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An evaluation of a life-coaching group program: initial findings from a waitlist control study

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Abstract

Life coaching has grown substantially in the last few years and received considerable media coverage worldwide (Rock, 2001). However, there have been few empirical investigations into its efficacy (Grant, 2003). The study outlined in this chapter aims to add to this limited empirical base.

Keywords

evaluation, life, coaching, group, program, initial, findings, from, waitlist, control, study

Disciplines

Arts and Humanities | Life Sciences | Medicine and Health Sciences | Social and Behavioral Sciences

An Evaluation of a Life-Coaching Group Program: Initial Findings From a Waitlist Control Study

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Life coaching has grown substantially in the last few years and received considerable media coverage worldwide (Rock, 2001). However, there have been few empirical investigations into its efficacy (Grant, 2003). The study outlined in this chapter aims to add to this limited empirical base.

Within the coaching literature the distinction is often made between business, executive, workplace and life coaching. The first three focus on work or team goals, whereas life coaching usually takes place outside the corporate environment and is concerned with the individual's whole life. It is important to note that the definition of coaching is evolving as the field establishes a clear identity. One definition popular in life coaching is bringing about sustained cognitive, emotional and behavioural changes that facilitate the attainment of goals and the enhancement of performance, either in work or personal life (Douglas & McCauley, 1999). The term coaching has been used in the corporate setting for decades. Executive coaching aims to help executives improve their performance, and consequently the performance of the overall organisation (Kilburg, 1996). Life coaching, which did not have a real presence until the early 1990s, has been more recently defined as "a collaborative, solution-focused, results-oriented and systematic process in which the coach facilitates the enhancement of life experience and goal attainment in the personal and/or professional life of … non-clinical clients" (Grant, 2003, p. 254). This definition will be used here.

Despite increased public interest in, and demand for, life-coaching services, psychologists have been slow to present themselves as possessing knowledge and skills applicable to life coaching. They have also been slow

to undertake research in the area. Consequently, the majority of life coaches are nonpsychologists. As the coaching industry is as yet unregulated in many countries including Australia, anyone may identify themselves as a life coach (Grant, 2001).

Coaching is an emerging theoretical and applied subdiscipline of psychology. It has been described as an applied positive psychology which draws on and adapts established psychological approaches and involves the "systematic application of behavioural science to the enhancement of life experience, work performance and well-being for individuals, groups and organizations who do not have clinically significant mental health issues or abnormal levels of distress" (Australian Psychological Society Coaching Psychology Interest Group, Mission Statement, 2003).

Grant (2001), formulated a psychology of coaching using theories and techniques from clinical and counselling psychology in a cognitive-behavioural solution-focused framework for application to a nonclinical adult population. These theories and techniques include the Transtheoretical Model of Change (Prochaska & DiClimente, 1984), a model of self-regulated learning, and other components that all have extensive research histories in psychology (see Grant, 2001, for a review). The study outlined in this chapter evaluates their efficacy in the coaching of a nonclinical population.

Coaching provides an environment conducive to setting and striving toward goals. Although there has been extensive research conducted on the benefits of goal-setting per se, the use of goal-setting strategies within a coaching environment is only just beginning to be researched. Grant (2001) suggests that coaching programs should draw on literature such as Locke's (1996) and Latham and Locke's (1991) research findings that cover a range of important findings about goals (e.g., goal-specificity, goal-difficulty). Developing a coaching methodology which involves setting and striving for goals, and leads to benefits such as attaining goals and wellbeing is a priority for research.

The constructs of wellbeing and happiness have received little empirical attention within the field of psychology during the last 50 years; rather, the focus has been on illness and depression. More recently, a positive psychology has emerged which focuses on personal strengths and virtues and what makes life meaningful, and investigates valued subjective experiences such as wellbeing, happiness, and hope (Seligman & Csikszentmihalyi, 2000). Prevention is foregrounded in positive psychology. In the last decade, prevention researchers have demonstrated that personal strengths (e.g., optimism, hope) help buffer against mental illness (Seligman & Csikszentmihalyi, 2000).

The World Health Organization Global Burden of Disease Study (Murray & Lopez, 1996) reported that mental-health problems account for almost 11% of the disease burden worldwide. In Australia, the 1997 National Survey of Mental Health and Well-being of Adults found that almost one in five (18%) Australian adults were affected by mental illness during the 12-

month period from mid-1996 to mid-1997 (Australian Bureau of Statistics, 1997). In an attempt to address the costs associated with this, which include lost wages, medical costs and disability claims (Mrazek & Haggerty, 1994), emphasis is currently being placed on both promoting mental health and pre-venting mental illness, with many government initiatives being put in place worldwide. Promoting mental health involves positive treatments which are targeted at the general population and aim to "promote levels of well-being or build upon or draw out a person's existing strengths" (Keyes & Lopez, 2002, p. 50), that is, which build on positive human traits (e.g., wellbeing, happiness, hope, authenticity) that may act as a protective factor to mental illness. Research into such interventions — of which life coaching is a prime example — is sorely needed. In addition, the study of traits such as optimism within a coaching environment may also help to integrate coaching psychol-ogy into the existing empirical psychological literature on these.

Positive psychology is also concerned with the study of hope. Hope theory emphasises thinking processes and consists of three cognitive com-ponents: goals, agency and pathways thoughts (Snyder, Michael, & Cheavens, 1999). Hope is seen as the belief in one's ability to initiate and maintain movement towards a goal (agency) and to conceptualise routes to a goal (pathways). Snyder, Rand, and Sigmon (2002) purport that positive emotions result from unimpeded movement towards one's desired goals or successfully overcoming obstacles. Conversely, negative emotions result from the unsuccessful pursuit of goals, where agentic and/or pathways thinking may not have been sufficient, and/or obstacles have not been able to be overcome. To support this claim, Snyder et al. (2002) refer to studies in which participants who encountered severe difficulties in attaining their goals reported lowered wellbeing (Diener, 1984; Emmons, 1986). Based on previous findings, it may be hypothesised that the act of setting a goal within a life-coaching program will trigger agentic and pathways thoughts, bringing about positive emotions and wellbeing.

Although life-coaching research is embryonic and more evidence is required to establish its effectiveness, there is some recent evidence to support its use. For example, in 2003, Grant conducted a study using the life-coaching program *Coach Yourself* (Grant & Greene, 2001), in which 20 adults focused on attaining goals that had eluded them for an average of 23.5 months. Results showed that participation in the program was associ-ated with significantly enhanced mental health and quality of life and increased goal-attainment.

Although Grant's (2003) study provides preliminary evidence for the effectiveness of life coaching he noted the lack of a control group as a limitation to his study. Without one, it can be argued that the effects may not have occurred as a result of the intervention. The study outlined in this chapter eliminated this limitation by using a randomised control design. In addition, it focused on the positive effect of life coaching on

hope and wellbeing. The hypothesis of this study was that those assigned to the life-coaching group would show significant increases on measures of goal-striving, wellbeing, hope and mental health.

Method

Participants

Potential participants were recruited by advertising in the local media of the Illawarra region, New South Wales, Australia. The Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) was used to identify healthy participants and exclude those who may have been better suited to a clinical intervention. A cut-off score was used to determine eligibility for the groups. Those participants identified as having scores two standard deviations above the mean on the Global Severity Index of the Brief Symptom Inventory (BSI) or on two subscales of the BSI (i.e., a score of 70 or above) were excluded from participation. Eligible participants were 56 adults (18–60 years), 42 females and 14 males. The majority fell within the 31–40 and 41–50 age ranges (mean age = 42.68, SD = 9.59). BSI t scores ranged from 33–67 (mean = 53.50, SD = 8.80), with the majority of participants' scores falling within the 51–60 range.

Procedures

Experimental Design

Appropriate participants were randomised to either a 10-week life-coaching intervention group or a waitlist control condition. The participants in the waitlist control group received no intervention during the time that the participants in the intervention group completed the 10-weeks of life coaching intervention; at the end of this period, and after assessments of both groups, they then also completed the same 10-week life-coaching intervention (see Table 1).

Randomisation

From an initial pool of 107 applicants, 56 participants were randomly assigned (using a waitlist control matched-randomisation procedure) to Group 1 (coaching group, n = 28) or Group 2 (waitlist control group, n = 28). The pool of remaining applicants included 25 participants who were

Table 1
Research Design

	Time 1 Baseline	Time 2 10 weeks	Time 3 20 weeks
Group 1	**Begin coaching**	Complete coaching	
Group 2	Waitlist	**Begin coaching**	Complete coaching

identified as having high levels of psychological distress and 26 participants that were not needed due to excess numbers. Of the 56 participants assigned to take part in the study, 6 participants (3 control, 3 experimental) withdrew before the initial intervention was completed (before Time 2).

All of the participants completed a set of questionnaires prior to the start of the life-coaching intervention or the waitlist control period (i.e., Time 1) and then were reassessed approximately 1 week after the 10-week life-coaching intervention or control period (i.e., Time 2).

Life-Coaching Intervention

The life-coaching intervention used was the *Coach Yourself* (Green, Oades, & Grant, 2002) group program. This is a structured life-coaching program based on a solution-focused, cognitive-behavioural model (Grant & Greene, 2001). Briefly, the experimental condition was a group-based life-coaching intervention consisting of a one-day workshop where the facilitators presented theories and techniques in a short-lecture format. Participants were introduced to the major theories and techniques of the program and participated in individual self-reflection exercises and small-group discussions. In the first session they completed a life-inventory task to examine the main areas of their lives (e.g., work, health, relationships) and then selected one specific, measurable goal that could be attained, or towards which significant progress could be made, within a 10-week period.

In the following nine 1-hour weekly sessions major theories and techniques of the *Coach Yourself* program were reviewed and then participants paired off to co-coach each other. This consisted of each participant spending approximately 15–20 minutes as coach and 15–20 minutes as coachee. In the co-coaching sessions, participants had the opportunity to discuss progress during the preceding week and to develop action plans for the forthcoming week, with the assistance of the facilitator. They were also encouraged to self-coach or to establish a co-coaching relationship during the week to monitor progress towards their goal.

A coaching checklist (developed by the researcher) was designed in order to assess fidelity to the *Coach Yourself* program. Participants were asked to check off the major components that they used in the 10-week program to provide scientific evidence of fidelity to the intervention.

Waitlist Control Group

Those participants randomly assigned to Group 2 (the waitlist control group) completed a 10-week waiting period simultaneous to Group 1's 10-week life-coaching intervention, and underwent identical assessment at the end of the period. Within 1 week postintervention, assessments were completed and the participants in the control group (Group 2) began the same life-coaching intervention (see Table 1).

Measures
Brief Symptom Inventory (BSI)

The Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) was used to determine eligibility for the groups. This is a 53-item self-report instrument that verifies whether psychiatric symptoms have been experienced in the preceding seven days. It covers nine symptom dimensions (somatisation, obsessive–compulsivity, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) and provides a general index of distress, the global severity index (GSI). It is a short form of the Symptom Checklist–90–Revised (SCL–90–R) and takes approximately 10 minutes to complete. Individuals endorse the relevance of each item to their experience in the past seven days on a 5-point scale ranging from 0 = *not at all* to 4 = *extremely*. Derogatis and Melisaratos (1983) reported relatively high alpha coefficients for each of the nine subscales, ranging from .71 (psychoticism) to .85 (depression). Test–retest stability for the measure is high, with a range of .68 (somaticism) to .91 (phobic anxiety). Previous studies have found very good test–retest and internal consistency reliabilities and high correlations with the comparable dimensions of the SCL–90–R (Derogatis & Melisaratos, 1983).

Striving for Personal Goals

To assess striving for personal goals we used Emmons's (1986) procedure of eliciting a set of personal "strivings" from each participant. These were defined as things that you typically or characteristically are trying to do in your everyday life. Participants were asked to identify eight personal strivings, which were assessed by the question, "In the last 10 weeks, how successful have you been in attaining your strivings?" Responses were rated on a Likert scale of 1 to 5 (1 = *0% successful* and 5 = *100% successful*).

Wellbeing

Wellbeing was assessed using measures of subjective wellbeing (SWB) and psychological wellbeing (PWB), as suggested by Ryan and Deci (2001), who state that the understanding of wellbeing may be enhanced by using both measures. SWB was assessed using the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1995) and the Positive and Negative Affect Scale (PANAS; Watson, Clark, & Tellegen, 1988).

The SWLS is a well-validated measure of subjective satisfaction with life that allows respondents to weight domains of their lives in terms of their own values (Pavot & Diener, 1993). It is a 5-item instrument using statements such as, "In most ways, my life is close to my ideal". Participants respond on a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*). This measure possesses adequate psychometric properties and exhibits good internal consistency (Larsen, Diener, & Emmons, 1985), moderate stability, and appropriate sensitivity to changing life circumstances (Heading & Wearing, 1991). Cronbach alpha coefficients (.80 to .89) and test–retest reliability values (.54

to .83) have been in the acceptable range (Pavot, Diener, Colvin, & Sandvik, 1991). A similar alpha coefficient of .85 was achieved in this study.

The PANAS (Watson, Clark, & Tellegen, 1988) was used to measure both positive and negative affect. This 20-item measure asks participants to rate how much they had felt 10 positive and 10 negative moods during the past month or so. Positive affect (PA) reflects the extent to which a person feels enthusiastic and alert, including feeling interested, strong and inspired. Negative affect (NA) reflects mood states such as feeling guilty, afraid, hostile and nervous. Participants respond on a 5-point scale (1 = *very slightly*, 5 = *extremely*). Internal consistency reliability coefficients for the PA and NA subscales are excellent, with alpha coefficients ranging from .84 to .90. Test–retest reliabilities for an 8-week retest interval ranged from .45 to .71 (Watson et al., 1988). The alpha coefficients in the study outlined in this chapter were .83 for PA and .80 for NA.

PWB was assessed using the Scales of Psychological Well-Being (Short Form; Ryff, 1989b). This 14-item measure has six subscales: autonomy, mastery, relationships, purpose, growth and meaning. The scales are theoretically grounded (Ryff, 1989b) and have been validated in numerous studies employing samples that are community and nationally representative (Ryff & Keyes, 1995). Ryff (1989b) found that the alpha coefficients ranged from .87 to .93, while in this study they ranged from .68 to .89.

Hope

The Hope Trait Scale (HTS; Snyder et al., 1991) is a 12-item measure of the two dimensions of hope (agency and pathways), ranging from 1 = *definitely false* to 4 = *definitely true*. It consists of four agency items designed to measure belief in the ability to initiate and maintain movement towards goals, four pathways items designed to measure ability to conceptualise routes to a goal, and four filler items. A total score is deemed most appropriate for the global measurement of hope and is calculated as the sum of the eight items (range = 8–32). Test–retest reliabilities for the HTS suggest temporal stability (.83 over a 3-week interval, .73 over an 8-week period; Synder et al., 1991). Alpha coefficients for the two subscales are acceptable (agency = .71–.77, pathway = .63–.80; Snyder et al., 1991). The alpha coefficients in the study outlined here were .79 for agency and .80 for pathways. This instrument demonstrates both internal reliability and temporal stability with two separate yet related factors, as well as an overarching hope factor (Babyak, Snyder, & Yoshinobu, 1993).

Mental Health

The 21-item Depression Anxiety and Stress Scale (DASS-21; Lovibond & Lovibond, 1995) was used as a measure of psychopathology. This scale has been used to assess psychopathology in both clinical (Brown, Chorpita, Korotitsch, & Barlow, 1997) and community populations (Antony, Bieling, Cox, Enns, & Swinson, 1998). Internal consistency (Lovibond & Lovibond,

1995) and test–retest reliability (Brown et al., 1997) have been found to be good. Cronbach alphas for the DASS-21 subscales have been found to be .94 for depression, .87 for anxiety and .91 for stress (Antony et al., 1998). The alpha coefficients in the study reported here were .81 for depression, .68 for anxiety and .82 for stress.

Statistical Analyses

Tests of normality on the scores of Group 1 and Group 2 at Time 1 were carried out. Assumptions of normality were violated for autonomy (PWB), negative affect, pathways (hope), and depression, anxiety and stress for Group 1 and pathways, agency, and total hope, and depression, anxiety and stress for Group 2. Shapiro-Wilks statistics produced significance levels below .05. On these scales, participants more frequently endorsed items at the extremes of ratings. Responses on the DASS-21 scales (Group 1 and 2) and the negative affect subscale (Group 1) were positively skewed, with typical responses indicating low levels of depression, anxiety, stress and negative affect. Responses on all other scales, that is, PWB (autonomy) and HTS (agency, pathways, total hope), were negatively skewed, with typical responses indicating that participants were experiencing a high level of the items on these measures. An attempt to transform these variables was made, though this proved unsuccessful. Consequently, relevant nonparametric tests were undertaken on all variables that violated the assumptions of normality.

To examine differences in the scores from Time 1 to Time 2, 2×2 repeated measures ANOVAs were conducted for each of the dependent variables. Alpha was set at .05. Where the interaction effects of time and group were found to be significant, further analyses were conducted. To examine between-group differences within times, pairwise comparisons of group means at Time 1 and 2 were made using the Bonferroni statistic to control for multiple comparisons. To examine differences in scores over time between groups the nonparametric Friedman and Mann–Whitney U-tests were used for those variables that violated assumptions of normality.

RESULTS

The means and standard deviations of scores at both pre- and postintervention by group assignment are presented in Table 2. Tests of differences between the scores of the life-coaching group (Group 1) and the waitlist control group (Group 2) at Time 1 were conducted. Paired samples t tests on Time 1 scores for all variables with a normal distribution (i.e., satisfaction with life, positive affect and environmental mastery, purpose in life, personal growth, self-acceptance, and positive relations with others) showed no significant differences between Group 1 and Group 2 at Time 1 (baseline), with the exception of Group 2 being significantly lower on the SWLS, t (52) = 2.837, p = .006. This difference was controlled for in subsequent analyses.

Table 2
Pre- and Postintervention Means and Standard Deviations of Psychological Measures

Measure	Coaching intervention		Control	
	Pre	Post	Pre	Post
Goal-striving				
M	2.27	3.47	2.47	2.63
SD	0.77	0.78	0.71	0.84
SWLS				
M	22.60	25.09	17.88	18.68
SD	6.13	5.73	5.75	6.87
PA				
M	32.08	37.32	31.68	32.00
SD	5.17	6.06	6.21	6.53
NA				
M	17.52	15.00	17.24	18.76
SD	5.92	5.11	4.31	6.60
PWB-PG				
M	67.76	73.36	70.98	71.54
SD	6.58	7.00	7.42	7.00
PWB-EM				
M	57.54	64.12	56.84	56.84
SD	10.64	9.80	8.26	10.36
PWB-AUT				
M	59.92	61.88	61.04	61.18
SD	13.86	11.48	9.38	10.78
PWB-PRWO				
M	62.44	68.18	59.50	64.04
SD	10.78	10.08	7.84	8.82
PWB-PIL				
M	60.06	70.28	60.06	60.20
SD	9.80	7.28	8.26	9.94
PWB-SA				
M	56.98	65.94	56.42	56.98
SD	12.32	9.80	10.08	11.90
AGENCY				
M	21.36	25.32	22.72	22.76
SD	5.60	3.73	3.88	4.99
PATHWAYS				
M	23.12	25.92	25.08	25.67
SD	4.90	4.05	3.16	2.60
TOTAL HOPE				
M	44.48	51.24	47.96	48.71
SD	9.51	7.10	6.31	6.71
DEP				
M	6.16	4.16	6.64	6.40
SD	6.45	3.78	4.92	6.90
ANX				
M	3.20	1.92	2.75	2.75
SD	4.32	2.27	4.20	4.40
STRESS				
M	12.40	9.60	11.52	12.48
SD	8.06	5.60	7.35	9.84

Note: SWLS = Satisfaction with Life Scale, PA = positive affect (PANAS), NA = negative affect (PANAS), PWB-PG = personal growth PWB scale, PWB-EM = environmental mastery PWB scale, PWB-AUT = autonomy PWB scale, PWB-PRWO = positive relations with others PWB scale, PWB-PIL = purpose in life PWB scale, PWB-SA = self-acceptance PWB scale, Agency = trait hope agency subscale, Pathways = trait hope pathways subscale, Total Hope = trait hope total scale, DEP = DASS-21 depression scale, ANX = DASS-21 anxiety scale, STRESS = DASS-21 stress scale; *p* values given as two-tailed.

Mann–Whitney U-tests were carried out on those variables that violated the assumptions of normality (i.e., negative affect, pathways, agency, hope, depression, anxiety, stress and autonomy) and revealed no significant difference between the two groups for these variables at Time 1. Analyses of the Coaching Checklist revealed that participants used 100% of the major components of the *Coach Yourself* program in the initial workshop; however, they only used 52% of components in the weekly review sessions during the 10-week coaching program. There were, however, no differences in self-reported frequency of use of such components, suggesting that one component was not used more than the other. These results indicate fidelity to the program. Significant treatment-by-time interaction effects were found for goal-striving, $F(1, 38) = 22.00$, $p = .000$, positive affect, $F(1, 48) = 12.46$, $p = .001$, and all remaining scales of psychological wellbeing: personal growth, $F(1, 48) = 14.03$, p .000, environmental mastery, $F(1, 48) = 10.84$, $p = .002$, positive relations with others, $F(1, 48) = 5.96$, $p = .018$, purpose in life, $F(1, 48) = 14.84$, $p = .000$, and self-acceptance, $F(1, 48) = 14.54$, $p = .000$. Pairwise comparisons were made to examine the simple effects of time on scores, using the Bonferroni statistic to control for multiple comparisons. Each primary study variable is reported on below.

Goal-Striving

In the coaching intervention group, follow-up tests revealed significant increases in goal-striving, mean difference (MD) = -1.201, $SE = .167$, $p = .000$, whereas participants in the control condition showed no such changes ($p > .10$).

Positive Affect (PANAS)

In the coaching intervention group, follow-up tests revealed a significant increase in Positive Affect (PANAS), MD = $-.5240$, $SE = .986$, $p = .000$, whereas participants in the control condition showed no such changes ($p > .10$).

Psychological Wellbeing (PWB)

In the coaching intervention group, follow-up tests revealed significant increases on the subscales of personal growth (MD = $-.405$, $SE = .068$, $p = .000$), environmental mastery (MD = $-.472$, $SE = .101$, $p = .000$), positive relations with others (MD = $-.407$, $SE = .087$, $p = .000$), purpose in life (MD = $-.728$, $SE = .132$, $p = .000$) and self-acceptance (MD = $-.640$, $SE = .110$, $p = .000$), whereas participants in the control condition showed no such changes ($p > .10$).

The Wilcoxen Signed-Rank Test, the equivalent nonparametric test for the repeated measures ANOVA, was performed to examine changes within each group over time for the variables negative affect, autonomy (PWB), agency, pathways, and total hope (HTS), and depression, anxiety and stress. Results revealed significant increases from Time 1 to Time 2 on the variables negative affect, autonomy, pathways, agency and total hope for Group 1,

Table 3

Significant Wilcoxon Signed-Rank Test Results for Group 1 From Time 1 to Time 5

Variable	Group	Result
Negative affect	1	$N = 25$, $T = -2.423$, $p = .015$
Autonomy (PWB)	1	$N = 25$, $T = -2.261$, $p = .024$
Agency (hope)	1	$N = 25$, $T = -3.826$, $p = .000$
Pathways	1	$N = 24$, $T = -2.625$, $p = .009$
Total hope	1	$N = 25$, $T = -3.461$, $p = .001$

whereas the control group (Group 2) showed no significant change in these scores over the same period. A Mann–Whitney U-test between groups at Time 2 indicated there was no significant difference between group scores at that time for the variables autonomy, pathways and total hope. However, there was a significant difference between Groups at Time 2 for negative affect and agency (hope). There were no significant decreases from Time 1 to Time 2 for depression, anxiety and stress. Significant results are summarised in Table 3.

There were no significant decreases in depression, anxiety and stress. This may be accounted for by a floor effect as participants were preselected to be low on such variables. Significant increases were found in measures of satisfaction with life, goal-striving, positive affect, hope and psychological wellbeing, together with a significant decrease in negative affect.

Discussion

The study sought to evaluate the effectiveness of a life-coaching group program. Results of the waitlist-control study indicated that a cognitive-behavioural solution-focused life-coaching group program led to increases in goal-striving, SWB, PWB and hope.

In regard to increased goal-striving, it was found that participants who had completed the life-coaching intervention reported significant progress towards the eight personal strivings they had listed prior to the intervention. Such attainment of higher-order goals suggests generalisability of the intervention beyond the specific goal each person chose to pursue during the 10-week coaching group.

The findings in regard to wellbeing involved increases in the measures which together represent SWB: satisfaction with life, positive affect and a significant decrease in negative affect. Additionally, there were significant increases on all six scales of PWB (Ryff, 1989b). Ryff (1989b) noted the following characteristics of high scorers:

> self-acceptance — possessing a positive attitude towards the self

> positive relations with others — having warm, satisfying, trusting relationships with others

> autonomy — being self-determining and independent

> environmental mastery — having a sense of mastery and competence in managing the environment
> purpose in life — having goals and a sense of direction
> personal growth — having a feeling of continued development.

These results suggest that the life-coaching program enhanced an array of wellbeing components, including many important aspects of positive psychological health. Thus, not only did the life-coaching intervention lead to increased goal-attainment, but also to increased wellbeing. These results are consistent with Grant's (2003) study, which also found significant increases in goal-attainment and quality-of-life measures.

However, results of the study did not support hypothesised increases in mental health as evidenced by significant decreases in depression, anxiety and stress. Although overall means on the depression, anxiety and stress subscales of the DASS-21 decreased for the life-coaching group postintervention, these were not statistically significant. These findings are not consistent with Grant's (2003) study, which did find significant decreases in depression, anxiety and stress. The results of the study outlined here may be explained by a floor effect, as participants in this study had been screened for psychological distress prior to undertaking the coaching program. The mean scores for both groups were within the normal range on all subscales of the DASS-21 preintervention.

Significant increases in agency, pathways and total hope for those participants undertaking the life-coaching intervention were also found in the study reported on in this chapter. These results are consistent with hope theory, which suggests the articulation of goals stimulates hope (Snyder et al., 1999). Hope theory may also be useful in explaining enhanced wellbeing as it states that the unimpeded pursuit of desired goals results in positive emotions and wellbeing (Snyder et al., 2002). Snyder (2000) claims that hope is best enhanced by integrating solution-focused, narrative and cognitive-behavioural interventions designed to "help clients in conceptualising clearer goals, producing numerous pathways to attainment, summoning the mental energy to maintain the goal pursuit and reframing insurmountable obstacles as challenges to be overcome" (p. 123). This definition describes the goals of a life-coaching intervention. It seems, therefore, that a cognitive-behavioural, solution-focused coaching intervention such as the one used in this study may be a hope-enhancing intervention.

This is the first waitlist control study completed of a group life-coaching intervention which shows significant increases in goal-striving, wellbeing and hope in participants. As the waitlist control group went on to become a life-coaching group, the as-yet unanalysed data collected from that second stage may provide further evidence for the efficacy of the intervention. A final question is whether the gains, especially those made in wellbeing, will be maintained over time. Data were also collected after the

coaching intervention. When it is analysed it is expected to provide information about the maintenance of gains, and any losses or further gains.

There are a number of limitations to the study that need to be considered when interpreting the results. Its design did not allow the researcher to determine whether this intervention was more effective than a standard support group offering only support and information about goals. Thus it is possible that some group-dynamic or group-cohesiveness variable might have been responsible for all or some of the changes in goal-striving and wellbeing. Future studies might benefit from examining these variables in a support group compared with a matched life-coaching group where cognitive-behavioural and solution-focused techniques are used.

In addition, participants were self-selected members of a specific community who may not have been representative of the general population. As volunteers, they may also have been particularly motivated to achieve their goals. Some participants stated the intervention had come along "just at the right time" (i.e., transition periods such as retirement, divorce). However, it can also be argued that the majority of coaching clients will be voluntary and motivated, with the exception of those who are required by an external authority to attend (e.g., workplace coaching).

The study relied on self-report inventories. Issues of particular relevance to self-report of wellbeing may be the perceived social desirability of wellbeing and consequent faking of it, and a general tendency to respond positively to test items. In addition, the participants may have felt a need to please the facilitator and thus may have overreported goal-striving and wellbeing (i.e., ingratiating bias). It should be noted that this phenomenon is not unique to the study reported on here. In future it would be preferable to minimise complete reliance on self-report inventories as measures of change.

Future research may also be enhanced by the use of qualitative analyses of what participants believe to be the most useful components of the program. This could provide further information about how to enhance goal-striving, wellbeing, hope and overall change.

Notwithstanding these methodological limitations, the study outlined here indicates that a cognitive-behavioural, solution-focused life-coaching group program can enhance goal-striving, wellbeing and hope. Given the impact that the life-coaching intervention had on wellbeing and hope for participants, future research could investigate the use of life coaching as an intervention for promoting mental health by increasing wellbeing, building resilience and buffering against mental illness. This potential of life coaching is particularly significant given the current cost of mental illness at an individual and societal level.

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