THE SELF-CONCORDANT MODEL FOR PROFESSIONAL COACHING: OVERCOMING OBSTACLES FOR MEANINGFUL GOAL ATTAINMENT

by

Keri L. Warren

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The Dissertation of Keri L. Warren
is approved and is acceptable in quality and form:

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Chancellor	Academic Dean

International University of Professional Studies

Maui, 2015

Your time is limited; so don't waste it living someone else's life.

Steve Jobs, 2005

This dissertation is dedicated to coaches seeking to help their clients live lives of authenticity in love and deep connection with God and his beloved children here on earth.

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I thank the Lord Jesus for the inspiration to do this work. And while it represents a completed dissertation at this point, it is also the beginning of a coaching manual that I hope will be a transformative tool for promoting wholeness and healing in the lives of my clients. That said, I am indebted to my clients and students for their trust in me as I have administered this coaching model as part of our collaborative work together. I am also grateful to my husband, Ricks Warren, for his unwavering support and encouragement during this three-year process. Many thanks to my dissertation advisors: Dr. Lloyd Thomas, for his helpful suggestions and monthly guidance, and Dr. Inula Martinkat, Provost of the International University of Professional Studies (IUPS), for her spiritual insight, words of wisdom, and kind loving support.

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Keri L. Warren

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One of the roles of a professional coach is to assist clients to think more strategically for developing sustainable motivation necessary for successful goal attainment. Sustainable motivation is enhanced when an individual's goals match his or her personal values and interests and basic psychological needs are met. According to self-determination theory (SDT) and the self-concordance model (SCD: Sheldon & Elliot, 1999) these basic psychological needs are competence, autonomy, and relatedness. Goals that match an individual's values and interests and are perceived as freely chosen are called "self-concordant" goals. Obstacles that thwart a person from choosing self-concordant goals can be complex and even hidden from one's conscious awareness. Examples of such obstacles are poor self-differentiation, unhealthy attachment styles, contingencies of self-worth, personality disorders, characterlogical deficits, and self-criticism. By understanding the tenants of self-determination theory and the self-concordant model of goal attainment, in conjunction with Bowen's concept of self-differentiation and Bowlby's attachment theory for meeting basic psychological needs, coaches

can facilitate sustainable motivation using motivational interviewing, rational-emotive behavioral therapy (REBT) techniques for becoming self-differentiated, and strategies for increasing self-compassion. Clients who embrace and practice these interventions are more likely to develop competence, autonomy, and relatedness. This dissertation also discusses the differences between coaching, counseling, and psychotherapy as well as the importance of thorough training and education for coaches, particularly in detecting deeper emotional disturbances that may inhibit goal obtainment. Finally, this dissertation provides a selective review of the history of coaching and emphasizes the need for coaches to support and practice from a multicultural perspective.

Keywords: Self-concordant goals, self-determination theory, self-differentiation, attachment injuries, attachment styles, rational-emotive behavioral therapy (REBT), motivational interviewing (MI), contingencies of self-worth, self-compassion, basic psychological needs, competence, relatedness, autonomy, motivation, and life coaching.

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CHAPTER 1

PROBLEM FORMATION

Introduction

People who pursue self-concordant goals, ones that are congruent with personal core values and interests, expend more effort to achieve their goals and are therefore more likely to obtain them (Koestner, Lekes, Powers, & Chicoine, 2002). Achieving self-concordant goals leads to meeting basic psychological needs resulting in a greater sense of well-being (Sheldon & Houser-Marko, 2001). Some studies have also shown that achieving self-concordant goals help to promote greater job and life satisfaction (Judge, Bono, Erez, & Locke, 2005).

Setting goals and attempting to attain them are often incorporated in daily activities. Examples of daily goals are getting up on time, finishing projects at work, completing homework, and keeping the house clean. Examples of major goals include graduating from college, getting a good job, and saving enough money for retirement. There are also many health related goals, such as eating nutritiously, exercising regularly, and managing diabetes. Interpersonal goals include making and keeping friends and creating high-quality relationships.

Achieving goals often result in a sense of accomplishment, better health, and a more balanced life. If one's chosen goals are not consistent with a person's values and interests, then disappointment, frustration, unhappiness and lack of fulfillment may result. Research suggests that the content of people's goals are important. For example, goals to achieve popularity, wealth, and material possessions are not associated with well-being, while

intrinsically motivated autonomous goals such as growth, connection, and contribution are (Sheldon, Ryan, Deci, & Kasser, 2004).

As the literature reviewed in this dissertation demonstrates, at the core of one's failure to select self-concordant goals are contingencies of self-worth (Crocker, Luhtanen, Cooper, & Bouvrette, 2003). Contingencies of self-worth refer to the specific domains on which people base their perceived self-worth. Such domains may include academics, approval, appearance, and relationships (Knee, Canevello, Bush, & Cook, 2008). With these contingencies, people pursue goals to prove their self-worth. These pursuits result in added psychological pressure, internal stress, emotional difficulties, and unfulfilling interpersonal relationships (Crocker et al., 2003). Contingencies of self-worth have been associated with unhealthy attachment styles (Park, Crocker, & Mickelson, 2004) and low levels of self-differentiation (Barnum, 2012). Both factors may result in an inability to meet basic psychological needs and the selection and fulfillment of self-concordant goals.

By understanding the tenants of self-determination theory and the self-concordant model of goal attainment, in conjunction with Bowen's concept of self-differentiation and Bowlby's attachment theory for meeting basic psychological needs, coaches can facilitate sustainable motivation and successful goal attainment using motivational interviewing, rational-emotive behavioral therapy (REBT) techniques, and strategies for increasing self-compassion. Clients who engage in self-compassion, become more self-differentiated, and develop secure and healthy attachment styles are more likely to develop competence, autonomy, and relatedness; the basic needs necessary for sustaining motivation and successful goal attainment.

Background of the Study

People of all ages have a natural tendency to move toward completion or fulfillment of their potential (Rogers, 1951, 1961). This innate tendency is influenced by the external values that are placed on them through society and culture. Placing value on things and developing personal and professional interests helps to determine individual goals that promote this actualizing tendency (Rogers, 1951, 1961). While realizing one's full potential is a life-long journey, it requires the completion of certain milestones and accomplishments that set the stage for ongoing goal setting. Thus, people of all ages and from all parts of the world, regardless of one's culture and background, set goals.

It is a common American custom for people to begin the New Year with a new set of goals they hope lead will lead to positive change for a bright new future. Early January often consists of crowded athletic facilities, greater seat occupancy at local churches, new diet programs, or promises to discontinue old vices and habits that are destructive or annoying. These types of New Year's resolutions are established year after year. Some are achievable and some are unrealistic. Yet even achievable and realistic goals sometimes end in despair. These goals then get pushed aside until the next year and the cycle repeats itself.

Why are resolutions renewed again and again, year after year? Asprey (2014), professional coach and author of The Bulletproof Diet (2014) reports that by mid-January, 92% of New Year's Resolutions have already failed and only 8% will be successful. Why do people fail to achieve well-meaning positive goals that are intended to promote personal health, healing, happiness, and wholeness? Why, especially when failure to achieve one's goals often results in anxiety, shame, doubt, and feelings of desperation often coupled with lowered self-esteem? The enormous number of self-help books on store shelves and also

through online resources, in addition to magazines, workshops, and other motivational seminar events, show how desperate people are to find ways for promoting positive change that is sustainable.

Rogers (1951, 1961) explains that people find their 'real self' as they grow towards actualization and continue to strive toward an 'ideal self' that is based on values and interests, but that the gap between one's real self and ideal self, a concept called incongruity, can thwart their progress, further explaining that conditions of worth represent the pivotal factor leading to success or failure of goal achievement. Bowen (1976, 1978) defines this growth path as becoming more self-differentiated. His studies show that people's level of differentiation of self significantly influences their ability to find individual fulfillment, purpose, and meaning in life. The path leading to increased levels of self-differentiation require the selection of self-concordant goals. These are goals that match an individual's values and interests and further the development of basic psychological needs known as autonomy, competence, and relatedness (Sheldon & Elliot, 1998).

Self-determination theory and the self-concordant goal model have provided a solid scientific foundation for understanding the importance of the kinds of goals people select and the personal and interpersonal consequences of choosing particular goals (Koestner, Lekes, Powers, & Chicoine, 2002; Sheldon & Elliot, 1998; Sheldon & Elliot, 1999). This knowledge base provides a conceptual groundwork for coaches to help clients reach their goals and to have a sense when clients' goals, even when self-concordant, may not lead to need fulfillment, well-being, and happiness. In this regard, research suggests that the content of people's goals are important. For example, goals to achieve popularity, wealth,

and material possessions are not associated with well-being, while intrinsically motivated autonomous goals such as growth, connection, and contribution are (Sheldon, Ryan, Deci, & Kasser, 2004).

Since persons who choose non-self-concordant controlled goals have difficulty sustaining effort toward achieving them and derive less satisfaction in goal attainment and less of a sense of well-being, an important question arises: "Why do some people select non self-concordant, externally controlled goals and thus fail to get their basic needs for autonomy, competence, and relatedness met?" Sheldon and Elliot (1998) "suggest that such goals are selected when the individual fails to create an accurate assessment of his or her deeper needs, values, and interests" (p. 554).

Sheldon (2002) posited that there are skills that are required for self-concordant goal selection: the ability to discern one's enduring values and interests to more transient and superficial impulses; the ability to "distinguish accurately between 'me' and 'not me', that is, between goals that represent one's *own* interests, values, and goals that instead represent *others* interests and values" (p. 76); and the ability to select goals whose content foster meeting the person's basic human needs.

Based on these posited abilities, Sheldon, Kasser, Smith, and Share (2002) developed a brief program designed to enhance goal attainment and personality integration. Their findings indicated that progress toward goal attainment was associated with a variety of psychological benefits, including increased vitality and personality integration. People who participated in the study were initially more psychologically healthy and benefitted most from the intervention as well as made the most progress toward goal attainment. In contrast, the less psychologically healthy participants did not find the intervention to be

helpful for their goal attainment. It seems that the main focus of the intervention in this study was to enhance goal attainment rather than enhance goal selection ability.

> Unfortunately, our brief intervention did not benefit individuals low in initial integration, arguably the population most in need of help. If indeed such individuals are 'stuck in ruts' it appears that it may take a different approach to unstick them. For example, future studies could use insight–based techniques to help participants explore the deeper reasons and historical roots of their goal choices…" (p. 25).

A main goal of this dissertation is to explore developmental and psychological factors that may be a part of these "deeper reason and historical roots of their goal choices" (p. 25). Developmental factors include maladaptive attachment styles and poor self-differentiation.

Psychological factors include contingencies of self-worth rather than non-contingent self-worth, self-image rather than compassion goals, and self-criticism rather than self-compassion. Each of these concepts has been studied as unique and disparate factors that lead to psychologically healthy rather than unhealthy outcomes. These factors have not, however, been investigated together as central to impediments in the selection of self-concordant and beneficial goals. Amassing a cohesive and inclusive approach for coaches is the central purpose of this dissertation.

Coaches' familiarity with the concept of self-differentiation may help coaches understand the struggles some clients may have with autonomous motivation and selection of self-concordant goals. For example, coaches' awareness of clients' attachment styles and issues of transference and countertransference may provide coaches with a greater awareness of what transpires in the coaching sessions, and perhaps allow coaches to tailor

their interventions to best meet their clients' needs. As an example in a clinical setting, Dozier, Cue, and Barnett (1994) found that clinicians with the most secure attachments responded more therapeutically to the attachment related behavior of clients. In addition, evidence suggests that the unresolved attachment issues of therapists might be a source of countertransference reactions (Hayes et al., 1998, cited by Mallincrodt, 2000). In another clinical study, support for the importance of matching interventions with patients' attachment style was found. Depressed patients with an avoidant attachment style did better with cognitive-behavior therapy (CBT) than interpersonal psychotherapy (IPT) (Zuroff et al., 2007) The authors suggested that CBT, with the emphasis on cognitions rather than relationships, might have been more accessible and less threatening than IPT which targets close interpersonal relationships (p. 1051). These findings highlight the importance of coaches' sensitivity to client attachment styles and what interventions to emphasize to fit the clients' needs.

The empirically based interventions provided in this dissertation are designed to help coaches address the incongruity that is rooted in conscious or unconscious psychological obstacles that can prevent self-concordant goal selection and achievement. They have not, however, been combined and integrated on theoretical and conceptual grounds as appropriate interventions for coaches whose goals are to assist clients in achieving self-concordant goals and detecting the developmental and psychological factors that may impede self-concordant goal selection and achievement.

In summary, the choices we make and the goals we pursue create our life journeys which involve great joys and immense suffering. While self-determination theory and self-concordant goal pursuit provide scientifically supported models for achieving goals and

meeting basic human needs, well-being, and even happiness. Human suffering may be the result of psychological vulnerabilities that sabotage the obtainment of our most cherished and valued goals. Fortunately, the scientific literature points the way to understand the nature of these vulnerabilities, how they affect clients and their coaches, and how they can be recognized and remedied in the coaching relationship or be signals that a referral to another helping professional is the right thing to do. To address these important issues is the self-concordant goal of this researcher.

Statement of the Problem

There are numerous psychological obstacles that may interfere with a person choosing self-concordant goals. For example, a person may have interests and know what they value, but are pressured to pursue goals that do not match their passions. The movies depicting the stories of Rudy (1993) and Billy Elliot (2000) are prime examples. Similarly, the late Steve Jobs, in his 2005 Stanford Commencement Address, describes his own refusal to "let the noise of others' opinions drown out his own inner voice", persuading people to develop the courage to follow their heart and intuition in order to "do what you love". Conversely, there are others who may not know what their core values or intrinsic interests are and find that their choices are extrinsically rather than intrinsically motivated. For example, they may choose goals in order to please parents or friends, or choose what they think they should do, versus what they really want to do. Sadly, they become so focused on pleasing others that they lose sight of what really pleases themselves.

Purpose of the Study

The purpose of this study is to provide an integrated and cohesive strategy consisting of unique factors that demonstrate how the self-concordant goal model can be a

practical guide for professional coaches. The research supporting the validity and utility of the model lends itself well to evidence-based coaching. Another study purpose is to document various psychological pitfalls that can derail a seemingly straightforward attempt to discern self-concordant goals and strategies to overcome the obstacles leading to successful goal attainment.

Hypothesis and Scope of Study

The central hypothesis is that there are psychological barriers to discerning and achieving self-concordant goals. Therefore, after discussing self-determination theory and the self-concordance model, the researcher will explain how an individual's attempt to select and obtain self-concordant goals may be thwarted by a variety of factors, including contingencies of self-worth, self-image goals vs. self-compassion goals, and self-criticism. Additionally, the researcher will describe how both the developmental factors of unhealthy attachment styles and low levels of self-differentiation that lead to the interference of goal attainment and failure to meet basic psychological needs. Finally, the researcher will present interventions that coaches can use to address conditions that can thwart concordant goal selection and attainment as well as meeting basic psychological needs. The subject population for this study included college MBA graduate students, coaching and counseling clients. The assessment inventory tools administered to participants are listed in the appendices.

Importance of the Study

This study is important because it is the first study that combines concepts from self-determination theory, the self-concordant goal model, self-differentiation, attachment theory and specific coaching interventions to wisely choose their goals and overcome

obstacles to achieving them. Moreover, this dissertation will contribute to the coaching profession by showing how some people, regardless of their most sincere efforts, fail to select goals that match their core values and interests. It demonstrates how individuals can mistakenly perceive goals as matching their values and interests, only to find themselves unfulfilled upon reaching their goals and find that they are aimlessly pursuing the next new set of goals. When such obstacles are identified, interventions leading to accurate goal selection and successful goal attainment will be introduced and developed as a model for effective professional coaching.

Definitions of Key Concepts and Interventions

Key Concepts

Attachment Theory Concepts, Attachment Bonds, Attachment Injury, Posttraumatic Stress Disorder, Self-Determination Theory (SDT), Self-Concordant Model, Contingencies of Self-Worth, Compassionate Goals, Self-Criticism, Attachment Styles, Differentiation of Self, Motivational Interviewing, Rational Emotive Behavioral Therapy (REBT), and Self-Compassion all are described as follows:

Self-Determination Theory (SDT)

SDT (Deci & Ryan, 1985) is a prominent theory of motivation that states that human beings have an innate organizational tendency toward growth and integration of the self. SDT describes behavior motivation on a continuum of external to internal motivation. Internal motivation resulting in self-regulation, fully integrates one's core values and interests. Self-determined behavior leads to the fulfillment of the innate human needs for autonomy, competence, and relatedness. True self-esteem emerges from the process of need fulfillment and does not have to be earned or sought after from others.

Self-Concordant Model

The Self-Concordance Model posits that when people's goals are consistent with their core values and interests, they expend more effort into achieving their goals, are more likely to obtain them (Koestner, Lekes, Powers, & Chicoine, 2002), and derive a greater sense of satisfaction (Sheldon and Elliot, 1998) and well-being by achieving them (Sheldon & Elliot, 1999). Further, "these effects are mediated by need satisfaction, i.e., daily activity-based experiences of autonomy, competence, and relatedness that accumulate during the period of striving" (Sheldon & Elliot, 1998, p. 482). Sheldon (2002) defined self-concordant goals as "those that are inspired by a person's lifelong evolving interests…and deeply-felt core values" (p. 68).

Contingencies of Self-Worth

Contingencies of self-worth (Crocker, Luhtanen, Cooper, & Bouvrette, 2003) refer to specific domains on which people base their perceived self-worth. Such domains usually include academics, approval, and appearance. While contingencies of self-worth lead to increased motivation to achieve goals that in the person's estimation would prove their self-worth, they also pay a price in terms of increased psychological pressure, stress, and debilitative emotions. Finally, the contingencies of self-worth do not always lead to better grades, meaningful relationships, or other outcomes the person may be striving to obtain.

Self-Image Goals

Self-image goals are the natural extension of contingencies of self-worth. While contingencies of self-worth are designed to prove to oneself that he/she has certain desirable characteristics or competencies, self-image goals are designed to prove to others that one has these attributes (Crocker & Canevello, 2008).

Compassionate Goals

Compassionate goals refer to those goals that have authentic relationships with others, and are based on shared values and common interests. Rather than trying to prove oneself by pursuing self-image goals, one tries to authentically share oneself with people he or she genuinely cares about. People who have compassionate goals believe in taking care of one's fellow man. They have a sense of connectedness to values larger than oneself (Crocker & Canevello, 2008).

Self-Criticism

Self-criticism involves a harsh and judgmental response to oneself for failing to live up to one's "idealized" self and achieving one's chosen goals. Self-criticism generates feelings of guilt, shame, a sense of inadequacy and low self-esteem. Self-criticism has been implicated in numerous clinical disorders, maladaptive relationship patterns, and failure to achieve one's goals (Blatt & Zuroff, 1992).

Differentiation of Self as Defined by Murray Bowen

Differentiation of Self is comprised of both intrapsychic and interpersonal dimensions. The intrapsychic dimension has to do with the ability to distinguish between thoughts and feelings particularly in the face of stress and conflict and engages in healthy emotional regulation. It also involves the ability to maintain a solid sense of self while relating in emotionally close relationships. The interpersonal dimension of differentiation of self involves the ability to maintain a balance between autonomy and togetherness. Better differentiation of self has been associated with numerous psychological and interpersonal benefits (Bowen, 1976, 1978).

Attachment Styles According John Bowlby

Attachment styles refer to caregiver-infant relationships that emerge through ongoing interpersonal interactions. The healthiest style of attachment is the "secure" attachment. This type of attachment leads to healthy, adaptive working models of self and others. Various forms of maladaptive attachment styles, such as fearful, avoidant, preoccupied, and disorganized have been identified. They all are associated with various forms of maladaptive relationships later in life, producing insecurity, and sometimes psychopathology (Bowlby, 1982, 1988).

Attachment Bonds

Attachment bonds are emotional enduring emotional connections that people develop with significant others over a period of time (Ainsworth, 1973). Bowlby (1982, 1988) suggests that attachment bonds are precursors to models of adult attachment relationships and have a profound effect on psychological well-being (Johnson, Makinen, & Millikin, 2001). Main and Solomon (1990) identified four attachment classifications following Ainsworth's (1967) experimental and observational studies of attachment behaviors.

Insecure-Avoidant (Classification A)

Infants who give the impression of self-reliance, as if to communicate that the attachment with their primary caretaker are not very important. Identified as a defensive strategy, avoidant babies were frequently ignored or actively rejected by their mothers. Their mothers were seen as angry and intolerant of the infant's distress and tended to reject or punish the infant for being distressed. Thus, they tend not to look to their mothers for help in regulating arousal and distress (Ainsworth, Blehar, Waters, & Wall, 1978).

Secure Attachment (Classification B)

Infant demonstrates confidence in his or her attachment to the primary caretaker and can tolerate the stress of brief separations because there are confident in their parents' responsiveness. They also show confidence in their parent's ability to accept their full range of feelings with an innate understanding that their parents' can help them regulate distressing feelings (Main & Hesse, 1990). As adults in couple relationships, they provide a safe haven for exploration and individuation. Spouses are connected, but free to develop their individual interests, passions, and goals. Their children are encouraged to do the same.

Insecure-Ambivalent/Resistant Attachment (Classification C)

Infants who show a strong need for attachment, but lack confidence regarding its availability and henceforth, react intensely to separation. Because of the child's uncertainty of her parent's responsiveness, "she tends to focus on the parent's behavior and moods, to the exclusion of other interest" (Davies, 2011, p. 16). These children remain preoccupied with attachment at the expense of exploration, a pattern that predicts later disturbances in an individual's capacity for autonomous behavior (Davies, 2011).

Insecure-Disorganized/Disoriented Attachment (Classification D)

Infants with this type of attachment experience an intense approach-avoid conflict that is linked with fear of the parent and is coupled with uncertainty about how the parent will react in a given moment. The child has experienced contradictory responses by the parent, ranging from inviting closeness to angry rejection and possibly physical or sexual abuse (van IJzendoorn et al., 1999). There is also evidence showing that infants develop this style of attachment when raised with other interacting risk factors on families such as parental death, divorce, poverty, intergenerational unresolved loss, parental substance abuse,

and other conditions that promote extreme and contradictory parental behavior (DeMulder & Radke-Yarrow, 1991; Melnick, Finger, Hans, Patrick, & Lyons-Ruth, 2008).

Attachment Injury

According to Johnson, Makinen, and Millikin (2001) an attachment injury is a relationship trauma that is to be distinguished from ordinary highs and lows of ongoing relationships. The distinction is that the injury is caused by a profound violation of trust resulting in shattered assumptions that forever change the way the injured person sees himself or herself because it induces a sense of existential vulnerability (p. 150) that provoke feelings of abandonment, rejection, fear, shock, shame, disbelief, that make the notion of forgiveness and reconciliation seemingly hopeless because the repercussions associated with the depth of emotional injury block any hope for repair (p. 154).

Posttraumatic Stress Disorder (PTSD)

PTSD is a reaction to witnessing or experiencing traumatic events (simple–type 1), such as an attachment injury, or when an individual experiences prolonged, extensive exposure to traumatic events (complex–type 2) causing disorders of extreme stress (more on the specific categories of complex PTSD later).

Motivational interviewing

Motivational interviewing (MI) is defined by Miller and Rollnick (2012) as "a collaborative style for strengthening a person's own motivation and commitment to change" (p. 12). The MI coach serves as a guide, but at times includes both directing and following. Central to MI is the "spirit of motivational interviewing" which provides partnership, acceptance, compassion, and evocation. The effectiveness of MI has been demonstrated across diverse populations and problems, from problem drinking to anxiety.

Rational Emotive Behavior Therapy (REBT)

REBT was created and developed by the late Albert Ellis. In the mid 1950's it was initially called "rational psychology" (Ellis, 1957) and was the first prominent active-directive form of psychotherapy that was effective in treating a wide variety of emotional problems (David, Szentagotai, Eva, & Macavei, 2005). A recent study with divorced applicants and conducted in Iran found that REBT led to increased self-differentiation (Yoosefi, 2011). Central to REBT is the "ABC model of emotional disturbance" (Ellis & Dryden, 1997). In this model, A stands for Activating Event, B stands for Beliefs, and C stands for emotional and behavioral consequences. In the ABC model, A does not cause C, but rather it is B that primarily causes C. The REBT coach teaches clients the ABC model to help them discover their irrational beliefs. REBT engages in both cognitive and behavioral interventions in order for the client to adopt more reasonable beliefs and adaptive behavior.

Self-Compassion

In 2003, Neff (2003) defined self-compassion and developed a scale to measure the concept. Self-compassion contains three different components: (1) extending kindness and understanding to oneself vs. harsh self-criticism and judgment, (2) common humanity–seeing one's experience as part of the human condition vs. feeling isolated and separate from others, and (3) mindfulness–holding one's thoughts and emotions in awareness without being engulfed or overwhelmed by them (Neff, 2003). Self-compassion has been associated with many psychological and interpersonal benefits (Neff & Germer, in press).

CHAPTER 2

LITERATURE REVIEW

As noted by Deci and Ryan (1995), people are motivated to the extent that they intend to accomplish something and, have a purpose or a goal. According to Grant and Cavanagh (2011; cited by Spence & Oades, 2011), "coaching is a goal directed activity" (p. 294). It would naturally follow that coaches will be more successful the more they are acquainted with evidence-based psychological science on motivation and goal attainment. Spence and Oades (2011) describe how one prominent theory of motivation, Self-Determination Theory (SDT), is highly relevant to the practice of coaching. Building on SDT, the Self-Concordance Model "extends self-determination theory by addressing individuals' proactive and self-generated initiatives for life-improvement and self-expansion, not just their responses to situation or domain-specific forces" (Sheldon & Elliot, 1999, p. 494).

Expanding on the work of Spence and Oades (2011), the purpose of this dissertation is to present the main tenets of SDT and the Self-Concordance Model and demonstrate how these models are highly relevant to the practice of coaching. Following this discussion, the researcher will go further and explain how, while the two theories are well grounded in psychological science and supported by extensive research, an individual's attempt to select and obtain self-concordant goals may be thwarted by a variety of factors. These factors include: contingencies of self-worth, self-image goals vs. self-compassion goals, and self-criticism. Additionally, the researcher will present the developmental factors of unhealthy attachment styles, traumatic adult attachment injuries, and low levels of self-differentiation that interfere with goal attainment or result in failure to meet basic

psychological needs. Thereafter, the researcher will recommend a professional coaching model and describe interventions that coaches can use to address conditions that tend to thwart concordant goal selection and attainment as well as forestall the fulfillment of one's basic psychological needs. The researcher will advocate for the integration of Rational-Emotive Behavior Therapy (REBT), (Dryden, 2011; Ellis & Dryden, 1977), motivational interviewing (MI), (Miller & Rollnick, 2012; Vansteenkiste & Sheldon, 2006), self-compassion interventions and forgiveness (Neff & Germer, in press) as an effective and useful coaching model.

Self-Determination Theory

Spence and Oades (2011, p. 39) note that "… the utility of interventions informed by SDT has been established across a range of clinical and non-clinical contexts" (Sheldon, Williams, & Joiner, 2003). These authors note the importance of motivation and autonomy for lasting change in counseling and coaching contexts (Ryan, Lynch, Vansteenkiste, & Deci (2011). Consistent with the humanistic personality theory of Rogers (1951) and Piaget's (1971) organizing principle, SDT theory holds that human beings have an innate organizational tendency toward growth and integration of the self.

Central to SDT theory is the postulation that motivation lies on a continuum from external to internal motivation. Intrinsic motivation occurs when the given behavior is experienced as autonomous and is consistent with one's interests, values, and enjoyment, and is thought to emanate from an integrated sense of self. The most externally controlled motivation, "external regulation," is determined by external rewards and punishment, e.g. living up to the expectation of parents, seeking praise and approval, and avoidance of criticism and judgment. "Introjected regulation" is next on the continuum, and refers to

behaving in accordance with what one thinks they *should* do, thereby avoiding feelings of guilt. While this type of motivation does not need to be prompted by external demands, it is maintained by a felt sense of coercion and driven by contingent self-esteem (to be discussed below). "Identified regulation" refers to that motivation which occurs when one begins to accept the behavior as personally important or valuable and has begun to incorporate it into one's sense of self.

> Integrated regulation is the most autonomous form of extrinsic motivation and results from the integration of identified values and regulations into one's coherent sense of self…According to self-determination theory, integrated extrinsic regulation, together with intrinsic motivation, represent the bases for self-determined functioning…and would be accompanied by the experience of true self-esteem (Deci & Ryan, 1995, p. 39-40).

The Self-Concordant Model

As noted above, the Self-Concordance Model is an extension of SDT. According to the Self-Concordance Model, when a person's goals are consistent with their core values and interests, they extend more effort into achieving their goals, are more likely to obtain them (Koestner, Lekes, Powers, & Chicoine, 2002), and derive a greater sense of satisfaction (Sheldon & Elliot, 1998) and well-being by achieving them (Sheldon & Elliot, 1999). Additionally, "these effects are mediated by need satisfaction, i.e., daily activity-based experiences of autonomy, competence, and relatedness that accumulate during the period of striving" (Sheldon & Elliot, 1999, p. 482). Autonomy refers to the person's perception that one's behavior is freely chosen. Competence refers to the feeling that one is capable and effective in various life domains. Relatedness refers to the feeling of being

connected to significant others. Sheldon (2002) defined self-concordant goals as "those that are inspired by a person's lifelong evolving interests…and deeply-felt core values" (p. 68).

The studies that have measured the degree to which chosen goals are self-concordant have had participants rate their reasons for pursuing their goals. These reasons were evaluated on a continuum from external to intrinsic motivation (e.g., Sheldon & Elliot, 1999). Self-concordant goals are "integrated with the self… and are felt to emanate directly from self-choices… Because the developing interests and deep-seated values that such goals express are relatively enduring facets of personality, self-concordant goals are likely to receive sustained effort over time" (p. 483-484).

Importantly, Sheldon and Elliot (1999) explain that striving to meet self-concordant goals does not always result in positive feelings and self-gratification. For example, a parent might not enjoy spending time each night helping a child with their homework. However, the goal of having the child learn good study habits and do well in school is consistent with the parent's value of the child's development and education. The process of striving may not always feel pleasant, as Sheldon and Elliot (1999) point out, "Achieving goals feels good (Emmons, 1996)…there are natural satisfactions to be found in the process of exercising one's competencies to move toward desired outcomes" (p. 484). This assumes, however, that the chosen goals are self-concordant and when obtained, the basic psychological needs are met.

Judge, Bono, Erez, & Locke (2005) found that core self-evaluations (Judge, Locke, & Durham, 1997) were associated with choosing self-concordant goals, which were associated with greater life satisfaction. Extending prior research on university students, a study with employees of two companies, one a large defense contractor and the other a

small financial services organization; core self-evaluations were again associated with choosing self-concordant goals which in turn was associated with job satisfaction.

It is often assumed that individuals would lose motivation to pursue their goals if they did not have their self-worth contingent on achieving their goals. However, if their goals are self-concordant, then they don't need this contingency. The natural satisfactions noted above will suffice. Much anxiety and stress coming from having one's self-worth on the line would be eliminated. In other words,

> Behavior that emanates from one's integrated sense of self is said to be 'autonomous' or 'self-determined'; it has what deCharms (1968) referred to as an 'internal perceived locus of causality.' As one behaves autonomously, acting with an internal perceived locus of causality, the behavior promotes further development of self and a stronger sense of true self-worth (Deci & Ryan, 1995, pp. 34-35).

Since persons who choose non self-concordant controlled goals have difficulty sustaining effort toward achieving them and derive less satisfaction in goal attainment and derive less of a sense of well-being, an important question arises: "Why do some people select non self-concordant, externally controlled goals and thus fail to get their basic needs for autonomy, competence, and relatedness met?" Sheldon and Elliot (1998) "suggest that such goals are selected when the individual fails to create an accurate assessment of his or her deeper needs, values, and interests" (p. 554).

Sheldon (2002) posits that there are skills that are required for self-concordant goal selection. He lists the following three: (1) The ability to discern one's enduring values and interests to more transient and superficial impulses, (2) The ability to "distinguish accurately between 'me' and 'not me', that is, between goals that represent one's *own*

interests, values, and goals that instead represent *others* interests and values" (p. 76), and (3) The ability to select goals whose content foster meeting the person's basic human needs.

Sheldon, Kasser, Smith, and Share (2002) developed a brief program designed to enhance goal attainment and personality integration. Their findings indicate that progress toward goal attainment was associated with a variety of psychological benefits, including increased vitality and personality integration. People who participated in the study were initially more psychologically healthy and benefitted most from the intervention as well as made the most progress toward goal attainment. In contrast, the less psychologically healthy participants did not find the intervention to be helpful for their goal attainment. It seems that the main focus of the intervention in this study was to enhance goal attainment rather than enhance goal selection ability.

> Unfortunately, our brief intervention did not benefit individuals low in initial integration, arguably the population most in need of help. If indeed such individuals are 'stuck in ruts' it appears that it may take a different approach to unstick them. For example, future studies could use insight–based techniques to help participants explore the deeper reasons and historical roots of their goal choices (p. 25).

Competence: Contingent vs. True Self-Esteem

Developing Awareness of Deeper Needs

Deci and Ryan (1995) makes a critical distinction between "contingent" and "true" self-esteem. "Contingent self-esteem refers to feelings about oneself that result from–indeed are dependent on–matching some standard of excellence or living up to some interpersonal or intrapsychic expectations" (p. 33). In other words, a person's perceived

self-worth is contingent on meeting performance expectations from self or others and on gaining the approval of others. By contrast,

> true self-esteem is more stable, more securely based on a solid sense of self…Her self-worth would essentially be a given…Her worth would not need to be continually put to the test, so she would not typically be engaged in a process of self-evaluation (p. 32-33).
>
> They would probably be pleased or excited when they succeed and disappointed when they fail. But their feelings of worth as people would not fluctuate as a function of those accomplishments, so they would not feel aggrandized and superior when they succeed or depressed or worthless when the fail (p. 33).

This definition of true self-esteem is quite similar to that of Kernis (2003). "True high self-esteem is not 'earned', nor can it be taken away." "Doing well is valued because it signifies effective expression of one's core values and interests, and it is this effective expression that is valued, not high self-esteem per se" (p. 9). In response to poor performances, "individuals with true high self-esteem may feel disappointed and perhaps somewhat sad or irritated; however these individuals are unlikely to feel devastated or enraged" (p. 9).

According to Deci & Ryan (1995), contingent self-esteem may derive from meeting performance expectations or gaining approval from others. True self-esteem is not strived for, but rather is the result of meeting the basic needs known as "qualities of experience universally required by human beings in order to thrive" (Sheldon & Elliot, 1999, p. 484). Recall that these qualities are the basic needs for autonomy, competence and relatedness.

Contingencies of Self-Worth

Deci and Ryan (1995) differentiate between contingent self-esteem and true self-esteem. After conducting programmatic research on the concept of contingent self-worth (CSW), Crocker, Luhtanen, Cooper, & Bouvrette (2003) have explored specific contingencies on which people base their self-esteem. Crocker et al. (2003) developed the Contingencies of Self-Worth (CSW) Scale and found that college students preferentially base their self-worth on specific domains, such as family support, competition, appearance, approval from others, God's love, academic competence, and virtue. Study results demonstrated that the contingency of self-worth valued most highly does in fact lead to increased motivation to obtain goals in various domains. Unfortunately, students paid significant costs to having their self-worth attached to desired outcomes. For example, while academic CSW was associated with more studying, it was also associated with a variety of academic and financial problems. It was also associated with psychological depression and high levels of internal stress. Additionally, the academic CSW did not lead to achieving the much sought after improvement in grades.

> These results, taken together with other research, suggest that students who base their self-worth on academics are caught in a compelling but ultimately unsatisfying quest for self-worth. They believe that good grades will validate their worth, they study long hours to obtain that validation (Crocker et al., 2003) and they tend to have achievement goals that focus on performance rather than learning (Bartmess, 2002)…because they have so much at stake they are stressed, and the motivation they have to do well in school ultimately does not increase their grades (Crocker & Luhtanen, 2003, p.709).

Crocker et al. (2003) posit that CSW is likely to be associated with non-autonomous, controlled motivation. They stated, "basing self-esteem on appearance predicted how much time students spent grooming, shopping, partying, and socializing" (Crocker, Brook, Niiya, & Villacorta, 2006, p.1754-1755). Park, Crocker, & Mickelson (2004) found that the physical attractiveness and approval from others CSWs were associated with the preoccupied attachment style, and the appearance CSW was associated with fearful attachment.

Other researchers have shown that appearance and approval CSWs are associated with negative outcomes, such as concerns about body weight and shape, which in turn have been associated with anxiety, depression, poor academic performance, and decreased life satisfaction (Overstreet & Quinn, 2012).

Self-Image Goals

Not only do individuals strive to meet their own contingencies of self-worth, they also want to prove to others that they have the desired qualities, such as being smart or attractive. For example, the person who's self-worth is based on being smart and appearing the same to others may answer questions in class, not just as part of the learning process, but to show others how smart they are. They may make a point of boasting about their grades (Crocker, Moeller, & Burson, 2011).

Interpersonal conflicts and loneliness often result from self-image goals about caring for others that are made mainly to gain others' approval and not motivated by genuine care about the other people. Crocker et al. (2006) suggest that this is really a self-image goal based a desire to bolster one's sense of self-worth, rather than being motivated by true concern for others. People who try to present their desired, (often idealized) images

to others may sabotage the potential of creating genuine relationships and authenticity. This leads to receiving less social support and consequent loneliness (Crocker et al., 2006). These people score higher on social anxiety and anxious and avoidant styles of attachment insecurity. They experience more negative affect related to their academic and friendship goals, experience setbacks, and have more performance-focused achievement goals (Crocker, Moeller, & Burson, 2010). Crocker et al. (2010) refer to CSWs and image goals as egosystem motivation.

Compassionate Goals

In contrast to self-image goals and egosystem motivation, Crocker et al. (2010) describe people with compassionate goals and ecosystem motivation as individuals who see themselves as separate individuals but are capable of connecting with others and genuinely care about their well-being. People who score high on universality and connectedness and low on entitlement, self-judgment, and attachment avoidance, have predominately compassionate goals. In one study (Moeller et al., 2008), participants with compassionate goals reported that, regarding their friendship and academic goals:

> Feeling connected to others, loving, present, engaged, peaceful, cooperative, empathic, and clear…. In sum, the more participants had compassionate goals, the more clear and connected their academic and friendship goals made them feel. Compassionate goals were associated with feeling humble following goal progress, and determined and realistic following goal setbacks (Crocker et al., 2010, p. 421).

Compassionate goals also predicted learning-oriented achievement goals, self-regulation, and goal progress.

In a study with college freshmen, Crocker and Canevello (2008) showed that students with compassionate goals scored high on spiritual transcendence (universality and connection), self-compassion, agreeableness, and extraversion; they scored low on avoidant attachment and psychological entitlement. Students with self-image goals scored lower on self-compassion and higher on attachment insecurity and entitlement. Students high in compassionate goals held beliefs about the interconnectedness of people and all life and that people should take care of each other. In contrast, students with self-image goals reported beliefs that people should take care of themselves. They reported more conflict, loneliness, and afraid and confused feelings. Roommates of students with compassionate goals reported more support from these roommates and in turn gave more support back. Compassionate goals, when self-image goals were not present, appeared to "create a supportive environment for themselves and others" (p. 555).

As the literature reviewed above demonstrates, contingencies of self-worth and self-image goals are inconsistent with true, non-contingent self-esteem as described by Deci and Ryan (1995) and Kernis (1983). Additionally, they lead to significant interpersonal, academic, financial, and emotional problems. When individuals with contingent self-worth fail to achieve their chosen goals there response is self-criticism.

Self-Criticism

Self-criticism is defined as "harsh punitive evaluation of the self, often accompanied by guilt, feelings of unworthiness and self-recrimination" (Powers, Zuroff, & Topciu, 2004, p. 61). While self-criticism is related to perfectionism, it is a separate construct. It is possible to demand perfection of oneself and still not be self-critical when attempts to be perfect fail. One also can be self-critical without demanding perfection

(Powers et al., 2004). Self-criticism is different from self-esteem, in that it is a more global negative view of oneself. Low self-esteem may be the result of harsh, pervasive, and chronic self-criticism (Dunkely & Grilo, 2007). The literature reviewed below will document the pervasive and debilitating effects of self-criticism and its association with clinical disorders, emotion regulation, interference with goal pursuit and achievement, interpersonal relationships, and social support.

Depression

Self-criticism may be considered a facet of the higher-order domain of neuroticism. It is, however, a distinct construct, which has incremental predictive validity in its association with current depression (Clara, Cox, & Enns, 2003). In addition, self-criticism predicted depressive symptoms, major depression, and global psychosocial impairment four years later, while neuroticism did not (Dunkley, Sanislow, Grilo, & McGlashan, 2009).

In a community sample of adults with a history of major depression who were contacted every six weeks for a year, high levels of self-criticism and low levels of self-esteem were associated with more depressive symptoms in the context of hassles (minor stressors) reported over the previous six weeks (Abela et al., 2012). In a study investigating self-criticism and regulation of negative affect, female college students recorded their affect and use of mood regulation strategies twice daily for a two-week period. Self-criticism was related to poor mood management, venting, and failing to spend time with others (Fishman et al., 1999).

Self-criticism has been associated with suicidal ideation and the lethality of suicide attempts in adults (Fazaa & Page, 2003) and depression as well as suicidal ideation and

hopelessness in adolescent psychiatric patients (Donaldson, Spirito, & Farnett, 2000; Enns et al., 2003). Self-criticism has also been shown to predict poorer outcome in short-term treatments for depression, e.g., interpersonal psychotherapy (Marshall et al., 2008), and cognitive therapy (Rector et al., 2000). In the cognitive therapy study, reduction in self-criticism predicted treatment outcome.

Self-criticism was originally studied mostly in depression. However, subsequent research revealed that self-criticism was common across disorders. Levels of self-criticism were almost three times higher in social anxiety disorder compared to panic disorder. Cox et al. (2002) suggested that self-criticism might be an important core psychological process in the development, maintenance, and course of social phobia (Cox et al., 2002, p. 481). In a study of CBT for generalized social phobia, changes in self-criticism were significantly associated with outcome (Cox et al., 2002).

Posttraumatic Stress Disorder

In the National Comorbidity Study, self–criticism was associated with PTSD (Cox et al., 2004). Self-criticism was higher for hospitalized patients with PTSD compared to patients with major depressive disorder (Southwick et al., 1991). Self-criticism predicted greater severity of combat related PTSD in hospitalized male veterans (McCranie & Hyer, 1995). Self-criticism distinguished between women victims of domestic violence with and without PTSD (Sharhabani-Arzy et al., 2005). In a study of holocaust survivors, those with PTSD scored higher on self-criticism than survivors without PTSD, perhaps related to survivor guilt (Yehuda et al., 1994).

Obsessive Compulsive Disorder

In one study, patients with OCD and patients with other anxiety disorders reported lower self-esteem than non-anxious controls, but were not different from each other.

> Both clinical groups reported that they believed that they must hide their emotions and weaknesses from others in order to appear worthwhile…OCD patients reported more fear that others would see them in a *completely* negative manner, e. g. others would 'loathe' or 'despise' them if it were possible that they would cause others harm or problems, suggesting a sensitivity to blame and criticism (Ehnthholt et al.,1999, p. 779).

Other Clinical Disorders

In a sample of 236 binge eating disorder patients, self-criticism was associated with over-evaluation of shape and weight, independent from the related constructs of low self-esteem and depression (Dunkley & Grilo, 2007). Self-criticism has also been implicated in borderline personality disorder, bipolar disorder, self-injurious behaviors, schizophrenia, paranoid beliefs (Shahar et al., 2012), and chronic pain (Karoly & Ruehlman, 1996). One study found that patients' self-criticism was a stronger predictor of physician's evaluation of prognosis than pain diagnosis or severity in chronic pain patients (Rudich et al., 2008).

Self-Criticism as a Mediator of Later Problems

In a longitudinal study, "self-criticism at age 12 predicted fewer involvements in high school activities, and at age 31, fewer years of education completed, lower occupational status in men, dissatisfaction with primary relationship (p.=10), dissatisfaction with being a parent, and personal/social maladjustment" (Zuroff et al., 1994, p. 367). Self-criticism was found to fully mediate the relationship between childhood verbal abuse from parents and depression and anxiety in adults (Sachs-Ericsson et al., 2006). Self-criticism in

adolescents mediated the relationship between childhood maltreatment and non-suicidal self-injury (NSSI), suggesting that interventions to reduce adolescent self-criticism might prevent and or treat NSSI (Glassman et al., 2007).

Self-Criticism and Goal Pursuit

Self-criticism has been shown to be associated with controlled motivation and goal progress in several studies with college students. In a study with college students investigating aspects of self-determination theory and personality characteristics, Powers, Koestner, and Zuroff (2007) found that autonomous motivation was associated with more successful goal attainment. Self-criticism was associated with controlled motivation and negatively related to goal progress. The findings held up across three distinct domains: academic, social, and health (weight loss). Rumination and procrastination of the self-critics appeared to play a role in less goal progress. Powers et al. (2007) suggest that the self-critics' focus on fear of failure and potential judgment from others may have contributed to difficulties in self-regulation.

Powers et al. (2009) explored self-criticism, self-concordant goal motivation and goal progress in high-level college athletes and musicians. Results indicated that self-criticism was associated with less self-concordant goals and less goal progress, with lower self-concordance mediating this outcome. Further, self-criticism was associated with greater negative affect in response to perceived poor progress. The authors suggest that "the self-critic largely defines the self by performance and achievement, and that the affective experience of the self-critics will be particularly contingent upon appraisals of such performances" (p. 282). Powers et al. (2011) reported the results of additional studies with college students showing that self-criticism was associated with less progress in

reaching academic, music, and weight loss goals. These studies also found that self-criticism was distinct from self-oriented perfectionism (high standards), which was associated with greater goal progress.

Self-Criticism and Interpersonal Relationships

Self-critics desire to be approved of but fear disapproval and rejection, leading to ambivalence about interpersonal relationships and not surprisingly, they have fearful-avoidant attachment styles (Zuroff, Moskowitz, & Cote, 1999). Self-criticism has been linked to a negative interpersonal style and a variety of interpersonal problems, including being more introverted and controlling, and receiving more complaints from spouses. Self-criticism has been associated with less agreeableness, more quarrelsome behavior, having fewer friends, less social support, and less satisfaction with their perceived social support (Zuroff & Duncan, 1999). Self-critical college women have been shown to be less likely to engage in self-disclosure to their boyfriends and girlfriends and have been rated by judges as less likeable during peer interactions. "Self-critical patients are socially isolated, consider themselves to be a personal and social failure, and are intensely and critically involved in work rather than in relationships, and their interpersonal involvement is limited by feelings of anger and resentment" (Blatt & Zuroff, 1992, p. 536).

Besser, Flett, & Davis (2003) studied the relationship between self-criticism, loneliness, depression and self-silencing (Jack, 1991) in third year undergraduate college students. "People high in self-silencing are self-sacrificing individuals who keep their distress to themselves in an attempt to maintain or improve interpersonal relationships" (Besser et al., 2003, p. 1737). They tend to present themselves to others in a positive way, but harbor resentments and anger. Self-silencing has been linked to depression. Bessere et

al. (2003) found that the relationship between self-criticism and loneliness was mediated by self-silence.

In a study with adolescents, Shahar, Henrich, Blatt, & Ryan (2003) found that self-criticism was associated with less autonomous behavior and experiencing more negative events. In addition, self-criticism was associated with engaging in less positive events (both interpersonal and achievement events were assessed). The authors suggest that self-critical adolescents may have internalized unrealistic standards toward which they push themselves and are not in touch with what is truly pleasurable for them. Instead, they are more focused on activities that may gain the approval of others.

In a study of the impact of self-criticism on interpersonal relationships under laboratory conditions, Zuroff and Duncan (1999) studied conflict resolution of serious dating partners. The authors found that levels of self-criticism were associated with more negative cognitive-affective reactions, which were mediated by more negative relational schemas. This pattern predicted more overt hostility of girlfriends toward their boyfriends, which predicted boyfriends' negative cognitive-affective reactions and overt hostility. However, boyfriends' hostility did not predict girlfriends' negative reactions or overt hostility. In attempting to explain these findings, the authors speculate that perhaps girlfriends take more responsibility for relationship maintenance and favor more active attempts at conflict resolution. Boyfriends may prefer to avoid conflict.

The research summarized above documents the deleterious effects of self-criticism across a variety of interpersonal relationships and contexts. It appears that the self-critics' interpersonal style may also be found in relationships with healthcare providers, as the

study showing that chronic pain patients who are more self-critical receive more pessimistic prognoses than less self-critical patients (Rudich et al., 2008).

Developmental Antecedents to Self-Criticism

With a nonclinical community sample of Portuguese adults, perceptions of low levels of caring and high levels of overprotection from mothers were associated with current self-criticism and depression (Campos, Besser, & Blatt, 2010). The authors conclude "our findings are also congruent with attachment theory, which emphasizes the construction of internal working models as the result of early interactions and the effects of these interactions on psychological development, feelings of well-being and psychopathology" (p. 1154). Using a prospective longitudinal design, mothers' reports of their mothers' parenting behavior as restrictive and rejecting were associated with the development of self-criticism, even when mothers' reported temperamental differences among children were considered (Koestner et al., 1991).

In a study with college students in England, recall of parents being over-protecting and rejecting was associated with inadequacy and self-hating forms of criticism. These forms of self-criticism were associated with an adult fearful attachment style (Bartholomew & Horowitz, 1991; Irons et al., 2006).

Using data from the National Comorbidity Survey, a nationwide epidemiological study, 5877 participants' current level of self-criticism fully mediated the relationship between parental verbal abuse and current depression and anxiety symptoms. Self-criticism partially mediated the relationships between childhood sexual and physical abuse and current depression and anxiety (Sachs-Ericsson et al., 2006). The authors noted that other researchers have suggested that verbal abuse may be most likely to lead to

development of negative self-schema "because the negative self-cognitions are directly supplied to the child by the abuser" (Sachs-Ericsson et al., 2006, p. 77).

Glassman et al. (2007), in their report on self-criticism and non-suicidal self-injury, make similar comments, "Emotional abuse during a child's formative years could result in a tendency to internalize critical thinking toward the self" (p. 2488).

Similarly, Clark, and Coker (2009) found in a study of mother and their daughters that mothers' comparative self-criticism (negative view of self in comparison to others) was related to daughters' internalized self-criticism (negative view of self in comparison to internal personal standards). The authors suggest that it is likely that these mothers are critical when interacting with their daughters, and that these comments "may be internalized by the child, leading to the development of a self-criticizing voice, which is activated when their high personal standards fail to be reached" (p. 325).

Once self-criticism develops, it may be maintained by positive and negative reinforcement. For example, if the child makes a mistake and criticizes him or herself overtly, parents or significant others may back off and be less critical, since the child has already done the criticizing. These functions might also be considered beliefs about self-criticism, as items on The Functions of Self-Criticizing/Attacking Scale. Examples of items are: to make sure I keep up my standards, to show I care about my mistakes, to stop me from being lazy, and to gain reassurance from others.

Relatedness: The Importance of Healthy Attachment

Early Life Prototype of Future Relationships: Attachment Theory

There are numerous studies that confirm that a child's first primary relationship (i.e., relationship with mother, father, primary caretaker) is most important because they form a

prototype for all other future relationships (Ainsworth, 1978; Bowlby, 1969, 1980; Mahler, Pine, & Bergman, 1975; Main & Solomon, 1986). Likewise, it is also common knowledge that the way parents behave and relate to their children contributes to their representation of God (Hutsebaut, 1982; Rizzuto, 1979; Silka, Hood, & Gorsuch, 1985; Vergote & Tamayo, 198).

According to Moustakes (1959),

> A relationship between a child and his mother or father through which the child discovers himself an important person, sees that he is valued and loved, and recognizes his irreplaceable membership in the family. It is a way through which the child opens himself to emotional expression and in this process releases tensions and repressed feelings (pp. 275-277).

People's longing for intimacy and love, according to Sullivan (1953), is fulfilled when they feel securely attached to members of their family of origin or in couple relationships, they feel securely attached to their spouses or significant others. Healthy couples long for openness and engagement. With healthy attachment and bonding, the couple can cultivate the necessary emotional, physical, and instinctual realities needed for healthy development (Hedges, 1994). They have an innate drive to become capable of flexibility and the ability to learn from experiences and are more capable of adapting to new situations. Health is also associated with a sense of responsibility for constructing one's own experiences and responses to those experiences.

Substantial research has confirmed that loss of connection to important attachment figures can manifest itself in a host of dysfunctional behaviors. Examples are restless over-activity (Rando, 1993); compulsive caretaking (Lazare, 1989); somatoform disorders

(Clayton, 1974; Bowlby, 1980); impulse control disorders (Rando, 1993); self-reproach and self-blame (Furman, 1974); loneliness, emptiness, and sadness (Parkes & Weiss, 1983; Raphael, 1983); yearning, pining, longing, and searching (Parkes, 1972); chronic feelings of helplessness (Call & Wofenstein, 1976); pain and tightness in the chest and throat (Bowlby, 1980; Lazare, 1989); preoccupation and obsessional thought patterns (Rando, 1993); withdrawal and isolation (Suttie, 1952); suicide ideation (Black, 1998; Freud, 1957); and anxiety, anger, and depression (Bowlby, 1980; Raphael, 1983; Worden, 2002).

Bowlby (1980) viewed anger in close relationships as an attempt to make contact with an inaccessible attachment figure and distinguished between the anger of hope and the anger of despair–a despair that ultimately becomes desperate and coercive. The desired coaching outcome when working with couples is to enable each partner to be released from their symbiotic prisons, to be able to communicate their own needs, and to stretch to meet each other's needs (Hendrix, 2005, p. 33), thus moving them closer to successful goal attainment.

Attachment Styles

As noted above, various forms of insecure attachment and parent/child relationships have been associated with contingent self-worth, self-image goals, and self-criticism. Secure attachment, on the other hand, has been associated with numerous advantages, including optimal brain development, competence, resilience (Atwool, 2006), better emotional regulation, autonomy, mature relationships, tolerance of ambiguity, and more accurate appraisal of self and others (Skowron & Dendy, 2004). Therefore, this dissertation will also review the relevant literature on attachment theory (Bowlby, 1982, 1988) and its importance for helping coaches better understand the working models of self and others that clients bring to the coaching situation.

In a study of attachment security from a self-determination theory perspective, La Guardia, Ryan, Couchman, and Deci (2000) found, as predicted from prior research on adult attachment styles, there are substantial differences between individuals in these working models of attachment relationships. They also found more than one half of the variance in current attachment security was accounted for by within-person variability.

> People showed substantial variability in their attachment styles to mothers, fathers, romantic partners, and best friends; for example, and this within-person variability in security was shown to be a function of the degree to which the various social partners were responsive to the individuals' needs to autonomy, competence, and relatedness (Deci & Ryan, 2000, p. 262).

It appears very important for coaches to be aware of these findings so they can have reasonable expectations that clients can have more secure attachments with people who are responsive to their needs and their well-being. Further, coaches' understanding and awareness of client attachment styles allow coaches to tailor interventions to best address these styles and increase the likelihood of helping clients reach their goals. Dozier, Cue, and Barnett (1994) found that clinicians with the most secure attachments responded more therapeutically to clients' attachment related behavior. Evidence suggests that therapists' unresolved attachment issues might be a source of countertransference reactions (Hayes et al., 1998, cited by Mallincrodt, 2000). In summary, attachment theory offers a rich framework that may help coaches have greater wisdom in relating to their clients. Familiarity with attachment theory can offer opportunities to provide a corrective emotional experience of a secure base and better foster engagement in the therapeutic interventions suggested below.

Attachment Injuries

According to Johnson, Makinen, and Millikin (2001) an attachment injury can be likened to a relationship trauma where the Latin meaning of trauma is "to wound" and the Latin meaning of injury is "to wrong" (Walser & Hayes, 1998, in Johnson et al., 2001). To be distinguished from the ordinary highs and lows of ongoing relationships, an attachment injury is caused by a profound violation of trust resulting in shattered assumptions that forever change the way the injured person sees himself or herself because it induces a sense of existential vulnerability (Johnson, Makinen, & Millikin, 2001, p. 150) that provoke feelings of abandonment, rejection, fear, shock, shame, disbelief, that make the notion of forgiveness and reconciliation seemingly hopeless because the repercussions associated with the depth of emotional injury block any hope for repair.

"An attachment injury occurs when one partner violates the expectation that the other will offer comfort and caring in times of danger or distress" (Johnson, Makinen, & Millikin, 2001, p. 145), resulting in a relationship defined as insecure such that the relationship distress is sustained and becomes the new standard of dependability from the perspective of the wounded partner (Johnson et al., 2001, p. 145).

Attachment injuries often result in irreparable damage because the injury stays "alive" much like PTSD symptoms with traumatic flashbacks, leaving the injured person with an inability to find relief, especially if the wounding partner fails to respond in a reparative and reassuring manner. Without the support needed for reparation, the wounded partner continues to experience deep despair and alienation (Johnson et al., 2001). Consequently, all future, even minor, disappointments, "echo back to major hurts and injuries and disproportionately reinforce relationship distress" (p. 148). Everything is then perceived through the lens of

negative past events, which is perplexing when you hear an injured spouse report that "they've never been happy in their marriage" or that they "don't remember a day of happiness while married." Distressed couples develop a negative schema about the entire relationship and tend to remember events that are consistent with their schema (p. 148). They then develop a rigidity of negative interactional cycles, a fearful dismissing attachment style, and remain highly ambivalent at the notion of trusting again (Johnson & Whiffe, 1999, in Johnson et al., 2001).

Coaching individuals, couples, and families who are blocked by attachment injuries will require strategies for helping clients to regulate their emotions, create secure and safe connections, construct new narratives, and develop personal and relational goals for the future (Johnson & Whiffe, 1999, in Johnson et al., p. 151).

PTSD and Attachment Injuries

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association 1994), posttraumatic stress disorder is a reaction to traumatic events that persist over a period of time. Terr (1994) has researched two distinct types of trauma: type I and type II. Type I suggests that an individual is traumatized after having witnessed or experienced a traumatic event that is catastrophic and unanticipated. Also coined as critical events, memories of the trauma remain with the individual until they are worked through. Individuals with type II PTSD experienced trauma early in life that was prolonged and interpersonal (Williams & Poijula, 2013, p. 17).

Herman (1992) defined seven categories of complex PTSD. The general symptoms include: problems with regulating emotion and anger; trouble staying in the "present" due to preoccupation with the trauma; difficulty in every day functioning; preoccupation with

revenge or other punitive fantasies and/or behaviors; inability to develop healthy relationships due to the need to engage in protective behaviors such as withdrawal and isolation, or constantly searching for empathy and understanding; an inability to find meaning and hope that was replaces with feelings of despair and hopelessness (Meichenbaum, 1994, in Williams & Poijula, 2013, p. 19). Examples of symptoms experienced by people with type II PTSD include: an inability to trust; shock and disbelief; triggers and flashbacks associated with the event; anxiety; anger; rage; deep hurt and depression. They often say that "everything seems surreal" and unsafe. If when coaching, such symptoms are observed, it would necessary to refer such clients for deeper psychological care and trauma treatment as these are not issues that should be addressed by a professional coach. They are only document to alert coaches as possible obstacles that may hinder the coaching process.

Autonomy: Developing Autonomy by Increasing Levels of Self-Differentiation

Highly related to Bowlby's attachment theory is Bowen's (1976, 1978) family systems theory concept of differentiation of self. Differentiation of self is comprised of both intrapsychic and interpersonal dimensions. The intrapsychic dimension has to do with the ability to distinguish between thoughts and feelings and engage in emotional regulation, particularly in the face of stress and conflict. This dimension also relates to the ability to maintain a solid sense of self in close relationships (Bowen, 1978; Skowron & Dendy, 2004). The interpersonal dimension of differentiation of self involves the ability to maintain a balance between autonomy and togetherness. In a study exploring attachment and differentiation of self and their relationships with the ability for self-regulatory control, Skowron and Dendy (2004) state, "These findings suggest that while the constructs of

attachment security and self-differentiation tap distinct dimensions of relational experience, they also share at least two similar, underlying dimensions, namely the dialectic needs for intimacy and autonomy in human experience" (p. 349). "In fact, differentiation of self involves the capacity to achieve an autonomous sense of self while remaining in intimate, emotionally connected relationships" (Skowron & Dendy, 2004, p. 350). These conclusions are consistent with self-determination theory's assertion that human beings have innate needs for autonomy and relatedness (Deci & Ryan, 2000).

Better differentiation of the self has been associated with less maladaptive perfectionism, self-criticism, and psychological distress in undergraduate college students (Aldea & Rice, 2006). In addition, differentiation of self, as measured by the Differentiation of Self Inventory, (DSI; Skowron & Friedlander, 1998) has been linked to lower chronic anxiety, less relationship violence and substance abuse. In addition, it has been associated with better psychological adjustment, physical health, marital satisfaction, and self-regulatory skills. Greater attachment security, social connectedness, and less shame have also been related to higher levels of differentiation of self (studies reviewed by Skowron, Van Epps, & Cipriano, in press).

As summarized in the preceding sections, secure attachment and higher levels of self-differentiation have been associated with numerous positive personality and mental health indicators, including autonomy and better interpersonal relationships. I also noted how coaches' awareness of clients' attachment styles, and issues of transference and countertransference may provide coaches with a greater awareness of what transpires in the coaching sessions, and perhaps allow coaches to tailor their interventions to best meet their clients' needs.

In the study cited above (Zuroff et al., 2007) comparing CBT, interpersonal psychotherapy, and pharmacotherapy with clinical management for depression patients with an attachment avoidance style did better with cognitive-behavior therapy than with interpersonal psychotherapy. The authors suggested that CBT, with the emphasis on cognitions rather than relationships, might have been more accessible and less threatening than IPT which targets close interpersonal relationships (Zuroff et al., 2007, p. 1051). These findings highlight the importance of coaches' sensitivity to client attachment styles and what interventions to emphasize to fit the clients' needs.

Coaches' familiarity with the concept of self-differentiation may help coaches understand the struggles some clients may have with autonomous motivation and selection of self-concordant goals. Low levels of self-differentiation may lead to clients' operating with controlled motivation related to difficulty discerning what is really important to them, separate from what they feel they *should* be pursuing, based on approval or disapproval from others. In addition, problems with emotional reactivity, a noted characteristic of individuals with low levels of self-differentiation, may be noted by the coach and targeted for REBT and/or mindfulness interventions which are a part of self-compassion interventions.

CHAPTER 3

UNDERSTANDING THE COACHING PROFESSION

Coaching vs. Psychotherapy

It is not uncommon for psychologists, social workers, and psychotherapists to either leave their role as therapists behind, or to add coaching to their professional services (Hart, Blattner, & Leipsic, 2001). Any number of factors may influence the decision to become a coach, but one often mentioned is the desire to become free from the control of managed care and insurance companies. These companies have considerable power over the nature of therapy authorized, how many sessions are allowed, and the frequency and detail necessary for obtaining authorization for additional sessions. When therapists become coaches, important and common questions often arise as to the similarities and differences between coaching and psychotherapy. These similarities and differences can be categorized in a variety of ways, but I will discuss the issues of client characteristics, nature of the professional relationship, purpose and focus, settings, and professional training and skill sets (Bluckert, 2005; Grodzki & Allen, 2005; Hart, Blattner, & Leipsic, 2001).

Client Characteristics

Clients who seek psychotherapy are often suffering from a DSM-IV disorder and may suffer from comorbid conditions as well. Major Depressive Disorder, Anxiety Disorders, Substance Abuse or Dependence, and Eating Disorders are common examples. In addition, clients may present problems with anger and/or aggression, and severe marital or family conflict. In most all cases, these clients are suffering and may be impaired or handicapped in work, social, or personal functioning.

In contrast, clients seeking coaching are usually functioning well in their various life roles. They desire to further improve in their functioning and accomplish specific goals that would make their lives even more fulfilling, meaningful, and successful. Coaching clients are looking for a collaborator in their journey to reach their life dreams.

Nature of the Relationship

Typically the relationship between a therapist and a client is more formal, hierarchical, and distant than the typical coaching relationship. The therapist is seen as the expert, at times the doctor, to whom the client or patient can turn to for help to overcome their particular disorder. In a survey of professionals who had either active or former practices in both coaching and therapy (Hart, Blattner, & Leipsic, 2001), the authors stated, "Overall, there is a profound difference in relating while conducting coaching versus therapy with clients" (pp. 230-231). Coaches described their relationship with clients as involving more humor, self-disclosure, looser boundaries, and more relaxed. Further, in the coaching role, respondents reported feeling less of a need to protect or take care of their clients. One respondent stated, "You can admit that you know them in the grocery store" (Hart, Blattner, & Leipsic, 2001, p. 231).

Confidentiality is a critical ethical issue, and therapists are well trained in how to protect confidentiality for both ethical and legal reasons. Therapists are required by their licensing boards and ethical guidelines not to socialize with a client outside of the therapist's office. While coaches are sensitive to issues of confidentiality, they have significantly more freedom to interact with clients in other settings, such as the golf course, corporate hospitality events. However, some coaching authorities would argue against this (Grodzki & Allen, 2005). In an interesting twist to the issue of confidentiality, a therapist

responding to the Hart, Blattner, & Leipsic (2001) survey stated that, "There is actually more confidentiality in coaching. People do not realize that when they submit their bills to their insurance company (for therapy), their information is public knowledge" (p. 235).

Purpose and Focus

As suggested above, the purpose and focus of therapy and coaching may be quite different. The purpose of therapy could be said to get well, while the purpose of coaching would be to obtain personal growth, a greater well-being and happiness, and achieving higher goals in life. Different forms of therapy vary in degree of focusing on the present versus the past, e.g., cognitive-behavior therapy and solution-focused therapy compared to psycho-dynamic therapy or psychoanalytic therapy (Bluckert, 2005; Grodzki & Allen, 2005). However, a critical distinction between therapy and coaching is the latter's focus on present and future goals.

Settings

Therapy almost always occurs within the confines of the therapist's office or, in some cases, a hospital setting. The 50-minute hour is the well-known time frame for the therapy session. At times, cognitive-behavior therapists may meet outside the office to engage in in-vivo exposure for phobias. For example, the therapist may ride in the car with a client afraid of driving or of going over bridges. This is rare for therapists of other therapeutic persuasions. In contrast, coaches have much more freedom as to where and how long their meetings last. For example, coaching could occur at Starbucks, the client's workplace, over the telephone, Skype, or videoconferencing (Hart, Blattner, & Leipsie, 2001). In an article describing his transition from psychologist/therapist to executive coach, Criddle (2007) writes: "I have held coaching sessions over a meal as well as while sailing

on the Puget Sound" (p. 124). Coaches and their clients might never actually have a live, face-to-face meeting (Grodzki & Allen, 2005).

Coaching vs. Counseling

Counseling was initially developed as an alternative to psychotherapy because it was viewed as a helping service made available to normal people (Young, 2013). An offshoot of the guidance movement of the 1900s, the counseling profession is focused on "helping individuals of all ages and stages avoid making bad choices in life while finding meaning, direction, and fulfillment in what they did" (Gladding, 2013, p. 3).

Parsons, the founder of vocational guidance as a professional service, "envisioned a practice of vocational guidance based on rationality and reason, with service, concern for others, cooperation, and social justice among its core values" (Hartung & Blustein, 2002, p. 41). According to Gladding (2013), the main difference between guidance and counseling is that guidance helps people identify and select goals based on their values and counseling helps people make positive changes in addition to goal setting based on values and interests. Both define my role as a professional coach seeking to help clients identify, select, and accomplish self-concordant goals. Sometimes a goal may require some form of change on the part of the client.

A better delineation can be best understood by the words of my advisor, Dr. Lloyd Thomas (2005). This is the analogy he describes when describing how coaching is different from counseling and psychotherapy:

> Let's suppose life is like riding a bicycle. You have ridden your bike since the day you were born. Riding the bike so long has resulted in a couple missing spokes, a slightly bent pedal, and perhaps relatively skewed handlebars. If you came to me as

> a clinical psychologist, I would have two choices: to fix the bike myself; or if I am a smart therapist, I would teach you how to fix it yourself. If you came to me as a life coach, the first question I would ask is, "Would you like to learn how to drive a car?" If you chose the latter, the more time, effort and energy you put into learning how to drive a car, the less significant the skewed handlebars and bent pedal become (personal communication, 2013).

In terms of education and training, counselors typically complete a two-year master's degree in counseling, a practicum, an internship, and one to two years of supervised experience with a licensed professional counselor. As noted above, the training and credentialing process for coaches is not this extensive, and there is much variability across training programs.

The 2014 State of Michigan Health Code found at http://www.michigan.gov/lara defines counseling as:

> The rendering to individuals, groups, families, organizations, or the general public, a service involving the application of clinical counseling principles, methods, or procedures for the purpose of achieving social, personal, career, and emotional development and with the goal of promoting and enhancing healthy, self-actualizing and satisfying lifestyles whether the services are rendered in an educational, business, health, private practice, or human services setting.

In a survey of 238 licensed professional counselors, Mellin, Hunt, and Nichhols (2011) explored licensed professional counselors' views of their professional identity. Findings suggested that many counselors endorsed a professional identity centering on a "developmental, prevention, and wellness orientation toward helping" (p. 144), a finding

consistent with how previous scholars have distinguished between psychology and social work. The implication was that psychotherapists' work with a medical model focused more on pathology. However, some respondents to the survey stated that they saw counselors and therapists as more alike than different and saw no real practical differences between counselors and therapists. This view is consistent with Corsini's (2008) assessment that the distinctions between counseling and psychotherapy are becoming less and less meaningful (Ryan, Lynch, Vansteenkiste, & Deci (2011). Furthermore, Corsini (2008) stated, "there is nothing that a psychotherapist does that a counselor does not do" (p. 2) (Ryan et al., p. 204)

Consistent with the view that counselors and therapists are more alike than different, the Oregon Board of licensed Professional Counselors and Therapists website (http://www.oregon.gov/OBLPCT/Pages/web-wi.aspx) states that

> LPCs & LMFTs assist people who are facing pre-marital, marital, couples, or sexual abuse problems; are suffering from depression, anxiety, grief, or personal growth issues; are experiencing problems with family members or in the workplace; or are recovering from chemical dependencies.

Interestingly, Oregon state licensing laws prohibit anyone other than a licensed psychologist from describing themselves as a psychologist and from using the term psychotherapist to refer to the activities in which they engage. Thus, in Oregon counselors may call themselves therapists, but not psychotherapist. Such laws likely vary from state to state, and it appears that the literature addressing the similarities between therapists and coaches are not making the kind of distinction in terminology referred to in the Oregon law.

Compared to counseling, coaching appears to have a more specific goal-oriented approach and has not been conducted, as the State of Michigan Public Health Code states, with groups and families. However, similar to the definition of counseling, coaches do provide services to organizations (e.g., executive coaches) and the general public.

The Continuum: Coaching, Counseling, and Psychotherapy

Based on the relevant literature, my personal experience, and knowledge on the practices of my professional colleagues who are counselors, therapists, and psychologists; I see coaching, counseling and therapy existing on a continuum in terms of client characteristics, purpose and focus, and professional training. Coaches and counselors both work with healthier clients and seek to promote personal growth, while therapists treat clients with emotional disorders. The term therapist can refer to mental health practitioners who are counselors, clinical social workers, psychotherapists, psychologists, and even psychiatrists who are providing psychosocial treatments and not only medications. Both coaches and some counselors tend to focus on going forward to help clients obtain their goals rather than focusing on healing old wounds. Psychologists have the most academic and professional training, followed by that of counselors, and then coaches. Both counselors and therapists are required to follow the regulations and ethical provisions of their respective licensing boards.

In the final analysis, if during the process of coaching a particular client, it becomes clear that a significant mental or emotional condition is impeding the goals of coaching, a referral should be made to a licensed counselor, licensed marriage and family therapist, licensed clinical social worker, or licensed psychologist. Referrals to a psychiatrist should be made if a medication evaluation seems appropriate. The referral should probably be

made based on the coach's awareness of who has the expertise to help this particular client. Other practical considerations, such as geographical proximity and mental health insurance coverage would also be involved in the choice of referral. The important issue for the coach is to know what their boundaries of training, competence, and interests are, and therefore when to refer.

To end this section on coaching versus counseling and therapy, the passage below from Grodzki and Allen (2005, p. 201) appears very important for coaches.

Definition of Coaching and Psychotherapy:

> Clarify the difference between coaching and psychotherapy for clients, to ensure that your services will be understood as coaching, not counseling.

Sample wording:

> My coaching can be confused with other professions, such a counseling, my work with you will be coaching, not psychotherapy. My coaching services are intended for well-functioning individuals who want to take action and make behavior changes in the service of their goals for life and work. Psychotherapy is a health care service that diagnoses and treats the symptoms of mental disorders.

Addition for mental health professionals:

> I believe that it is ethically inappropriate for me to be both coach and psychotherapist with a client. If either of us recognizes that you have a problem that would benefit from psychotherapy, I will refer or direct you to appropriate resources.

I will describe interventions that coaches can use to address conditions such as attachment injuries that tend to thwart concordant goal selection and attainment as well as hinder the fulfillment of ones' basic psychological needs. I will advocate for forgiveness to occur by integrating the following techniques: Rational-Emotive Behavior Therapy (REBT), (Dryden, 2011; Ellis and Dryden, 1977), motivational interviewing (MI), (Miller & Rollnick, 2012; Vansteenkiste & Sheldon, 2006), and self-compassion interventions (Neff & Germer, in press) as an effective and useful coaching model. First, it is essential that I provide a brief history of coaching and the training and education necessary to create healthy and knowledgeable coaches since they will not be providing counseling and psychotherapy services, but without a doubt, will be exposed to similar issues that counselors, social workers, psychotherapists, and marriage & family therapists face.

A Brief History of Coaching

Vicki Brock, a colleague and graduate student from the International University of Professional Studies wrote a dissertation on the history of coaching (Brock, 2008). Her work is an encyclopedic sourcebook tracing the origins of coaching from ancient times thru the modern era and has recently been published as a book (Brock, 2012). It is not the author's intent to duplicate her efforts and hard work, but to provide a brief history of the coaching profession and also make references to Brock's research to help justify the legitimization of the coaching profession.

The definition of coaching describes a phenomenon that exists in all of us. We have seen this during times of crises such as: 9-11; natural disasters such as hurricanes Katrina in New Orleans and Sandy in New York; the tsunami in the Philippines; and manmade disasters such as the mass murder at Sandy Hook Elementary School. When these

situations have occurred, there is a natural and innate drive to help each other through support, care, and the exploration of resources.

In general, people are naturally inclined to seek improved lives for themselves and their fellow human beings. We learn this from stories of people written in the Torah (B.C.) and also in the New Testament Scriptures (A.D.) There are other ancient and current religious writings that depict individuals being helped by older or wiser individuals with goals promoting personal growth, enlightenment, health and wellbeing, community and culture.

Early Life Models of Coaching Promoting Change in the 1600s, 1700s, and 1800s

A few examples can be seen in the lives of Margaret Fell (1614-1702), John Wesley (1703-1791) and Angelina Grimke (1805-1879). How do these examples reflect the actions of a professional coach? Garvey (2011) referenced the concept of a coach in the 1880s as providing training and instruction for the development of strong academic skills and the teaching of parenting skills. Although coaching as an industry is more recent, coaching as a style of teaching, helping, and improving the lives of other people is ancient. Mentoring, advising, supporting, instructing or providing guidance and help with decision-making are forms of practices that are documented throughout history. They are used in many disciplines such as sports, business, religion, academics, psychotherapy, and various social movements with causes seeking change in people and organizations.

Margaret Fell

Margaret Fell Fox (1614-1702) was born Margaret Askew in 1614 in Lancaster England. Known as a prolific writer of her time, Fell's most valued cause was the establishment of the Quaker Women's Meetings. These meetings were "notable for

ignoring social barriers and admitting women of all social classes to equal fellowship…Fell argued that they were necessary to make possible women's spiritual development free from men's inhibiting presence" (Bizzell & Herzberg, 2001, p. 751). In 1664, Margaret Fell was arrested and imprisoned for four years after refusing to take an Oath to the King. It was during her imprisonment that Fell wrote her most famous work Women's Speaking Justified, published in 1666. Her influence as coach and teacher prepared women in business to be stronger leaders and public speakers in social movements such as abolition, suffrage, and feminism.

John Wesley

John Wesley (1703-1791) was deeply disturbed by the lack of education offered to the poor. Since most of the schools were private, church-affiliated schools, the poor could not afford the tuition. Wesley devoted himself to the role of coach as a tutor and teacher to disadvantaged children and uneducated adults. He established schools where he also provided educational coaching. Creating lessons in writing, reading, religion, and mathematics. Wesley's most notable achievements were his involvement in the founding of the Kingswood School for children of miners in Bristol as well as other schools associated with the London Foundry and the Orphan House at Newcastle. Wesley visited these schools regularly. He conducted hours of instruction, created school curricula, wrote books, and coached parents on child rearing. He also coached teachers on how to resolve actions of injustice from school administrators (Wesley, 1998).

Angelina Grimke

Angelina Grimke (1805-1879) was born during an era when women, like children, were supposed to be "seen" and not heard. Angelina's father, John Grimke, was a judge on

the Supreme Court of South Carolina, and was committed to his own belief that all people had the right to think for themselves, a sign of a healthy individuated person that influenced his daughter, Angelina. Her sister, Sarah, who followed her father's modeling by choosing to think for herself, also influenced her. Both Sarah and Angelina were sympathetic towards the poor and underprivileged. Deeply burdened by the injustices of slavery, she and her sister broke state law by secretly teaching them how to read at night. At age 31 Angelina embarked on an unthinkable journey for woman of her time–public speaking. When women were only allowed to share their opinions in the privacy of their homes, she and her sister Sarah planned a large gathering at a local church and over three hundred women showed up for the first gathering. Her purpose and mission was to promote equal education for women and to provide the coaching they needed to grow in this area.

While the activities noted above seemingly match the work of a coach, the actual "term" coach was not known in the English language until 1830, when Oxford University used the term as slang for tutor (Morrison, 2010). "Coach–meaning 'instructor/trainer' is a tutor who 'carries' a student through an exam; 'to convey coach' means, "to prepare (someone) for an exam" (Morrison, 2010, p. 2). According to this definition, the term coach is associated with instructor and trainer who prepares and carries someone through a particular goal for the purpose of achieving a particular outcome, such as a successful grade on an exam.

Coaching Defined in the 1800s

The term "coach" is referenced again in an 1849 novel written by William Thackeray, *Pendennis*. Eager to find his place in life and society, Arthur Pendennis leaves home to study in Oxford after a heart-shattering breakup with an actress named Emily

Fotheringay. While traveling in a horse drawn coach with friends, Pendennis hears that one of his friends is "coaching at Oxford" and learns that coaching is synonymous with tutoring, an action that one pursues for the purpose achieving one's academic goals. This was particularly relevant to Pendennis, since he had failed his final exams and needed coaching to graduate (Garvey, 2011, p. 12).

Evered & Selman (1989) also make reference to coaching in the 1880s as training a group of athletes to win a boat race. Garvey (2011) expands on this further by showing that coaching was used to describe the action of teaching defense in the game of cricket, developing strong academic skills in the sciences, teaching parenting skills, or for improving boating and rowing skills. These examples are illustrations of coaching in a general sense: helping people to improve their skills for achieving goals.

Given that the actual term "coaching" has its origin in the 1800s, it is possible to track events and people who have either engaged in coaching as a profession, or have significantly influenced the coaching field, thus making it what it is today. This rich and enormous history also suggests that it may not be possible to identify and document all those whom have engaged in the act of coaching, as it could easily be said that all people have coached others at one time or another. For example, a sibling may teach a younger sibling how to throw a ball. A parent may teach a child how to tie his or her shoe. A teacher will teach her students how to read or do math. A friend may teach another friend how to navigate the internet or a wife may show her husband how to use the computer. The very act of coaching takes place every day and can be done by just about anyone living on the face of the earth. The same is true for animals that teach behaviors and techniques necessary for hunting and survival.

Given that it is not possible to document all of the people in the world who have engaged in some act of coaching, it may be better to start with coaching as we know it today. From there the practice can be traced backwards to the roots of some of the major coaching organizations, educational institutions, and motivational leaders working in the coaching profession, and also to explore what led up to their work as self-identified professional coaches.

Key Contemporary Influences on Coaching

According to Brock's (2008) evolution of coaching research she identifies the 1990s as the time when the coaching profession exploded. Evidence supporting her claim is the spreadsheet (see Appendix A) of the books on coaching published in 1990 through 2007 (Brock, 2008). While there were many contributors, she lists Daniel Goleman, David Cooperrider, Ken Wilber, Martin Seligman, Mihaly Csikszentmihali, and Peter Senge as the key influencers on coaching from the originator generation (Brock, 2008, p. 289-300).

Continuing backwards, Brock lists Brian Tracy, Robert Dilts, Stephen Covey, and Tom Peters as key influencers in the 1980s. The 1970s include the following key influencers: Shula, Fernando Flores, John Grinder, Peter Block, Richard Bandler, Werner Erhard, Zig Zigler, and Wayne Dyer. In the 1960s she lists Chris Argyris, Edgar Schein, Fritz Perls, and Ken Blanchard. The 1950s introduce us to Albert Ellis, Carl Jung, Carl Rogers, John Wooden, Milton Erickson, Peter Drucker, Red Auerbach, and Earl Nightingale as key influences. The 1940s gifts the public with motivator speaker and coach, Dale Carnegie. The 1930s and 1920s show Alfred Adler, Martin Heidegger, and Napoleon Hill. Perhaps to close the gap between the end of the 1800s and the first and second decade of the 1900s and 1910s, I would point to the work of Frank Parsons, Jesse B.

Davis and Clifford Beers for 1900 and Frank Parsons and his colleagues for pioneering the guidance movement in the 1910s.

Key Personal Coach Influence: Dale Carnegie

Brock (2008) mentions a very important motivational coach of the 1940s. He is listed as the only key influential coach for that particular era, which is misleading since his programs continue to help millions of people in over 150 different countries. His name is Dale Carnegie. He is important because his programs and coaching model is the one I aspire to the most. Born in 1912, his work is still alive and prospering and has helped people and organizations achieve their goals and live richer intentional lives.

After taking my first Dale Carnegie class, I began working as a Dale Carnegie teaching assistant. The Dale Carnegie program's concepts, teachings, and principles significantly influenced my life and confirmed my desire to work as a professional coach, with plans to promote my own concepts and principles for promoting healthy connectedness, self-differentiation, competence, and the healing of broken families and marriages. One of the greatest strengths of the Dale Carnegie program is the manner in which it encourages participants to create a vision and set measurable goals to reach that vision. To accomplish this task, the program teaches participants how to lead intentional lives by providing an experiential environment for learning and practicing new skills. With the support and encouragement from the class participants, clients are successful in reaching their goals. Moreover, participants seem to achieve deep and transformative change to last a lifetime.

Deep change, a concept fully articulated by Quinn (1996), is change that is major in scope, is discontinuous with the past, is generally irreversible, involves taking risks and

giving up control, and produces new thinking and behavior. I experienced this level of change when taking and teaching the Dale Carnegie class. It is the change and transformation that I hope to promote in the lives of my clients.

Training and Education Requirements for the Coaching Profession

The brief history of coaching provided earlier shows that coaching has been around for over 100 years and that its popularity grew significantly starting in the 1990s. Through the study of its history and origin, one quickly discovers that professional coaching was significantly influenced by many people and disciplines and is an outgrowth of many different theories. Hence, the question asked by many professional coaching researchers is how to establish standardized training and a core set of educational courses for the business.

The issue of training and education is important, as anyone can be a coach. Anyone can simply state that they have expertise in the many areas of professional coaching that exists today. They can hang a sign on the outside of a building or design a website and advertise their services in all sorts of coaching disciplines such as sports, career, business, finances, leadership, life coaching, academic coaching, wellness coaching, spiritual life coaching, motivational coaching, and so forth.

Why is this unsettling? Because the "anyone can be a coach" model means that there are no regulated standards for determining what makes coaching an ethically and morally safe profession grounded in evidenced-based research. As one who has been educated and trained in psychology, clinical counseling, marriage and family therapy, spiritual direction, teaching, management, and motivational coaching, there is great reason for concern of clients receiving help from untrained coaches and equally so for the coaches themselves. While this assumption may not be true for all untrained coaches, both the

coach and the client are at risk of causing harm to each other, especially since no profession is exempt from mistakes or misunderstandings that sometimes cause harm.

On the other hand, there is something to be said about the notion of freedom. That is, freedom to do one's best work based on instinct, wisdom, and sound judgment –without the bureaucracy and other policy or procedural limitations due to state regulation. For me personally, it is easier to be myself when openness and spontaneity are welcomed in my work as a professional life coach. Having the freedom to be authentic and to act with autonomy allows for more creativity, surprise, and openness to the spirit, thus leading to knowledge from one's own intuition, insight, and wisdom. It is these same forces at work in the client that help drive their understanding of what is and what is not for them a self-concordant goal. A coach acting as a "guide on the side" can help facilitate this awareness, knowing that the answer to any perceived obstacle lies within the heart of the client.

Standardization of Training

Coaching is not recognized as a separate professional entity, and so there are no established standards for training, education, and credentialing. When comparing the steps for becoming a professional coach to that of a professional counselor, counselors must obtain a master's or doctorate degree in counseling and complete a core set of classes. Following their education, they must complete at least 600 clock hours of a supervised clinical internship and pass a state or national board exam (Kurpius, 1988). This credentialing process not only provides credibility to the counselor, it ensures that the counselor has been trained in areas necessary for ethical and optimal care of the client. Other helping fields such as social work, marriage and family therapy, and psychotherapy require a similar set of standards for credentialing and licensing. Thus, such requirements

missing from the coaching profession also marginalize the credibility of coaches. There is no guarantee that a coach has been adequately educated, trained, and has received supervision before working solo as a coach themselves. Perhaps those individuals already trained to work as psychologists, counselors, social workers, and marriage & family therapists are the exception to the rule. They may confuse the coaching role with their other professions, but they've been educated and trained and have worked with clients under the guidance of approved supervisors in their field.

To help mitigate potential risks, dangers, and harm to coaches and coaching clients, a standard training and credentialing program should be offered. Just as professions in law, medicine, nursing, psychology, counseling, social work, and marriage and family therapy have both ethical and legal requirements (ethical standards and various legal mandates) that professionals in their respective disciplines must adhere to, the same should be true for the professional coaching field. Bennett (2006) provides a list showing the criteria used for determining whether a profession can be considered legitimate by the United States Department of Labor. They are presented below:

1. Identifiable and distinct skills, which are skills that are widely accepted as required for the performance of skilled coaching (Feit & Lloyd, 1990; Goode, 1960; Harries-Jenkins, 1970; Larson, 1977; Ritchie, 1990; Rossides, 1998).
2. Education and training required in order to acquire proficiency, such as a minimum initial and ongoing training required to coach; generally accepted competencies required for coaches; means of assessing competence and so forth (Goode, 1960; Harries-Jenkins, 1970; Larson, 1977; Ritchie, 1990).

3. Recognition outside the community as a profession, such as recognition by the federal government as having an identification and classification code for the coaching profession (Goode, 1960; Ritchie 1990).
4. Developed, monitored, and enforced code of ethics by a governing body making the profession a self-disciplined group having an established code of ethical conduct that is widely understood and accepted with a system for monitoring and enforcing ethical conduct and rights to terminate coaching when necessary (Canadian Medical Association, 2002; Feit & Lloyd, 1990; Goode, 1960; Greenwood, 1966; Harries-Jenkins, 1970; Ritchie, 1990).
5. Public service that is motivated by altruistic service rather than financial gains (Ritchie, 1990).
6. Formalized organization that represents the profession and those practicing coaching (Larson, 1977; Rossides, 1998).
7. Evaluation of merit (credentialing) and self-regulating, encouraging diversity and thought, evaluation, and practice such as accepted requirements for coaches; systems for accessing competence; systems for monitoring and regulating services by coaches; means of encouraging a wide array of thought and discussion (Canadian Medical Association, 2002; Goode, 1960; Ritchie, 1990).
8. Established community of practitioners, forums for practitioners to develop relationships and exchange ideas to the practice of coaching, publications that support the establishment of the community of practice (Harries-Jenkins, 1970; Larson, 1977; Ritchie, 1990).

9. Status or state of recognition associated with membership in the profession such as recognition by those served and the general public as a profession (Greenwood, 1966).
10. Public recognition from outside the practicing community that the profession is distinct and actually in existence (Goode, 1960; Greenwood, 1966).
11. Practice founded in theoretical and factual research and knowledge with on-going evidence-based theoretical and practical research (Greenwood, 1966; Harries-Jenkins, 1970; Ritchie, 1990).

Professional Training and Skills

Therapists usually have masters or doctoral degrees, having spent two to five years in graduate school and then a year of internship. Therapists are exposed to an extensive curriculum, including courses in human development, basic psychology, psychopathology, and assessment and diagnosis of mental disorders. They are exposed to a number of therapeutic approaches such as cognitive-behavior therapy (CBT), rational-emotive behavior therapy (REBT), psychodynamic therapy, dialectical behavior therapy, and acceptance and commitment therapy (ACT). They are taught active listening skills and how to convey empathy, positive regard, and genuineness to their clients.

While coaches who have not been trained as therapists do not have this type of professional training, training programs for becoming a professional coach are becoming increasingly available. Grodski and Allen (2005) summarize some of the main findings of the International Coach Federation (ICF) first membership survey published in 2003. Findings indicated that 18% of the membership was certified and 50% reported working

toward credentialing. Most coaches had received formal training in coaching and had a coach for a mentor. Seventy per cent were graduates of a coach-training program.

While different coaching schools may vary somewhat in the competencies they train coaches to have, certification through the ICF requires that each coach become familiar with and demonstrate his or her ability to use eleven 'core competencies'. These competencies are posted on the ICF website www.coachfederation.org/icfcredentials/core-competencies and their abbreviated versions are listed below:

A. Setting the Foundation

1. Meeting Ethical Guidelines and Professional Standards

   Understanding of coaching ethics and standards and ability to apply them appropriately in all coaching situations.

2. Establishing the Coaching Agreement

   Ability to understand what is required in the specific coaching interaction and to come to agreement with the prospective and new client about the coaching process and relationship.

B. Co-Creating the Relationship

3. Establishing Trust and Intimacy with the Client

   Ability to create a safe, supportive environment that produces ongoing mutual respect and trust.

4. Coaching Preference

   Ability to be fully conscious and create spontaneous relationship with the client, employing a style that is open, flexible and confident.

C. Communicating Effectively

5. Active Listening

   Ability to focus completely on what the client is saying and is not saying, to understand the meaning of what is said in the context of the client's desires, and to support client self-expression.

6. Powerful Questioning

   Ability to ask questions that reveal the information needed for maximum benefit to the coaching relationship and the client.

7. Direct Communication

   Ability to communicate effectively during coaching sessions, and to use language that has the greatest positive impact on the client.

D. Facilitating Learning and Results

8. Creating Awareness

   Ability to integrate and accurately evaluate multiple sources of information, and to make interpretations that help the client to gain awareness and thereby achieve agreed-upon results.

9. Designing Actions

   Ability to create with the client opportunities for ongoing learning, during coaching and in work/life situations, and for taking new actions that will most effectively lead to agreed-upon coaching results.

10. Planning and Goal Setting

    Ability to develop and maintain an effective coaching plan with the client.

11. Managing Progress and Accountability

Ability to hold attention on what is important for the client, and to leave responsibility with the client to take action.

While a background as a therapist can be quite valuable for a coach, the competencies listed above include examples of additional skills that therapists who become coaches should have. The question arises as to whether one can serve as both coach and therapist. The answer is yes, but not for the same client. If the coach is working with a client that, as it turns out, is having serious emotional problems, referral to a psychotherapist would be warranted. It must be made very clear at the outset whether coaching or therapy is what the client is seeking and what the coach or therapist sees as being in the client's best interest.

The International University of Professional Studies (IUPS) is an excellent coaching and human development doctoral program that provides a solid education in the areas similar to those courses required in counseling, marriage and family therapy, and psychotherapy programs. The current core course requirements are:

- The Essential Foundation of Coaching Psychopathology
- Theories of Counseling Legal and Ethical Issues
- Human Development & Personality Theory Research Methods in Coaching
- The Spiritual Dimension of Coaching Fieldwork and Application
- Awareness of Cross-Cultural Issues Dissertation Research Project

The courses listed above were also courses required in my own graduate programs in counseling and marriage and family therapy. Moreover, the list of electives offered by IUPS cover the core essential studies for most counseling, psychotherapy, and marriage and family therapy programs. It also includes an all-encompassing and widespread course

load of options for successful preparation in general and can be tailored to meet specific areas of focus and interests. Examples include Advanced Personality Theory, Clinical Neuropsychology, Coaching with the Enneagram, Communication and Team Building, Conscious Parenting, Human Sexuality Counseling, Organizational Psychology, Conscious Relationships, Consulting Skills, EMDR, Gestalt Therapy, Family and Marital Therapy, Entrepreneur and the Small Business, Stress Management, Death and Dying, Wellness Coaching, and DISC or PIAV assessments. The website showing its core courses and electives can be found at www.iups.edu/Programs/ProfessionalCoaching HumanDevelopCurriculum/tabid/224/Default.aspx.

Multicultural Awareness: The Influence of Contextual Variables

The understanding and awareness of individual and cultural differences is necessary for effective coaching. In the literature review of this dissertation, the following question is explored by Sheldon and Elliot (1998): "Why do some people select non self-concordant, externally controlled goals and thus fail to get their basic needs for autonomy, competence, and relatedness met?" Sheldon and Elliot (1998) suggest that "such goals are selected when the individual fails to create an accurate assessment of his or her deeper needs, values, and interests" (p. 554). An example that may further compound this problem is to have a coach working with a client helping him or her assess and select self-concordant goals without considering differences that are often overlooked, especially differences that are culturally or ethnically based. Other differences should include a client's demographic variables such as gender, age, place of residence; ethnographic variables such as religion, language, nationality, and ethnicity; and status variables such as membership affiliations, community, social, economic and educational differences (Pedersen, 1991).

Helping clients select self-concordant goals takes on a whole new meaning when viewing a client's goals from a multicultural perspective. Moreover, such awareness is necessary for optimal understanding, selection and attainment of such goals.

> Numerous conferences held by the American Association for Counseling and Development (AACD), the American Psychological Association (APA), and other government-sponsored events have noted the serious lack and inadequacy of training programs in dealing with racial, ethnic, and cultural matters (Sue, Arrendodo, & McDavis, 1992, p. 477).

Pedersen (1987, 1991) emphasizes this concern when referring to multiculturalism as psychology's "forth force" and is perceived as the "the hottest topic" in today's helping profession (Lee, 1989; Lee & Richardson, 1991; in Sue et al., 1992, p. 479). Yet surprisingly, there is no universal agreement or standard for conceptualizing what it means to work with clients from a multicultural perspective (Sue et al., 1992). Locke (1990) sums it up in a very clear and concise understanding when writing about the counseling profession. The same is true for the coaching profession. "Multicultural counseling [coaching] is a relationship between client and profession such that the counselor [coach] and client differ" (p. 18).

Common knowledge confirmed by the 2010 government census provides data showing that many cultural and ethnic groups live in the United States and Canada. While previous year's show that European Americans made up the largest population of 64%, the data also shows that the Asian population grew faster than any other group from 2000 to 2010. For example, the percentage of foreign born who were naturalized in 2010: Vietnam (74%), Philippines (65%), India (46%), China (57%), and Mexico (23%). Other significant

ethnicities in the Unites States in include African Americans at 13%, Hispanics and Latinos at 16%, the Asian population at 5%, and Native American Indian at 1%.

Most interesting is that one third of the United States now represents a minority culture, which is confirmed by the latest release of a set of estimates reported in year 2001; the results show that 50.4 % of the nation's populations younger than age 1 are minorities. A population that has more than 50% minority is called a "majority-minority" (Census, 2012). Overall, the statistics report that 36.6 % of the population in the United States is made up of minorities with some majority-minority states. The five majority-minority states show Hawaii with 77.1% minority, the District of Columbia at 64.7 % minority, California with 60.3 % minority, Texas at 55.2% minority and New Mexico with 59.8 % minority.

Other important 2012 statistics show that the most populated minority groups are Hispanics. African-Americans are the second largest minority group, with Asians cited as the second "fastest-growing" minority group. American Indian and Alaskan Native populations have also increased. Percentages for the Arab American group are not listed, though it is also increasing in the United States and is every bit as important for coaches to understand when working with multicultural clients of different backgrounds and ethnicities.

According to Sue and Sue (2008), due to negative first time experiences, minorities typically terminate counseling after one session. While coaching may not be perceived the same as counseling (a coaching relationship may be less personal or intrusive than a counseling or psychotherapy relationship), the fact that there is such a high population of

minorities in the United States and that minorities are the majority in certain areas makes it imperative that coaches learn to understand their clients from a multicultural perspective.

Cohen (1998) describes a culture as having a set structure of behaviors, thoughts, perceptions, values, goals, and cognitive process associated with a specific population or ethnic group. Axelson (1999) provides a broader definition, describing culture as a group of "people who identify or associate with another on the basis of some common purpose, need, or similarity of background" (p. 2). Rotter (1954) makes reference to another cultural perspective that is every bit as influential as the variables already mentioned. He describes two orientations in life that greatly impact an individual's worldview: Those whose actions and behaviors driven by Internal Control (IC) and those who actions are influenced and driven by External Control (EC). People with an IC worldview believe that they are responsible for what happens to them. People with an EC worldview are more likely to believe that they have very little control over their circumstances. Internal or external control can also be likened to cultures that value individualism over collectivism. Individualism being similar to IC and Collectivism being similar to EC, although EC could arise in situations such as an enmeshed family system or people who perceive themselves as supporting individualism, but demand that others comply because of their own lack of individuation.

Additionally, Spiegel (1982) describes how one culture may value self-reliance and individualism while another may encourage more closeness, reliability, and collectivism. I became aware of these differences when I recently conducted a field interview with an adult man from India. Insights received from the interview significantly impacted me on three accounts: First, it was astounding to discover that although he has lived in America

for nine years now, he still feels like a stranger in the land. Second, his description of what he refers to as our "paranoid society" is unsettling for him. In his mind, there is a "driven-ness" for privacy and autonomy in our "individualistic society" that makes him feel that it is impossible to develop a sense of connectedness or belongingness in our culture. Third, "breaking in" or becoming a part of our culture would require a certain level of conformity, which makes him feel that he must disown his own values and "roots" in order to fit in. He further added that even if he were to conform, he is convinced that he would still feel like an outsider.

Hazen and Shaver (1994a) propose that because different cultures are likely to encourage different degrees of closeness, the developmental phase of attachment must be culturally learned. For example, Boyd (1989) found that many cultures foster a closer mother-daughter relationship, which is often determined by the degree of segregation of gender in the society and living arrangements in the family. In contrast, Kakar (1981) describes the mother-son relationship in India as having an emphasis on connectedness over separation. Hispanic families value strong ties, geographical closeness, and the exchange of resources within extended family members (Uribe, LeVine, & LeVine, 1993; Vega, 1990). Conversely, a study involving European Americans found that a greater emphasis is placed on being independent, especially when compared to Asian Americans (Julian, McKenry, & McKelvey, 1994).

When conducting cross-cultural coaching, coaches should ask themselves if their coaching approach is universal across cultures. It is also necessary for coaches to expand their knowledge regarding differences in age, culture, and ethnicity that may affect the coaching process. For example, in Jewish families, women have traditionally held power at

home while the husband is embroiled in the business world for gaining financial security. Irish fathers (except for my grandpa, J.W. Maguire) also play a peripheral role in intergenerational family relationships, where mothers are usually at the center. African American families believe that one does not succeed just for themselves, but for one's family and the entire ethnicity.

Historically, the goals and values that make up a societal structure were largely influenced by the religious practices of that society. China is a good example. The Chinese lifestyle, morals, and beliefs are largely defined by the rules, roles, and values of the Buddhist religion. Thus, the goal for people in China is to value and pursue peace and happiness. For people practicing the Muslim faith, the goal is to proclaim the unity, omnipotence, omniscience, and mercy of God by way of total dependence upon him, although they value spiritual fulfillment and virtue through the process of discovering one's own individual potentialities and uniqueness (Smith, 1991). Those practicing Judaism believe that life is to be whole and there is a consistent way in which life is to be lived such that people should move toward individual fulfillment while taking account of the "other" (Smith, 1991, p. 272).

Coaching Awareness of Specific Cultural Groups

Sections earlier in this dissertation showed that the 2010 Census Bureau reported the following culture and ethnic groups as representative of the general population in the United States: European Americans, African Americans, Hispanics and Latinos, Asian Americans, Native American Indians, Orthodox Jews, and Arab Americans. It is necessary to demonstrate that there are differences that should be accounted for when engaging in the coaching profession, especially in such a diverse population such as the United States. It

can no longer be assumed that a Caucasian looking person represents the average "white" American. Statistics now show that 1 in 4 children under the age 18 have at least one foreign-born parent (2010 Census).

European Americans

Research by Baruth and Manning (2012) shows that the European American population consists of 53 known cultural heritages that include England, France, Italy, Germany, Austria, Sweden, Poland, and Russia. Spanish immigrants from Spain also consider themselves as Europeans. There are several key pioneers and contributors to psychological theories from these parts of the world. Examples are Sigmund Freud, Carl Jung, B. F. Skinner, Whilhelm Wundt, Francis Galton, Margaret Mahler, and John Bowlby. Their theories and concepts are embraced and practiced in the United States and Western world in general. With exception to the psychoanalytic approach practiced by Freud and his followers, research suggests that the European Americans prefer a rational approach to understanding people and how best to motivate them toward accomplishing self-concordant goals. Hence, coaching practices that incorporate cognitive behavioral concepts such as the model presented in this dissertation are good options for this population.

African Americans

As evidenced by the ongoing dialogue in U.S. politics and the ongoing reports about discriminatory actions that take place in the legal system of the courts, the reality of racism and discrimination cannot be denied or minimized when working with the African American population. Moreover, the professional coach needs to recognize that any coach/client relationship that engenders a power differential will be less effective due to the nature of resistance or reluctance to embrace the process by members of this group

(Brammer, 2012; Carter & McGoldrick, 1999; Garretson, 1993; Schwartz & Feisthamel, 2009; Sue & Sue, 2008). Therefore, coaching this population will lead to a more positive experience and successful outcome if the coach treats his or her client as an equal by communicating that the client already has the answers to their given situation and already knows what steps to take in order to accomplish any goals. The coach just acts as a companion for communication, brainstorming, and dialogue over solutions already known to the client (Brammer, 2012). This strategy is essential, as suggested by Priest (1991), who contends that African Americans may not engage if they sense that their independence and ability to make decisions for themselves is being challenged.

Hispanics and Latinos

Populations of similar groups can be very diverse within their own group. Latinos and Hispanics represent cultures having vast differences within-group populations and between group populations. Moreover, both may emigrate from geographic locations that exist on opposite ends of the earth. For example, Hispanics from Mexico are different from Hispanics from Spain. Likewise, Latinos are a Spanish group of Indian descent. Therefore, awareness of the within-group differences is necessary for understanding how their ethnic roots influence their worldview, family dynamics, and approach to individualistic success in the context of collectivist groups (Miranda, Bilot, Peluso, Berman, & Van Meek, 2006).

Coaches should also understand that the Hispanic and Latino groups are just as sensitive to discrimination as the African American population. Therefore, the coaching approach should cultivate an egalitarian relationship with their clients. In so doing, the coach assumes that their clients already know how to select and accomplish self-concordant goals, but may need encouragement due to the collective nature of the family

system (Carter & McGoldrick, 1999). Especially since individuals in collective family systems tend to make choices on behalf of the family because of the high valued that is placed on family loyalty (Garza & Watts, 2010). Lastly, Catholicism is central to the Hispanic and Latino community. Knowledge and appreciation of these practices will also benefit the coach/client relationship.

Asian Americans

According to Sandhu (1997), the Asian cultures include more than 40 distinct cultural groups. Most common to the American culture are the Chinese, Korean, Filipino, Japanese, Vietnamese, Indonesian, and Taiwanese groups. These groups have also suffered from various forms of discrimination and prejudices that have resulted in distrust for other outside cultures and especially white populations (Morrissey, 1997). There are also many stereotypes associated with the Asian cultures. College students often report that Asians are smarter and more focused on their educational disciplines than the typical White student. Collectively, they are perceived as intelligent, hardworking, and successful in their endeavors. More poignant is their ability to regulate their emotions, even during periods of high stress. They value observation and indirect communication often through facial expressions or eye gestures understood mostly by individuals from their own culture (Carter & McGoldrick, 1999; Iwamasa, 1996). Therefore, when coaching an Asian American client, coaches should emphasize similar values that include hard work ethic, intelligence, sound reasoning, and an emphasis on academic or academic role models as examples of people having already achieved similar goals selected by the client. It is also important to note that the collective nature of these groups often require a level of

compliance by certain authoritative figures from the client's family of origin (Carter & McGoldrick, 1999; Sue & Sue, 2008).

Native American Indians

When coaching individuals from Native American Indian populations, attention and appreciation for a client's history and traditions are important (Carter & McGoldrick, 1998). The U.S. Bureau of Indian Affairs reports close to 300 different languages spoken among 517 tribes. While such within-group differences in languages and tribes exist, one common similarity among the entire Native American Indian population is the reliance on one's family of origin and extended family, cooperation between members, and harmony with nature (Heinrich, Corbin, & Thomas, 1990). Coaches working with clients from this population must remain sensitive to historical issues related to the loss of land and the negative stereotyping placed on them from American culture (Atkinson, 2004). Coaches should also willingly reveal their true authentic selves to clients from this population if they wish to develop a strong coach/client connection (Herring, 1996). Strategies that promote authenticity could be a willingness to admit one's own mistakes or engage in activities that include creative arts such as music, drama, visual art, literature/writing, dance or movement. The latter is an approach that promotes great merit simply because emotional, religious, and artistic expression is "an inalienable aspect of Native culture" (Herring, 1997, p. 105).

Arab Americans

Arab Americans also represent a fast growing population in the United States. Representing 22 different countries such as Egypt, Lebanon, Morocco, Yemen, Tunisia, and Palestine, the Arabic and Muslim countries sometimes overlap (Nassar-McMillan & Hakim-Larson, 2003). This creates vast within-group and between-group differences that

include level of education, languages, age, gender, income, religion, and length of time living in the Unites States (Aprahamian, Kaplan, Windham, Sutter, & Visser, 2011). Arab Americans typically place a high priority on honor and because they try to avoid shame; they may not seek the help of other professionals. However, if a coach finds him or herself working with an Arab American, especially an immigrant, the coach needs to be aware that the client's selection of a self-concordant goal will mostly likely have a collective context that includes the influence of the male authority figure in the client's family. Known to have a patriarchal family system, there will be a sharp delineation of gender roles, conservative worldviews with conservative sexual standards, and a less differentiated sense of self since the family system unit is highly valued such that an individual's life is dominated by family relations and family approval (Abudabbeth & Aseel, 1999).

Jewish Americans

The Jewish population in the United States represents the largest in the world, citing 6.4 million or 2.1% in 2012. According to Paradis et al. (1996), there are two main divisions within Jewish Americans: Ashkenazi Jews who emigrated from Europe and Sephardic Jews who emigrated from North Africa and the Middle East (Rosen & Weltman, 1996). Within these factions are Jewish subgroups that vary in their cultural and familial traditions, although certain core beliefs adapted from the "Torah and the laws of God are unchangeable and nonnegotiable" (Hirsch, 1967). Maintaining a solid Jewish identity is a life-long focus and priority for Jewish families, thus significantly influencing how they raise their families. With strong ties to their Jewish community, Jewish clients, especially Orthodox Jews, may find it difficult to trust a therapist from outside of the Jewish community (Cinnirella & Loewenthal, 1999; Wikler 1986). As such, confidentiality is an

essential component when coaching Jewish individuals, especially since there is a pervasive prejudice against individuals with mental illness (Wikler, 1996). Giving this reality, brief therapies such as cognitive behavioral therapy, rational emotive behavioral therapy (REBT), and goal-oriented interventions are preferred. This too is beneficial for the role of a coach, since the stigma attached to mental illness can be abated.

Multicultural Coaching Summary

In summary, the examples depicted in this dissertation demonstrate the need for education producing greater awareness of within-group and between-group differences among the many cultures in the United States and throughout the world in general. Understanding cultural differences is a necessary component for helping clients to select and achieve self-concordant goals. For example, the European American group comprising French, Italian, English, Scottish, or Irish people are in and of themselves vastly different and to label them as a "particular group" almost seems to minimize those differences. The same is true for the other categories listed, as well as the general individual differences in men and women that are often taken for granted. Moreover, Tannen (1990) reports that men more often communicate by reporting facts, while women communicate for the purpose of creating community and seeking commonality, suggesting yet another important consideration when helping different genders select and achieve self-concordant goals.

Understanding such differences on as many levels as possible (all of the many variables that make up a culture, community, and population) should not be minimized and in fact, represent a good argument for generating an established set of core course requirements for the professional coaching field. Without an established curriculum, however, it is beneficial to integrate guidelines that are helpful when working from a

multicultural perspective. Adapted from Sue and Sue (1978) are the five guidelines for providing effective counseling services. In reading the guidelines, I believe that they hold true for the coaching profession as well. They are:

1. Coaches should share the worldview of clients without question its legitimacy.
2. Coaches should understand the sociopolitical environment that has influenced the lives of members of minority groups.
3. Coaches should understand working with clients is never culture-free; therefore, culturally generic research studies and interventions that do not include diverse populations should not be generalized.
4. Coaches should understand their own values and beliefs so that they can recognize the differences between theirs and their clients' values and beliefs in order to extend acceptance and support of individual differences.
5. Coaches should remain sensitive and willing to apply strategies associated with the specific lifestyles and experiences of their clients.

Coaching Limitations

Coaching as a Legitimate Profession

According to Myers and Sweeney (2001), a profession is distinguished by having: a specific body of knowledge, an accredited training program, a professional organization of peers, the credentialing of practitioners such as licensure, a code of ethics, legal recognition, and other standards of excellence. Based on my own education and knowledge of coaching, it seems that the legal recognition is the one main obstacle preventing coaching from being

distinguished as a true profession. The other standards of excellence requirement is also vague at this point.

Another reason for instituting a standardized training and educational program for coaches is related to the concept of attribution. Attribution is what a person attributes the cause for his or other people's inability to accomplish goals. For example, I might feel puzzled as to why a client cannot seem to accomplish a desired goal. My strategy will include the steps presented in this dissertation: motivational interviewing, challenging any self-defeating beliefs through the REBT model, active listening for assessing whether or not the selected goals are self-concordant goals (goals that match their values and interests) and helping clients become more self-differentiated if there are relational concerns (the notion of cybernetics) also preventing them from accomplishing their goals. If I do not have the education and understanding, I may not be as effective in understanding what is hindering the client from achieving his or her goals (Kernes & McWhirter, 2001).

Different from psychotherapy and other clinically based helping professions, coaching is goal oriented and forward-thinking. Clients may seek out a professional coach because they like the idea of engaging in a forward-thinking modality, one that doesn't focus on one's past problems or family-of-origin issues. Despite best efforts on the part of the coach and client, coaches may find themselves feeling mystified by a client's inability to make the breakthroughs necessary for accomplishing goals. Before both client and coach spin their wheels in mere confusion, a well-educated and trained coach can make more headway when having obtained a deeper understanding of issues that may thwart the coaching process. It is important to note that obtaining this deeper understanding of psychologically based symptoms does not mean that coaches treat these symptoms. The

education and training is only to provide awareness so that such clients can be referred to helping resources that are appropriate for the situation at hand. For example, an understanding of unconscious or pre-conscious behaviors in clients reveal why they are seemingly stuck in self-defeating behaviors regardless of their best intentions. A lack of education and training can only promote frustration and possibly resentment if the coach is frustrated by the client's seemingly lack of motivation and the client develops feelings of resentment because his or her coach doesn't understand or provide insight that can explain the current behavioral rut.

Adherence to legal and ethical guidelines

Legal and ethical guidelines that are established for various professions are for the protection of both the professional and his or her clients. Guidelines represent an organized set of principles and behaviors that put boundaries between the professional providing services and the client receiving such services. They are developed by licensing and credentialing board members who discuss potential ethical or legal problems often based on research, and agree on established regulations that are mandated for safety and protection of all parties involved. Since the coaching profession is not bound to such regulations and mandates, a lack of education and training could make both the coach and client vulnerable and at risk for problems harmful to both.

Lack of understanding and knowledge of cultural differences

The coaching program should also include classes that generate learning, understanding, and awareness of cultural differences so that coaches are working from a multicultural lens both domestically and internationally. Otherwise, potential harm to both client and coach is a reality for those coaches lacking an understanding of cultural

differences. Educational programs in counseling, social work, marriage & family therapy, and clinical psychology require core courses in treating clients from a multicultural perspective. As part of the training and education, clients learn differences between people of different ethnic backgrounds and cultures, with awareness that differences also exist within cultures having the same ethnicity. A lack of awareness of such differences among people from different geographical locations, ethnicities, and cultures could negatively impact the coaching relationship, thus producing an unwanted or harmful outcome also to both parties.

Limitations Concerning the Unconscious Mind

With all good intent and purposes, there are times when a coach's greatest efforts are thwarted by issues that are unknown not only to the coach, but also to the client. This is when you find yourself at a loss at what to do, after discovering that your efforts are of no avail. In my own work as a coach, counselor, and marriage and family therapist, I have come to realize that failure to promote change in my clients is often the result of hidden obstacles that are driven by the unconscious.

As mentioned earlier in this work, there are many avenues for becoming a coach. And because the coaching profession is not recognized as a legitimate profession, anyone can call him or herself a coach. About all one needs to do is display a sign the door, create a website, and purchase business cards. Even these activities are not required, but only helpful for promoting one's coaching business.

Imagine the training that psychologists, social workers, counselors, and marriage & family therapists obtain just to practice their profession as defined by state laws. There are professional coaches who understand the value and importance of obtaining proper training

and education and therefore, go through similar training, but it's not a requirement. Nor are there the same requirements of supervised internship hours for working as a coach. Even with the rigorous education and training required by the professions mentioned above, some of them do not include theories, education, and training on how to understand the hidden and unconscious motivations that drive behavior (examples are graduate programs that emphasize a cognitive behavioral approach).

According to psychoanalytic theory, the term 'unconscious' does not represent repressed content alone (Freud, 1957, p. 166). The concept can be referenced in three different ways: (1) *descriptive unconscious*, representing content that is not accessible to reflective self-awareness, (2) *system unconscious*, representing the part of the brain's reaction to the 'pleasure-unpleasure' principle and 'primary process' thinking, and (3) *dynamic unconscious,* which refers to repressed material that manifests itself as 'unconscious fantasy' (Akhtar, 2009, p. 299).

It is challenging enough for clients to agree or even comprehend that at times, they are driven by unconscious motives. The very suggestion as such often results in various expletives that are loudly and vehemently expressed by my clients. Yet regardless of their unwillingness to look at unconscious drives, they are there.

Freud once said, "unexpressed emotions will never die. They are buried alive and will come forth in uglier ways" (Coenn, 2014). In my own professional work, I have discovered peculiar ways in which unconscious or hidden and unexpressed emotions are seemingly nurtured in order to keep them alive and consequently continue to block the most well-intentioned efforts of clients consciously working toward certain goals. Whether stemming from protective defense mechanisms, characterlogical issues, or

unacknowledged but destructive core beliefs; clients who are entrenched in unconscious behaviors and relational patterns are unable to make the necessary changes without exposure and understanding that often takes the work of a highly trained professional with extensive training and years of experience. Examples would include the intensive clinical treatment required to help clients who from a diagnostic perspective, may be considered to have an Axis II personality disorder. These are clients with cluster A and cluster B personality disorders such as the borderline, narcissistic, schizoid, schizotypal, paranoid, avoidant, dependent, obsessive-compulsive, and histrionic personality disorders (DSM-5, 2013).

Even the most severe types of personality disorders or characterlogically-impaired individuals can present themselves as intelligent and competent when first seeking the assistance from a professional coach. I am a professional coach. I work as a coach because I can help people across the state boundaries. As I have accepted coaching opportunities with clients, I have discovered later that many of them suffer from issues matching those mentioned in the previous paragraph. For example, I have coaching clients with avoidant type attachment styles, clients with sadomasochistic characterlogical styles of relating to significant others, clients with severe attachment injuries, and clients with both borderline and narcissistic personality disorders. My awareness and knowledge of the root issues associated with client suffering and struggles in their attempts accomplish self-concordant goals is the direct result of my training and education in counseling, psychology, and marriage and family therapy. In light of this, I shudder to think of uninformed coaches trying to help clients accomplish goals without the knowledge of issues that are not always

present at the surface, but lie deep beneath the complex layers of the human personality and public persona.

My only hope is that coaches who find themselves failing in their attempts to help clients accomplish goals is to accept their limitations and refer them to the type of clinical assistance that is more appropriate for the client's needs. But how does a coach recognize these deeper issues? For example, I have a troubled married couple that had been working with a professional coach by phone through weekly contact with a coach from the state of Washington. Feeling a need to work face-to-face with a local coach, they hired me. Their goal was to overcome the attachment injury as a result of infidelity in a marriage. Following a few months of work with this couple, I soon realized that my attempts were going nowhere until I recognized the sadomasochistic dance between the two of them. A client with a masochistic character

> unconsciously provokes and enjoys rejection but consciously reacts with righteous indignation. This helps him deny his responsibility in the rejection and his unconscious pleasure in it. After the outburst of pseudo aggression, he indulges in self-pity and unconsciously enjoys wound-licking (Akhtar, 2009, p. 166).

Some professional coaches may not readily recognize this couple dance and therefore, not know when to refer them on for appropriate medical and psychotherapeutic interventions.

The same is true for the sadistic character who unconsciously enjoys inflicting pain on to others and the two often marry each other in order to continue their unconscious dance. This discovery has helped me to understand why my efforts are for naught. And once this awareness surfaces, my choice is to communicate my desire and need to shift to a more clinically focused type of intervention or to refer them on to clinicians with expertise

in this particular area. With this particular couple, I had suggested referral options, but they have already developed an attachment and secure base with me and refused the idea of working with someone else. I have opted to continue my work with them as a counselor and not a coach, but it makes me question the education of a coach if he or she is unaware and does not know to refer them on when in need of deeper, more intense, psychological healing and reparation.

I have two more examples that should help to emphasize my concern regarding the work of coaches without adequate training and education. A man living on the West Coast recently hired me. His goal was to develop better communication skills with his wife, who currently lives in the Midwest, close to where my office is located. After speaking to this individual by phone, I learned that he was highly articulate, bright, realistic, and eager to repair his marriage with hopes that his wife would join him on the West Coast. I jumped in and started my work with both of them. Within a two-month period, I realized that the wife matched the DSM-5 criteria describing the borderline personality disorder character type. As with my other later discovered borderlines, I wondered how it is that they keep finding my door. With some reluctance, I agreed to continue my coaching work with this couple and although I am witnessing some progress, it has not come without intensive clinical work, paired with exhaustion and multiple weekly sessions with the wife. This example is similar to others in my practice.

I bring these examples to light because they represent limitations that every coach may face when working with clients. My client couples with attachment injuries are perfect examples because the betrayal from infidelity often triggers past traumatic wounds from childhood – wounds that had never surfaced until they were reactivated by current life

trauma, rejection, humiliation, and disillusionment. Even in my own life, the level of training, education, understanding, years of experience, and personal therapy has not resulted in complete success when trying to accomplish a goal as simple as ending my sessions on time. I know that when sitting with clients who are suffering, I understand and relate to their pain at such a deep level that it's hard to ask them to leave when they're processing and working through the pain. It is natural that clients would want to spend the afternoon in my office. I am a listening ear extending genuine care and empathy. They know that I accept them and will not judge them, regardless of the content shared in the office. However, extending time past the clinical or coaching hour is not realistic on my end given that other clients are waiting for their schedule appointments. My own weakness shows me that there are deeper issues to address. I am resonating with their pain because of my own early-life trauma when my mother died unexpectedly when I was three years of age. As such, I know my limitations and will continue to seek professional help until this goal is accomplished. But could I do this deep work with another professional coach? I don't think so.

I will close with other more general concepts that represent potential limitations for the coaching profession. Will the coach know when a client is projecting his or her own issues onto the client? Will a coach know a client is experiencing transference issues with the coach? Will the coach maintain healthy boundaries when love transference reactions occur? What about negative transferences that elucidate hate, hostility, and aggression having nothing to do with the coach? Likewise, will a coach know to maintain healthy boundaries when working with borderline clients? There is much to write about concerning coaching limitations. Client issues associated with deeper woundedness, personality

disorders, unconscious motives, and unresolved family or origin interactional patterns are examples that unfortunately, only scratch the surface. In summary, I do not believe that a fine line delineation between coaching and counseling psychology can be obtained. From my experience, there the lines will always be blurred and therefore, those individuals interested in working as a professional coach should be sure to obtain adequate training and education.

The limitations facing coaches described above are clearly limitations of my self-concordant goal model of coaching, and the interventions I have proposed to facilitate achievement of self-concordant goals. Clients with severe mental health issues may reject rational thinking or be able to see the logic of rational versus irrational beliefs, but not be able to change on the emotional level. Motivational interviewing may help clients see what would be autonomous goals, but still be unable to withstand external pressures to pursue other goals, such as those of their parents, and thus be limited in getting their needs for competence, relatedness, and autonomy met. More disturbed clients need self-compassion more than more fully functioning clients, who are probably already less self-critical. In fact research has revealed that fears of self-compassion are not uncommon (Gilbert et al., 2011). Clients who have unhealthy attachment relationships with significant others are often not interested in becoming more self-differentiated, see this as a threat to their emotional survival. Coaches who are aware of these issues are in a position to detect when they occur with their clients, decide if they can help their clients overcome these obstacles in a coaching relationship, need to switch to a counseling/psychotherapy role, or refer to a mental health professional.

CHAPTER 4

COACHING INTERVENTIONS

Selecting and Achieving Self-Concordant Goals

Motivational Interviewing and SDT

In the third edition of Motivational Interviewing (MI), by Miller and Rollnick (2012), the authors emphasize the "spirit of motivational interviewing" over the specific techniques. The authors summarize the critical ingredients of the spirit of motivational interviewing as viewing the relationship with the client with a profound acceptance of the client and what they bring.

> Taken together, these four person-centered conditions convey what we mean by acceptance. One honors each person's absolute worth and potential as a human being, recognizes and supports the person's irrevocable autonomy to choose his or her own way, seeks through accurate empathy to understand the other person's perspective; and affirms the person's strengths and efforts. (p. 19)

The third edition also adds compassion as another core value in MI, and the authors define it as "To be compassionate is to actively promote the other's welfare, to give priority to the other's needs" (p. 20).

Markland, Ryan, Tobin, and Rollnick (2005) and Vansteenkiste and Sheldon (2006) discuss the striking similarities between self-determination theory (SDT) and MI, and suggest that SDT can provide a theoretical framework for understanding MI related change. Markland et al. (2005) state that SDT and MI share the same view that human beings have an innate tendency toward psychological integration and personal growth.

Markland et al. (2005) clearly outline how motivational interviewing provides the conditions for addressing the person's innate psychological needs for competence, autonomy, and relatedness. Therapeutic structure enhances competence, as MI presents clear information about behavior and outcomes, helps develop appropriate goals, provides positive feedback, and supports self-efficacy.

Passmore (2011) presented MI as a model for coaching practice and suggested that MI may be especially valuable in executive coaching (Passmore, 2007; Passmore & Tinwell, 2008). Recent articles have discussed the role of self-determination theory and MI in behavioral nutrition, physical activity, and health (Teixeira, Palmeira, & Vansteenkiste, 2012). MI has been described as the only evidence based health coaching technique associated with positive behavioral outcomes (Linden, Butterworth, & Prochaska, 2010).

Supporting autonomy is a central aspect of self-determination theory, the self-concordant model, and MI. In fact, Deci and Ryan (2012) state that, not only does autonomy support facilitate the basic human need for autonomy, but it has also been found to relate to satisfaction of the needs for competence and relatedness. Extensive evidence has demonstrated that autonomously motivated behavior is associated with valued goal attainment (Ryan et al., 2011).

Research has documented the association of autonomous motivation with better therapy outcome (Michalak, Klappheck, & Kosfelder, 2004). In a study comparing short-term treatments for depression using cognitive-behavior therapy (CBT), interpersonal psychotherapy (IPT), and pharmacotherapy with clinical management, "Autonomous motivation was a stronger predictor of outcome than therapeutic alliance, predicting higher

probability of achieving remission and lower posttreatment depression severity across all three treatments (Zuroff et al., p.137).

Pelletier, Tuson, & Haddad (1997) found that not only is therapy outcome associated with autonomous motivation, but clients appeared to do better with the process of therapy. They were less distracted, had less tension about therapy, were more satisfied with therapy, and had greater intentions to persist in therapy. Ryan et al., (2011) conclude that, "More detailed understanding of the therapist attitudes and behaviors that promote autonomous motivation is also needed, and useful guidance may be found in the motivational interviewing literature" (Vansteenkiste & Sheldon, 2006, p. 140).

Motivational interviewing supports autonomy by avoiding coercion, rolling with resistance, exploring options, encouraging change talk, and facilitating clients' decisions and choices about what to change and how. Relatedness is fostered by the coaches' conveying acceptance, unconditional positive regard, accurate empathy, affirmation of the client's strengths and efforts, and compassion. Passmore (2011) presented motivational interviewing as a model for coaching practice.

In conclusion, motivational interviewing has been effectively utilized to help people reach a variety of goals, from decreasing substance abuse and gambling to increasing a variety of health promoting behaviors. The fourth and most recent meta-analysis of MI confirmed these findings and provided evidence that motivational interviewing is appropriate not only with individuals with high levels of distress, but is successful for individuals with relatively low levels of distress as well (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010, p. 152). The various findings reviewed above confirm that motivational interviewing can be a valuable intervention for coaching.

Rational Emotive Behavioral Therapy (REBT)

REBT, created by the late Albert Ellis and first called rational psychotherapy in the mid-1950s (Ellis, 1957), was the first prominent active-directive form of psychotherapy. Its effectiveness in treating a wide variety of emotional problems has been documented (David, Szentagotai, Eva, & Macavei, 2005). REBT with its distinct focus on fostering unconditional acceptance of self, others, and difficult life situations, as well as addressing the "tyranny of the shoulds" fits nicely with the tenets of self-determination and the self-concordance models. In addition, there are a number of publications describing the use of REBT in Coaching. While REBT is a prominent model for psychotherapy, it is quite suitable for coaching for a number of reasons. First of all, REBT is present and future oriented. While REBT theory acknowledges that irrational beliefs may have been created in the context of past experiences, it is the present holding onto these beliefs that are causing current problems. Second, REBT can be a very directive approach which may resonate with high functioning individuals who are motivated to reach self-concordant goals. Executives who seek coaching may find this approach particularly appealing. Third, the application of REBT to executive leadership (Ellis, 1972) and organizations (Klarreich, DiGiuseppe, & Di Mattiaha, 1987) have been documented.

According to Ellis (1998) "RET specializes in its applications to business and industrial problems" (p. 219). Ellis (1998) states that Klarreich et al. (1987) found that "in a study of over six hundred employees in a major corporation… RET, when used in an employee assistance setting, yielded a cost/benefit ratio of $2.74 saved for every $1 spent" (p. 219). Moreover, Criddle (2007), a long time practitioner of REBT, described how he made the transition from using REBT in therapy to using it in executive coaching, and how

specific REBT principles and techniques were highly suited to his coaching practice. Finally, REBT works well when integrated with spirituality for those seeking and following their highest calling and purpose in life as authentic and self-differentiated unique human beings.

Central to REBT is the ABC model of emotional disturbance (Ellis & Dryden, 1997). In this model, A stands for Activating Event, B stands for Beliefs, and C stands for emotional and behavioral consequences. For example, if a person fails to reach a chosen goal (A), believes that this proves they are a failure and decreases their self-worth (B), emotional consequences might be anxiety, depression, or shame. Behavioral consequences might include giving up on trying again to obtain the goal, not disclosing the failure to others, or using alcohol to numb the emotional pain (C). In contrast, another person might fail to reach a goal (A), believe that this is unfortunate but they are likely to succeed if they keep trying (B), and have the emotions of disappointment and frustration. They may have behavioral consequences such as problem-solving to figure out why they failed and how to improve on the next try (C). In the ABC model, A does not cause C, but rather it is B that primarily causes C. If a person realizes that external events, situations, people, etc. (A's) do not directly cause their emotions and behaviors, then they are likely to feel less externally controlled, contributing to more of a sense of autonomy. Consistent with SDT theory, this should lead to choosing self-concordant goals and gaining a greater sense of well-being.

From its inception, REBT has promoted from philosophical, theoretical, and practical reasons the critical importance of unconditional self-acceptance (USA). USA has been found to be associated with less depression and anxiety and higher levels of happiness and general well-being in community adults (Chamberlain & Haaga, 2001). Compared

with self-esteem, USA is more closely associated with general psychological well-being (Macinnes, 2006). In a laboratory study with college students, those who scored higher on USA were more objective in their evaluation of a speech performance, less defensive to critical feedback, and less prone to denigrate people who provided performance evaluation. They were also less prone to depression and self-esteem liability.

In a study of junior elite soccer players in England, USA was found to mediate the relationship between perfectionism and burnout. There is also evidence that REBT interventions increase USA and decrease low self-esteem and related general and social-evaluative anxiety, anger, and depression (Warren, McLellarn, & Ponzoha, 1988). The literature presented above suggests that contingent self-worth, self-image vs. compassionate goals, and self-criticism present obstacles to successful goal pursuit. These obstacles also seem likely to interfere with meeting the basic psychological needs of autonomy, competence and relatedness. Helping clients achieve unconditional self-acceptance appears to be critical. Ellis has defined USA in the following manner:

> I can choose to accept myself unconditionally–whether or not I do well or get approval by others. I can thereby refuse to rate 'myself,' my totality,' 'my personhood' at all. Instead, I can rate my traits, deeds, acts, and performances–for the purpose of surviving and enjoying my life more, and not for the purposes of 'proving myself' or being 'egoistic' or showing that I have a 'better' or 'greater' value than others (Ellis, 2005, p. 72).

Maslow (1970, pp. 155-156) quoted by Wessler & Wessler (1980) in discussing the meaning of self-actualization, beautifully captures the essence of USA:

> They can accept their own human nature in stoic style, with all its shortcomings, with all its discrepancies from the ideal image, without feeling real concern. It would convey the wrong impression to say that they are self-satisfied. What we must say is that they can take the frailties and sins, weaknesses and evils of human nature in the same unquestioning spirit with which one accepts the characteristics of nature. One does not complain about water because it is wet, or about rocks because they are hard, or about trees because they are green. As the child looks out upon the world with wide, uncritical eyes, simply noting and observing what is the case, without arguing the matter or demanding that it be otherwise, so does the self-actualizing person tend to look upon human nature in himself and others (Wessler & Wessler, 1980, p. 50).

"A person who does not blame himself or devalue himself for failing finds many options open to him. Easily willing to risk failure, he experiences life as an adventure, not a test" (Wessler & Wessler, 1980, p. 57).

In addition to USA, Ellis also promoted UOA or unconditional acceptance of others. One can readily see how UOA would foster satisfying interpersonal relationships and facilitate getting the human need of relatedness met. Finally, REBT promotes acceptance of difficult life conditions. Such acceptance would facilitate high frustration tolerance that would lead to persevering to reach self-concordant goals. In addition, it would facilitate emotional regulation in the face of frustration, disappointments, and daily hassles.

REBT, more than other forms of cognitive-behavior therapy, has emphasized what Karen Horney first called the "tyranny of the shoulds".

> There is one further quality of the shoulds that distinguishes them from genuine standards…that is their coercive character. Ideals, too, have an obligating power over our lives. For instance, if among them is the belief in fulfilling responsibilities which we ourselves recognize as such, we try our best to do so even though it may be difficult (Horney, 1950, p.73-74).
>
> To fulfill them is what we ourselves ultimately want, or what we deem right. The wish, the judgment, the decision is ours. And because we are thus at one with ourselves, efforts of this kind give us freedom and strength. In obeying the shoulds, on the other hand, there is just about as much freedom as there is in a 'voluntary' contribution or ovation within a dictatorship (Horney, 1950, p. 73-74).

One can readily see the relevance of the "tyranny of the shoulds" in sabotaging autonomy and fostering contingent self-worth, self-image goals and self-criticism. Ryan (1982) conceptualized *shoulds*, whether coming from an external source or internally, as a form of controlling performance feedback. The experimenters gave university students an experimental task with varying types of feedback. "In each case, the feedback was made controlling by in some way, referring to or implying how subjects *should* be doing to live up to expectations or to maintain self-esteem" (Ryan, 1982, pp. 453-454). Results indicated that *should* feedback, whether coming from self or experimenter, undermined intrinsic motivation and was associated with more sense of pressure. It also resulted in expending less effort on the task, compared to subjects in the information only feedback condition.

REBT has often had the reputation of being too directive, dogmatic, and minimizing the importance of the therapeutic relationship. However, as Warren and McLellarn (1987) found in an international survey of REBT therapists, REBT is often

practiced in a less confrontive style. Cheston (2000) described how REBT could be profitably combined with a person-centered style. Furthermore, there is relevant literature on how therapists can manage the working alliance to enhance therapy outcome and respond to breaches in the alliance in ways that build client social competences (Mallinckrodt, 2000). This literature is of course relevant to the coaching relationship, not just psychotherapy. There are a number of publications on the use of REBT in coaching (Anderson, 2002; Criddle, 2007; Dryden, 2011; Kodish, 2002; Neenan, 2008; Sherin & Caiger, 2004). REBT practiced with the spirit of motivational interviewing would produce a methodology for exploring and changing maladaptive beliefs that may strengthen their motivation for effectively achieving their goals. In other words, REBT's focus is more a philosophical and intellectual approach to self-acceptance that fosters the exploration of ambivalence, supports autonomy, and conveys to the client empathy and positive regard.

Self-Compassion

Self-compassion, as defined by Neff (2003), addresses acceptance but facilitates it by helping clients to also, on an emotional level, feel compassion for oneself in times of suffering. Self-compassion interventions are designed to elicit the emotion of compassion in the face of human suffering. Neff (2003) defined self-compassion and developed a scale to measure the concept. Self-compassion contains three different components: (1) extending kindness and understanding to oneself vs. harsh self-criticism and judgment, (2) common humanity–seeing one's experience as part of the human condition vs. feeling isolated and separate from others; and (3) mindfulness–holding one's thoughts and emotions in awareness without being engulfed or overwhelmed by them (Neff, 2003).

Since 2003, research on the nature of self-compassion and its association with positive mental health has burgeoned.

> In fact, so many positive associations with self-compassion have been documented that the research "is almost getting boring," says Mark Leary, PhD, a professor of psychology and neuroscience at Duke …Everybody who studies this finds that high self-compassion is related to higher emotional well-being across the board…There's no question there are all sorts of emotional benefits. (Weir, 2011, p. 42)

Benefits of self-compassion

Self-compassion has been found to be concomitant with greater life satisfaction, emotional and social intelligence, wisdom, curiosity and exploration. It has also been associated with happiness, optimism, positive affect, extraversion and agreeableness, social connectedness, and better interpersonal relationships. Further, self-compassion has been correlated with personal initiative, mastery vs. performance goals, compassionate goals with friends and roommates, self-improvement motivation, and health related behaviors (dieting, smoking, exercise). Still further, self-compassion has been associated with willingness to take responsibility, more adaptive coping and emotional regulation skills, forgiveness, and secure attachment styles (Neff, 2012).

Self-compassion has also been associated with more social support (Akin et al., 2011) and less self-criticism, depression, anxiety, rumination, thought suppression, perfectionism, disordered eating, narcissism, neuroticism, defensiveness, loneliness, and procrastination. Moreover, self-compassion has been associated with lower levels of symptoms in a variety of clinical conditions, including mixed anxiety and depression (Van

Cam, Sheppard, Forsyth, & Earleywine, 2011), PTSD (Dahm et al., 2012; Thompson & Waltz, 2008), social anxiety disorder (Werner et al., 2012), GAD (Roemer et al., 2009), and OCD (Wetterneck et al., 2012).

Of particular interest is the finding that scores on the Self-Compassion Scale were significantly correlated with scores on the Self-Determination Scale (Sheldon, 1995) and on the autonomy, competence, and relatedness subscales of the Basic Psychological Needs Scale (Illardi, Leone, Kasser, & Ryan, 1993). Neff noted that these findings "suggest that self-compassionate individuals are likely to have a sense of true self-worth that is not contingent on meeting set standards but is based simply on being one's authentic self" (Neff, 2003, p. 241).

Self-compassion facilitates intrinsic motivation, mastery rather than performance goals, greater perceived competence, less fear of failure, and more adaptive coping with perceived failure. In explaining the connection between perception of competence, Neff, Hsieh, & Dejitterat (2005) suggest that highly compassionate individuals, who take a balanced perspective on their shortcomings rather than amplifying them through harsh self-judgment, feelings of isolation, or over-identification with their emotional reactions; should have relatively more positive perceptions of their abilities than those with low levels of self-compassion.

Shepherd and Cardon (2009) in a study published in the Journal of Management Studies, state that:

> We propose that individuals that show caring to oneself in assessing project failure (self-kindness), place project failure in perspective with others (common humanity) and keep emotions in balance (mindfulness), generate less of a negative emotional

> reaction to project failure and are better able to user project failure as an opportunity to learn (p. 933).

While people who do not understand the concept of self-compassion may feel that self-compassion could lead to "letting oneself off the hook" when they don't perform well, Breines and Chen (2012) in a series of creative experiments, demonstrated that experimentally induced self-compassion, when compared to induced self-esteem, increased the belief that shortcomings can be changed, increased the desire to make amends and avoid repeating a moral transgression, increased effort in studying for a subsequent test following an initial failure, and increased motivation to improve a personal weakness.

Particularly relevant to the relatedness need in SDT theory, self-compassion has been found to be associated with less loneliness and more extraversion and agreeableness, social connectedness, and better interpersonal relationships. Self-compassion has been associated with compassionate goals with friends and roommates, forgiveness, secure attachment styles, and more social support (Akin et al., 2011). In light of the immense benefits of self-compassion and the detrimental effects of self-criticism, it would be of great value if methods were available for increasing self-compassion and decreasing self-criticism. Fortunately a number of studies have demonstrated the effectiveness of interventions to increase self-compassion (Barnard & Curry, 2011; Gilbert & Proctor, 2006; Gilbert et al., 2011). Recently, randomized controlled trials have been conducted (Jazaieri et al., 2013; Neff & Germer, in press) with positive results.

Associations between self-compassion and a multitude of indicators of positive mental health and adaptive functioning have been repeatedly documented. Among the many findings, self-compassion has been associated with self-determination, autonomy,

competence, and relatedness. In addition, self-compassion facilitates intrinsic motivation, mastery rather than performance goals, greater perceived competence, less fear of failure, and adaptive coping with perceived failure (Neff, 2012).

In addition to the correlational studies (Neff, 2012) and some experimental studies (Breines & Chen, 2012; Leary, Tate, Adams, Allen, & Hancock, 2007) that have induced self-compassion and found positive results, Neff and Germer (2013) recently reported the effectiveness of an intervention to increase self-compassion in community volunteers. Results indicated that participants reported significant increases in self-compassion, mindfulness, well-being, compassion for others, social connectedness, life satisfaction, happiness and decreases in depression, anxiety, stress, and emotional avoidance. These increases were maintained at six-month and one-year follow-up.

These studies indicate that self-compassion skills can be taught without participation in psychotherapy and focusing on the past, where difficulties in self-compassion may have developed. If such skills are seemingly lacking, a coach may want to direct his or her client to reading materials that demonstrate the benefits of self-compassion and why incorporating self-compassion as a personal goal is advantageous. Thus increasing self-compassion seems highly amenable to the coaching context. Thus far, there do not appear to be any published articles on self-compassion and coaching, except for a one-page article describing the use of compassion-focused imagery in coaching (Palmer, 2009). However, there is an exciting literature on "coaching with compassion" (Boyatzis, Smith, & Beveridge, 2012). The authors state that, "The hallmark of coaching with compassion is the focus on invoking the Ideal Self to initiate and guide the change process. The Ideal Self is the individual's vision of who he or she wants to be and includes his or

her goals, values, and deepest aspirations for the individual's future" (p. 3). The authors note how this is consistent with the self-concordance model of Sheldon (2002). Coaching with compassion focuses on identifying strengths more than weaknesses. Boyatzis et al., (2012) expand on the traditional definition of compassion as a response to one's suffering to also include noticing ones needs or desires, including the desire to self-actualize and obtain valued goals.

> In a study using functional magnetic resonance imaging (fMRI),
>
> Half an hour of coaching that focused on the participants' long-term dreams, as compared with half an hour of coaching that focused on their problems and deficiencies, activated neural circuits associated with imagining and more cognitive and perceptual openness when participants recalled the session several days later (Boyatzis, Jack, Cesaro, Khawaja, & Passarelli, 2010, p. 14).

The "coaching session that focused on performance problems and stressful experiences led to activation of regions of the brain that are associated with the sympathetic nervous system (SNS) when participants recalled the session several days later" (Boyatzis et al., 2010, p. 14).

Boyatzis et al. (2012) further suggest that the positive emotions derived from the coach's compassionate approach will spread to the client and even from the client to the organization in which the client works, ultimately leading to a "culture of compassion" (p.18). This work of Boyatzis et al. (2012) reinforces the value of coaches not only coaching with compassion, but also intentionally guiding clients to become more self-compassionate.

Compassion Leading to Forgiveness

An inability to extend or receive forgiveness may be another obstacle leading to successful goal attainment. The work of forgiveness is defined as an effort in restoring love and trustworthiness to relationships such that injured individuals and offenders can eliminate destructive entitlement behaviors. Destructive entitlement behaviors can manifest in many ways, including paranoid attitudes, hostility, rage, emotional cutoffs, and destructive harm to other individuals. For example, when individuals are violated, they are likely to feel rage as they experience uncontrolled anger toward their offender or they may experience shame as they accuse themselves for being unlovable and undeserving of a trustworthy relationship. A coach may want to encourage his or her client to explore the forgiveness construct and notion of self or other forgiveness in light of such inhibiting factors.

The forgiveness construct

To understand the forgiveness construct, it is necessary to first explain its roots that are grounded in contextual family therapy. Contextual family therapy describes relationships in four dimensions depicted as: (1) facts, (2) individual psychology, (3) family or systemic transactions, and (4) relational ethics. The last construct, relational ethics, is based on an understanding that people have an innate sense of justice that demands balance between what they are entitled to receive from a relationship and what they are obligated to give to a relationship. The fourth dimension, relational ethics, represents a person's subjective balance of justice, trustworthiness, loyalty, merit, and entitlement between members in important relationships and is the most powerful dimension of couples and families (Hargrave, 1994).

The goal of the forgiveness paradigm is to bring forth "true differentiation, or the ability to balance the needs and drives of individuality and togetherness" (Hargrave, 1994, p.

107). Therefore, the best hope for both the injured and the offender lies in their ability to be distinct individuals with clear boundaries who choose to embrace relational intimacy. "The restoration and reconciliation of relationships will include confrontation and protection in a trustworthy and disciplined way as well as compassion and understanding" (Hargrave, 1994, p. 216). "We learn to trust people with whom we have relationships by the demonstration of their responsible giving and by their absence of efforts to intimidate or manipulate us" (Hargrave, 1994, p. 212).

A common theme facing clients who contact me for coaching services occurs after having experienced a severe violation of love or trust that culminates into shattered assumptions, feelings of betrayal, rejection, shock, and deep hurt. When individuals experience such violations, the notion of forgiveness seems to be an impossible feat. They fear that if they forgive and forget, nothing will change between the injured individual and the offender, thus leaving the injured person open to repeated patterns of betrayal and never ending relational pain. Resisting the act of forgiveness is often the only way an injured person knows how to secure safety and protection. As difficult as it is to imagine extending forgiveness to the offender, forgiveness is one effective method that can promote healing and restoration between couples and among family members (Hargrave, 1994).

The first effort of the coach is to help the injured person develop a new relational perspective by exploring and encouraging acceptance of the relational damage and current status of the relationship. This is to ensure that the intense mourning and anger that had previously immobilized the therapeutic effort has oscillated enough such that the injured person is able to work with the offender without re-experiencing intense emotional reactions of rage, shame, depression, and chaos. The second stage involves the internalized work of

understanding. The injured person needs to identify the injustices and be acknowledged the by the offender, who willing takes responsibility for his or her actions as an effort to release the burden of shame and pain on both parties. The third stage involves a coming together to address the past damage and hurt in a direct and overt manner. Overt acts of forgiving are most helpful when the coach takes on the role of relational mediator. If this stage is to be successful, the injured person and offender must come to agreement on the violation such that there is acknowledgement of responsibility, apology, and promise for a future relationship. This usually entails a tough face-to-face bargaining and communication between the injured and the offender (Hargrave, 1994).

In my current coaching practice, each one of my clients has hired me for clinical services because of their deep pain resulting from some form of betrayal and violation of trust. In my own professional work, I name this phenomenon as an attachment injury that is eloquently defined by Johnson, Makinen, and Milliken (2001). The pain and trauma associated with attachment injuries result in emotional cutoffs at varying degrees, even when there is no geographical distance between the injured person and the offender (spouses and family members are examples).

Coined by Bowen (1978), an emotional cutoff occurs when an individual intentionally separates from one or more members from the family of origin in order to find relief from extremely intense and anxiety-provoking feelings. While there are times when separating from family members are necessary, e.g., cases of physical or emotional abuse, control, and manipulation, the person seeking distance may experience deep inner conflict until they can emotionally integrate the problem and learn the difference between forgiveness and reconciliation for finding relief, acceptance, and peace.

Forgiveness and the Christian Faith

The Scriptures show that Jesus demonstrated an amazing ability to avoid getting emotionally "hooked" by hurtful people (e.g., Luke 23:34). Richardson noted that

> The disciples and the church leaders distanced themselves from Jesus and Paul, but Jesus and Paul did not let themselves be overcome with feelings of abandonment (although as humans, they must have felt such feelings) or become reactive to the reactivity of others. They maintained their side of the connection and got on with their understanding of their mission. Eventually the church joined them at a new level of functioning (Richardson, 1996. p. 181).

Jesus' ability to remain connected and non-reactive while setting limits and making others accountable demonstrates how the Scriptures are clear about two principles: (1) It is helpful to forgive, but (2) we don't always achieve reconciliation. Forgiveness is something that we do in our hearts; we release other people's wrongful actions against us so that we can cleanse ourselves of feelings of bitterness, hurt, rejection, shame, humiliation, etc. We do this so that we can further the facilitation of healing and spiritual growth while allowing the other person's wrongful actions to become new information about what kind of boundaries are necessary for healthy, future interactions or separations (Richardson, 1996).

The concept "separation" is included as an option because some families are deeply embedded with complex emotional dysfunction, and from their misguided viewpoint; they resist the healthy development of individuals seeking to grow spiritually and be self-differentiated by insisting that that individual "remain" in a certain role. Thus, they attempt to use extreme manipulative tactics and guilt to keep that person in the role they want to see him or her maintain. "Boundaries play a primary role in this process. Our limits create a

spiritual and emotional space, a separateness, between ourselves and others" (Cloud and Townsend, 1992, p. 177).

CHAPTER 5

SUMMARY AND NEXT STEPS

When reflecting back to the Indian fable, recall that the jungle reverberated by the roar of the tiger cub when he tasted, feasted, and digested on the awareness of his true self. Likewise, clients who develop deeper awareness and growth as self-differentiated, connected, and competent individuals are more likely to select self-concordant, motivationally sustainable, compassionate goals leading to goal attainment and the development of one's true self.

The literature reviewed above has made the case that self-determination theory and the self-concordant models of goal pursuit are critically important for an evidence-based coaching practice. While extensive evidence demonstrates that self-concordant goals are more likely to be achieved and promote greater satisfaction and a sense of well-being by meeting the basic human needs of autonomy, competence, and relatedness, people do not always select self-concordant goals. Though some researchers have offered hypotheses of why this is, I am not aware of an integrated psychological model that explains this phenomenon or can guide coaches to most effectively help clients better select and achieve self-concordant goals. I have described the relevance of REBT, self-compassion, motivational interviewing, attachment theory and self-differentiation to the self-determination theory, the self-concordant model, and more broadly to the practice of coaching. The next section of the dissertation will expand on these interventions and their integration as a comprehensive intervention that I believe will make an important contribution to evidence-based coaching.

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APPENDIXES

APPENDIX A
KEY INFLUENCERS ON COACHING

Alfred Adler Psychology 1920s	Tom Peters Business 1980s
Martin Heidegger Philosophy 1930s	Daniel Goleman Psychology 1990s
Napoleon Hill Motivation 1930s late	David Cooperrider Business 1990s
Dale Carnegie Motivation 1940s	Ken Wilber Psychology 1990s
Abraham Maslow Psychology 1950s	Martin Seligman Psychology 1990s
Albert Ellis Psychology 1950s	Mihaly Csikszentmihalyi Psychology 1990s
Carl Jung Psychology 1950s	Peter Senge Business 1990s
Carl Rogers Psychology 1950s	
John Wooden Sports 1950s	
Milton Erickson Psychology 1950s	
Peter Drucker Business 1950s	
Red Auerbach Sports 1950s	
Earl Nightingale Motivation 1950s late	
Chris Argyris Psychology 1960s	
Edgar Schein Business 1960s	
Fritz Perls Psychology 1960s	
Ken Blanchard Business 1960s	
Don Shula Sports 1970s	
Fernando Flores Philosophy 1970s	
John Grinder Liberal Arts 1970s	
Peter Block Business 1970s	
Richard Bandler Psychology 1970s	
Werner Erhard Business 1970s	
Zig Ziglar Motivation 1970s	
Wayne Dyer Motivation 1970s late	
Brian Tracy Motivation 1980s	
Robert Dilts Psychology 1980s	
Stephen Covey Business 1980s	

(Adapted from Brock, 2008)

APPENDIX B
DSI-SF INSTRUCTIONS

Instructions for Differentiation of Self Inventory – Short Form

The following inventory contains questions concerning your thoughts and feelings about yourself and relationships with others. Please read each statement carefully and decide how much the statement is generally true for you on a 1 (not at all) to 6 (very) scale. If you believe that an item does not pertain to you (e.g., you are not currently married or in a committed relationship, or one or both of your parents are deceased), please answer the item according to your best guess about what your thoughts and feelings would be in that situation. Be sure to answer every item and try to be as honest and accurate as possible in your responses.

DSI-SF Scoring Key

As with the DSI-R (Skowron & Schmidt, 2003) several of the items in the DSI-SF are reverse scored (i.e., 6 = 1, 5 = 2, 4 = 3, etc.) Reverse score the following items: ECI, EC2, EC3, ER1, ER2, ER3, ER$, ER5, ER6, FO1, FO2, FO3, FO4, FO5, FO6, and IP5. To calculate a subscale score take the average of all items within a subscale (i.e., the average of EC1 + EC2 + EC3).

APPENDIX C

DIFFERENTIATION OF SELF INVENTORY – SHORT FORM

Questions		Not at all characteristic of me.					Very characteristic of me.	
1. I tend to remain pretty calm even under stress.		1	2	3	4	5	6	IP1
2. I usually need a lot of encouragement from othe when starting a big job or task.		1	2	3	4	5	6	FO1
3. No matter what happens in my life, I know that I'll never lose my sense of who I am.		1	2	3	4	5	6	IP2
4. I tend to distance myself when people get too close to me.		1	2	3	4	5	6	EC1
5. When my spouse/partner criticizes me, it bothers me for days.		1	2	3	4	5	6	FO2
6. At times my feelings get the best of me and I have trouble thinking clearly.		1	2	3	4	5	6	ER1
7. I'm often uncomfortable when people get too close to me.		1	2	3	4	5	6	EC2
8. I feel a need for approval from virtually everyone in my life.		1	2	3	4	5	6	FO3
9. At times, I feel as if I'm riding an emotional roller-coaster.		1	2	3	4	5	6	ER2
10. There's no point in getting upset about things I cannot change.		1	2	3	4	5	6	IP3
11. I'm overly sensitive to criticism.		1	2	3	4	5	6	ER3
12. I'm fairly self-accepting.		1	2	3	4	5	6	IP4
13. I often agree with others just to appease them.		1	2	3	4	5	6	FO4
14. If I have had an argument with my spouse or partner, I tend to think about it all day.		1	2	3	4	5	6	ER4
15. When one of my relationships becomes very intense, I feel the urge to run away from it.		1	2	3	4	5	6	EC3
16. If someone is upset with me, I can't seem to let it go easily.		1	2	3	4	5	6	ER5
17. I often feel unsure when others aren't around to help me make a decision.		1	2	3	4	5	6	FO5
18. I'm very sensitive to being hurt by others.		1	2	3	4	5	6	ER6
19. My self-esteem really depends on how others think of me.		1	2	3	4	5	6	IP5
20. I tend to feel pretty stable under stress.		1	2	3	4	5	6	IP6

APPENDIX D
SELF-CONCORDANT GOAL INVENTORY

Participants were asked to rate their motivation for pursuing goals using a four items that assessed **external** ("Because somebody else wants you to, or because you'll get something from somebody if you do"), **introjected** ("Because you would feel ashamed, guilty, or anxious if you didn't – you feel that you ought to strive for this), **identified** ("Because you really believe that it is an important goal to have – you endorse it freely and value it wholeheartedly"), and **intrinsic** ("Because of the fun and enjoyment which the goal will provide you – the primary reason is simply your interest in the experience itself) reasons for goal pursuit (Koestner et al., 2002). All responses were made on a 7-point scale of -3 (strongly disagree) to 3 (strongly agree).

Questions		Strongly Disagree			Strongly Agree

1. You strive for your goal because somebody else wants you to or because the situation demands it.	-3	-2	-1	0	1	2	3
2. You pursue this goal because you would feel ashamed, guilty, or anxious if you didn't.	-3	-2	-1	0	1	2	3
3. You pursue this because you really believe that it's an important goal to have.	-3	-2	-1	0	1	2	3
4. You pursue this goal because of the fun and enjoyment that it will provide you.	-3	-2	-1	0	1	2	3

(Adapted from Koestner et al., 2002).

Self-Concordant Goal Questionnaire Scoring: A general measure of self-concordance for each goal is computed by adding the intrinsic and identified (autonomous) scores and subtracting the external and introjected (controlled) scores.

APPENDIX E
DEMOGRAPHIC QUANTIONNAIRE

Age: _____

I consider myself to be:

_____ Male

_____Female

_____Transgender

Race/Ethnicity (Check all that apply)

_____ Black, African American

_____ Asian or Pacific Islander

_____ European American

_____ Native American Indian

_____ Arab American

_____ Jewish American

_____ White, Caucasian

_____ Hispanic

_____ Latino

_____ Other

APPENDIX F
10 RELATIONAL NEEDS INVENTORY

TEN RELATIONAL NEEDS					
Instructions: Select three needs which you sense are most important to you right now by marking the appropriate boxes in the column "You." Next, go through **each** of the listed needs and indicate in the area on the left whether this need was met in your family or origin by your **mother**, **father**, **both**, or **neither**.					
Mother	Father	Both	Neither	Relational Needs	You
				Acceptance: Receiving another person willingly and unconditionally, especially when the other's behavior has been imperfect. Being willing to continue loving another, in spite of offenses (Romans 15:7)	
				Affection: Expressing care and closeness through physical tough; saying "I love you." (Romans 16:16; Mark 10:16)	
				Appreciation: Expressing thanks, praise, or commendation. Recognizing accomplishment or effort. (Colossians 3:15b; I Corinthians 11.2)	
				Approval (Blessing): Building up or affirming another; affirming both the fact of and the importance of a relationship. (Ephesians 4:29; Mark 1:11)	
				Attention: Conveying appropriate interest, concern, and care; taking thought of another; entering another's "world." (I Corinthians 12:25)	
				Comfort: Responding to a hunting person with words, feelings, and touch; to hurt with and for another's grief or pain. (Romans 12:15b; Matthew 5:4; II Corinthians 1:3-4; John 11:35)	
				Encouragement: Urging another to persist and persevere toward a goal; stimulating toward love and good deeds. (I Thessalonians 5:11; Hebrews 10:24)	
				Respect: Valuing and regarding another highly; treating another as important; honoring another. (Romans 12:10)	
				Security (Peace): Harmony in relationships; freedom from fear or threat of harm. (Romans 12:10)	
				Support: Coming alongside and gently helping with a problem or struggle; providing appropriate assistance. (Galatians 6:2)	

Adapted from David Ferguson's The Great Commandment Principle
(Weaton, III: Tyndaile House Publishers, 1998, 44-52).
Dr. Keri Warren, October 2012