

Coaching and Personal Crisis: Managing mental health and suicide risks in coaching



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Introduction

We all have mental health in the same way that we have physical health. The World Health Organisation (WHO; 2021) views mental health to be an integral component of our overall health, and defines it as 'a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.' This definition acknowledges there is more to mental health than the restoration of it. There are also benefits to the promotion and protection of mental health. This shift in perspective throughout the western world has echoed across the health sector, therapy and coaching (Evans-Krimme, 2023).

Key words: Coaching & mental health, well-being, ethics

The mental health pandemic

Mental illness continues to be stigmatising and disabling, with depression as one of the world's leading causes of disability (WHO, 2021). An estimated 5% of adults suffer from depression worldwide; this equates to around 374 million people (Institute of Health Metrics and Evaluation, 2020). Mental health however is not spread evenly: some groups of people suffer more than others.

COVID-19 has had a profound impact on mental health and psychological distress (Cénat, 2021). This increase results from measures such as quarantine, social distancing, and self-isolation which are associated with increased loneliness, social isolation and entrapment (Holmes et al, 2020). Another consequence of COVID-19 was the disruptions to mental, neurological, and substance use services, with the prevention and promotion of mental health services and programmes most severely affected:ⁱ the WHO (2020) reports that around three-quarters of school and workplace mental health services were either wholly, or partially, disrupted.

To counteract the disruption and adverse impact of COVID-19 on mental health services, many countries and organisations responded by adopting digital solutions, such as telephone or video conferencing, to replace the need for in-person services (WHO, 2020). The combination of the global pandemic deteriorating people's mental health, reduced accessibility of mental health services, and an increased accessibility of coaching delivered through technical platforms (Passmore & Evans-Krimme, 2021) has led to a 'boom' in interest in coaching for mental health and wellbeing.

Whilst the growing number of applications of coaching is generally viewed as a positive development, there are concerns over the safety of people with mental illness engaging with coaching (Cavanagh, 2005; Bachkirova, 2007; Aboujaoude, 2020). For example, encouraging clients with clinical depression to set goals beyond their capacity is detrimental to their recovery (Cavanagh, 2005). This is in part due to the huge variation in the level of mental health training amongst coaches so coaches may fail to recognise subtle signs of mental illness in their clients (Cavanagh, 2005). We believe that coaching should explicitly exclude the treatment of mental health disorders unless coaches are explicitly trained in managing clinical conditions, such as in clinical psychology. This perspective is based on the current state of health coaching research which confirms a lack of research into the effectiveness of coaching for mental health (Todorova, 2022), as well as our own view that few coaches have adequate training or support to work with clinical conditions. Although coaching is showing promising psychosocial outcomes in areas such as quality of life, self-efficacy, and other indicators of mental health (Grover & Furnham, 2016; Theeboom, 2014), research remains limited on the impact of coaching on mental health (Bishop, 2018).

Coaching is not a replacement for mental health treatments and coaching practitioners need to be clear on their professional boundaries and how to respond appropriately when a client presents with mental illness. At the same time, coaching can play an important role in the mental health pandemic as a proactive and preventative tool that enhances mental health and wellbeing in the general, 'non-clinical' population.

Walking the line

The 'grey-area' between coaching and therapy

The reality is there is a 'grey-area' between coaching and therapy. While coaches may believe they focus on dreams and desires, leaving counsellors and psychotherapists to work with damage and distress: the reality in many cases is not clear cut. Many clients live with both dreams and distress, and their state fluctuates day-to-day, and across the day. If statistics are correct and 1 in 4 people have mental health issues (now or have experienced them in the past) it's pretty likely most coaches have one or more such clients.

But like all conditions, mental health issues are on a continuum, from historical (i.e. in the past) and mild, to severe and clinical. They include a wide range of different conditions which each create their own effects. A starting point is to better understand this variety.

The risk of causing harm to clients with mental health disorders

Mental health disorders include illnesses such as major depression, anxiety disorders, psychotic disorders, personality disorders, substance misuse disorders, self-harming behaviours and suicidal ideation. Mental illness can severely impair a person's overall functionality, characterised by a danger of harm to self or others, serious impairments to judgement, mood, relationships, or occupation (APA, 2013, WHO, 2019). When considering the coaching process, mental illness can reduce a person's capacity to make choices and be self-determining (Bora et al., 2010) in addition to having low levels of intentional goal-strivingⁱⁱ. This can lead to a power imbalance in the coaching relationship that can negatively impact the strength of the working alliance (MHFA, 2022).

There is also a risk of indirect harm caused to those around the client, such as their family and colleagues at work. It's helpful for coaches to consider how to prevent these occurrences by remaining within their competency level and making continuous assessments throughout the coaching engagement about the client's suitability for coaching, referring to another helping profession where appropriate (see section 'How to refer coaching clients to other helping professionals'). Programmes such as the UK's 'Mental Health First Aid' training offer professionals the opportunity to develop their mental health literacy and may be a valuable tool for coaches (Cavanagh, 2005).

For whom is coaching most appropriate?

Considering the concerns over the safety of people with mental illness engaging with coaching (Bishop, 2018) and lack of research into coaching for people with mental health disorders, we argue that coaching is not appropriate for people with clinical mental health disorders. However, Grant (2007) highlights the crossover between counselling and coaching populations and that suggests some experienced and relevantly qualified coaching professionals may be able to work with clients who experience subclinical psychopathologies. In his 3D model (Figure 1), Passmore (2021) identifies three distinct groups along the distribution of mental health in the general population: Diagnosis, Damage, and Desire. **Diagnosis** refers to the clinical population where a client needs to receive treatment for their mental health disorder by a mental healthcare professional and recover, which could take months or years. **Damage** is the poor mental health, also known as languishing, that the general non-clinical population will experience at some point in their lives and can recover from with little to no additional intervention from a helping professional. Clients in the **Desire** phase tend to be experiencing some to high levels of mental health and wellbeing and this is where coaching is most appropriate.

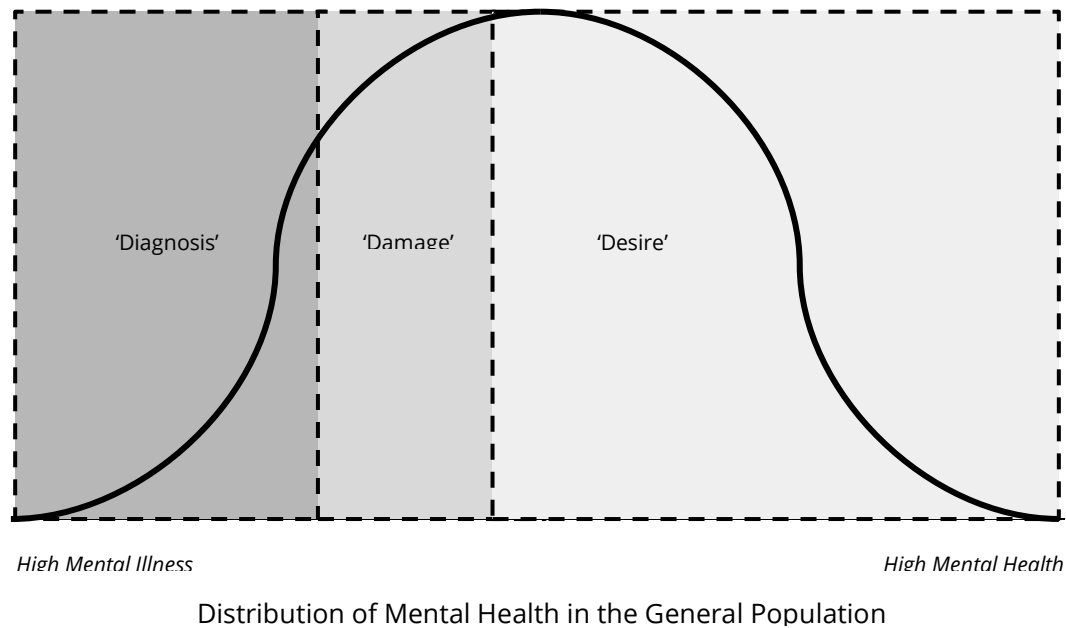


Figure 1: Distribution of 3D model along the mental health continuum (Passmore, 2021)

Identifying mental health issues

It is not the responsibility of the coach to diagnose a mental health disorder but coaches can benefit from enhancing their understanding and ability to recognise potential problems that may benefit from a referral to a healthcare professional. Table 2 shows possible warning signs of mental illness and offers reflective questions that coaches can consider when assessing potential warning signs of mental illness Cavanagh & Buckley, 2014). It is based on the clinically used mental state examination (Soltan & Girguis, 2017) and should also include an assessment of the level of the client's impairment to their daily functioning, amount of time these issues are present, and the impact on their progress in coaching. If uncertain, coaches can share and explore with their supervisor and refer to Passmore's guide on referrals (Passmore, 2021) detailed overview of signs for referral for the most common mental health issues, which are: anxiety, depression, eating disorders, post-traumatic stress disorder (PTSD), substance abuse or addiction, suicidal ideation and thought disorders.

Table 2: Potential warning signs of mental illness

<i>Factor</i>	<i>Questions</i>
<i>Appearance</i>	Does the person dress in an expected way? Has the person engaged in personal care? How does the person move? How is the person's body language?
<i>Behaviour</i>	Is the person's behaviour unusual? Is the person excessively agitated or lethargic? Does the person engage in repetitive behaviours? How congruent is the body language with what they are saying?
<i>Mood</i>	Does the person's mood fluctuate significantly with no apparent cause? Is the person overly optimistic or overly pessimistic? Is the person apathetic?
<i>Thoughts</i>	Is the person preoccupied or fixated with a particular situation or event? How clearly is the person communicating their thoughts? Is the person rational in their thoughts?
<i>Perceptions</i>	Is the person's perception of their world normal or abnormal? Does the person appear to hear, see or feel phenomena that are not visible from your own perception?
<i>Intellect</i>	Has the person's intellect changed over time? Is the person as 'intellectual' as you expected given their education, role, history? How present and active is the person when you meet or connect with them? Does the person appear to struggle to engage / answer questions?

<i>Insight & Judgement</i>	How self-aware is the person of any of the above? How does the person explain these signs you have identified?
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(Adapted from Cavanagh and Buckley, 2014, p.410)

Ethical contracting that considers mental health

Ethical contracting includes an assessment of a client's suitability for coaching. As 25-52% of people engaging with coaching present significantly high levels of psychological distress (Green et al., 2006) in initial 'screening' should become standard practice for all coaches. The coach must use this opportunity to assess whether the client's goal or topic, especially when around wellbeing, is within the scope of the coaching relationship, the coach's competency level and their formal training (for example as a psychologist).

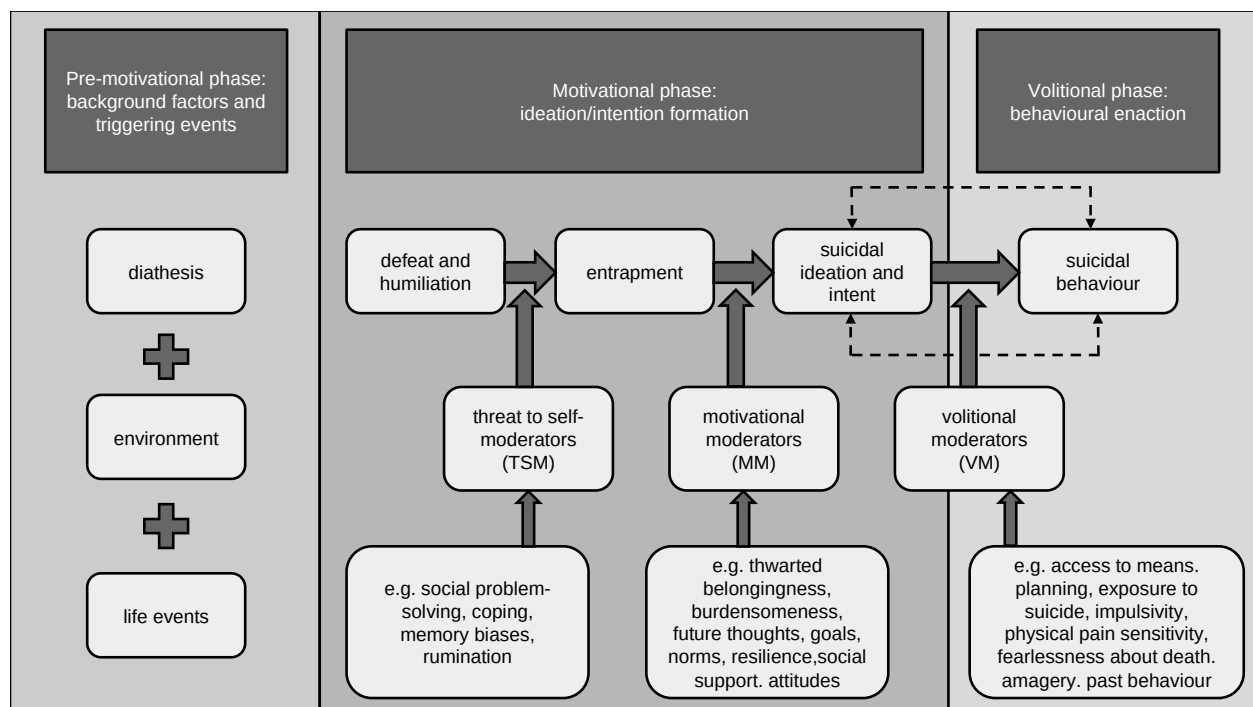
The following 'BE WELL' model of ethical contracting for mental health offers an overview of the core areas that coaches need to consider when contracting around mental health or wellbeing topics.

- **Be** clear about professional qualifications;
- **E**xplore the mental health or wellbeing goal/ topic;
- **W**hat is the impact of the topic on the client's daily life;
- **E**xplain the difference between coaching and psychotherapy / therapy / counselling;
- **L**isten to the client's preferred route for mental health support;
- **L**ook out for the potential risks of discrimination and conflict.

Recognising suicidal ideation and behaviours

One model that describes the biopsychosocial context of the common pathways to suicidal behaviour is the integrated motivational-volitional (IMV) model of suicidal behaviour (O'Connor & Kirtley, 2018). It describes three phases (Figure 2) in which suicidal ideation and behaviour may emerge: the pre-motivational, motivational and volitional.

Figure 2. The IMV model of suicidal behaviour



(The Integrated Motivational-Volitional (IMV) Model by O'Connor & Kirtley, 2018, p. 2)

The pre-motivational phase is when suicidal ideation and behaviour may emerge and is when practitioners can identify individual and environmental vulnerability factors and potentially triggering negative events. Higher levels of perfectionism and socially prescribed perfectionism have been consistently associated with suicide risk and the likelihood of feeling defeated when faced with an interpersonal crisis. Combined with low socio-economic status and early life adversities this can further contribute towards an individual's risk of suicidal ideation and behaviour. However, negative life events are a potential risk factor at any stage in life. Table 2ⁱⁱⁱ gives an overview of the psychological risk and protective factors for suicidal ideation and behaviour that coaches can monitor as part of their risk of suicidal ideation and suicide assessment. In identifying pre-motivational factors of suicidal ideation and behaviour, coaches can assess which clients are more likely to be susceptible to the threat to self (TSM) or motivational moderators (MM) outlined in the motivational phase, and have planned pathways to mental health support if needed.

Table 2: Psychological risk and protective factors for suicidal ideation and behaviour

Personality and individual differences	Cognitive factors
Risk: Hopelessness, impulsivity, perfectionism, neuroticism and extroversion Protective: Optimism, resilience	Risk: Cognitive rigidity, rumination, thought suppression, autobiographical memory biases, lack of belonging, feeling like a burden, fearlessness about injury or death, insensitivity to pain, inability to problem solve and cope, agitated, implicit associations, attentional biases, defeat and entrapment Protective: Future thinking, goal adjustment, reasons for living, sense of belonging, ability to problem-solve and cope
Social Factors	Life events
Risk: social isolation, exposure to deaths by suicide of others, modelling, contagion, assortative homophily, social transmission Protective: Social support	Risk: traumatic life events in childhood and/ or adulthood, physical illness, other interpersonal stressors, and psychophysiological stress response Protective: Social support, sense of belonging

(Adapted from O'Connor & Nock, 2014, p. 77)

The motivational phase focuses on the relationship between the core constructs of defeat/humiliation, entrapment, suicidal ideation and suicidal behaviour. Clients who perceive that there is no escape from the defeat and/or humiliation, such as social rejection or loss, are close predictors of suicidal ideation. However, the absence of threat to self (TSM) or motivational moderators (MM) contribute towards the increase or decrease in entrapment translating into suicidal ideation. For example, unemployment has been shown to affect an individual's feelings of hopelessness or entrapment, which increases the risk of

suicide, yet not everyone who is unemployed will feel suicidal. These predictors should be red flags to coaches, who can turn towards their supervisor for support on how to best respond to their client. When there is an urgent need to discuss a client's wellbeing, supervisors can contract with their supervisees the option to speak within hours rather than waiting for the next planned session. Coaches must honestly assess the need to terminate or delay coaching in the best interest of the client and refer to an appropriate helping professional.

The volitional phase outlines the transition from suicidal ideation to suicide attempts and suicide. The volitional moderators include: access to means, planning, exposure to suicide or suicidal behaviour, impulsivity, physical pain sensitivity/ endurance, fearlessness about death, mental imagery of death/ dying, and past suicidal behaviour. Table 3 offers some questions practitioners can reflect on to assess if and how many of these factors are present. If the client shares any information that confirms one of these factors, then the coach must ask about suicide in a direct but sensitive manner. Asking individuals about suicide has been shown to be beneficial to those at high risk and does not increase the risk of suicidal ideation or self-harm.

Table 3: Volitional moderators within the IMV model and reflective questions for coaches

Volitional moderator	Question
Access to means	<i>Does the client have ready access to likely means of suicide?</i>
Planning ('if-then' plans)	<i>Has the client formulated a plan for suicide?</i>
Exposure to suicide or suicidal behaviour	<i>Has a family member, friend or colleague engaged in suicidal behaviour?</i>
Impulsivity	<i>Does the client tend to act impulsively or on the spur of the moment?</i>
Physical pain sensitivity/ endurance	<i>Does the client have high or increased physical pain endurance?</i>
Fearlessness about death	<i>Is the client fearful about death? Has this changed?</i>

Mental imagery	<i>Does the client describe visualising dying or after death?</i>
Past suicidal behaviour	<i>Does the client have a history of suicide attempt or self-harm?</i>

(Adapted from O'Connor & Kirtley, 2018, p. 5)

The purpose of identifying these risk factors is to consider how they interact with one another in complex ways and potentially increase an individual's vulnerability to suicidal ideation and behaviour. In doing so, practitioners embody their ethical practice because they are taking responsibility for their client's welfare and can safeguard them more effectively. However, there are a number of dilemmas that coaching practitioners face when a client is at risk of self-harming or suicide. On occasions the coaches' or therapists' own personal and ethical beliefs may conflict with their legal and professional responsibilities when responding to a client threatening suicide or self-harming behaviour. As a result, coaches must become aware of how their biases may conflict with their ethical and legal responsibilities.

How to refer coaching clients to other helping professionals

It is imperative that coaches refer clients to other healthcare professionals as needed. As confidentiality is an essential ingredient in coaching, there are occasions when breaching confidentiality may be necessary and this poses a potential ethical dilemma that coaches may face. It must be noted that breaking confidentiality to protect the safety of the client or others is rare, however, coaches must be prepared to effectively manage these situations.

In the coaching agreement with the client and potential third parties, such as the sponsor, coaches can clearly state the circumstances in which they will break confidentiality. The non-negotiable circumstances include risk of serious illegal activities and harm to the client or others. Coaches can include circumstances such as the referral to a healthcare professional when mild to severe mental health problems arise, in the cases of physical illness, and when the topic is outside of the coach's competencies.

Conclusion

In this article we have explored mental health and how this can on rare occasions play out in suicide or self-harming behaviours in coaching. By enhancing our awareness as a coach, we can be best-placed to identify and manage these risks in our coaching practice.

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