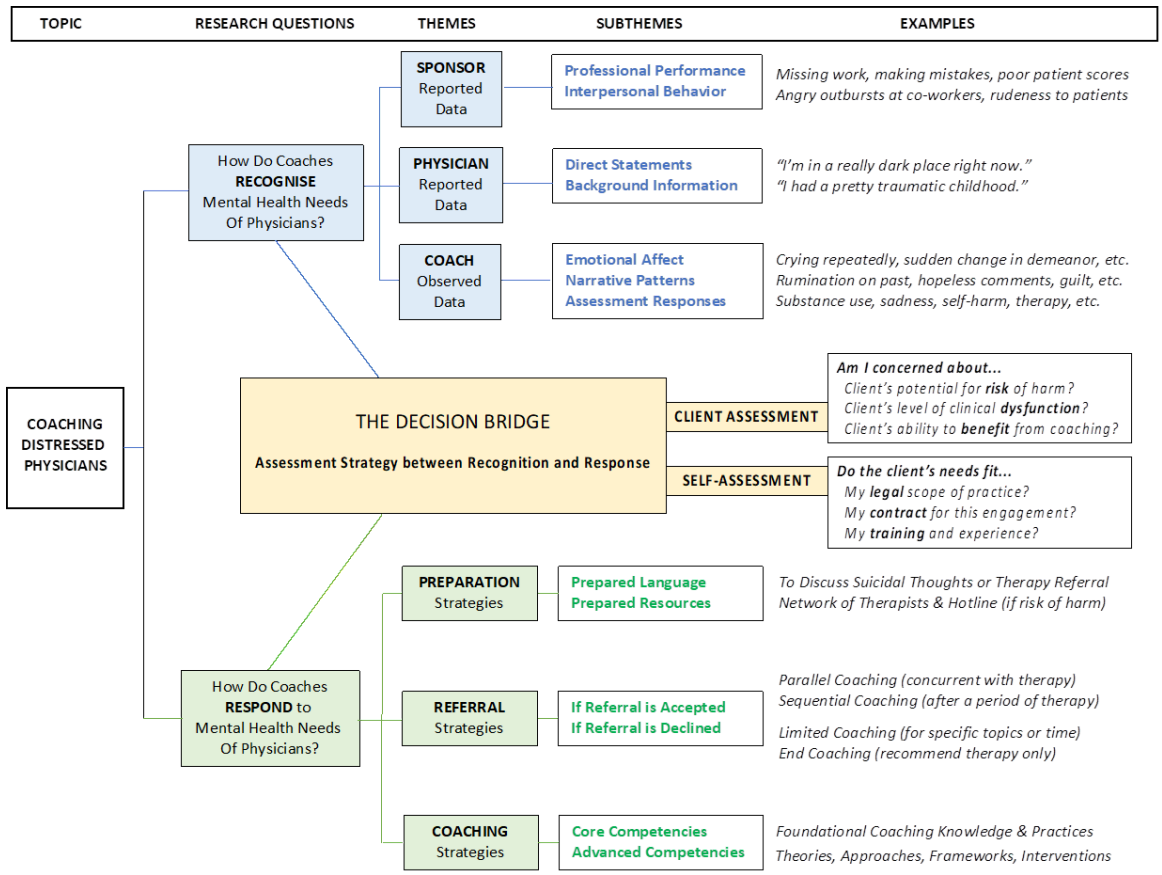
To answer the question "How do experienced coaches recognise and respond to mental health needs of physicians?", 12 coaches from nine U.S. states were interviewed. All had Masters, PhD or MD level education, with additional training in coaching, psychology, and healthcare, plus 91

combined years' experience coaching physicians. Over a nine-week period, 15 hours of interviews yielded 24 incidents coaching distressed physicians. Seven incidents involved risk of harm or suicide, or distress over suicide of a colleague. In 12 of 24 incidents, coaches referred clients to therapy.

Three themes and seven subthemes were identified showing how coaches **Recognised** mental health needs of clients. Three themes and six sub-themes were identified showing how coaches **Responded** to those needs. Finally, a connecting theme emerged as the core variable, and was developed as the **Decision Bridge**, a substantive theory modeling how coaches move from recognition to response.

Table 2 outlines the overall structure of these findings as a **Decision Map**, which combines elements of the **Recognition** and **Response** themes with the emergent theory of the **Decision Bridge** to answer the question *"How do coaches recognise and respond to mental health needs of physicians?"*

Table 2. The Decision Map: How Coaches Recognise and Respond to Mental Health Needs of Physicians



Recognising Physician Distress

Recognition Theme 1: Sponsor-Reported Data

In 5 of 24 stories, the first indication of physician distress had been information from a sponsor or administrator who referred the physician for coaching. These included two sub-themes; concerns about the physician's ***professional performance*** such as missing work, making mistakes, or poor

patient scores; or ***interpersonal interactions***, such as angry outbursts at co-workers or rudeness to patients.

While coaches considered sponsor-reported data a valid potential indicator of distress, they sought to put these behaviours into context by eliciting the perspective of the physician-client about their working environment and personal background.

Recognition Theme 2: Physician-Reported Data

In all 24 stories, coaches described gaining insight through two sub-themes of physician-reported data. One involved ***direct statements*** from the physician about their own mental state, with comments like *"I'm not sure if I need coaching or mental health help."* or *"I'm in a really dark place"*. The other involved ***background information*** shared by the physician about their personal life, including childhood trauma, abusive residency, difficulties in personal life, substance use, and history of psychotherapy.

Recognition Theme 3: Coach-Observed Data

In all 24 stories, coaches described indicators of physician distress that were noted through direct observation. These observations developed into three sub-themes; observation of ***emotional affect*** such as repeated crying or agitation; ***narrative patterns*** like frequently describing feelings of victimhood, cynicism, hopelessness, or being emotionally overwhelmed; and ***responses to questions*** which caused concern regarding substance use, non-suicidal self-injury, and potential risk of harm to self or others.

Responding to Physician Distress

Response Theme 1: Preparation Strategies

In 7 of 24 incidents, conversations included suicide of a colleague or suicidal thoughts. In 12 of 24 incidents, therapy was recommended. Coaches described two sub-themes of preparation; ***prepared language*** and ***prepared resources.***

Some described feeling unprepared the first time the topic of suicide or self-harm came up with a client, or the first time they needed to recommend therapy. Others said preparation and practice for these conversations had been integral to their training.

Response Theme 2: Referral Strategies

All 12 coaches described referring clients to therapy at some point in their practice. Two sub-themes were identified based on the client's decision to ***accept*** or ***decline*** the referral to therapy.

If referral is accepted, some coaches preferred *sequential coaching*, or returning to coaching after a period of therapy. In other situations, coaches described *parallel coaching*, or continuing with coaching concurrent with therapy.

If referral is declined, coaches occasionally decided to pause or even *end coaching*, recommending only psychotherapy for the client. In most cases, *limited coaching* was continued with the client, taking care to clarify the topics that coaching would engage.

If therapy was initially declined, most continued coaching and were eventually successful in helping clients accept therapy. In a few cases, there was a delay getting an appointment. Coaches expressed the importance of not abandoning the client during this time, instead continuing coaching support.

Response Theme 3: Coaching Strategies

Participants' ***coaching strategies*** for distressed physicians have been coded into two sub-themes, the first is ***core competencies***; strategies grounded in ethical considerations and foundational knowledge and practices. The second was coded as ***advanced competencies***; coaching applications of psychology-based theories and frameworks acquired during years of training and experience.

Examples of ***core competencies*** included ethical considerations such as creating clear agreements, confidentiality, and responsibility to refer. Core competencies also included foundational knowledge and practices such as self-awareness, holding space, skilled listening and facilitating growth.

Examples of ***advanced competencies*** included training in Positive Psychology Coaching, Gestalt Coaching, Trauma-Informed Coaching, Immunity to Change, Internal Family Systems Coaching and others. Coaches were explicit about staying within the coaching application of these competencies, rather than employing therapeutic or clinical-level interventions.

Whether or not the coach was a physician themselves, all coaches expressed the critical importance of understanding the context in which doctors train, work and live as a key competency in physician coaching. Their description of familiarity with the physician experience included both an understanding of the external landscape of the medical environment, as well as the individual personality, background, and specialty of the physician.

The Decision Bridge

The second segment of each interview invited participants to go beyond describing a specific incident, to comment on *how* they make decisions about responding to a client's mental health needs.

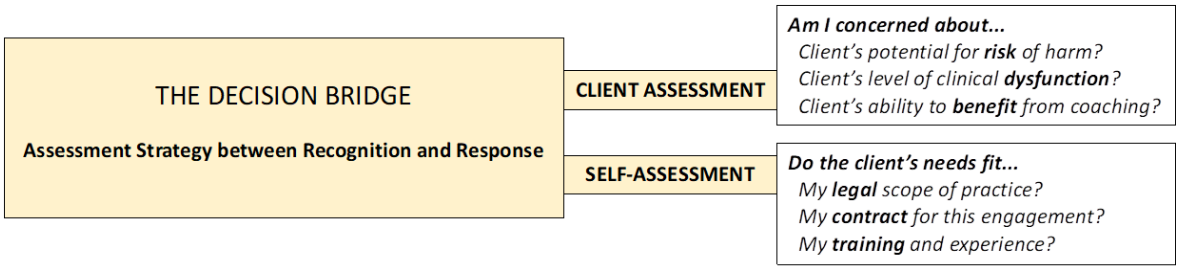
Boundaries between coaching and therapy were discussed by all participants, including ***diagnosis***, ***treating clinical dysfunction***, and using a ***clinical depth of intervention***. This was true even for coaches who, in their role as a physician or therapist, were qualified for those activities.

Overlaps between coaching and therapy were also discussed. These areas of overlap included; ***ethical standards***, such as ongoing training, clear agreements, and confidentiality; ***foundational practices***, including non-judgmental mindset, language, listening, enabling autonomous insight and facilitating growth, and ***evidence-based approaches*** which included theories, frameworks, models and coaching applications of interventions.

As they articulated their legal, ethical, professional and individual position in these areas, coaches revealed details about how they made decisions on a case-by case basis. As they reflected on how they assessed a physician's level of distress, they used examples to describe their chosen responses.

These secondary conversations thereby revealed common patterns of how these coaches moved from recognition to response. This pattern of comments is represented here as a separate theme called the Decision Bridge, shown in Table 3 and described in two sub-themes; ***client-assessment*** and **self-assessment**, each of which is represented by a set paraphrased questions that coaches seemed to ask themselves, as a mental model forming a bridge between recognition and response.

Table 3: Decision Bridge



Client Assessment: Risk, Dysfunction, and Benefit

In deciding how to respond to distress, participants evaluated the client's ***risk of harm***, level of ***clinical dysfunction***, and ***ability to benefit*** from coaching. These can be delicate areas to assess for coaches who are not psychotherapists, raising the red flag of diagnosis in relation to coaching.

However, when faced with concerns about a client who seems distressed, coaches must develop a professional opinion about whether the client should be referred to a mental health professional, or if coaching is appropriate. Therefore, this study specifically looked at the process used by coaches to *decide how to proceed* in these situations. The result then becomes, not a clinical diagnosis about the underlying cause, but the subjective recognition that there may likely be a problem, and a decision about what to do based on that recognition. It is framed by a *concern* on the part of the coach, not a diagnosis. Therefore, the ***client assessment*** questions are paraphrased in the Decision Bridge as beginning with the phrase *"Am I **concerned** about this client's (...risk, dysfunction, benefit)?".*

Table 4: Client Assessment Questions and Quotes in the Decision Bridge Model

QUESTIONS	DECISION BRIDGE: *CLIENT ASSESSMENT*		
Am I concerned about the client's...			
...potential for risk of harm?	*"It was a very distressing experience for [the client] and also, I would say, brought up a lot for me. I was thinking about imminent safety risk." [TC4]*	*"It's when I hear a certain flavor of hopelessness... evolving and worsening hopelessness, and obviously, suicidal thoughts. Especially when it's accompanied with feelings of being a burden." [TB28]*	*"The guiding principle of 'First, do no harm' is probably the most important. And second, beneficence. How much good am I doing, and what's the risk of harm with this person?" [PA11]*
...level of clinical dysfunction?	*"So at this point you're trying to say 'to what degree is she a responsible person who doesn't have mental health issues or other kinds of personality disorders?'" [CA2]*	*I think first is trying to ascertain the level of distress, the length of time that it has been, they've been experiencing it, and the impact on their lives. When somebody is so distressed that they really can't focus on the future, that's a clear boundary for me." [CB25]*	*"She opened up about her past, and there was some significant trauma, and we talked about that in depth. But I really got the feeling that she was in a pretty high functioning place. There were certainly problems, but they weren't really overwhelmingly impairing her ability." [PA11]*
...ability to benefit from coaching?	*"When I did my intake, it became very apparent that he had a very, very traumatic childhood; abuse, all sorts of stuff... I had a pretty good sense from the beginning that the depth and breadth of his trauma and distress, and the way it was showing up, was going to be an impossible barrier to using coaching approaches." [PA11]*	*"If somebody tells me they're deeply depressed, or shows signs of deep depression, my thoughts about coaching in those situations are that it may be harmful. Don't ask somebody to set a goal or vision for themselves when they're having a hard time getting out of bed." [CC25]*	*"I had never seen somebody who'd gone through what she had. But she was able to explain, not just how hurt she felt, but what her objective was. In other words, is she able to rise above the emotion and to be able to say 'Okay, I know this is how I feel. But this is what I think, this is what I want. And I'm willing to work on this.'" [CA2]*

Self-Assessment: Law, Contract, and Training

In this study, coaches described how client needs compared with honest self-assessment of the coach's ***legal scope of practice***, ***contract for the engagement***, and relevant ***training and experience***. This decision process helped them create an appropriate contract for coaching, or a referral if needed.

Table 4 provides supporting quotes as examples of ***client-assessment*** reasoning by coaches in this study. Table 5 shows quotes on ***self-assessment***. Note: Participant codes begin with the letter of their professional group; [C=Coach] [P=Physician/Coach] [T=Therapist/Coach].

Table 5: Self-Assessment Questions and Quotes in the Decision Bridge Model

QUESTIONS	DECISION BRIDGE: *SELF-ASSESSMENT*		
Do the client's needs fit with...			
...my legal scope of practice?	*If it means revisiting primary trauma, if this person cannot be present, without regressing to something that's a psychological developmental issue, that is not my skill. That's got to go to another. [PD30]*	*"I felt like I was talking somebody off a ledge, you know, and I'm not a psychiatrist or a psychologist." [CA2]*	*"[When I'm coaching] I don't offer diagnoses. I will speak to medication use and psychotherapy in generalities, but not in a position to say, you know, this or that would be helpful. [Coaching] is not the place for providing a diagnosis." [TC4]*
...my contract for this engagement?	*"I am not a diagnostician when I'm a coach...but sometimes, if there's a sponsor that's involved, they'll say 'So what's your diagnosis?' and I make it very clear, I do not have a diagnostic hat on." [PB13]*	*"I recognized the distress right away. She was coming into something that she thought was going to be more therapy, and I am a psychologist, but nobody is coming in to see me for therapy here. In this system I don't do therapy, what I do is coaching." [TD7]*	*"There were parts of me that wanted to coach...and also parts of me that wanted to diagnose. There's a part of me that might feel compelled to say 'Well, I'm a physician, but on the other hand, I'm not actually THAT person's physician." [TC4]*
...my training and experience?	*"When her childhood abuse and trauma kept coming up in the context of present issues, I felt she needed to explore those things with a therapist. She was reluctant, and I didn't want to abandon her, so we agreed to begin working on how her assumptions around therapy may be limiting her ability to thrive personally and professionally. She finally agreed to do both, and it's working well." [CD30]*	*"I've had so many trainings...and classes in many, many modalities. I'm always reading and I'm always researching. Every time I have a client who has something new, I'm looking at the whole field around it...I have enough confidence in my skills to see these challenges as testing my skills, and giving me opportunities to learn." [CC25]*	*"It was tough. I have now shied away from doing distressed and remedial coaching. I've 'been there, done that'. I enjoy the coaching, and the positivity of it. I don't want to have the responsibility, the mental anguish, and really the amount of energy you have to use when you're working with somebody who's really, really distressed. It's tough." [PA11]*

Discussion

This study identified how coaches recognise and respond to mental health needs of distressed physicians, but it also introduced an unexpected theme that emerged as the core variable: ***What assessment process happens between recognition and response?*** This section discusses the answer, using relevant ideas from literature and the emergent theory of a Decision Bridge, developed here using grounded theory.

The Decision Bridge Theory

Grounded Theory aims to identify a core variable that could be described to generate and test theory grounded in the data (Simmons, 2010). In the course of coding data and analysing themes from interviews, a common pattern of assessment emerged in these coaches' decision-making process. This core variable was explored in later data collection. The resulting theme is represented in the form of six paraphrased questions, expressed as a mental model called the Decision Bridge.

Assessment questions are a well-established process for reflection in coaching, and authors have provided excellent questions and guidelines for coaches to consider when evaluating their competencies and the mental health needs of clients (Buckley, 2007; Buckley & Buckley, 2012; Cavanagh & Buckley, 2018). However, no previous publication has described the process that physician coaches are actually using as they make decisions about how to respond. This study explored the questions coaches tend to ask themselves when making decisions, identifying three key questions about the client, and three questions about themselves.

The Decision Bridge is proposed as a mental model that can help coaches reflect systematically on both ***the client's*** level of dysfunction and ***their own*** suitability for addressing the client's needs. Examples of each paraphrased question in the Decision Bridge is represented in Tables 4 and 5, and is supported in published literature.

Client-Assessment: Risk, Dysfunction, and Benefit

In deciding how to respond to distress, coaches in this study evaluated the client's ***risk of harm***, level of ***clinical dysfunction***, and ***ability to benefit*** from coaching.

Based on concerns about ***risk of harm***, Cavanagh and Buckley (2018) describe *"rare and extreme cases"* that may necessitate *"taking action on behalf of the coachee"* in the form of calling emergency services. While rarely necessary, one coach in this study, working remotely with a client in another state, realised they had no address on file for the client, and were not sure of how to reach emergency services in the client's area, during a conversation in which they became concerned about potential risk of harm, saying: *"I found myself more and more anxious as I heard more about it. The situation became more complicated with the addition of a gun." [TC4]* This underscores the need for advance preparation to deal with potential risk, compiling a list of local resources for emergency and therapeutic referral.

Risk of harm also includes reflecting on whether the modality of coaching itself might pose a risk of harm to a client who actually needs psychotherapy. Berglas (2002 p.87) claims that coaching can actually *"make a bad situation worse"* if the client's problems stem from deeper psychological difficulties, when the coach lacks appropriate psychological training. Cavanagh (2005) cites the example of coaching as potentially harmful in some cases of depressed clients, who may be encouraged to set goals beyond their capability, deepening their sense of despair.

Regarding level of ***clinical dysfunction***, some recommend coaching as only appropriate for clients in the "normal" range of mental health (Fairley & Stout, 2003). Others acknowledge that individuals may slide back and forth over a spectrum of mental health in a way that may be *"hard to identify"* (Nowers, 2006). Buckley (2007) poses a more practical approach, which is for a coach to ask—not *"what is wrong?"*—but instead, *"what to do?".* This approach aligns with comments from coaches in this study.

A third question in the Decision Bridge involved the client's ***ability to benefit*** from coaching. Coaches described concerns for the best interest of the client, in cases where some mental health need was recognised that seemed beyond the scope of coaching. This is supported by coaching literature and professional standards of practice ensuring that *"client's mental health will not*

interfere with their ability to identify, set, and work toward appropriate goals" and is, in fact, in the *"best interests of the coachee."* (Standards Australia, 2011; Cavanagh & Buckley, 2018). Even where a coaching framework might be used without harm, coaches described thoughts that the client may be unable to benefit from coaching processes, until they first received therapeutic support from a mental health professional to deal with deeper issues.

Self-Assessment: Law, Contract, and Training

Participants assessed their ***legal scope of practice***, ***contract for the engagement***, and relevant ***training and experience,*** compared to the client's specific needs. This helped them make a referral, or create an appropriate coaching contract.

Fielder and Starr (2008) emphasize the critical role a contract plays in clarifying the ***legal scope of practice*** for a coach, whether they work within an organization, or are hired as an outside vendor. In cases where the coach may also have other qualifications (e.g. as a physician, therapist, or psychiatrist) the coaching contract serves as a container by which the activities and expectations of the engagement are clearly bounded. Even coaches who are licensed physicians or therapists concluded that their legal scope extends only to coaching activity in a coaching contract. As one participant said, *"Well, I'm a physician, but on the other hand, I'm not actually THAT person's physician." [TC4]*

Coaches in this study also asked themselves, do the client's mental health needs fit my ***contract for this engagement?*** If this contract is for coaching, is coaching what this client really needs? Is there a potential for coaching itself to be *"ineffective, inappropriate, or potentially harmful?"* (Cavanagh and Buckley, 2014). One participant described the formal agreement as a *"safe container" [TC21].* Beyond the legal aspects, the formal coaching agreement can indeed serve, not only to set expectations for the sponsor and client, but also to protect the psychological safety of the coach. Clear expectations about the boundaries between coaching and therapy, set out in the coaching contract, can reinforce appropriate scope of relationship in the coach's mind when faced with a distressed client whom they want to help.

Kets de Vries (2010) cautions against falling into the Rescuer Syndrome, when a coach's desire to help goes too far. This can occur because coaching is not guided by the kind of oversight present in licensed professions, potentially *"turning helpers into 'rescuers', unable to differentiate between their own needs and those of their clients."* This could lead coaches to blur boundaries and take their relationship with clients into inappropriate areas.

Self-reflection, training, and supervision can help coaches avoid this pitfall, and the coaching contract itself can serve as a clear reminder of the coach's scope of practice, even if they have advanced training.

Finally, when coaching does seem to be an appropriate modality in a situation, coaches must consider their personal level of ***training and experience*** to address a physician's need. Bachkirova (2020) describes the highest level of self-understanding in coaching as the *"fully professional self"* which requires *"taking responsibility for the interventions that we offer to our clients".* Experienced coaches in this study described a passion for continuing professional development, including supervision and participation in one or more professional coaching groups, to broaden their repertoire of interventions, and hone their skills in using them.

When a coach recognises a client's need that goes beyond their training and experience, continuing education and supervision is critical, and the best decision may be to make a referral (Iordanou, Hawley & Iordanou, 2017; Bachkirova, Jackson & Clutterbuck, 2021). In all cases, *"coaches who care about their model of coaching practice will be wise to constantly reform, refine, re-examine and rebuild that model."* (Bachkirova, Clutterbuck & Cox, 2018).

As the coaching profession matures, scholars are calling for expanded research in outcomes, effectiveness, and competencies (Boyatzis et al, 2022). Mental health literacy is a critically important competence for coaches, and it is hoped that studies like this will complement the body of information being gathered and shared in that area (Institute of Coaching, 2022).

Conclusion

This study answered the research question "How do experienced coaches recognise and respond to mental health needs of distressed physicians?" Findings demonstrated ***how coaches recognise*** mental health needs; by gathering data from sponsors, physicians, and personal observations. Next, it revealed a ***decision bridge*** that coaches use in assessing how to proceed when distress is recognised. Finally, the study answered the question of ***how coaches respond*** to mental health needs of clients, by using preparation strategies, referral strategies, and coaching strategies.

The **Decision Bridge** was identified in this research as a core variable which was developed into an emergent theory of how coaches process decisions about responding to a client's distress, using these six questions:

Am I concerned about the client's...	***Do the client's needs fit with...***
• Potential for **risk** of harm? • Legal of clinical **dysfunction**? • Ability to **benefit** from coaching?	• My **legal** scope of practice? • My **contract** for this engagement? • My **training** and experience?

Implications for this research are twofold: 1) to further the contribution to literature on how experienced coaches make decisions about working with physicians in distress and 2) to offer the Decision Bridge model as a tool that can be generalised and developed for coaching distressed clients in any profession.

Acknowledging the limited sample size of this study, it remains to be seen whether these findings can be generalised to other coaching situations. If these findings do turn out to be widely applicable, the following recommendations are offered to coaching researchers, coaching organizations, and coaches: First, more research is needed in the area of physician coaching, and in the competencies required to work with this population of highly stressed professionals. Second, Mental Health Literacy training should be offered by coaching organizations as continuing development for all coaches, to understand how to recognise and make informed decisions about how to respond to clients' needs. And finally, individual coaches should take personal responsibility for their own continuing professional development, familiarity with local laws on coaching parameters, and preparation of personal materials for mental health emergencies and therapeutic referrals.

Effective coaching can provide critically needed mental health support for the doctors who care for us all. Coaching research, personal preparation, and continuing professional development are important keys to effectively coaching distressed physicians.

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About the author

Pamela Nemecek specializes in communication and wellness support for physicians. She holds an MBA in Coaching, Mentoring and Leadership, a credential in Education from ACEHP, and in Communication from Stanford Graduate School of Business. Pamela is a Fellow at the Institute of Coaching, certified in Mental Health Literacy for Coaches.