
Health & Wellness Coach Certifying Examination



2018

CONTENT OUTLINE WITH RESOURCES

**Health & Wellness Coach Certifying Examination
Content Outline with Resources**

Table of Contents

How to use this Content Outline with Resources..... 2

1. Coaching Structure 4

 1.1. Coach preparation prior to session..... 4

 1.2. First session or before begin..... 5

 1.3. Early (typically in the first, second or other early session) 6

 1.4. Routine Follow-Up Sessions 7

 1.5. Coaching Program Termination 8

2. Coaching Process: Coaching Relationship/Communication/Techniques..... 9

 2.1. Client-centered relationship..... 9

 2.2. Trust & rapport 10

 2.3. Active listening and presence..... 11

 2.4. Client emotions and energy..... 12

 2.5. Reflections 13

 2.6. Expand the conversation 14

 2.7. Focus and refocus the conversation 15

 2.8. Assist client to evaluate and integrate health information 16

 2.9. Goals and implementing action..... 16

 2.10. Client awareness, perspective shifts and insights 18

 2.11. Client’s freedom of choice, autonomy, and intrinsic motivation 19

 2.12. Client self-efficacy 20

 2.13. Improve support 21

 2.14. Client active experimentation and self-discovery 22

 2.15. Increase positive psychological resources..... 23

3. Health & Wellness 24

 3.1. Health, health promotion and disease prevention, applying a whole person perspective 25

 3.2. Chronic Disease..... 26

 3.3. Health behaviors, social and behavioral risk factors 30

4. Ethics/Legal 36

 4.1. Professional Conduct 36

 4.2. Ethics 36

 4.3. Legal 38

Health & Wellness Coach Certifying Examination Content Outline with Resources

How to use this Content Outline with Resources:

Read the **Overview** and specific **Competencies**. For most topics, you should recognize the content from your training program. Therefore, we recommend reviewing the materials from your program.

Resources. If the topic sounds unfamiliar, or if it was not covered by your training program, you would likely benefit from further study. To assist you, we suggest resources with page numbers that correspond to specific topics. Note that many suggested resources cover the same topics. We encourage you to select those you prefer, as well as use other resources you already have.

1.1. Coach preparation prior to session

Overview

Prior to a coaching session, the coach reviews materials, eliminates distractions, and takes time to become mindful and present. The coach's state helps the client become calm and receptive, which fosters self-awareness and self-discovery.

Competencies

- 1.1.1. Coach is calm, present, and emotionally available
- 1.1.2. Review available client materials
- 1.1.3. Logistics (meeting location, conference call arrangements, etc.)

Resources

- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). Nurse Coaching: Integrative Approaches for Health and Wellbeing. pp 86-87 (Topics 1.1.1)
- Livingstone, J.B., Gaffney, J. (2016). Relationship Power in Health Care: Science of Behavior Change, Decision Making, and Clinician Self-Care. pp 64-67, 71-79, 148-150 (Topic 1.1.1)
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). Coaching Psychology Manual; 2nd ed. p 32-35 (Topic 1.1.1); p 156 (Topic 1.1.2)

The examination covers the following categories:

1. Coaching Structure	17-23%
2. Coaching Process (Relationship/Communication/Techniques)	47-53%
3. Health & Wellness	17-23%
4. Ethics/Legal	7-13%

Health & Wellness Coach Certifying Examination Content Outline with Resources

For your convenience, below is the list of books referenced throughout the Content Outline. Note that the outline also contains web links and peer-reviewed journal articles (with free full-text links).

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. Duluth, MN: Whole Person Associates, Inc.
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. San Francisco, CA: Createspace.
- Dossey, B. M., Luck, S., & Schaub, B. G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. North Miami, FL: International Nurse Coach Association.
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. San Rafael, CA: Global Medicine Enterprises, Inc.
- Kimsey-House, H., Kimsey-House, K., Sandahl, P., & Whitworth, L. (2011). *Co-active coaching: changing business, transforming lives*. Boston, MA: Nicholas Brealey Pub.
- Livingstone, J. B., & Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. Boca Raton, FL: CRC Press, Taylor & Francis Group.
- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. New York: Guilford Press.
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. Philadelphia: Wolters Kluwer.
- Muth, N.G., & Green, D.J. (2014). *Coaching behavior change*. San Diego, CA: American Council on Exercise.
- Prochaska, J.O., & Prochaska, J.M. (2016). *Changing to thrive: using the stages of change to overcome the top threats to your health and happiness*. Center City, MN: Hazelden Publishing.

ICHWC is always looking to expand our resource list. Please let us know if there are other references you find helpful. Contact us at info@ichwc.org.

1. Coaching Structure

1.1. Coach preparation prior to session

Overview

Prior to a coaching session, the coach reviews materials, eliminates distractions, and takes time to become mindful and present. The coach's state helps the client become calm and receptive, which fosters self-awareness and self-discovery.

Competencies

- 1.1.1. Coach is calm, present, and emotionally available
- 1.1.2. Review available client materials
- 1.1.3. Logistics (meeting location, conference call arrangements, etc.)

Resources

- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 287-289 (Topic 1.1.1).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 86-87 (Topic 1.1.1).
- Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 64-67, 71-79, 148-150 (Topic 1.1.1).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 32-35 (Topic 1.1.1); p 156 (Topic 1.1.2).

1.2. First session or before begin

Overview

The coach's aims for the initial session, or intake session, are to describe the coaching process, review information and assessments provided by the client, and determine if the client is an appropriate candidate for coaching. The coach clarifies roles and expectations; e.g., the coach will not diagnose or prescribe, nor give unsolicited advice; the client will self-determine his/her vision, goals, and action steps; and the client will be actively engaged in trying new behaviors as planned with the coach. Logistics and responsibilities (client vs. coach) are confirmed in a written Coaching Agreement.

Competencies

- 1.2.1. Set the climate/stage
 - 1.2.1.1. Establish rapport
 - 1.2.1.2. Gauge client's intentions for coaching/obtain information why coaching is sought
- 1.2.2. Determine if the individual is a candidate for health and wellness coaching and is an appropriate candidate for you specifically
- 1.2.3. Explain the coaching process
- 1.2.4. Establish the Coaching Agreement
 - 1.2.4.1. Guidelines and specific parameters of the coaching relationship (e.g., roles, logistics, fees, scheduling, inclusion of others if appropriate, confidentiality)
 - 1.2.4.2. Client vs. coach responsibilities, setting appropriate expectations
 - 1.2.4.3. Understand type of coaching relationship (i.e., short laser coaching session vs. long-term coaching relationship, telephonic, coaching apps, face-to-face, incentivized coaching)
- 1.2.5. Review assessments, if any used, and other data sources
- 1.2.6. Ensure appropriate time management of this and all sessions

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 101-115 (Overview); pp 130-149 (Topic 1.2.5).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. p 283 (Topic 1.2.1); pp 28-30, 33-36, 62-80 (Topics 1.2.3, 1.2.4); pp 130-134, 327-328 (Topic 1.2.5).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 75-83 (Overview).
- Kimsey-House, H., Kimsey-House, K., et al. (2011). *Co-active coaching: changing business, transforming lives*. pp 22-27 (Overview).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 155-167 (Overview); pp 20-22 (Topic 1.2.2); pp 126-129 (Topics 1.2.3, 1.2.4); pp 113-124 (Topic 1.2.5); p 156 (Topic 1.2.6).

1.3. Early (typically in the first, second or other early session)

Overview

In the initial stages of coaching, time is spent exploring the client's values, vision, purpose, and priorities. The coach refers to these in subsequent sessions to elicit motivation. During early sessions, the coach also spends adequate time exploring the client's understanding of his/her health and wellness, so goals are not set prematurely. Note that when choosing a focus (Topic 1.3.4), the coach is not the "expert" deciding what is most appropriate; instead, the client is empowered to select an area that feels important, motivating, or timely.

Competencies

- 1.3.1. Have client assess current state of his/her health and/or wellbeing
- 1.3.2. Explore the client's vision of his/her optimal health and/or wellbeing
- 1.3.3. Identify gaps between current state and client's desired lifestyle/outcomes
- 1.3.4. Explore client preference for priority areas of focus
- 1.3.5. Establish or refine client's specific long-term goals that lead toward desired outcomes
- 1.3.6. Establish or refine client's short-term SMART goals or action steps for what will be accomplished between sessions
- 1.3.7. Support the client in achieving the SMART goals or action steps including back-up plans
- 1.3.8. Establish client's preferences for maintaining accountability

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 124-149 (Topic 1.3.1); pp 153-159 (Topic 1.3.2); pp 159-160 (Topic 1.3.3); pp 161-162 (Topic 1.3.4); pp 162-166 (Topics 1.3.5, 1.3.6, 1.3.7); pp 198-200 (Topic 1.3.8).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 327-328 (Topic 1.3.1); pp 328-329 (Topic 1.3.2); pp 70, 155, 335-336 (Topics 1.3.6, 1.3.7).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 88-93 (Overview); pp 132-135 (Topic 1.3.2); pp 110-116 (Topics 1.3.5, 1.3.6, 1.3.7); p 116 (Topic 1.3.8).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 155-167 (Overview); pp 113-124 (Topic 1.3.1); pp 129-132 (Topic 1.3.2); pp 82-85 (Topic 1.3.3); pp 82-87, 118-124 (Topic 1.3.4); pp 132-134 (Topics 1.3.5, 1.3.6, 1.3.7); p 158-159 (Topic 1.3.8).
- Muth, N.G., & Green, D.J. (2014). *Coaching behavior change*. pp 76-86 (Topic 1.3.2).

1.4. Routine Follow-Up Sessions

Overview

A coaching program starts with an initial phase, followed by routine (follow-up) coaching sessions for a pre-determined period of weeks or months. At the opening of each session, the coach asks about the client's current state (e.g., energy, mood); throughout the session, the coach refers to shifts in the client's state. The coach facilitates review of previous action steps, uses other processes as appropriate (Section 2: Coaching Process), and supports the client in defining new action steps. The coach reflects the client's understanding, perspectives, and learning. At the end of each session, the client articulates new personal discoveries.

Competencies

- 1.4.1. Connect, have client self-assess state at beginning of each session
- 1.4.2. Check-in on prior session commitments/action steps
- 1.4.3. Invite client to select focus for session
- 1.4.4. Establish or refine client's short-term SMART goals or action steps for what will be accomplished between sessions
- 1.4.5. Use appropriate skills/processes depending on client's focus (see Section 2)
- 1.4.6. Articulate new action steps and adjust plan if needed, with self-monitoring
- 1.4.7. Discover and reflect client's learning, including "take-aways" from session
- 1.4.8. Communicate appreciation of client's work
- 1.4.9. Invite the client to provide feedback to the coach on the coaching provided
- 1.4.10. Schedule next session

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. p 200 (Topic 1.4.6).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 328-336 (Overview); p 70 (Topics 1.4.2, 1.4.4, 1.4.5, 1.4.8).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 88-93 (Overview); p 114 (Topic 1.4.6).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 297-299 (Topic 1.4.6).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 155-167 (Overview); pp 68, 145-147 (Topic 1.4.3); pp 132-134 (Topic 1.4.4); pp 162-163 (Topic 1.4.7, 1.4.8, 1.4.9, 1.4.10); p 139 (Topic 1.4.9).

1.5. Coaching Program Termination

Overview

In the final coaching session, the coach's focus is on recognition of progress, learning, and closure. The client articulates successes and looks back at what s/he has learned. The coach helps the client to establish a plan for how s/he will maintain or continue progressing toward goals, with an emphasis on support and resources.

Competencies

- 1.5.1. Invite the client to reflect on, assess, and to articulate progress made, challenges experienced, lessons learned, and growth attained
- 1.5.2. Assist in developing sustainable pathway forward and/or maintenance/relapse prevention plan including available support and resources

Resources

Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 94-95 (Overview).

Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. p 164 (Overview).

2. Coaching Process: Coaching Relationship/Communication/Techniques

2.1. Client-centered relationship

Overview

A coach facilitates behavior change by empowering the client to self-discover values, resources, and strategies that are individualized and meaningful. The client is the expert in navigating his/her own life, based upon personal preferences and past experiences. The coach provides the structure of the session and serves as a facilitative partner. The coach's primary role is NOT that of a content expert or educator who diagnoses, advises, or instructs the client on what to do.

Competencies

- 2.1.1. Client's agenda, needs, interests, and preferences (vs. coach's) drives the coaching relationship
- 2.1.2. Share coach's personal information/experience only when appropriate
- 2.1.3. Share information or recommendations only when specifically asked or given permission to do so or as otherwise required within scope of practice
- 2.1.4. Observe, name, and refer to client's beliefs and values
- 2.1.5. Convey the belief that client is resourceful, expert in own experience
- 2.1.6. Adjust approach according to client's health literacy

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. p 72-73 (Topic 2.1.1); p 105 (Topic 2.1.3); pp 69-71 (Topic 2.1.5).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 63-74 (Overview); pp 33-36, 41-42 (Topic 2.1.5).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 103-106 (Topic 2.1.1); pp 87-88 (Topic 2.1.4); p 41 (Topic 2.1.5).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. p 102 (Topic 2.1.4); p 107 (Topic 2.1.1).
- Kimsey-House, H., Kimsey-House, K., et al. (2011). *Co-active coaching: changing business, transforming lives*. pp 124-129 (Topic 2.1.4); pp 3-4 (Topic 2.1.5).
- Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 124-127 (Topic 2.1.3).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 5-7 (Topic 2.1.1); pp 9, 90 (Topic 2.1.2, 2.1.3); pp 108, 147-148 (Topic 2.1.4); pp 46-47, 145 (Topic 2.1.5).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. p 22-23 (Topic 2.1.1); pp 131-154 (Topic 2.1.3); pp 74-89 (Topic 2.1.4).

2.2. Trust & rapport

Overview

The coach establishes a positive and safe environment where the client feels accepted and supported. The client is better able to clarify values and access motivation when s/he feels safe to be honest and vulnerable. Importantly, the coach's confidence in the client's ability to learn, grow, and change supports the client's self-efficacy (Topic 2.12). The coach builds trust by attending to the client's emotions as well as words and behaviors; for example, when the coach senses conflict, discomfort or confusion, the coach acknowledges what is happening with curious interest.

Competencies

- 2.2.1. Demonstrate benevolence, honesty, sincerity, and authenticity
- 2.2.2. Convey unconditional positive regard
- 2.2.3. Follow through on commitments made to the client
- 2.2.4. Openly name and address discord/conflict between coach & client as it occurs and resolve in a timely manner

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 113-115 (Overview).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. p 68 (Topics 2.2.1, 2.2.2).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. p 41 (Topic 2.2.1).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. p 100 (Overview).
- Kimsey-House, H., Kimsey-House, K., et al. (2011). *Co-active coaching: changing business, transforming lives*. p 18 (Overview).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 39-47 (Overview); pp 196-211 (Topic 2.2.4).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 29-32 (Topics 2.2.1, 2.2.2, 2.2.3); pp 40, 162-164 (Topic 2.2.4).

2.3. Active listening and presence

Overview

In addition to listening to verbal information shared by the client, the coach is attuned to nonverbal cues: expression, tone, emotions, and energy. The coach also notices relevant behaviors (or lack thereof). The coach uses mindful awareness to notice with curiosity and nonjudgment what is happening with the client, as well as what is happening within him/herself during coaching. Coach self-management is required when the coach finds him/herself “knowing” what the client needs. Finally, active listening involves using silence appropriately to “hold the space” and allowing clients time to reflect, process, and identify what emerges.

Competencies

- 2.3.1. Be attentive and mindful
- 2.3.2. Be open-minded
- 2.3.3. Be curious without assumptions
- 2.3.4. Pace communication to fit client’s needs
- 2.3.5. Listen for what is not being said
- 2.3.6. Nonverbal communication
 - 2.3.6.1. Use silence appropriately
 - 2.3.6.2. Attend to and address nonverbal communication

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 115-119 (Overview).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 68-69 (Overview).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 40-41, 86-87, 240-244 (Topic 2.3.1).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 100-101, 130-131 (Overview).
- Kimsey-House, H., Kimsey-House, K., et al. (2011). *Co-active coaching: changing business, transforming lives*. pp 31-40 (Overview).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 32-35, 44-45 (Topic 2.3.1); pp 50-51, 119 (Topic 2.3.2); p 50 (Topic 2.3.3); p 30 (Topic 2.3.4); pp 34-35, 37-38 (Topics 2.3.5, 2.3.6.2); p 39 (Topic 2.3.6.2).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 50-51 (Topic 2.3.6); pp 265-266 (Topic 2.3.6.1).

2.4. Client emotions and energy

Overview

Emotions can generate insight and impact the brain's capacity for learning and change. The coach calls attention to positive shifts in the client's energy or emotion that may support healthy behavior change. The coach encourages the client to foster self-compassion and acceptance of emotions, since these qualities allow a more honest appraisal of one's behaviors and better self-care. Harsh self-criticism, on the other hand, tends to lead to avoidance and undermines insight.

Competencies

- 2.4.1. Attend to the client's state of being (mood/affect/presence)
- 2.4.2. Acknowledge client's emotions
- 2.4.3. Ask client to describe emotions when appropriate
- 2.4.4. Show empathy (resonance with)
- 2.4.5. Foster self-compassion

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 118-119 (Topics 2.4.1, 2.4.2); p 247 (Topic 2.4.4).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 290-293 (Topics 2.4.4, 2.4.5).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 315-316 (Topic 2.4.4).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. p 100 (Topic 2.4.4).
- Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 63-64 (Topic 2.4.3); pp 68-71 (Topic 2.4.4).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 18, 392-393 (Topic 2.4.4).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 34-35 (Topic 2.4.1); p 82 (Topic 2.4.2); pp 55-56 (Topic 2.4.3); pp 45-46, 58-62, 143-144 (Topic 2.4.4); pp 57-58 (Topic 2.4.5).
- Muth, N.G., & Green, D.J. (2014). *Coaching behavior change*. p 18 (Topic 2.4.4).

2.5. Reflections

Overview

Reflections convey active listening (“I’m hearing...”) and give clients the powerful opportunity to witness the sound of their own words, perspectives, and beliefs. Nonjudgmental reflections engage the client and inspire learning. When the coach notices a discrepancy in the client’s words, emotions, or behavior, a double-sided reflection may raise the client’s awareness of the discrepancy. Similarly, when the coach uses an amplified reflection, the client may reconsider aspects of resistance when s/he hears the exaggerated reflection.

Competencies

- 2.5.1. Simple content reflections, paraphrasing
- 2.5.2. Double-sided & other types of reflections as indicated in Motivational Interviewing (e.g., amplified, feeling & meaning reflections)
- 2.5.3. Summaries
- 2.5.4. Recall previous information and experiences of client

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 115-121 (Overview).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. p 69 (Topic 2.5.1).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 317, 322 (Topic 2.5.1); pp 317-318 (Topic 2.5.2); p 321 (Topic 2.5.3).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 52-61, 198-200 (Topics 2.5.1, 2.5.2); pp 66-69 (Topic 2.5.3).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 37-38, 82, 84 (Topics 2.5.1, 2.5.3); pp 84-85 (Topic 2.5.2); pp 68-70 (Topic 2.5.4).

2.6. Expand the conversation

Overview

The coach helps the client expand possibilities by asking curious questions that evoke deeper thinking and self-reflection. Open-ended questions (starting with “what” or “how”) encourage exploration, as well as highlight strengths, values, and opportunities for learning. The coach helps expand the client’s perspective by exploring interconnections in the client’s life.

Competencies

- 2.6.1. Open-ended questions
- 2.6.2. Evocative (powerful) questions
- 2.6.3. Use of metaphors based on client language and interests
- 2.6.4. Brainstorm
- 2.6.5. Connect the focus to multiple dimensions of client’s life
- 2.6.6. Explore broader perspectives and inspire interest in new possibilities
- 2.6.7. Incorporate coach’s intuition

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 120-121 (Topic 2.6.1); pp 119-120 (Topic 2.6.2); p 119 (Topic 2.6.7).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 136-137 (Topic 2.6.2); pp 209-247 (Topic 2.6.7).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. p 42 (Topic 2.6.1); pp 245-247 (Topic 2.6.3).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 102-103, 107-108 (Topic 2.6.2).
- Kimsey-House, H., Kimsey-House, K., et al. (2011). *Co-active coaching: changing business, transforming lives*. pp 69-73 (Topic 2.6.2); p 43 (Topic 2.6.3); p 88 (Topic 2.6.4); pp 12, 48-57 (Topic 2.6.7).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 62-64, 75-77 (Topic 2.6.1); pp 171-174 (Topic 2.6.2); pp 219-220 (Topic 2.6.3).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 35-37, 144 (Topics 2.6.1, 2.6.2); pp 135-137, 144-145, 149-151 (Topic 2.6.4); pp 120-121 (Topic 2.6.7).

2.7. Focus and refocus the conversation

Overview

The coach facilitates a conversation that balances a client's exploratory thinking (Topic 2.6) with action-oriented focus. After engaging the client in an exploration process, the techniques listed below help narrow the conversation toward decisions, goal-setting, and commitment – all of which support action.

Competencies

- 2.7.1. Closed-ended questions
- 2.7.2. Interrupt and re-direct
- 2.7.3. Bottom-lining
- 2.7.4. Scaling questions (using a scale of 0-10)
- 2.7.5. Ask the client to summarize the topic

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 133-137 (Topic 2.7.4).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 137-141 (Topic 2.7.4).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. p 73 (Topic 2.7.4)
- Kimsey-House, H., Kimsey-House, K., et al. (2011). *Co-active coaching: changing business, transforming lives*. pp 72-73 (Topic 2.7.1); pp 57-60 (Topic 2.7.2); pp 104-105 (Topic 2.7.3).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 93-154 (Overview); pp 174-175, 216-217 (Topic 2.7.4)
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 86-87 (Topic 2.7.4).

Notes

The coach may be familiar with different terminology for Scaling questions (Topic 2.7.4), including “rulers” for readiness, importance, confidence, commitment, motivation, etc.

2.8. Assist client to evaluate and integrate health information

Overview

An objective of coaching is for the client to be well-informed of the status of his/her health and well-being. This process begins with identifying what the client understands. The coach then assists the client in finding and utilizing health and wellness resources, as well as accurately evaluating and integrating multiple sources of health information. These sources may include health care provider input, health & wellness assessments (including self-assessments), health risk assessments, basic biometrics, and appropriate referrals.

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. p 251.
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 109-121.
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. p 68-69.
- Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 61-63, 87-91.
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 115-124.

2.9. Goals and implementing action

Overview

The coach supports the client in choosing goals and action steps carefully, since small, gradual successes predict long-term engagement. The coach recognizes the client's readiness to change (Topic 2.9.1) and supports the client in designing appropriate action steps that move the client toward self-determined goals. Tracking progress over time is strongly linked to long-term success, so clients learn to track their own behavior, problem-solve, and observe the impact of their actions. When reviewing progress, the coach does not focus on the outcome, but rather emphasizes the client's effort and what is learned during both successes and setbacks.

Competencies

- 2.9.1. Transtheoretical Model (stages of change)
- 2.9.2. Specific, measurable, achievable/attainable, realistic/relevant, timely (SMART) goals
- 2.9.3. Patient activation and engagement models
- 2.9.4. Facilitate visualizing to elicit intrinsic motivation and goal direction
- 2.9.5. Commitment to action
- 2.9.6. Encourage behavioral stretches but also set a comfortable pace of learning and implementation of client's goal
- 2.9.7. Anticipate, plan for, and help client navigate challenges
- 2.9.8. Outcomes tracking

Resources (Topic 2.9 cont'd)

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 166-172 (Topic 2.9.1); pp 162-166 (Topics 2.9.5, 2.6.7); pp 196-198 (Topic 2.9.8).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 95-103 (Topic 2.9.1); pp 51-52 (Topic 2.9.3); pp 193-195 (Topic 2.9.4); pp 83-103 (Topic 2.9.7); p 70 (Topic 2.9.8).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 298-303 (Topic 2.9.1); p 306 (Topic 2.9.2); pp 307-309 (Topic 2.9.3); pp 245-250 (Topic 2.9.4).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 110-113 (Overview); pp 65-68 (Topic 2.9.1); pp 115-116 (Topic 2.9.2); pp 113-114 (Topic 2.9.4).
- Kimsey-House, H., Kimsey-House, K., et al. (2011). *Co-active coaching: changing business, transforming lives*. pp 86-87 (Overview).
- Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 32-33 (Topic 2.9.1).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 285-291 (Topic 2.9.5); pp 277-280, 291-292 (Topic 2.9.7).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 93-111 (Topic 2.9.1); p 133 (Topic 2.9.2); pp 129-132 (Topic 2.9.4); pp 132-137 (Topic 2.9.5); pp 138-139 (Topic 2.9.8).
- Muth, N.G., & Green, D.J. (2014). *Coaching behavior change*. pp 114-121 (Overview); pp 45-57 (Topic 2.9.1).
- Prochaska, J.O., & Prochaska, J.M. (2016). *Changing to thrive: using the stages of change to overcome the top threats to your health and happiness*. pp 1-32 (Topic 2.9.1).
- Simmons, L.A., Wolever, R.Q., Bechard, E. M., & Snyderman, R. (2014). Patient engagement as a risk factor in personalized health care: A systematic review of the literature on chronic disease. *Genome Medicine*, 6:16. (Topic 2.9.3). <https://doi.org/10.1186/gm533>

Notes

The coach should be able to apply the Transtheoretical Model by recognizing what stage of change a client appears to be in based upon what s/he says, and knowing which techniques to apply in which stages.

2.10. Client awareness, perspective shifts and insights

Overview

The coach reflects the client's views (Topic 2.5) and asks open-ended questions (Topic 2.6.1) to enhance the client's self-awareness and foster new perspectives. The coach may offer positive reframing—i.e., looking at things in an alternative, more positive way—to shift perspectives, since positive conversations are more likely to inspire motivation and forward progress. The coach also listens carefully for the client's self-talk—i.e., the way s/he talks to and about him/herself and judges his/her own behavior—and helps the client consider more positive self-talk.

Competencies

2.10.1. Reframe

2.10.2. Address self-defeating perceptions

2.10.3. Explore patterns related to client behaviors and decision tendencies (e.g., triggers, thoughts, emotions, physical sensations, and environment)

2.10.4. Awareness of self-talk and adjustment as appropriate

Resources

Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 184-193 (Overview).

Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 70-74, 179-185, 203-205 (Topic 2.10.1); pp 179-185 (Topic 2.10.2); pp 149-153, 141-144 (Topic 2.10.3); pp 197-203 (Topic 2.10.4).

Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 103-104 (Topic 2.10.1); pp 152-154 (Topic 2.10.3).

Kimsey-House, H., Kimsey-House, K., et al. (2011). *Co-active coaching: changing business, transforming lives*. p 109 (Topic 2.10.1).

Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 87-91 (Topic 2.10.3).

Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 201-202, 220 (Topic 2.10.1).

Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 38-39 (Topic 2.10.1); p 88 (Topic 2.10.3); pp 38-39, 55-56 (Topic 2.10.4).

2.11. Client's freedom of choice, autonomy, and intrinsic motivation

Overview

Coaching psychology involves eliciting the client's intrinsic motivation, which is based upon the client's purpose, meaning, values, and preferences, and not external sources. The knowledge and experience of the client—not the coach—are the raw materials for coaching conversations that facilitate lasting change.

Competencies

- 2.11.1. Elicit the client's perspectives (including reasons for change, solutions, ideas, experiments, desires, reactions, desired outcomes, rewards/incentives)
- 2.11.2. Help client explore and articulate values, sense of meaning, and purpose
- 2.11.3. Help client envision desired of his/her optimal health and/or wellbeing
- 2.11.4. Discuss and honor client's preferences for self-monitoring (without judgment), accountability, mode of connecting (email, text, phone call)
- 2.11.5. Self-determination theory
- 2.11.6. Motivational interviewing concepts

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 172-184 (Overview); pp 155-159 (Topic 2.11.3); pp 196-200 (Topic 2.11.4).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 289-290 (Topic 2.11.1, 2.11.2); p 155 (Topic 2.11.4); p 97 (Topic 2.11.6).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 331-332 (Topic 2.11.3); pp 314-321 (Topic 2.11.6).
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 121-123 (Overview); pp 71-73 (Topic 2.11.6).
- Kimsey-House, H., Kimsey-House, K., et al. (2011). *Co-active coaching: changing business, transforming lives*. pp 124-129 (Topic 2.11.2).
- Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 170-181 (Topics 2.11.1-2.11.3); pp 33-35 (Topic 2.11.5); pp 30-33 (Topic 2.11.6).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 167-182 (Overview); pp 74-89, 177-178, 252-253 (Topic 2.11.2); entire book (Topic 2.11.6).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 77-111 (Topic 2.11.1); pp 85-86, 108 (Topic 2.11.2); pp 129-134 (Topic 2.11.3); pp 158-159 (Topic 2.11.4); pp 11-12 (Topic 2.11.5); pp 77-91 (Topic 2.11.6).
- Muth, N.G., & Green, D.J. (2014). *Coaching behavior change*. pp 74-75 (Topic 2.11.2); pp 59-71 (Topic 2.11.6).

Notes (Topic 2.11 cont'd)

Self-determination theory (Topic 2.11.5) posits several universal needs for psychological health and well-being: autonomy (not feeling persuaded or controlled), competence (seeking confidence and mastery), and relatedness (being connected to others). The coach does not need to memorize minute details of the theory, such as how qualities interact, but should recognize how the qualities may be fostered during coaching.

2.12. Client self-efficacy

Overview

The coach helps the client develop self-efficacy, which is the client's belief in his/her ability to initiate change and achieve goals. The coaching process cultivates self-efficacy as the client better understands his/her needs, gains self-awareness and insight that supports behavior change, learns from setbacks, develops new resources, and finds new ways to navigate his/her environment.

Competencies

2.12.1. Explore ways to improve self-efficacy

2.12.2. Engage client in problem-solving

2.12.3. Engage client to evaluate options, considering both short and long-term benefits and consequences

2.12.4. Use client's awareness, learning, and tools to support the client to improve confidence in make informed decisions

2.12.5. Social Cognitive Theory (Social Learning Theory and Self-Efficacy Theory, including role models, mastery)

Resources

Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 208-214 (Topics 2.12.2, 2.12.3, 2.12.4).

Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 141-144 (Topic 2.12.3); pp 33, 41-42, 130-137 (Topic 2.12.4).

Caldwell, K.L., Grey, J., & Wolever, R.Q. (2013). The process of patient empowerment in integrative health coaching: how does it happen? *Global Advances in Health and Medicine*, 2(3), 48-57. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3833537/>

Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 69-70 (Overview); p 147 (Topic 2.12.1).

Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 35-37 (Topic 2.12.5).

Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. pp 212-230 (Topic 2.12.1, 2.12.4); pp 268-284 (Topic 2.12.3).

Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 77-92 (Overview).

2.13. Improve support

Overview

In addition to providing support during client sessions, the coach assists the client in developing supportive relationships and identifying community resources. The coach helps the client to build a support system—relationships, tools, resources, environments—that enable ongoing success after the coaching program ends.

Competencies

2.13.1. Social

2.13.2. Structural/environmental

Resources

Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 224-229 (Topic 2.13.1).

Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. p 94 (Topic 2.13.1); pp 260-263 (Topic 2.13.2).

Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 152-153 (Topic 2.13.2).

Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 73, 148-149 (Topics 2.13.1, 2.13.2).

2.14. Client active experimentation and self-discovery

Overview

The coach establishes a trusting environment where the client feels safe to experiment with new ideas and new behaviors. The coach helps the client develop a growth mindset (Topic 2.14.1), the belief that the client's abilities are not fixed and can be improved continuously through experimentation and persistent efforts. The coach may help the client gain confidence by rehearsing with the client how the client will behave in a situation (Topic 2.14.2).

Competencies

2.14.1. Growth mindset

2.14.2. Practice techniques in session

2.14.3. Decisional balance

Resources

Growth mindset: <https://www.mindsetworks.com/science/Impact>

Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 30-31 (Topic 2.14.1).

Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 302-303, 319 (Topic 2.14.3).

Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. p 238 (Topic 2.14.3).

Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. p 74 (Topic 2.14.1); pp 82-83, 104-106 (Topic 2.14.3).

Muth, N.G., & Green, D.J. (2014). *Coaching behavior change*. p 67 (Topic 2.14.3).

Prochaska, J.O., & Prochaska, J.M. (2016). *Changing to thrive: using the stages of change to overcome the top threats to your health and happiness*. pp 35-41 (Topic 2.14.3).

Notes

Decisional balance (Topic 2.14.3) refers to evaluating the pros and cons of changing behavior, as well as pros and cons of not changing behavior.

2.15. Increase positive psychological resources

Overview

The coach helps the client develop positive psychological resources by cultivating meaning, reflecting positive emotions, applying strengths, and affirming self-worth and efforts. Positive psychology has demonstrated the value of positive resources in improving creativity, open-mindedness, strategic thinking, resilience, connection, and health.

Competencies

- 2.15.1. Prompt for, and amplify positive resources (including past successes, qualities, strengths, and skills)
- 2.15.2. Validate effort, skills, insights; learnings and successes
- 2.15.3. Identify and reflect strengths
- 2.15.4. Affirm/acknowledge the client's being (value, qualities, strengths, skills, worth)
- 2.15.5. Cultivate positive emotions
- 2.15.6. Acknowledge and explore effort and progress
- 2.15.7. Positive psychology

Resources

- Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 189-193 (Overview).
- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. p 141 (Topic 2.15.1); pp 203-205, 290-293 (Topics 2.15.4, 2.15.5); pp 65-66, 70 (Topic 2.15.6); pp 44-46 (Topic 2.15.7).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 88-92 (Topic 2.15.1).
- Fredrickson, B. L., Cohn, M. A., Coffey, K. A., Pek, J., & Finkel, S. M. (2008). Open hearts build lives: positive emotions, induced through loving-kindness meditation, build consequential personal resources. *Journal of Personality and Social Psychology*, 95(5), 1045-1062.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3156028/>
- Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 101-102 (Overview); p 62 (Topic 2.15.7).
- Miller, W.R., & Rollnick, S. (2013). *Motivational interviewing: helping people change*. p 219 (Topic 2.15.1); pp 217-219 (Topic 2.15.3); pp 64-66 (Topic 2.15.4, 2.15.6).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 63-75 (Overview).
- Muth, N.G., & Green, D.J. (2014). *Coaching behavior change*. pp 27-41 (Overview).

3. Health & Wellness

By definition, health and wellness coaches are not content experts in health or disease; they do not diagnose or prescribe, unless a coach has credentials in another profession that allow expert advice to be given. However, it is important for coaches to have a solid working familiarity of current evidence-based recommendations provided by public health groups such as the Center for Disease Control and National Institutes of Health. Relevant guidelines and recommendations fall in the areas of health promotion, disease prevention, and lifestyle medicine.

The coach should be able to identify risk factors for chronic disease, commonly used biometric measures, and current lifestyle recommendations for optimizing health. An important focus for the coach is to recognize potential imminent danger and medical red flags, and to know when and how to refer to another health care professional.

Healthy lifestyle ideals, as in most areas of health care, are continually evolving. Recommendations change frequently for everything from interpretation of biometric markers (e.g., cholesterol, blood pressure) to evidence-based suggestions in lifestyle areas like nutrition and physical activity. Moreover, guidelines vary by organization. The coach stays abreast of trends, controversies, and evolutions in the lifestyle fields, since these will impact client choices and the resources they need.

Since the coaching relationship is client-centered, the coach's focus is determining what the client already knows, needs, and wishes to learn about. The coach then supports the client in obtaining credible health and wellness information. General knowledge about healthy living is required for the coach to facilitate the various topics that arise in a coaching conversation.

The Centers for Disease Control (<https://www.cdc.gov>) has a robust, evidence-based website that offers useful information for the coach and the client. Another valuable resource is Healthy People 2020 (<https://www.healthypeople.gov>), a program of nationwide health-promotion and disease-prevention goals set by the U.S. Department of Health and Human Services (HHS). Finally, the American College of Lifestyle Medicine provides peer-reviewed resources (<http://www.lifestylemedicine.org/Scientific-Evidence>). Links from these and other reputable organizations are contained in the topics below.

Notes regarding web links on the following pages:

Unless otherwise specified, the coach is responsible for content that appears when you first click the link (i.e., not responsible for additional links on the page).

If the hyperlink appears broken, manually copy and paste the link into your web browser (some PDF readers do not recognize hyperlinks over two lines).

3.1. Health, health promotion and disease prevention, applying a whole person perspective

Health and wellness involve more than the absence of disease. Wellness, as a concept, includes all aspects of physical, psychological, spiritual and social well-being; it is multi-dimensional and holistic. Wellness also involves a self-directed and evolving process to achieve full potential. Many coach training programs emphasize this whole-person perspective using a “wheel” or other framework that recognizes multiple dimensions of one’s health.

3.1.1. Wellness and well-being concepts (including the Travis Illness-Wellness Continuum)

Resources

- Health-related quality of life & well-being
 - <https://www.healthypeople.gov/2020/topics-objectives/topic/health-related-quality-of-life-well-being>
- Well-being concepts
 - <https://www.cdc.gov/hrqol/wellbeing.htm>
- Travis Illness-Wellness Continuum
 - <https://www.thewellspring.com/wellspring/introduction-to-wellness/357/key-concept-1-the-illnesswellness-continuum.cfm>
- Book resources
 - Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 27-57, 71-72.
 - Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 109-119.
 - Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 46-51.
 - Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 2-5, 115-118.
 - Prochaska, J.O., & Prochaska, J.M. (2016). *Changing to thrive: using the stages of change to overcome the top threats to your health and happiness*. pp 235-251.

3.2. Chronic Disease

The coach often works with clients living with chronic medical conditions, as well those who are not yet ill, but are increasing their risk through unhealthy behavior. The coach should have a basic understanding of common chronic diseases and conditions including hypertension, diabetes, obesity, cardiovascular disease, high cholesterol, and a constellation of symptoms known as metabolic syndrome, which together place individuals at higher risk for heart disease, diabetes, stroke, and some cancers. Inflammation is one of the key pathophysiological processes that underlie most chronic diseases, and a rudimentary understanding of the role of inflammation in disease should also be recognized.

3.2.1. Hypertension/prehypertension, blood pressure

- Blood pressure basics
 - <https://www.cdc.gov/bloodpressure/about.htm>
- Measuring blood pressure
 - <https://www.cdc.gov/bloodpressure/measure.htm>
- Risk factors for hypertension, including:
 - Medical conditions
 - <https://www.cdc.gov/bloodpressure/conditions.htm>
 - Behaviors
 - <https://www.cdc.gov/bloodpressure/behavior.htm>
 - Family history and other characteristics
 - https://www.cdc.gov/bloodpressure/family_history.htm

3.2.2. Diabetes/pre-diabetes, fasting glucose, hemoglobin A1c

- Diabetes basics (Note: open each section on the page, including symptoms, types of diabetes, risk factors, treatment, etc.)
 - <https://www.cdc.gov/diabetes/basics/diabetes.html>
- Prediabetes
 - <https://www.cdc.gov/diabetes/basics/prediabetes.html>
- Diagnosing diabetes (cutoff values for A1c, fasting plasma glucose, etc.)
 - <http://www.diabetes.org/diabetes-basics/diagnosis/>
- Book resources
 - Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success.* pp 122-128 (Case study).
 - Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing.* pp 180-187 (Case study).
 - Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care.* pp 170-181 (Case study, contains web link with video session).

3.2.3. Obesity, BMI, waist circumference

- Obesity causes and consequences
 - <https://www.cdc.gov/obesity/adult/causes.html>
- BMI
 - <https://www.cdc.gov/obesity/adult/defining.html>
- Waist circumference
 - <http://www.health.harvard.edu/staying-healthy/abdominal-obesity-and-your-health>
- Book resource
 - Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 156-157.

3.2.4. Cardiovascular disease (mainly heart disease and stroke)

- Heart disease
 - Coronary artery disease basics
 - https://www.cdc.gov/heartdisease/coronary_ad.htm
 - Heart attack signs and symptoms
 - https://www.cdc.gov/heartdisease/signs_symptoms.htm
 - Risk factors for heart disease, including:
 - Medical conditions
 - <https://www.cdc.gov/heartdisease/conditions.htm>
 - Behavior
 - <https://www.cdc.gov/heartdisease/behavior.htm>
 - Family history and other characteristics
 - https://www.cdc.gov/heartdisease/family_history.htm
- Stroke
 - Stroke basics
 - <https://www.cdc.gov/stroke/about.htm>
 - Stroke signs and symptoms
 - https://www.cdc.gov/stroke/signs_symptoms.htm
 - Risk factors for stroke, including:
 - Medical conditions
 - <https://www.cdc.gov/stroke/conditions.htm>
 - Behavior
 - <https://www.cdc.gov/stroke/behavior.htm>
 - Family history and other characteristics
 - https://www.cdc.gov/stroke/family_history.htm

3.2.5. Metabolic syndrome, arthritis and inflammation

- Metabolic syndrome
 - Metabolic syndrome overview
 - <https://www.nhlbi.nih.gov/health/health-topics/topics/ms>
 - Risk factors for metabolic syndrome
 - <https://www.nhlbi.nih.gov/health/health-topics/topics/ms/atrisk>
 - Diagnosis of metabolic syndrome
 - <https://www.nhlbi.nih.gov/health/health-topics/topics/ms/diagnosis>
 - Book resources
 - Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 158-159; 194-200 (Case study).
- Arthritis
 - Types of arthritis (Note: open and read sections on Osteoarthritis (OA), Rheumatoid arthritis (RA) and Fibromyalgia)
 - <https://www.cdc.gov/arthritis/basics/types.html>
 - Risk factors for arthritis
 - <https://www.cdc.gov/arthritis/basics/risk-factors.htm>
- Inflammation
 - The coach recognizes that chronic inflammation is a common factor in most chronic diseases. Whereas acute inflammation is a healthy response to injury, chronic inflammation causes problems over time. Common and well-studied conditions associated with chronic inflammation include coronary artery disease, diabetes, obesity, arthritis, cancer, and Alzheimer Disease. Dietary interventions (see anti-inflammatory diet in Section 3.3), moderate exercise, and effective stress management are thought to be central in preventing inflammatory disease.
 - Scientific papers (Note: the coach is not responsible for the level of detail in these scientific articles; however, peer-reviewed papers are a reliable source and may help with a conceptual understanding)
 - Prasad, S., & Aggarwal, B. B. (2014). Chronic diseases caused by chronic inflammation require chronic treatment: anti-inflammatory role of dietary spices. *J. Clin. Cell. Immunol*, 5(238), 10-4172. <http://doi.org/10.4172/2155-9899.1000238>
 - (Note: the coach is *not* responsible for the role of spices discussed in the above article; focus on the Introduction and Role of Inflammation in Chronic Disease)
 - Manabe, I. (2011). Chronic inflammation links cardiovascular, metabolic and renal diseases. *Circulation Journal*, 75(12), 2739-2748. <http://doi.org/10.1253/circj.CJ-11-1184>
 - Video: Inflammation and Heart Disease: a PBS Production
 - <https://youtu.be/5X-VTMF10Vl>

3.2.6. Lipid abnormalities, lipid panels

- Cholesterol basics
 - <https://www.cdc.gov/cholesterol/about.htm>
- Types of cholesterol (LDL, HDL, triglycerides)
 - https://www.cdc.gov/cholesterol/ldl_hdl.htm
- Reference values (Note: the coach is required to know only normal lipid values; i.e., does not need to know borderline high vs. high vs. very high)
 - <https://labtestsonline.org/understanding/analytes/lipid/tab/test/>
- Risk factors for high cholesterol, including:
 - Medical conditions
 - <https://www.cdc.gov/cholesterol/conditions.htm>
 - Behaviors
 - <https://www.cdc.gov/cholesterol/behavior.htm>
 - Genetics, family history, and other characteristics
 - https://www.cdc.gov/cholesterol/family_history.htm

3.3. Health behaviors, social and behavioral risk factors

3.3.1. Healthy weight and 3.3.2. Optimal nutrition & hydration

Guidelines around healthy weight, nutrition, and hydration are among the most controversial topics in lifestyle medicine. Thus, in this area, it is particularly important for the coach to follow a client-centered approach, beginning with what the client understands, needs, and wants, and engaging in a partnership that allows the client to access new information and ultimately create new habits.

The coach should be familiar with recommendations and resources currently offered by leading government and health agencies. There are differing professional opinions, and many controversies exist that are not always readily apparent within conventional expertise. For example, the CDC recommendation for dietary guidelines (MyPlate) has been contested by some experts in nutrition, and alternative recommendations have been put forth, such as Harvard’s Healthy Eating Plate. In this circumstance, the coach should be familiar with both popular resources, even though they may be contradictory.

It is widely agreed that there is no “one size fits all” diet, and everything from ethnicity, family history, lifestyle, age, sex, body habitus, overall health, and environment needs to be considered by and for any given individual. How these individual considerations are made varies widely between experts. The coach and client have the unique opportunity to explore together what works best for the client.

The coach understands the basics of a healthy diet, which include knowledge of unprocessed (or minimally processed) whole foods, lean proteins, adequate fiber, healthy fats, and the recommended intake of fruits and vegetables. Regarding water intake, the coach recognizes the role of hydration in health, and weight balance in particular, since people sometimes confuse the body’s signals for hunger and thirst.

- Nutrition and weight status
 - <https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status>
- MyPlate (current CDC guidelines)
 - <https://www.choosemyplate.gov/MyPlate>
- Healthy eating plate
 - <https://www.health.harvard.edu/healthy-eating-plate>
- Katz, D. L., & Meller, S. (2014). Can we say what diet is best for health? Annual review of public health, 35, 83-103. <https://doi.org/10.1146/annurev-publhealth-032013-182351>

- Common evidence-based nutritional interventions for prevalent medical conditions
 - The coach recognizes that professional organizations recommend nutrition guidelines for specific medical conditions, and may choose to refer clients to these links. The coach has a conceptual understanding of the diet (e.g., DASH diet for hypertension, reduced sodium intake); however, the coach is not required to memorize specifics of each diet.
 - Hypertension (DASH)
 - <https://www.nhlbi.nih.gov/health/health-topics/topics/dash/benefits>
 - <https://www.nhlbi.nih.gov/health/health-topics/topics/dash>
 - Diabetes
 - <http://www.diabetes.org/food-and-fitness/food/what-can-i-eat/making-healthy-food-choices/?loc=ff-slabnav>
 - Arthritis (anti-inflammatory diet)
 - <https://www.arthritis.org/living-with-arthritis/arthritis-diet/anti-inflammatory/anti-inflammatory-diet.php>
 - <http://www.health.harvard.edu/staying-healthy/foods-that-fight-inflammation>
 - Weight loss
 - Because there is no “one size fits all” approach to weight-loss, the coach utilizes coaching skills that engage the client to choose a strategy that fits his/her preferences and lifestyle. The NIH resource below offers general tips for choosing a safe and successful weight-loss program
 - <https://www.niddk.nih.gov/health-information/health-topics/weight-control/choosing-safe-successful-weight-loss-program/Pages/choosing-safe-successful-weight-loss-program.aspx>
- Hydration
 - Water and nutrition
 - <https://www.cdc.gov/healthywater/drinking/nutrition/>
- Book resources
 - Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success.* pp 263-267.
 - Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing.* pp 148-156.
 - Jordan, M. (2013). *How to be a health coach: an integrative wellness approach.* pp 138-150.
 - Prochaska, J.O., & Prochaska, J.M. (2016). *Changing to thrive: using the stages of change to overcome the top threats to your health and happiness.* pp 161-202.

3.3.3. Physical activity, sedentary lifestyle

Regular physical activity reduces the risk of many chronic diseases, including heart disease, high blood pressure, diabetes, cancer, and depression. The coach must be familiar with current recommendations for healthy adult exercise according to HHS guidelines (summarized in the CDC link below). Given the prevalence of mobile devices and wearable technologies that track physical activity, the coach should also be able to support the client with an awareness of evidence-based methods used to track physical activity.

- Overview of physical activity
 - <https://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity>
- Benefits of physical activity
 - <https://www.cdc.gov/physicalactivity/basics/pa-health/index.htm>
- Physical activity guidelines for adults
 - <https://www.cdc.gov/physicalactivity/basics/adults/index.htm>
- ACSM position stand on individual exercise programs (Note: the ACSM position stand is a compendium of findings and provides a rich resource; however, the details of the position stand are beyond the scope of what the coach is expected to know)
 - Garber, C. E., Blissmer, B., Deschenes, M. R., Franklin, B. A., Lamonte, M. J., Lee, I. M., ... & Swain, D. P. (2011). Quantity and quality of exercise for developing and maintaining cardiorespiratory, musculoskeletal, and neuromotor fitness in apparently healthy adults: guidance for prescribing exercise. *Medicine & Science in Sports & Exercise*, 43(7), 1334-1359. <https://doi.org/10.1249/MSS.0b013e318213febf>
- Physical activity tracking: mobile devices and wearable technology
 - With the rise of wearable technology and mobile devices that track physical activity, the coach should be familiar with the use of tracking devices and mobile apps. Peer-reviewed papers in journals are the preferred method of obtaining information, since devices are heavily marketed, often with little regard for scientific evidence or approved guidelines (see Modave 2015 paper below). Note: the coach is not responsible for specific findings from these publicly available articles, but should be aware of the trends and controversies surrounding such technology.
 - Jee, H. (2017). Review of researches on smartphone applications for physical activity promotion in healthy adults. *Journal of Exercise Rehabilitation*, 13(1), 3-11. <https://doi.org/10.12965/jer.1732928.464>
 - Modave, F., Bian, J., Leavitt, T., Bromwell, J., Harris III, C., & Vincent, H. (2015). Low quality of free coaching apps with respect to the American College of Sports Medicine guidelines: a review of current mobile apps. *Journal of Medical Internet Research mHealth and uHealth*, 3(3), e77. <https://doi.org/10.2196/mhealth.4669>
 - Sullivan, A. N., & Lachman, M. E. (2017). Behavior change with fitness technology in sedentary adults: a review of the evidence for increasing physical activity. *Frontiers in Public Health*, 4. <https://doi.org/10.3389/fpubh.2016.00289>

- Book resources
 - Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 138-141.
 - Prochaska, J.O., & Prochaska, J.M. (2016). *Changing to thrive: using the stages of change to overcome the top threats to your health and happiness*. pp 203-224.

3.3.4. Sleep

According to the CDC, insufficient sleep is a public health epidemic. Like nutrition and physical activity, sleep is a critical determinant of health and well-being. Adequate sleep is necessary for proper immune, endocrine, and neurological functioning. Lack of sleep is also linked to traffic accidents, work errors, and decreased productivity. The coach should have a basic understanding of sleep and the important role it plays in overall health and well-being, as well as familiarity with common recommendations for healthy sleep hygiene.

- Overview of sleep health
 - <https://www.healthypeople.gov/2020/topics-objectives/topic/sleep-health>
- Common sleep disorders
 - https://www.cdc.gov/sleep/about_sleep/key_disorders.html
- Sleep and chronic disease
 - https://www.cdc.gov/sleep/about_sleep/chronic_disease.html
- Sleep hygiene
 - https://www.cdc.gov/sleep/about_sleep/sleep_hygiene.html
- Book resource
 - Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 137-138.

3.3.5. Stress & emotional wellness

In addition to understanding major biological risk factors associated with chronic conditions, the coach should understand the most common psychosocial risk factors for chronic disease, including unmanaged stress, depression, and social isolation. The coach should recognize symptoms of depression and know how to refer for treatment. The coach also appreciates the impact of social and environmental stressors. Social determinants for health-related issues include socioeconomic status, transportation, housing, access to services, discrimination by social grouping (e.g., race, gender, or class), and social or work-related stressors.

Stress management is an inevitable topic for coaching. Stress can be both positive and negative; the coach recognizes negative stress and leverages positive stress. It is important to understand the basics of the physiology of stress, the relaxation response, and common techniques for stress management. Most importantly, the coach understands the wide variance in coping mechanisms that work for individual clients.

The coach should also be comfortable supporting the client's resilience, positive mental health, well-being, and flourishing. Being emotionally well involves more than just managing stress. It also requires being attentive to thoughts, feelings, and behaviors, whether they are positive or negative. The knowledgeable coach recognizes the crucial role of self-awareness in growth and maturation and has tools to support personal development. In addition, the coach should understand the role of healthy relationships with self and others. Finally, the coach understands that a sense of meaning or purpose is linked to positive health outcomes and emphasizes the importance of relating health issues to life purpose and values.

- Mental health
 - Basic overview
 - <https://www.cdc.gov/mentalhealth/basics.htm>
 - Depression and anxiety
 - <https://www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm>
 - <https://www.cdc.gov/mentalhealth/basics/mental-illness/anxiety.htm>
- Social determinants of health
 - https://www.cdc.gov/dhdsp/maps/social_determinants_maps.htm
- Social isolation
 - Umberson, D., Crosnoe, R., & Reczek, C. (2010). Social relationships and health behavior across the life course. *Annual review of sociology*, 36, 139-157. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3171805/>
- How stress affects the body
 - <http://www.apa.org/helpcenter/stress-body.aspx>
- Coping with stress
 - <https://www.cdc.gov/features/copingwithstress/>
- Relaxation techniques
 - <https://nccih.nih.gov/health/stress/relaxation.htm>
 - Note: the coach should be familiar with relaxation techniques as described on the above page (click on Autogenic Training, Biofeedback-Assisted Relaxation, Deep Breathing or Breathing Exercises, Guided Imagery, Progressive Relaxation and Self-Hypnosis)
 - <https://nccih.nih.gov/health/meditation/overview.htm>
- Book resources
 - Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 287-293.
 - Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 177-189.
 - Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 135-136, 241-256.

3.3.6. Avoiding tobacco use

Tobacco use is one of the largest preventable lifestyle habits associated with death and chronic disease. It is linked to multiple cancers, cardiovascular disease, reproductive issues, and chronic illnesses like type 2 diabetes and rheumatoid arthritis. The product landscape of tobacco use is constantly changing, and the coach recognizes trends such as the recent popularity of e-cigarettes. The coach should be familiar with the support services available for clients who wish to stop smoking or using tobacco.

- Overview of tobacco use
 - <https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use>
- Smoking health effects
 - https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_s_moking
- Quitting smoking
 - https://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm
- Book resources
 - Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 136-137.
 - Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 161-170 (Case study, contains web link with video session).
 - Prochaska, J.O., & Prochaska, J.M. (2016). *Changing to thrive: using the stages of change to overcome the top threats to your health and happiness*. pp 93-131.

3.3.7. Moderate or no alcohol use, substance abuse

Substance abuse refers to the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. It is important to note that counseling on substance abuse is beyond the scope of practice for the coach. However, self-medicating behaviors are common in clients, particularly those with chronic pain, so the coach should recognize red flags. It is important to know when and how to make appropriate professional referrals for clients whose active risk behaviors exceed the scope and practice of coaching, such as alcohol abuse, prescription painkiller abuse, and other substance abuse.

- Overview of substance abuse
 - <https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse>
- Alcohol
 - <https://www.cdc.gov/vitalsigns/alcohol-screening-counseling/index.html>
- Prescription opioids (Note: open and read all 4 tabs on the page)
 - <https://www.cdc.gov/drugoverdose/opioids/prescribed.html>
- Book resources
 - Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. p 137.
 - Prochaska, J.O., & Prochaska, J.M. (2016). *Changing to thrive: using the stages of change to overcome the top threats to your health and happiness*. pp 133-160.

4. Ethics/Legal

4.1. Professional Conduct

Overview

Health and wellness coaches commit to the same level of professionalism as all health care providers. This includes ongoing development of skills, staying up-to-date with relevant research, and following recertification procedures established by ICHWC. In addition, coaches aim to “walk the talk” and model healthy behavior skills, particularly prioritizing self-care.

Competencies

- 4.1.1. Continue ongoing training and development as a health coach including emerging research
- 4.1.2. Engage in personal health and well-being, including physical and emotional health and potential burnout
- 4.1.3. Engage in self-awareness practices, including emotional self-regulation

Resources

- Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 217-218, 220 (Topics 4.1.2, 4.1.3).
- Dossey, B.M., Luck, S., & Schaub, B.G. (2015). *Nurse coaching: integrative approaches for health and wellbeing*. pp 407-417 (Overview).
- Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 71-79 (Topic 4.1.3).
- Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 18-19 (Topic 4.1.1); p 19 (Topic 4.1.2); pp 44-45 (Topic 4.1.3).

4.2. Ethics

Overview

The ICHWC Code of Ethics provides guidelines, accountability, and standards for health and wellness coaches. The coach maintains and promotes excellence in the field of coaching by ensuring ethical treatment of each individual client. The ICHWC Code of Ethics also notes the importance of ongoing professional development as well as “walking the talk” of health through lifestyle behaviors, self-care, and self-awareness, including self-monitoring of emotions and triggers. The ICHWC Health & Wellness Coach Scope of Practice describes the role of the coach and clarifies the handling of dual professional roles (Topic 4.2.7).

Competencies (Topic 4.2 cont'd)

- 4.2.1. Confidentiality
- 4.2.2. Working within an organization; serving sponsor and client
- 4.2.3. Conflicts of interest
- 4.2.4. Demonstrate dignity and respect for all people, honor diversity, cultural sensitivity
- 4.2.5. True and accurate representation of your training, experience, expertise, credentials
- 4.2.6. Provide attribution for contributions of others, including copyrighted material
- 4.2.7. Scope of practice and refer when necessary
 - 4.2.7.1. Balancing multiple roles (nurse/coach, physician/coach, therapist/coach, etc.) and dual relationships
 - 4.2.7.2. Maintaining professional boundaries
 - 4.2.7.3. Consent and approval from relevant parties
- 4.2.8. Self-monitoring and management of triggers and boundaries
- 4.2.9. Seek consultation or supervision as needed

Resources

ICHWC Code of Ethics

<http://ichwc.org/wp-content/uploads/2015/03/Final-Code-of-Ethics-Feb-1-ICHWC.pdf>

ICHWC Scope of Practice (Topic 4.2.7)

<http://ichwc.org/wp-content/uploads/2015/03/ICHWCHealthWellnessCoachScopeofPractice-FinalFeb12017.pdf>

Arloski, M. (2014). *Wellness coaching for lasting lifestyle change*. pp 238-239 (Topic 4.2.7).

Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 62-63 (Topics 4.2.1, 4.2.3, 4.2.4, 4.2.5, 4.2.7).

Kimsey-House, H., Kimsey-House, K., et al. (2011). *Co-active coaching: changing business, transforming lives*. pp 17-18 (Topic 4.2.1); pp 163-169 (Topic 4.2.7); pp 3-4, 95-105 (Topic 4.2.8).

Jordan, M. (2013). *How to be a health coach: an integrative wellness approach*. pp 84-87 (Topic 4.2.4).

Livingstone, J.B., Gaffney, J. (2016). *Relationship power in health care: science of behavior change, decision making, and clinician self-care*. pp 201-203 (Topic 4.2.7); pp 74-79 (Topic 4.2.8).

Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. pp 21-24 (Overview); p 32 (Topic 4.2.1); p 20 (Topic 4.2.7).

Muth, N.G., & Green, D.J. (2014). *Coaching behavior change*. p 7 (Topic 4.2.7).

4.3. Legal

Overview

The coach ensures that client records are protected (Topic 4.3.1) as part of maintaining confidentiality. The coach also remains aware of the pertinent regulations given their practice setting. For example, all who practice in health care settings must abide by HIPAA; therefore, at a minimum, the coach must be well-versed in basic HIPAA requirements. Other legal requirements will vary depending on the state in which the coach practices and other credentials the coach holds (e.g., licensure in health or allied health professions).

Competencies

4.3.1. Maintain security and privacy of client records

4.3.2. Awareness of relevant federal and state regulations that affect health coaching

Resources

ICHWC Code of Ethics: Section 1, #11 (Topic 4.3.1)

<http://ichwc.org/wp-content/uploads/2015/03/Final-Code-of-Ethics-Feb-1-ICHWC.pdf>

HIPAA Privacy Summary

<https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/>

<https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html>

Bark, L. (2011). *The wisdom of the whole: coaching for joy, health, and success*. pp 62-63 (Topic 4.3.1).

Muth, N.G., & Green, D.J. (2014). *Coaching behavior change*. p 167 (Topic 4.3.1).

Moore, M., Jackson, E., & Tschannen-Moran, B. (2015). *Coaching psychology manual*. p 32 (Topic 4.3.1); pp 32, 120-121 (Topic 4.3.2).

We acknowledge the contribution of many people to this document, including support for Section 3 through resources provided on the ICHWC Healthy Lifestyle Basics by Duke Integrative Medicine's Healthy Lifestyle Basics for Integrative Health Coaches.

Addendum to Content Outline with Resources – Modifications to Section 3 links
June 2018 Exam

As of 4/30/18, some of the website links previously noted as references in the Content Outline with Resources have been changed or are no longer active. Below are the adjusted links for those that no longer work; these will allow you to still access the relevant information that is covered on the HWCC Examination.

Page 28: Metabolic syndrome

- The three NIH links for metabolic syndrome (overview, risk factors, and diagnosis) are still active. However, the page has a new layout, so all links go to the following page: <https://www.nhlbi.nih.gov/health-topics/metabolic-syndrome>
- The examinee should review all sections on this page.

Page 29: Lipid abnormalities, lipid panels

- Disregard the links in the Content Outline for Section 3.2.6. Instead, use this link and the instructions below: <https://www.cdc.gov/cholesterol/about.htm>
- Review the following sections:
 - About Cholesterol
 - LDL and HDL Cholesterol: “Bad” and “Good” Cholesterol
 - Getting your Cholesterol Checked
 - Knowing Your Risk: High Cholesterol
 - Review all sections on this page (Health conditions, Behaviors, etc.)
- Note: the examinee no longer needs to review the link in the Content Outline for Reference Values (labtestsonline.org). Reference values are now in the above CDC link (About Cholesterol: Getting your Cholesterol Checked)

Page 31: Hypertension (DASH) diet

- The two NIH links for the DASH diet are still active. However, the page has a new layout, so both links go to the following page:
 - <https://www.nhlbi.nih.gov/health-topics/dash-eating-plan>
- The examinee should review the first two sections:
 - Description of the DASH Eating Plan
 - Health Benefits of the DASH Eating Plan

Page 34: Mental Health

- The CDC links are no longer active. See the PDF pages below to review the original content.

Mental Health Basics

The term mental health is commonly used in reference to mental illness. However, knowledge in the field has progressed to a level that appropriately differentiates the two. Although mental health and mental illness are related, they represent different psychological states.

Mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”¹ It is estimated that only about 17% of U.S. adults are considered to be in a state of optimal mental health.² There is emerging evidence that positive mental health is associated with improved health outcomes.

Mental illness is defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.”² Depression is the most common type of mental illness, affecting more than 26% of the U.S. adult population.³ It has been estimated that by the year 2020, depression will be the second leading cause of disability throughout the world, trailing only ischemic heart disease.⁴

Evidence has shown that mental disorders, especially depressive disorders, are strongly related to the occurrence, successful treatment, and course of many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity⁵ and many risk behaviors for chronic disease; such as, physical inactivity, smoking, excessive drinking, and insufficient sleep.

Mental Health Indicators

In the health care and public health arena, more emphasis and resources have been devoted to screening, diagnosis, and treatment of mental illness than mental health. Little has been done to protect the mental health of those free of mental illness. Researchers suggest that there are indicators of mental health, representing three domains.⁶⁻⁸ These include the following:

- Emotional well-being
 - such as perceived life satisfaction, happiness, cheerfulness, peacefulness.
- Psychological well-being
 - such as self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one’s environment, spirituality, self-direction, and positive relationships.
- Social well-being
 - social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

The former surgeon general notes that there are social determinants of mental health as there are social determinants of general health that need to be in place to support mental health. These include adequate housing, safe neighborhoods, equitable jobs and wages, quality education, and equity in access to quality health care.

Learn more details on [mental health promotion \(http://www.who.int/mediacentre/factsheets/fs220/en\)](http://www.who.int/mediacentre/factsheets/fs220/en) .

References

1. World Health Organization. *Strengthening Mental Health Promotion*. Geneva, World Health Organization (Fact sheet no. 220), 2001.
2. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.
3. Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005;62:617–627.
4. Murray CJL, Lopez AD. *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected to 2020*. Geneva, Switzerland;World Health Organization, 1996.
5. Chapman DP, Perry GS, Strine TW. The vital link between chronic disease and depressive disorders. *Prev Chronic Dis* 2005;2(1):A14.
6. Ryff CD, Keyes CLM. The structure of psychological well-being revisited. *J Pers Soc Psychol* 1995;69:719–727.
7. Ryff CD. Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *J Pers Soc Psychol* 1989;57:1069–1081.
8. Keyes CLM. Social well-being. *Soc Psychol Quart* 1998;61:121–140.

Depression

Overview

Depression is a serious medical illness and an important public health issue. Depression is characterized by persistent sadness and sometimes irritability (particularly in children) and is one of the leading causes of disease or injury worldwide for both men and women. Depression can cause suffering for depressed individuals and can also have negative effects on their families and the communities in which they live. The economic burden of depression, including workplace costs, direct costs and suicide-related costs, was estimated to be \$210.5 billion in 2010.¹

Depression is associated with significant healthcare needs, school problems, loss of work, and earlier mortality.

Depression...

- Is associated with an increased risk for mortality from suicide as well as other causes, such as heart disease
- Is associated with lower workplace productivity and more absenteeism, which result in lower income and higher unemployment.
- Is associated with higher risk for other conditions and behaviors, including:
 - Other mental disorders (anxiety disorders, substance use disorders, eating disorders)
 - [Smoking](#)

Although effective treatments are available, many individuals with depression do not have access to treatment or do not take advantage of services. If not effectively treated,

Depression can occur at any time over a person's life. Follow the links below to learn about depression and different life stages.

- [Depression in Children](#)
- [Depression and Pregnancy](#)
- [Depression and Aging](#)

depression is likely to become a chronic disease. Just experiencing one episode of depression places an individual at a 50% risk for experiencing another episode, and further increases the chances of having more depression episodes in the future.

Public health surveillance systems measure the prevalence and impact of depression providing valuable information that can be used to guide mental health promotion, mental illness prevention, and treatment programs.

Diagnostic Criteria

According to the American Psychiatric Association's diagnostic criteria for Major Depressive Disorder, a person must experience five or more symptoms below for a continuous period of at least two weeks.²

- Feelings of sadness, hopelessness, depressed mood
- Loss of interest or pleasure in activities that used to be enjoyable
- Change in weight or appetite (either increase or decrease)
- Change in activity: psychomotor agitation (being more active than usual) or psychomotor retardation (being less active than usual)
- Insomnia (difficulty sleeping) or sleeping too much
- Feeling tired or not having any energy
- Feelings of guilt or worthlessness
- Difficulties concentrating and paying attention
- Thoughts of death or suicide.

Most symptoms must be present every day or nearly every day and must cause significant distress or problems in daily life functioning.

For more information about depression or where you can go to find help, please visit [MentalHealth.gov](http://www.mentalhealth.gov/what-to-look-for/mood-disorders/depression/index.html) (<http://www.mentalhealth.gov/what-to-look-for/mood-disorders/depression/index.html>) .

Depression Statistics

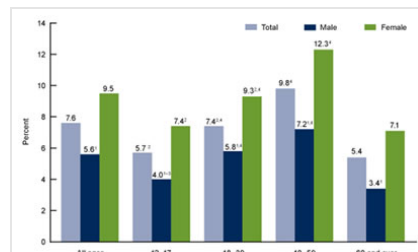
- More than 1 out of 20 Americans 12 years of age and older reported current depression (moderate or severe depressive symptoms in the past 2 weeks) in 2009-2012. (Figure at right.)

On this Page

- [Overview](#)
- [Major Reports and Publications](#)
- [Surveillance Data Sources for Depression](#)
- [Behaviors and Conditions Associated with Depression](#)
- [Related Topics](#)

- Among Americans 12 years of age and over, a greater percentage of females reported depression than males. Almost 10% of adults aged 40-59 reported current depression.

[Read full report](#)



(<http://www.cdc.gov/nchs/data/databriefs/db172.htm>)

Percentage of persons aged 12 years of age and older with depression by age and sex: United States, 2009-2012. Pratt LA, Brody DJ. Depression in the U.S. household population, 2009-2012. NCHS data brief, no 172. Hyattsville, MD: National Center for Health Statistics. 2014.

More

(<http://www.cdc.gov/nchs/data/databriefs/db172.htm>)

>

Major Reports and Publications

- CDC. Mental illness surveillance among adults in the United States. MMWR 2011 (<http://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm>)
- CDC. Mental health surveillance among children – United States, 2005–2011. MMWR (<http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm>)
- Pratt LA, Brody DJ. Depression in the U.S. household population, 2009–2012 (<http://www.cdc.gov/nchs/data/databriefs/db172.htm>). NCHS data brief, no 172. Hyattsville, MD: National Center for Health Statistics. 2014.
- Other Featured Publications

Surveillance Data Sources for Depression

Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS is an annual state-based telephone survey of the U.S. civilian, non-institutionalized adult population. The core questionnaire contains questions asked of all respondents, while states may choose to also include optional modules addressing various topics. The core questionnaire asks about whether a person has been diagnosed with depression. An optional Anxiety and Depression Module assesses the prevalence of anxiety and depressive disorders in the general population at the state level. This module is composed of the Patient Health Questionnaire (PHQ-8) which has been validated against the diagnostic criteria for a depressive disorder in the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV).

- For more information on BRFSS

National Health and Nutrition Examination Survey (NHANES)

NHANES is a program of studies designed to assess the health and nutritional status of adults and children in the U. S., which is conducted in 2-year cycles. The survey is unique in that it combines interviews and physical examinations. A depression screener has been administered during a computer-assisted personal interview as part of NHANES since 2005.

During 2000–2004, NHANES assessed major depression and dysthymia during the past 12 months using parent and child report using the Diagnostic Interview Schedule for Children (DISC-IV). Currently, NHANES uses self-reported symptoms drawn from the Patient Health Questionnaire (PHQ-9) to assess depression during the past 2 weeks among adolescents aged 12–17 years.

- For more information on NHANES.

National Survey of Children’s Health (NSCH)

The NSCH is a cross-sectional national (50 states and DC) telephone survey of parents in households with at least one child aged 0 to 17 years at the time of the interview. Parents report on their children’s health. To assess for depression, parents are asked: “Has a doctor or other health care provider ever told you that [CHILD] had depression?” If “yes” parents were asked “Does [CHILD] currently have depression?” and if yes, parents were asked to rate current depression as mild, moderate or severe.

- For more information on NSCH.

National Survey of Drug Use and Health (NSDUH)

The NSDUH is sponsored by SAMHSA and uses a series of questions asked through an audio computer-assisted self-interviewing (ACASI) household interview to assess whether adolescents have experienced a major depressive episode, based on DSM criteria and is measured for the lifetime and past year.

- More on NSDUH (<https://nsduhweb.rti.org/respweb/homepage.cfm>)

Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is a state-based, cross-sectional survey of women who have recently delivered a live-born infant. The survey provides population-based data that can be used to develop maternal and infant health programs and policies. Data are collected in 37 states and New York City and represent approximately 75% of the births in the U. S. PRAMS provides estimates of postpartum depression by using two questions similar to those included in the Patient Health Questionnaire (PHQ-8): 1) "Since your new baby was born, how often have you felt down, depressed, or hopeless?" and 2) "Since your new baby was born, how often have you had little interest in doing things?" Possible responses are "never," "rarely," "sometimes," "often," and "always."

- For more information on PRAMS.

Youth Risk Behavior Survey (YRBS)

The national Youth Risk Behavior Survey (YRBS) was developed to monitor health-risk behaviors that contribute substantially to the leading causes of death, disability, and social problems among children and young adults in the United States. YRBS uses a three-stage cluster sample design to produce a representative sample of public and private high school students in grades 9–12 in the 50 states and DC. YRBS questionnaires are self-administered; students record their responses on a computer-scannable booklet or answer sheet. One symptom of depression, feeling sad or hopeless, is assessed by the question: "During the past 12 months, did you ever feel so sad or hopeless almost every day for 2 weeks or more in a row that you stopped doing some usual activities?"

- For more information on YRBS (<http://www.cdc.gov/yrbs/>).

Behaviors and Conditions Associated with Depression

In addition to the many symptoms associated with depression, depression is associated with several chronic and other diseases as well as with factors that increase risk for those diseases. In many cases, it is difficult to determine whether depression is the result of a behavior or condition, or whether depression causes (or contributes to) the behavior or condition. Depression may also affect whether individuals follow the treatments for diagnosed conditions as recommended by their healthcare providers. Follow the links below to learn more about selected behaviors and conditions associated with depression.

- Smoking
- Alcohol Consumption
- Obesity and Physical Inactivity
- Sleep Disturbance
- Epilepsy
 - See also, The PEARLS Program (<http://www.pearlsprogram.org/Default.aspx>)
- HIV/AIDS (<http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6305a1.htm>)

Related Topics

- Anxiety Disorders (<http://www.mentalhealth.gov/what-to-look-for/anxiety-disorders/index.html>)
- Attention-deficit/hyperactivity disorder (ADHD) (<http://www.cdc.gov/adhd>)
- Tourette Syndrome (<http://www.cdc.gov/ncbddd/tourette/otherconcerns.html>)
- Suicide (<http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html>)
- Traumatic Brain Injury (<http://www.cdc.gov/TraumaticBrainInjury/index.html>)
- Adolescent and School Health (<http://www.cdc.gov/HealthyYouth/>)

More detail on mental health/mental illnesses may be found at:

- National Institute on Mental Health (<https://www.nimh.nih.gov/health/topics/depression/index.shtml>)
- Substance Abuse and Mental Health Services Administration (<http://www.samhsa.gov/topics/mental-substance-use-disorders/mental-disorders#depressive>)
- Mental Health.gov (<http://www.mentalhealth.gov/what-to-look-for/mood-disorders/depression/index.html>)

References

1. Greenberg PE, Fournier AA, Sisitsky T, Pike CT, Kessler RC. The economic burden of adults with major depressive disorder in the United States (2005 and 2010). *J Clin Psychiatry*. 2015 Feb;76(2):155-62.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. 5th ed. Washington, DC: American Psychiatric Publishing; 2013.

Anxiety

Anxiety disorders are characterized by excessive and unrealistic worry about everyday tasks or events, or may be specific to certain objects or rituals. Simple phobias involve excessive anxiety evoked by specific objects (e.g., marked fear of snakes). As its name implies, social phobias are fears of interacting with others, particularly in large groups. In obsessive-compulsive disorder (OCD), the individual experiences an obsession – an intrusive and recurrent thought, idea, sensation or feeling – coupled with a compulsion – a behavior that is recurrent and ritualized, such as checking, avoiding, or counting.¹ In addition to being helped by pharmacotherapies, anxiety disorders are often addressed by exposure (to the object or event obsessed over) and response prevention – not permitting the compulsive behavior, to help the individual learn that it is not needed.¹

References

1. Sadock BJ, Sadock VA. *Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry (10th ed.)*. Philadelphia, PA, Lippincott, Williams & Wilkins; 2007.

More detail on mental health/mental illnesses may be found at: <http://www.nimh.nih.gov/health/index.shtml>
(<http://www.nimh.nih.gov/health/index.shtml>) or www.samhsa.gov/(<http://www.samhsa.gov/>).

Page last reviewed: July 1, 2011

Page last updated: October 4, 2013

Content source: Centers for Disease Control and Prevention (/index.htm), Program Performance and Evaluation Office (<http://www.cdc.gov/program/overview/index.htm>)