IDENTITY AND LEGITIMACY IN THE EMERGING PROFESSION OF HEALTH COACHING

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INTRODUCTION

This qualitative study began in the fall of 2012 with three related research objectives. First, as an organizational behavior scholar, I wanted to understand how people working in new, emerging professional roles (i.e., health coaches) construct a sense of work identity (i.e., a sense of "who they are" in their jobs), and how that process informs (and is informed by) the collective identity of their emergent profession. Second, I wanted to explore how not-yet-legitimate (e.g., multi-disciplinary, counter-normative, or simply new and unproven) professionals, again using health coaches as a prime example, could attain legitimacy in their institutional fields. Third, I wanted to turn to the actual practice of health coaching and explore how these new professionals are currently impacting health care delivery and the work of other health care professionals.

Given these broad objectives, I proposed that this project would contribute new understanding regarding (1) the ways in which individual health coaches are contributing to the collective identity of their profession; (2) the ways in which the health coaching profession is actively shaping the work lives of its members; (3) the individual tools and strategies which enable health coaches to craft successful work identities; (4) the current state of the profession's legitimacy from the perspective of other members of its institutional field; and (5) the ways in which health coaches are re-shaping the health care landscape. I am glad to report that this completed research project offers insight along each of these dimensions. As such, this project advances theory in organizational behavior/management research while also speaking to the practical realities faced by health coaches.

In the course of this research project, I discovered two phenomena around which the emergent data (and the energy of my interviewees) clearly coalesced, as is consistent with my inductive methodological approach (Charmaz, 2006; Charmaz & Mitchell, 2001; Glaser & Strauss, 1967): 1) individual-level occupational identity "work" in the absence of identity "resources" (i.e., in a relative resource "void"); and 2) individual-level legitimacy "work" in the absence of similar legitimating "resources." In the pages to follow, I thus dedicate two essays to addressing these respective phenomena using the tools of grounded theory. Indeed, in keeping with grounded theory guidelines, I tailored the foci of this research project as the data directed—if the data could not speak well to any of my intended contributions listed above (1-5), I adjusted my approach in order to find the most compelling, empirically-grounded theoretical threads.

For example, I found that cross-level identity work (i.e., a process wherein the individual's identity construction efforts influence the collective's identity and vice-versa) is not all that visible yet in the health coaching profession (i.e., the upward influence—from individual to collective—is largely limited to individual coaches providing guidance to other coaches via message boards). Instead, I found that coaches are more likely to be engaged in identity work in a relative resource "void"—a situation wherein the individual coach feels somewhat disconnected from a larger social structure to guide her/his identity work efforts. Indeed, although health coaching programs are providing certain identity resources to coaches (see Figure 1 under identity "supports"), the majority of health coaches I spoke with do not yet feel connected to a bounded, coherent professional collective known as "health coaching." It appears that the profession is simply still too new for such identification patterns to have developed among individual health coaches. Hence, many of my interviewees were able to speak only about their idiosyncratic approach to defining and legitimizing themselves as health coaches, rather

than about the professional identity prototype to which they are aspiring (as would likely be the case for individuals working in more established professional fields, such as physicians, lawyers, etc.).

In addition, I also found that most health coaches are still working on the periphery of the healthcare industry, and that the prospect of entering that industry still presents a number of challenges. Thus, the possibility that health coaches might be re-shaping the healthcare industry is difficult at this point to confirm or disconfirm. As is evident at various points throughout the second essay, however, my data hint at a few ways this may be starting to happen (e.g., by supplying patients with the "hands-on" approach they have sorely missed getting from their physicians, thus reorienting the expectations of patients regarding how a healthcare provider should treat them). The first essay, which deals with identity work, begins in the following section, and the second essay, which deals with legitimacy work, begins on page 67.

CREATING IDENTITY CLARITY IN THE ABSENCE OF IDENTITY RESOURCES: THE CASE OF HEALTH COACHES

Organizational behavior scholars continue to explore the processes involved in creating, maintaining, and/or changing an identity, often referred to as identity work (Snow & Anderson, 1987; Van Maanen, 1998) or identity construction (Pratt, 2012). This research tends to highlight the individual's agentic efforts involved in building a sense of "who one is," thus taking a different approach from research on identi*fication*, which attends to the factors that lead individuals to view "a collective's or role's defining essence as self-defining" (Ashforth, Harrison, & Corley, 2008: 329). Many identity work studies thus center on the interpretive "tactics" (Alvesson & Willmott, 2002) individuals employ as they strive to construct an occupational or professional identity—that is, a "repertoire of meanings that are used to make sense of who one is" in a particular work role (Fine, 1996: 91; Kreiner, Hollensbe, & Sheep, 2006b). Scholars have approached these tactics from various angles, focusing, for example, on how people in demanding occupational roles are able to maintain their sense of individuality (Kreiner et al., 2006b), or how individuals customize their identity when faced with work tasks that seem to contradict it (Pratt, Rockmann, & Kaufmann, 2006).

Despite the many contributions of these studies, they share a rather narrow interest in highly-institutionalized occupations and professions with largely understood norms, values, and cultures (Kreiner et al., 2006b; Pratt et al., 2006). As a result, extant theory and empirical findings are limited to work contexts rich in identity "resources"—conceptual and/or material entities that facilitate the construction of a sense of "who one is." Examples of such resources include a shared ideology concerning the purpose of one's work; a shared understanding of the credentials, work style, or physical appearance required to be an "ideal" member of the

occupation (an "identity prototype"); and an occupational narrative (and public image) that is readily understandable to outsiders, thus justifying the existence of that particular line of work. In the current global economy, however, people are increasingly pursuing careers in occupations that lack many such resources—for example, individuals working in ill-defined roles (e.g., generational consultant) or ambiguously-defined roles (e.g., entrepreneur) (Gerber, 2012; Steinberg, 2009), often without the benefit of an organizational affiliation. Such individuals are thus required to craft an identity in the relative absence of identity resources that have long been available to members of traditional, well-established occupational cultures. Extant research does not speak well to these experiences of these people.

This paper thus explores the following question: How do these individuals construct work identities? To answer this question, I took an inductive, grounded theory approach to understanding the identity dynamics of individuals working in the emerging profession of health coaching. Health coaching is a new and rapidly-growing health care profession, though as yet the occupation lacks a shared ideology of work, an identity prototype, and a public image that is fully transparent to outsiders, making it fitting space for exploring my research question. By way of preview, my findings suggest that health coaches construct a sense of identity over the course of three stages—"encountering," "experiencing," and "facing" the void—each of which presents different challenges and opportunities.

This study makes a number of contributions to research and practice. First, I introduce and develop the concept of *identity resources* by providing examples based on the current state of the health coaching profession. Second, I bring the construct of *identity clarity* from psychology into organizational behavior and theorize about the passive factors and agentic tactics that can influence such clarity. Third, I develop a conceptual model that suggests

relationships between three stages of individual-level identity development, identity challenges, identity work tactics, and a key identity-related outcome (i.e., identity clarity). Fourth, using my conceptual model, I likewise suggest concrete ways that health coaches and other individuals in less-traditional work contexts can improve the clarity of their sense of self vis-à-vis their work. Thus, this study speaks practically not only to health coaches but also, for example, to individuals working in ill-defined organizational roles (e.g., social media officer), ambiguously-defined organizations (e.g., for-profit social enterprises), or emerging markets with unproven or unclear standards, processes, and/or boundaries (e.g., green energy). I will discuss this issue of transferability in more detail.

Because I take an inductive approach in this study, I do not provide an in-depth literature review for the purpose of deducing hypotheses to test with data. Instead, in the next section I briefly survey existing literatures and establish how the present study contributes to our understanding of these topics, after which I discuss the methods and findings.

CRAFTING AN OCCUPATIONAL IDENTITY: A BRIEF LITERATURE REVIEW

Identity Work

The concept of identity, as it relates to organizational contexts, has long been an interest of organizational behavior scholars (Ashforth et al., 2008). Indeed, identity is widely considered a "root construct" in management and organizational studies, because it is a key antecedent to the behavior of social entities, both collectives and individuals (Albert, Ashforth, & Dutton, 2000; Ashforth et al., 2008). Specifically, an identity can provide an entity with a sense of orientation vis-à-vis other entities in a social environment—this orientation then shapes decisions regarding how to act, think, and feel. To understand motivation and behavior, then, one must understand

socially-oriented identities, in particular how such identities develop (Oyserman, 2009). *Identity work*, a term employed for this purpose, refers to the "range of activities individuals engage in to create, present, and sustain [] identities that are congruent with and supportive of the self-concept" (Snow & Anderson, 1987: 1348), or, more broadly, "how identities are formulated or reformulated, embraced or resisted, inscribed or proscribed" (Ybema et al., 2009: 303). Snow and Anderson (1987: 1337) gave the term a positive valence, describing it as the processes though "which a sense of personal significance and meaning is generated and sustained among individuals." Other scholars have added that the aim of identity work is a "sense of coherence and distinctiveness" (Alvesson, 2010: 201), and that the drive for such coherence may become more intense or necessary depending on the precariousness of one's situation (e.g., if one is in a state of transition or crisis, identity work becomes more important) (Alvesson, Ashcraft, & Thomas, 2008; Sveningsson & Alvesson, 2003). Identity work has been studied in many different ways, yet in organizational behavior research there continues to be a strong interest in processual dynamics, the meaning-making functions of rhetoric, narrative, and discourse, all from the perspective of a constructivist epistemological orientation (Goffman, 1959; Ibarra & Barbulescu, 2010; Ybema et al., 2009). In addition, identity work is most often used to describe the agentic, identity-crafting efforts of individuals in delineated work *roles* (e.g., occupational and professional roles), with the term "identification" most commonly used to capture the identity dynamics of individuals with respect to traditional business *organizations.* Indeed, informed by decades of research in social psychology (Brewer, 1991), research on organizational identification has a longer history than research on identity work (Albert et al., 2000; Ashforth et al., 2008; Ashforth & Mael, 1989). However, identity work continues to attract significant interest, particularly from scholars interested in efforts to "return" agency to individuals

embedded in social structures—the so-called "turn to work" (Phillips & Lawrence, 2012). Without glorifying the unlimited agency of the individual, this "turn to work" stream of research seeks to understand how individuals shape different "social-symbolic aspect[s]" of the context in which they are embedded—the individual's sense of identity with respect to that collective being one example (Phillips & Lawrence, 2012: 226).

Occupational/Professional Identity Work

Given the rising importance of professionals and professional*ism* in organizations (Dent & Whitehead, 2013; Pratt et al., 2006), as well as the continued proliferation of new professions in American society (Copeland & Kelleher, 2007; Wilensky, 1964), organizational behavior scholars have increasingly attended to profession- and occupation-based sources of individual identity (Ibarra & Barbulescu, 2010; Pratt et al., 2006). However, as noted above, most research to date has explored this topic in the context of well-established professions with largely understood norms, values, and cultures, such as medicine (Pratt et al., 2006), consulting, investment banking (Ibarra, 1999), the priesthood (Kreiner et al., 2006b), architecture (Jones & Livne-Tarandach, 2008), journalism (Russo, 1998; Slay & Smith, 2011), management (Clarke, Brown, & Hailey, 2009), law enforcement (Van Maanen, 1998), and engineering (Beyer & Hannah, 2002). In fact, scholars have often selected professions precisely for their "prototypical" character, the idea being that findings should therefore be more easily transferred to other professional contexts (Hotho, 2008; Pratt et al., 2006). One way in which a profession can be "prototypical" is by being a "proper" profession—that is, by being an occupation that has achieved exclusivity over a particular work domain on account of esoteric, specialized expert knowledge (Abbott, 1988; Larson, 1979; Macdonald, 1995). Such professionalized contexts have loomed large in many prior studies.

For example, Kreiner et al. (2006b) found that Episcopal priests use a variety of "tactics"—i.e., cognitive and behavioral strategies—to achieve a sense of belonging to a strong occupational culture while still maintaining one's individuality (Brewer, 1991; see also Parry, 1980). Other studies have considered how individuals working in stigmatized occupations are able to stitch together a positive self-concept, including, for example, by reorienting the occupation's ideology of work toward a positive societal value and then incorporating that ideology into one's identity (Ashforth & Kreiner, 1999; Cahill, 1995; Kreiner, Ashforth, & Sluss, 2006a). Yet other studies have examined the "playful" (Ibarra & Petriglieri, 2010) identity "experiments" conducted by bankers and management consultants (Ibarra, 1999), which entailed testing out possible identities and then evaluating them against role models or prototypes. As another example, Pratt and colleagues (2006) keyed in on a range of identity work tactics used by medical residents to recover their original sense of "who they were" as professionals when the work they did seemed to contradict that supposed identity. Notably, the tactics described by Pratt and colleagues—"patching," "splinting," and "enriching"—all involved relying on built-in features of the medical profession (e.g., its strong collective professional identity, standardized knowledge base, norms, and/or values) for support in moments of task-induced identity crisis. Other research has investigated how an individual's marginalized cultural identity can influence the way that person constructs an identity as a member of a mainstream profession (e.g., journalists from minority groups) (Slay & Smith, 2011).

As is evident from this brief review, organizational behavior scholars have tended to approach the study of individual-level occupational identity from the perspective of powerful, deeply-entrenched professions. Even studies that have not been set in "proper" professions nonetheless center on well-understood and comprehensible occupations with traditions, norms,

values, ideologies, and socialization rituals (Ashforth, Kreiner, Clark, & Fugate, 2007). As a result, scholars are left to assume that occupational identity is something that develops only in such contexts. Indeed, a work context rich in identity resources—e.g., professional associations, socialization rituals, a jurisdictional mandate, standard work routines, an identity prototype, or a clear professional logic—appears necessary for the construction of a sense of identity in an occupational role. Work contexts that lack such resources are likely to also lack a coherent collective identity, and members of any collective must first understand "who we are" as a collective in order to conceive of "who they are" as members (Dutton, Dukerich, & Harquail, 1994; Kreiner et al., 2006b). The question remains, then, of how individuals construct a sense of self vis-à-vis a collective in the absence of resources that facilitate identity development—a common situation in today's economy, where individuals are increasingly relying on ad-hoc, non-organizational support in their quests to construct a coherent work identity.

It is important to mention that this study did not begin with a focus on individual-level identity work *per se*. Instead, one of the original objectives of this study was to explore how individual and collective identities shape—or "co-evolve" with—one another. The focus of the study evolved, however, over the course of the data collection and analysis, as is consistent with a grounded theoretical approach, as I discuss in the next section. Indeed, although I began the study with an interest in multi-level identity dynamics, the data suggested a different story, one more clearly focused on the individual level of analysis. As I discovered, the majority of my interviewees did not feel connected enough to an existing professional system/association to even comment on co-evolutionary processes. What I originally saw as a shortcoming in my data, then, later turned into the central theme upon which this study is built.

METHODS

Research Setting—The Emerging Profession of Health Coaching

I chose to explore my research question in the context of the emerging profession of health and wellness coaching (hereafter "health coaching"). Given its newness, health coaching does not yet have certain identity resources that could help individual coaches construct an identity—namely, a shared ideology of work, an identity prototype, and an image that is readily grasped by outside audiences. Importantly, this relative "void" became apparent in the course of data collection and analysis. Moreover, health coaching currently lacks a single, consistent definition of what the role entails (Snyder, 2013), though coaches and researchers continue to make progress on this front. See Table 2 for an overview of the evolution of these definitions (Palmer, Tubbs, & Whybrow, 2003; Wolever et al., 2013).

Generally speaking, health coaching involves empowering clients to rely on their own inner strengths and thereby attain optimal mind/body/spirit wellness. As such, health coaching takes a different tack than the traditional biomedical model, which encourages a more paternalistic, reactionary, command-and-control approach to patient/client compliance. The key concepts of health coaching can be traced to an array of different professions and academic disciplines: behavioral counseling, complementary and alternative medicine, integrative medicine, nursing case management, health education, and psychotherapy, to name a few (Dossey & Hess, 2013; Jordan & Livingstone, 2013). For example, "mindful presence," one of the "pillars" of health coaching (Lawson, 2013), comes out of various traditions of mindfulness meditation, particularly those directed at stress- and pain-reduction (Kabat-Zinn, 1995, 2009). "Appreciative inquiry," an interpersonal strategy for establishing an emotional connection with clients, originates in organizational development, specifically as an effort to improve the

functionality of organizations by building on pre-existing strengths (Cooperrider & Srivastva, 1987).

Similarly, the concept of "motivational interviewing" (or "MI"), which is used by many health coaches to establish rapport with clients and initiate positive change (Simmons & Wolever, 2013), was first used by clinical psychologists in the early 1980s (Miller, 1983). MI has been promoted as a supplementary skill set for health care professionals as well, not just for health coaches (Rollnick, Miller, & Butler, 2008). In its essence, MI is an addiction counseling technique—developed by psychologists William Miller and Stephen Rollnick—that helps professionals pinpoint and resolve client ambivalence about moving past old behaviors (Miller & Rollnick, 1992). What distinguishes MI from traditional counseling approaches is its emphasis on providing the client with just the "right" amount of guidance in order to help them develop intrinsic motivation toward change (Miller, Zweben, DiClemente, & Rychtarik, 1994). Such a balanced "hands-on"/"hands-off" approach is different from the more directive 12-step programs (used, for example, for alcohol cessation) and, at the other extreme, the Rogerian "person-centered" humanistic approach to psychotherapy, which is almost entirely non-directive and exploratory (Rogers, 1951, 1979). Health coaching's holistic flavor is another defining feature, one that draws substantially on the premise (and promise) of complementary and alternative medicine (CAM), a healthcare subfield that includes such treatments as herbal therapy, chiropractic care, acupuncture, hypnosis, naturopathy, energy healing, and biofeedback (Hirschkorn, 2006).

The emergence of health coaching as a profession has been supported by certain key trends in medical care and society at large, such as growing public interest in positive psychology (Seligman & Csikszentmihalyi, 2000), the "wellness movement" (Ardell, 1988), and

the rising demand for coaching services, including executive, workplace, and life coaching (Cavanagh, Grant, & Kemp, 2005; Joo, 2005; Silsbee, 2008; Tobias, 1996). One of the most noteworthy trends, however, is the increasing popularity in the U.S. of the natural, alternative, and preventative (CAM) health treatments cited above (Goldstein, 2000; Rose, 1992; Tindle, Davis, Phillips, & Eisenberg, 2005). Such treatments have been particularly popular over the last 10 years, often among people who have had unsatisfactory experiences with mainstream medicine and/or have found the cost of mainstream treatment prohibitive (Su & Li, 2011; Tindle et al., 2005) Indeed, as CAM has continued to make inroads in American life, certain healthcare professionals have integrated CAM with traditional evidence-based medicine, resulting in the field of "integrated medicine" (Snyderman & Weil, 2002). Integrated medicine subscribes to ideals of provider-client partnership and preventive focus, all while incorporating "alternative" health care practices into standard mainstream medical care. Dr. Andrew Weil is perhaps the most well-known proponent of this approach, establishing the Arizona Center for Integrative Medicine at the University of Arizona in 1994. Other schools have followed—Duke University, for example, established a school of Integrated Medicine in 2000.

Other movements contributing to the rise of health coaching can be found within mainstream medicine itself. What was originally called "patient education"—which typically amounted to nurses providing patients with the necessary information (e.g., pamphlets) to self-manage their health conditions—has been absorbed into the philosophy of health coaching but altered to accommodate the coach's role as facilitator, rather than director or disseminator, of a patient's goal-setting and health behaviors (Huffman, 2007). Case management has certain historical resonances with health coaching as well, although the emphasis in the former is on tracking the progress of patients in order to provide the best continuity of care at the lowest cost.

Perhaps most relevant, then, is the recent groundswell of "patient empowerment" ideologies (Anderson, 1995). For example, as patients have become more involved in researching their health concerns online, health policy researchers have noted (and even advocated for) patients' changing perceptions of traditional medical authority (i.e., physicians): younger generations are less idealistic about and reverential toward conventional physician authority (Hardey, 1999; Lowrey & Anderson, 2006), while patients on the whole are increasingly expecting a "flattened" (i.e., more collaborative) relationship with their health care providers—a trend sometimes referred to as "consumerism" in health care (McMullan, 2006; Murray et al., 2003; Wald, Dube, & Anthony, 2007). Recent studies suggest, however, that although patients seemingly have more control over their health as a result of better access to information, they are not necessarily good judges of the *quality* of that information (Bates, Romina, Ahmed, & Hopson, 2006). Given this mismatch between patient preferences and capabilities, the role of a health *coach*—an informed supporter who can help "connect the dots" for a client—seems a potentially promising development. Moreover, the PPACA (Patient Protection and Affordable Care Act, otherwise known as Obamacare), with its interest in preventive health, poses intriguing opportunities for the future of health coaches, especially vis-à-vis mainstream medicine (Hodgin, 2013).

Although the professionalization of health coaching continues apace (see Table 1 for a timeline of key events), the growth of the field has particularly benefited from the legitimizing presence of the newly-established Institute of Coaching (established in 2009 at McLean Hospital, an affiliate of Harvard Medical School) and the NCCHWC (National Consortium for Credentialing of Health and Wellness Coaches), both of which are advancing the professionalization project by organizing symposia and conferences, developing a national set of standards for health coach education, and by promoting scientific studies that evaluate the

effectiveness of health coaching as a treatment approach. To the latter point, many key studies are currently underway (Sahlen, Johansson, Nystrom, & Lindholm, 2013; Sforzo, 2013; Vorderstrasse, Ginsburg, Kraus, Maldonado, & Wolever, 2013; Willard-Grace et al., 2013). Thus far, clinical (Wolever et al., 2010) and case (Gorman, 2013; Jordan, 2013a; Moore, 2013; Sherman, Crocker, Dill, & Judge, 2013) studies have suggested that health coaching can lead to positive health outcomes including improved management of chronic diseases (Olsen & Nesbitt, 2010) such as diabetes (Berna, 2013), as well as weight loss (Schwartz, 2013; Yang, Wroth, Parham, Strait, & Simmons, 2013) and decreased risk for cardiovascular disease (Smith et al., 2013). However, current leaders in the field have expressed concern over the methodological and definitional plurality that exists around these studies (Wolever et al., 2013). Thus, although health coaching may not be considered a "proper" profession just yet, it is certainly aspiring to such status and already has certain features of established professions. For example, health coaches do indeed view themselves as "professionals"; many coaches subscribe to a code of ethics from the International Coaching Federation (Jordan, 2013b); most coaches consider their patients "clients" and view their work as a force for good in the world; and coaches who are successfully attracting and retaining clients can make a sizable income. And indeed, health coaching is growing rapidly. To my knowledge, there are no official statistics on the current number of health coaches, but an informal count via LinkedIn suggests that there around 20,000 health coaches in the U.S. alone.

Methodological Approach—Grounded Theory

To gain purchase on the relatively ill-explored research question of this study, I employed a grounded theory approach used in prior top-tier organizational behavior publications (Charmaz, 2006; Glaser & Strauss, 1967; Kreiner, Hollensbe, & Sheep, 2009; Treviño, den Nieuwenboer,

Kreiner, & Bishop, 2013). The objective of grounded theory is to build—not test—theory, and thus in this study I develop a conceptual model from which hypotheses might plausibly be drawn rather than test theoretically-derived hypotheses (see Figure 1 for the model). For grounded theorists, the key to theory-building is a process known as "constant comparison," which entails continually iterating between emerging data, extant data, and extant literature in order to develop a theoretical model that is "grounded" in (i.e., informed and supported by) those data (Strauss & Corbin, 1990). To build my conceptual model, I used this comparative method with both primary and secondary data.

Data Collection and Analysis

My primary data are based on interviews with 51 health coaches (and adjacent professionals) from a wide variety of training programs, work circumstances, and professional backgrounds. Thirty of my interviewees practice health coaching as their only primary profession; 14 of them work part-time as a health coach and part-time in another role (e.g., personal trainer); 5 work as professionals in an adjacent healthcare field (e.g., physician, nurse practitioner, physician's assistant) but have deep knowledge of health coaching (e.g., people who once worked as coaches but left the field); and 2 of my interviewees are trained health coaches who are currently focusing on administrating health coaching training programs. My interviewees live and work in various places across the U.S. (e.g., Minnesota, Wyoming, Pennsylvania, Virginia, North Carolina, Illinois, Utah, Arizona, Hawaii, Oregon, Washington, Maine), and one interviewee was trained in a U.S. health coaching program but now practices in Europe.

The first step in primary data collection was to develop an interview protocol, which I did based on my research question and my understanding of existing literature on the topic. Using

this protocol, I conducted "semi-structured" interviews. That is, I asked a core set of interview questions that remained consistent across interviewees but left room for spontaneous comments and questions. This approach allowed me to pursue promising leads and theoretical insights wherever they cropped up in the course of the interviews. Naturally, then, my interview protocol evolved as the data emerged. Seventy-one percent of my interviewees were female (36 women, 15 men—a distribution reflective of the fact that women outnumber men in the field). The interviewees came from five of the largest health coaching programs—the Institute for Integrative Nutrition, Take Shape for Life, the University of Minnesota, Duke Integrative Medicine, and Wellcoaches. When possible I used snowball sampling, which involved asking interviewees for referrals to other health coaches who might be interested in being interviewed. As the interviews progressed, however, I increasingly used "theoretical sampling" techniques, the objective of which is to find informants who—because of their past or current experiences—can speak to specific theoretical issues (e.g., gaps) in the emerging model (Charmaz, 2006). In this way, early interviews allowed me to narrow the subsequent pool of potential interviewees, whom I most often contacted through searches on LinkedIn, Google, health coach training program registries, or some combination thereof. The interviews lasted on average 57 minutes, and all 51 interviews were professionally transcribed. The transcripts were on average 19.5 pages long and totaled 992 pages. In grounded theory, data collection ends once "theoretical saturation" has been reached—in other words, when (1) emerging data no longer shed new light on the theoretical process of interest; and (2) when theoretical categories have been "saturated," or their parameters and meanings fully fleshed out (Locke, 2001). Only one new "code" emerged after the 43rd interview and no new codes after the 47th interview, providing evidence for theoretical saturation.

Coding primary data. Consistent with the grounded theory approach, the data analysis began with the "initial" or "open" coding (Charmaz, 2006) of the interview transcripts. This process involved reading each transcript and attaching labels—or "codes"—by hand to specific units of interview text in order to capture their gestalt meaning, all while remaining flexible to new codes that might appear in subsequent data (Charmaz, 2006). Codes can be applied to any segment of text, no matter how small, as long as the segment conveys the basic idea of the code. An example of a code from this study is "identity ambiguity," which I applied to every instance of text wherein that meaning was conveyed. Moreover, "in vivo" codes—text labels that came verbatim from interviewees—were used as often as possible (Charmaz, 2006: 55). As one might imagine, codes are continually revised, combined, and delineated throughout the coding process, as determined by the data. Indeed, the objective of open coding is to not only create codes but to distinguish them from simple iterations or elucidations of existing codes (Strauss & Corbin, 1990). To facilitate this process, I arranged the codes into a macro-format—i.e., a coding "dictionary"—that gave structure to the data. The dictionary consisted of abstract, primary codes to which I linked more specific "sub"-codes on the basis of their conceptual or logical similarity—this process of determining relationships among codes is known as "axial" coding (Strauss & Corbin, 1990). Primary codes were called "parent" codes, while sub-codes were called "children," thus establishing a "family" of codes centered on a specific construct or theme.

Throughout the open and axial coding processes, I scrutinized all existing and emerging codes, questioning whether they were sufficiently clear and properly linked to other codes, all with the intent of refining the relationships between them (Spradley, 1979). This scrutiny was especially critical because, consistent with other grounded theory studies, I considered both parent and child codes to be viable sources of "boxes" (i.e., theoretical categories) in the

emerging conceptual model (Kreiner et al., 2006b; Treviño et al., 2013). During initial and axial coding, I was also keeping track of various characteristics of my interviewees in order to get a bird's eye view on potential "between-subject" patterns in the data. To this end, I used a spreadsheet to keep track of interviewees' personal attributes and characteristics such as gender, age range, program affiliation, reason for becoming a health coach, years in health coaching, and work arrangements. One especially important attribute was professional background: I found that if a coach had previously worked as a healthcare professional in a nearby field (e.g., nursing), this prior experience had implications for how that person made sense of and dealt with the challenges of being a health coach. I will discuss this factor in more detail throughout the Findings section. I used the NVivo 10 software program to manage all the hand-coded interviews and the spreadsheet of interviewee attributes, which made the data accessible for theory-building.

Secondary data. Secondary data came from a number of archival sources. First, I gathered health coaching textbooks (Jordan, 2013b; Moore & Tschannen-Moran, 2010) and academic and popular articles through Google scholar (e.g., Wolever et al., 2013), which I then read with an eye toward how they illuminated or contradicted my primary data. I also subscribed to health coaching newsletters, including those from Duke Integrative Medicine, the Institute of Coaching, Health Coach Weekly, and the Spencer Institute. These newsletters totaled 93 emails, which I collected as they were released. In addition, I listened to training calls, webinars, and recorded coaching sessions, which altogether comprised 17.5 hours of listening and note-taking. Webinars were open to the public, but I gained access to the training calls through a contact at a well-known health coaching training program. These calls were conference calls between expert coaches and trainees of that program, providing rich insight into the internal culture and emergent philosophy of health coaching. The calls each centered on a particular theme, such as

"client listening skills," "coaching behavior change," or "client assessments." In the course of these calls, trainees often went into extensive detail about their personal experiences with and impressions of the coaching process, the challenges faced by their clients, and the points of confusion or difficulty they faced as coaches. Coaching instructors frequently coached the trainees through these concerns, and these interactions were nicely captured in the audio recordings. I also listened to and watched a number of recordings of actual health coaching sessions. Video recordings were accessed via YouTube and audio recordings of actual coaching sessions were accessed via a personal contact at a health coach training program.

I also spent a considerable amount of time reading through the blogs and websites of individual coaches (especially during my search for interviewees who could speak to the concepts in my model), focusing on their self-description, their values, training, interests, therapeutic approach, services, and rates. Altogether I studied 74 blogs and websites. To gain a fuller picture of the coaching process, I also compiled a database of relevant client testimonials I found on these and other coaches' websites. I read through the testimonials carefully and considered them relevant if they illuminated some aspect of the coaching experience in a unique way—e.g., if the testimonial described the client's impressions of the coach's personality, strengths, or reasons for success. Altogether I found 49 testimonials that fit this criterion.

Participant observation. To further sensitize myself to my research context, I enrolled in and completed a certification course with an online health coaching program known as the Spencer Institute. The four-month course gave me an insider's view on this program's perspective on the profession—in particular, it allowed me to gain first-hand experience with the educational process and with the mental work of defining health coaching for myself and thinking through how I would describe it to other people. The course was administered entirely

online, and the certification exam consisted of 100 questions covering the entirety of the course material. To prepare for the exam, I listened to 7 online lectures (approximately 30 minutes each) in addition to reading and taking notes on the 148-page course training manual, which provided in-depth information on health coaching fundamentals, emotional wellness, basic human anatomy, risk factors for various health conditions, weight training regimens, nutrition fundamentals, and protocols for working with clients. I received a passing score on the exam in January 2014 and I am now certified by the Spencer Institute as a health and wellness coach.

Trustworthiness of Qualitative Findings

Qualitative methods, such as grounded theory, are situated activities in which researcher and researched are bound by cultural and temporal constraints, a contingent reality made tangible only by the interpretive interactions between the two. For this reason, the traditional positivist criteria of internal validity, external validity and researcher independence make little sense in a qualitative context. In qualitative research, the rigorousness of a finding is determined not by the "objective truth of what is being stated," but by how clearly the researcher shows the complex, value-laden process by which he or she came to claim that particular finding as "knowledge" (Altheide & Johnson, 1998: 496). This is a function of the belief that there is never just one "true" account of any phenomenon (Maxwell, 1992: 283). Still, qualitative findings must be considered "trustworthy" in the sense that they are accurately capturing the reality they describe. Such trustworthiness is commonly established through four criteria: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Credibility refers to whether or not one's findings are "true" and "accurate" (i.e. internally valid, in the parlance of quantitative methods). However, this becomes a slightly different determination for qualitative researchers. Indeed, given the subjectivity inherent in the

qualitative approach, accuracy vis-à-vis an unchanging objective reality becomes instead a question of accuracy *for whom* and *according to whom*. Theory constructed from qualitative research can thus achieve "credibility," rather than internal validity, by aligning with the interpretations of those same processes held by the participants themselves (Lincoln & Guba, 1985: 294-296). For this reason I frequently did "member-checking," which involved asking my interviewees about my findings and whether or not they "rang true" to them—I was continually encouraged by these responses. Another way of developing credibility is to become intimately familiar with the issues faced by the sample population, which I have done through participant observation, by conducting interviews, and by reading various secondary materials relevant to health coaches and their careers. In this way, I have avoided relying on one source of data (interviews), which can be problematic from a credibility perspective (Alvesson, 2003).

Transferability is a correlate of the quantitative notion of external validity. Because qualitative findings are localized and bound within a specific temporal and cultural context, the concept of universality—generalizability across disparate contexts—does not easily fit with a qualitative approach (Lincoln & Guba, 1985: 316). Instead, there is the notion of "transferability," which is "an empirical matter [that depends] on the degree of similarity" between earlier and later contexts (Lincoln & Guba, 1985: 297) rather than a straightforward assessment of statistical representativeness. Before any such judgment of transferability can be made, the researcher first must consider whether the findings are generalizable among *similar* contexts (which is necessary because positivist practices of statistical sampling are not used). Next, the researcher considers whether the findings can be applied to *disparate* contexts (Lee, 1991). To facilitate this judgment, the researcher must provide—as I have—a "thick description" of the context and findings, which may later "enable someone interested in making a transfer to

reach a conclusion about whether transfer can be contemplated as a possibility" (Lincoln & Guba, 1985: 316). In the end, the findings of a qualitative research project may be largely transferable across contexts, but such is never the *a priori* aim of the project. Indeed, as Charmaz (2006: 180) notes, by analyzing phenomena in their "social, historical, local, and interactional contexts," generality can *emerge* rather than be pursued as a primary goal. The initial aim of a grounded, interpretive method is *understanding*, which can evolve into *explanation* as situated particulars (Spradley, 1979; Van Maanen, 1979) are abstracted into general concepts and then linked to different contexts within the same or subsequent studies (Charmaz, 2006: 181). In this way, constructivist approaches can lead to "substantive theories" that can become formal theories as they are duplicated across a wider range of studies (Glaser & Strauss, 1967). In the Discussion section I assess the potential transferability of the conceptual model presented in Figure 1.

Dependability refers to consistency (accuracy from multiple viewpoints). In order for the findings to be dependable, I jointly coded half of the primary data with a prospective co-author well-versed in grounded theory. This approach has advantages over coding independently and then comparing notes. Namely, idiosyncratic interpretations made by either of us could be discussed and reconciled in real-time. Although inter-rater reliability, in the quantitative sense, is not possible in the open and axial coding processes, when categories are rapidly emerging and the coding dictionary is continually being revised, my co-author served as an independent check through this joint coding approach. The final criterion, *confirmability*, refers to neutrality of assessment (replicability). To achieve this, the qualitative researcher must clearly demonstrate how he or she arrived at the findings, such that future researchers might in principle be able to reach similar conclusions based on the same data. To this end, I have been as transparent as

possible in describing my methodological approach and data sources, in addition to providing in the Findings section (as well as in Table 1) multiple accounts of the same idea or code from multiple interviewees. Throughout the coding process, I likewise did a substantial amount of memo-taking, which is "the pivotal intermediate step between data collection and writing drafts of papers" (Charmaz, 2006: 72). This involved continually making notes on transcripts, in electronic documents, and on notepads, in order to speculate about possible theoretical connections. Memos capture flashes of insight and create a "paper trail" of the processes by which the eventual findings have emerged, thereby increasing dependability.

I thus made the transition from data to theory (i.e., the grounded model in Figure 1) through a combination of "between-subject" pattern recognition (i.e., via a spreadsheet of interviewee attributes) and memo-taking (i.e., hand-written analytical notes and diagrams). Indeed, although memo-taking is "*the* fundamental process" by which the grounded theorist "transforms data into theory" (Lempert, 2007: 245), I went the extra mile, so to speak, by keeping track of emergent data patterns across interviewees, as discussed above. Ultimately, however, the trustworthiness of any grounded model is determined by the criteria I've discussed in this section—credibility, transferability, dependability, and confirmability.

INTRODUCTION TO FINDINGS

Before describing the findings, I first provide an overview of the conceptual model (see Figure 1). The model is structured around the different identity-relevant experiences individuals can have when they operate within an identity resource "void." In particular, my data suggested that identity construction in the context of such a void can be described in terms of three "stages": *encountering* the void (recognizing a lack of identity resources), *experiencing* the void

(struggling with certain identity challenges as a result), and *facing* the void (seeking out compensatory resources via identity work tactics to help overcome those identity challenges). In the first stage—"experiencing the void"—individuals become aware of and vocalize the fact that there is no clear ideology, identity prototype, or public awareness regarding their work role that could help them construct a sense of self. In the second stage—"experiencing the void"—individuals find themselves struggling with identity challenges—namely, identity ambiguity, hyper-complexity, a lack of confidence, temporal instability, and logical inconsistency—as a result of these resource deficiencies. In the third stage—"facing the void"—individuals strive to overcome these challenges through various cognitive or behavioral "tactics" that can increase their identity clarity, the key outcome under which multiple specific identity challenges can be subsumed. As indicated in the model, these tactics include relying on "identity anchors," employing "identity devices," seeking "identity supports," and imposing "identity constraints." I will describe each of these tactics, as well as the stages, in the next section. It is crucial to note, however, that although the stages are suggestive of a temporal sequence, they do not always play out in a linear fashion. Indeed, in the case of health coaching, some of the coaches I have spoken with seem to have progressed through the stages and have created for themselves a quite clear and confident identity. However, the majority of coaches appear to continually revert back to "earlier" stages. In this sense, the stages are not a firmly unidirectional, temporal sequence; I thus include a recursive set of arrows in Figure 1 to capture the often cyclical nature of these stages.

In the next section, I unpack the conceptual model using the two-order approach used in previous published articles (Gioia & Thomas, 1996; Kreiner et al., 2006b; Van Maanen, 1979). The sub-headings thus represent "second-order" abstract conceptual themes—these themes serve as the key components of the conceptual model. These "second-order" themes emerged and were

aggregated from interview data ("first order data") and secondary data sources. Supporting data examples, from both interviews and secondary materials, are included under the sub-headings of their respective themes. Further data examples are included in Table 3.

FINDINGS

Key Outcome: Occupational Identity Clarity

I begin with an overview of the key outcome of my model—*occupational identity clarity*. My interviewees described and manifested a number of specific identity challenges—e.g., confidence in one's identity as a health coach, temporal instability, and logical inconsistency—which I will discuss in more detail below (under "Experiencing the Void"). By comparing these challenges with extant literature in psychology, I found that they could almost all be linked to the concept of "identity clarity," which is defined as "the extent to which one's self-beliefs are clearly and confidently defined, internally consistent, and [temporally] stable" (Campbell et al., 1996; Usborne & Taylor, 2010: 883). Importantly, however, this definition did not capture all the indicators of clarity (or a lack thereof) that appeared in my data. In particular, multivocal (i.e., ambiguous) and/or complex identity statements seemed to me strong indicators of a lack of clarity, but this aspect was not included in the original definition of identity clarity. Thus, here I expand this definition to include statements that convey a univocal and/or simplified identity.

Although the majority of health coaches I spoke with either currently struggle (or have in the past struggled) with identity clarity, certain coaches appear to have arrived at occupational identity clarity. To illustrate, one coach emphasized the uniqueness of her sense of identity, saying, "I feel like I have a very strong sense…that I am a health coach and what that means for me, and it's very distinct" (Interview # 24). Similarly, another coach said, "I feel pretty clear

about what I do and what I can do…I don't think I have much internal ambiguity about how or what type of coaching I can do with someone" (Interview # 35). Finally, one coach described the personalized aspect of his identity as a coach, saying, "Through my understanding of what a health coach is…I think I'm very clear on how I use it and what it is for me" (Interview # 20).

In the next section, I will discuss the first stage of the model—"encountering" the void—after which I will discuss the specific identity challenges that coaches experience as a result of this encounter, all of which can be linked to the key outcome of the model—occupational identity clarity. Then, I discuss the tactics that help coaches improve their sense of identity clarity—i.e., the strategies that help them "face" the void.

Encountering the Void: Identity Resources Become Conspicuous in Their Absence

The first stage of the model is called "Encountering the Void." This stage comprises a set of realizations wherein individuals become aware of the fact that the social context in which they are situated lacks certain resources to help them construct a sense of self vis-à-vis that context. See the left side of Figure 1. This notion of an identity resource "void" emerged in the course of data collection and analysis, as interviewees repeatedly described the health coaching profession in terms of the identity resources it currently lacks. The data further suggested that health coaches encounter and re-encounter this void at various points in their careers, yet that such realizations are often most prominent during the early stages—for example, when the coach is first exposed to the field of health coaching in their training program.

(Un)shared ideology of work. One absent resource that coaches described was a *shared ideology of work*, or shared beliefs about the ultimate purpose of a line of work—a key factor in any coherent collective or individual work identity (Ashforth et al., 2007; Scott, 2007). As one

coach noted, the field of health coaching is fractured in this respect and is thus split into two "worlds":

> One world is the very academic healthcare…professional world, and then there's also the online entrepreneurial world…I think people in the healthcare world, that more professional world, have a lot of respect for a very academic and rigorous way of going about the profession and researching it. And people in the more entrepreneurial world are very much about personal development and health help and growth and making a profit and aren't as concerned about research and professional licensure. It's sort of like, 'Just go out and do your thing' and like, 'Stand in your power.' All of that. (Interview # 21)

Although this distinction between the professional and entrepreneurial worlds may not appear drastic at first glance, a number of my interviewees expressed concern at the depth of this ideological division. On the one hand, the professional world values establishing a scientific foundation for coaching in order to more effectively facilitate the client's self-healing, thereby creating a defined jurisdiction for the profession itself; the entrepreneurial world, on the other hand, prioritizes making health coaching into a lucrative business option for people with a passion for wellness. Similar to other professionals that straddle the line between professional and entrepreneurial values (e.g., lawyers—pro bono versus money-making), many coaches reported that these two goals—to heal people and to make money—exist in a tension. As one coach vividly said:

> One thing I struggle with….is these marketing folks will tell you that if you want to be successful, you have to have a mind for success, you have to get over your issues about earning money, you have to not see earning money as a bad thing or as a necessary evil. You have to see it as a healthy part of living a good life, and you feel entitled to the money that you earn. And I kind of half believe that stuff, but half of me doesn't still. There's half of me that kind of says, "Yeah, I wish I didn't have to take any money from people," and I think about people like Jesus and Buddha. They weren't charging people. They didn't carry around a little credit card processing machine when they went out to sit in the field and tell people about how they could improve their lives. Do you know what I mean? Or if they did a healing, they weren't like, "Okay, pay up or put out." You know? (Interview # 36)

A contributing factor to this ideological tension is the combination of various kinds of individuals getting into health coaching: some have healthcare backgrounds and thus care about building a service-based professional role in the healthcare industry; others do not have a relationship with the healthcare industry and thus care more about simply creating a profitable business. As a result, the two worlds often talk past one another, failing to understand the core values motivating each. For example, one founder of a health coaching program in the entrepreneurial world said the following in an emailed newsletter about the concerns some coaches have with the business side of health coaching:

> When I write to you about growing your business, I pause when it comes to talking about "the money." It's so strange, but people respond so strongly to the topic. Yet, we all need it. It makes the world go around. It lets you provide for your family. It lets you get the things you want and need. It lets you be charitable. Yet, people (in some cases) feel funny talking about the financial side of things. Why? Who taught anyone to think and feel like that? (emailed newsletter)

This lack of common understanding can occasionally manifest itself as distaste for the values of the other "world." For example, health coaches working on the entrepreneurial side sometimes see the professional world as trying to place too much emphasis on "gobbledygook medical stuff" that "just doesn't speak to people" (Interview # 23), whereas the professional side often sees the entrepreneurial world as interfering with and even cheapening the mission of professional health coaching. For example, one coach said:

> You know….you just Google [health coaching and] you'll see all the sites. I mean, you just drown in these health coaching sites. I had to unplug from so many different health coaching things….I just was like whoa, enough, stop, just stop, because what has happened is a lot of people will see it as an opportunity of making money. It's not so much that that it's really helping educating the public in general as to who we are and what we're doing. That's just throwing a whole bunch more people into the works or into the category of being health coaches that may or may not mean anything to, not only the public, but to the actual person themselves. Sally was a hairdresser. Now she's a health coach. (Interview # 18)

Indeed, as this quote illustrates, the professional world's distrust of the entrepreneurial world is primarily due to the divergent goals held by both groups, which differences are largely informed by these groups' divergent professional backgrounds.

(No) identity prototype. Closely related to this fractured collective ideology is another identity resource not yet available to health coaches—an *identity prototype*. A concept that emerged from my data, this resource is best defined as a collective understanding of who constitutes an ideal member of a particular group. An identity prototype thus answers the questions: what does a prototypical member of this profession look like? What are their qualifications? Where do they work? How do they interact with clients? How do they dress, act, and speak? This collective understanding is facilitated by, in part, a standard credentialing system, a feature that is not yet in place in the health coaching profession. As one coach said, "I have been involved with fields just like this, personal trainers…. and they are very similar, absolutely similar in that there is no national certification like there would be in nutrition, like a registered nutrition, like a nurse. So it's all very mushy out there" (Interview # 1).

Without a standard certification in place, virtually anybody can take any kind of training course (or bypass training altogether) and call themselves a health coach. Understandably, this fact perturbs many of the coaches I spoke with who attended expensive, in-depth training programs. As one coach said:

> I don't like that there's this whole spectrum of health coaching where... Like I was over at [work] talking with my supervisor there one day, we were talking about a project, and she goes, "Let me ask you to look at this. I got this resume." And she had a resume, and I actually know who the person is because she lives in my neighborhood, and she does group coaching at the Y. She does like an aerobics class. And she's like, "You know, what do you think of this?" And she had given, with her resume, a certificate of completion or a certification, or... What was it called?... When you work at the Y as a wellness coach or as a group instructor, you have to take two classes….It's just like a basic, you know, on muscles, and movement, and exercise, and that kind of thing. And if

> you're a wellness coach, you have to take their coach approach training. Well, she taken that two day certification thing, which has sort of a nifty title, and put it in with her resume and said she was a health coach. (Interview # 24)

Just as there is no standardized credentialing process, there are no licensing requirements for coaches either. Health coaches, who have different levels of education and prior professional experience, are thus free to meet with and advise clients without any state-level regulation of their practices. For example, one coach who is also a registered nurse said:

> A registered nurse, a registered dietician, you can look and see that we're all licensed by the state. At this time, to my knowledge, there really isn't any licensing. There's a certification but we all get certified in something. You get certified in CPR or whatever. There's more regulations, I think, associated with nursing and other health professions as compared to wellness coaching. (Interview # 15)

This absence of credentialing and licensing is reflected in the fact that there is no standard curriculum for health coach training programs. As a result, each training program has its own idiosyncratic approach to educating and evaluating their coaches—the theoretical frameworks and philosophies vary widely. Some programs focus on nutrition, for instance, while others emphasize the psychology of health behaviors. The training format differs as well: some programs require on-campus residency while others use distance learning (online or telephone-based coursework). What these programs lack in collective consistency, however, they make up for in interdisciplinarity. Indeed, all health coaching curricula are extremely eclectic, with principles and skills drawn from an array of academic disciplines. As one administrator of a coaching program said about their competitor programs:

> Oh, my gosh....they don't have a concise foundation and content that builds from that foundation. It's like they've pulled this, that, and the other out of the psychological realm of behavioral science and health and tried to make something of it. Like, they'll have lectures about all kinds of things. I call it fireworks. They just kind of go here and there. You know, this one's over here and looks this color, and this one's over there. (Interview # 43)

All of the above missing pieces—credentialing, licensing, and a standard curriculum—can be linked to the fact that the exact role responsibilities (i.e., the job description) of a health coach have yet to be defined. However, health coaches do have a consortium (the NCCHWC) that is striving to do this definitional work, from which credentialing and licensing can flow. As one administrator of a coaching program said:

> That's one of the reasons [leaders in the field] are working on this National Consortium for Credentialing Health and Wellness Coaches because there is an evidence-based best practices process to define a new job….and there are steps that you take and then you come up with a certification and then you figure out what training and education standards deliver the skills and knowledge that the tasks require. It's all well-laid down, the psychometric process because out there in the world you've got everybody with different motives defining a coach differently, and then the people who are on the high ground saying, "Yeah, but we're up here. This is a very sophisticated skill set" because these people out there, if you've noticed, are really struggling. We're not going to turn this boat around in a ten minute conversation. We need really, really great skills. So as industry leaders, we're all working together to define that standard over the next few years. It's a multi-decade process. I would say that first decade….I think we built a foundation….And it's still got a long way to go. (Interview # 5)

As a result of the above milieu, health coaches are free to practice in virtually any way they deem acceptable, in virtually any work context. Thus, there is no prototypical health coach against which individuals might compare themselves to assess the degree to which they fit the mold. Simply put, there is no such mold. As one coach said, "we have a very schizophrenic population when it comes to a lot of things, because we are, we're a melting pot" (Interview # 18).

(No) image transparency. Related to but distinct from this missing identity prototype is another identity resource problem, namely, a lack of image transparency. This image problem, simply put, can be boiled down to the fact that the general public has very little understanding of health coaching—what it is, what health coaches do, and why it is important. Thus, it is not that the general public simply *misunderstands* what health coaching is while having a general sense

for it; rather, it's that the general public does *not yet understand* that health coaching is an actual occupational role that exists for a specific purpose. As one coach noted, "The definition of health coaching is something that I think the general public doesn't understand. That I think is an obstacle" (Interview # 33). This lack of understanding is not limited to the general public either. As one coach said, "It's a hard sell right now. You even talk to physicians and nurses, and they're like, they look at you with this blank look on their faces like, 'Huh? A health coach?" (Interview # 47). Another coach illustrated one of the problems this poses by comparing health coaching to the (more established) law profession:

> My brother who is a lawyer, family law, and if he's at a party or whatever... he's at a social event and somebody asks him what you do—a lawyer. It's like, "Oh, okay. Yeah." For me, I always feel like I have to like justify. Like, I know I can't say, "Well, I'm a health coach or a wellness coach." You know, there's got to be a second layer, "Okay, let me explain what that is," and some people are still sort of confused like, "Why?" It's sort of ironic. The thing that should be most important to us is our health. (Interview # 39)

This lack of image transparency is likely informed by the lack of a health coaching identity prototype, as this quote illustrates:

> Just looking at who I've explained it to...my neighbors...when you say health coach because of the integrative part, whether you say it or not, they don't even absorb that part. They just hear health coach, and they think Jillian Michaels. Then they think, "Oh, you're going to help me lose weight" or "You're going to help me start a nutritional program."…. so, we're always defining to people....it's just because, you know, look at the population. You've got life coaches out there. You do have people who call themselves health coaches and they're like Body By Vi salespeople....so it's a very broad term. (Interview # 23)

This lack of understanding on the public's part is also due, according to many of my interviewees, to health coaching's own failure to spread their message in a coherent way. In other words, it is not due to a lack of interest or need for health coaching that the general public does not understand that health coaching exists and can help them. Indeed, as one founder of a health coaching training program said, "It's just not clicking with the public. They have no clue.

Every single person on the face of this earth needs a health coach. I need a health coach. Everybody needs a health coach" (Interview # 25). This disconnect has implications for coaches' identities, since it can create confusion and negativity in coaches' minds regarding the value of their role. As once coach said:

> The public has not been educated to the value of what health coaches are. Now every now and then, there's this big, you know, shining star flying through the air with this great article that comes out in *Time* magazine or talked about on Oprah or Dr. Oz has given us 12 seconds advocacy that health coaches are great, which I've seen literally it's like 12 seconds. You know what, okay, yippee kiyay, okay. It's not sticking mostly. So there's a big gap. It's not just that whoever you're talking to is just having this big identity crisis as to who they really are as a health coach. It's in fact, the people on the other side of the table, they're just like what the heck are you? What are you doing? This just sounds like something, you know, bunch of stuff on a zillion web sites….Congrats. And nobody cares, okay. (Interview # 18)

This problem is recognized and discussed internally among health coaches, and there are ongoing debates regarding how exactly to label this new professional role so that others can understand its value. For example, one coach shared the following experience:

> As I was going through my recertification and I had to listen to hours….of continuing education, there was one learning activity that really struck me and it was a women who was a coach, but I don't think she was a wellness coach. What she said was, "Never call yourself a wellness coach because nobody knows what that is. Nobody knows what a wellness coach is and what that connotes is hiring a carpenter to come to your house and redo your kitchen and you say to the carpenter, "I want a new kitchen and here's my vision. Can you get me to that vision?" The carpenter says, "Well, I have this wonderful chain saw and then I have this other piece of equipment that makes mitered corners and then I have a wood-shaper." So when you tell people you're a wellness coach, you're really showing them your toolbox and you're not giving them the vision of where they can be. (Interview # 15)

In sum, given the lack of a shared ideology of work, an identity prototype, and image transparency, health coaches are operating within what might be termed an identity resource "void" relative to other established professions. One coach summed this idea up nicely, saying

that health coaching is “like walking through a fog. There’s just no solid ground anywhere” (Interview # 51).

Experiencing the Void: Key Identity Challenge—Lack of Identity Clarity—Becomes Salient

The second stage in the model is called “Experiencing the Void.” This stage involves becoming aware of and going through recurring identity challenges, to greater or lesser degrees, as a result of the identity resource void in which one is situated. Health coaches described and exemplified a number of such challenges, namely, identity ambiguity, low self-confidence in one’s identity, temporal instability, and logical inconsistency, all of which indicate a lack of identity clarity vis-à-vis their occupational role, as noted above. I describe each of these indicators in more detail below.

Lack of occupational identity clarity. Among my interviewees, the majority mentioned having experienced some degree of occupational identity ambiguity at some point in their health coaching career. For example, one coach mentioned the identity ambiguity she deals with on account of being stuck between the professional and entrepreneurial worlds of health coaching:

> I've got feet in both worlds right now, and I think I'm not sure where I want to set up camp. And I have thought about that, but I think it's probably possible to be in both worlds, but I think how you define yourself, or how people in those two camps define themselves is a little different…. And so, I have to admit I'm sort of like caught internally between those two different...because I work in in the academic world, and I have a lot of respect for that. But there's also this other message in the entrepreneurial community that you can make a lot of money as a coach if you just really hone your identity and clear your emotional blocks and all that stuff. (Interview # 21)

Beyond this confusion about how to define oneself, this sense of identity ambiguity also surfaced through an inability to describe one’s identity except through complex, multifaceted identity descriptions. Indeed, sometimes my interviewee’s descriptions of their identities as

coaches became so complex that it was difficult for me to visualize how these pieces fit together into a coherent whole. For example, one interviewee reflected on how she defines herself as a coach as follows:

> I think it's an accountability partner. I think it's an advocate. I think it's an inspirer, someone who really inspires you to live a different way, or helps you think about things in life, so I would say a problem solver, maybe a catalyst of change. I would say a... maybe an instigator a little bit, an instigator to help you kind of see different ideals, kind of coax you and instigate maybe changes in your life that you maybe wouldn't be so inclined to take on on your own, and I think, really a support system. So knowing that if you do make these changes, and take these leaps of faith, and kind of move mountains, that you have someone to lean into, and someone who gets you and understands and supports you. So it can be a lot of different things. (Interview # 38)

Beyond ambiguity, there were other specific identity challenges that emerged from the data. For example, another key challenge for health coaches is confidence in one's occupational identity. This confidence can refer to either a basic positive belief in oneself or a high level of certainty in the accuracy of one's self-definition. My interviewees repeatedly mentioned that confidence is crucial, but that it can be difficult given the lack, for example, of a standard credential that could offer a sense of credibility:

> So let me claim, I want to try to be real here, I...Either I'm at a period... I guess I've had more hopeful times and more energetic. For whatever reason, I'm in this time of kind of re-exploration, and part of that... I mean, I lack self-confidence for this field right now…and that obviously says something about my own internal perspective….So the example of the friend and mentor. I guess, I've looked at it more from his perspective, to say, "Okay, I really need to consider going back for more education, possibly to MSW, possibly to LPC, a Licensed Professional Counselor." Then I have that credential, and I can link in coaching if possible, as a part of that. (Interview # 27)

This lack of a standard credential also creates confidence problems because it means there is no health coaching identity prototype (as noted earlier), which would necessarily narrow the field of health coaches to a qualified, limited set of people. In the latter scenario, one could feel confident that the profession to which one belongs is composed of other highly qualified

people. Yet this is not the current perception of many health coaches. One coach, who had previously worked as a college professor, said the following about how this confidence problem leaves her unwilling to even describe herself as a health coach to others:

> For me, coming from another highly professional, highly credentialed field, into this, which has everything. Out here in [this U.S. state], we have people who call themselves health coaches, and it's all about lining up crystals and vibrating with the universe, which if that's your thing, that's cool. But that's not what I want my vocation to be known as. Like, that's not what I'm about. So, yeah. I'm trying to call myself a health coach, but when people ask me what I do, with everything, I just sometimes default back to professor. (Interview # 28)

Confidence is especially important for coaches, however, precisely because there is no standard credential and identity prototype to rely on in this regard. For example, one coach recalled how confidence in her identity helped her become a successful health coach:

> For me….I just said, "Okay, I need to brand myself. So what is a health coach, and tell the story in 30 seconds." You know, what are the benefits to people I'm trying to sell to, and who am I, because they're buying me right now, because I'm not a team of 20 coaches, a telephonic service for Wells Fargo yet. It's just me, myself, and I. So that's what I looked at in January…. I said, "All right, just got to brand myself to the market and be really confident in my skills." You know, because if you're wishy-washy, who's going to pay $75 an hour to talk to you that's anybody? (Interview # 23)

Confidence is also important because it can set in motion a virtuous cycle whereby one's nascent identity is recognized and thus reinforced by other people. As one coach put it:

> If you caught me….when I had only just completed my coaching program, I myself had not assimilated thinking of me as a coach, all those worries and fears of am I doing it right. Just like a new graduate nurse doesn't necessarily have the confidence to think of themselves as a nurse, even though they've finished the training and taken the test. It's just so new to them. Then once people – for some it's an internal thing and it's reinforced by externals because then people start associating you as a nurse so you start associating yourself more as a nurse, and then if you've been a nurse for ten, twenty, thirty years, it's a habit to think of yourself as a nurse. Then if you've only been a coach for one or two years, it's a new habit to think of yourself as a coach. You haven't even gotten there yet. (Interview # 16)

In addition to confidence, a related but distinct challenge for many coaches involves constructing an occupational identity that is stable over time. As one coach said, emphasizing the fleeting nature of her sense of identity, "My solution, at the moment, and again, this is a moment to moment development, is to call myself an integrative health and lifestyle coach" (Interview # 28). Another interviewee, when asked to describe his identity as a coach, illustrated in real-time the different ways his identity is shifting:

> Just think of it like I'm a financial adviser for your health....You know, it's sort of kind of... I was always sort of changing how I define it. So I would just think of myself more as a health ambassador, or try to live out the life and be a role model. So, I guess, it's sort of...how I define it is sort of constantly changing or evolving to some degree. (Interview # 39)

Coaches also described this instability in the context of their encounters with current and potential clients. More specifically, coaches described how they define themselves in different ways in order to accommodate others. For example, some coaches fluctuate their identity descriptions depending on whom they are speaking to, as illustrated by this quote:

> I think that it is particularly with health coach, and...it goes the way from branding, you know, identity, to how you explain it to people, and quite honestly.... I branded it, and I've done that, and showed examples on my web site. And when meeting people face to face, it's explaining it in a way that I think they will get, and I personalize it. You know, if I was working, as an example, if I was working with a healthcare practitioner, I'm not a business person by the way, I would say I'm like a midwife. You know, and I help facilitate change, and so I think that that is something that all coaches and people in this profession, particularly like when we say integrative health coaching at [my training program], even the word integrative, really what does it mean. And so, I think that part of the identity is meeting and crafting that is coming up certainly with something, you know, I use personal growth a lot, change, going around...if someone's an outdoors person, going around the eddies, you know, if someone's into canoeing or kayaking, whatever. (Interview # 33)

In other similar cases, coaches' identities are left open to the whims of their clients—whatever the client needs to achieve their health goals, the coach takes on whatever identity and associated values can address those needs. To be sure, coaches often tried to put this flexibility in

a positive light. As one coach said, “Whoever comes to me, if they read my materials or whatever it is, they’re all different, so my identity is really just being focused on their needs. I mean, so pouring out all my energy on whatever their needs are and helping them to work those through” (Interview # 37). By contrast, certain coaches do not allow themselves to be defined by their clients, nor do they define themselves differently in order to accommodate their audience’s level of understanding. One coach, for example, said:

> I think you need to just pretty much tell [current and potential clients], “This is what I do.” However you define it yourself, and let it go, because I think you can try too hard, and I think you can get to a point where you're over-explaining….to others because you know that perhaps they don't get it, or they don't understand it. Right? So I think you have to really, I think you have to pare it down, “Hey, I am a wellness coach, and this is what I do,” or, “I am a wellness coach,” and stop.… So from a coaching standpoint, it's just important that we sort of convey what we do in a nutshell, and then let the other people sort of think about it and whether they want to pursue it or not. (Interview # 35)

Another coach offered a similar example of temporal stability, describing how she no longer caters to every new audience by using different “personalized” self-definitions:

> I used to feel like I was a whole pie, and that I could speak to someone and if they didn't honor, for instance, the spirituality side of things, then I would leave out in my discussion of identity with them that piece of it. And over time I've gotten more comfortable and more integrated and less ambiguous internally. So now, I don't see it as a pie like leaving something out or picking and choosing pieces. Now, I see it more like turning up or down the damper say on a fluorescent light....it's more like I bring now my whole self to the table all of me in my own clarity at the moment....I kind of picture it as a faucet and a hose. You know, sometimes you can be a fire hydrant, but sometimes it just needs to be a trickle, but it doesn't need to be dummied down or changed or partial, if that makes sense. It can always be the pure essence of what I'm about and where my beliefs lie and what my professional identity is. (Interview # 49)

In addition to the challenge of defining oneself in a temporally consistent way, I found that many coaches also struggle with creating a sense of identity that is logically consistent, adding up to a congruent, harmonious whole. This particular challenge was likely less evident to my interviewees in real-time, but through the data analysis this challenge became apparent.

Specifically, I noticed that certain interviewees described their identities in ways that were contradictory. That is, they made identity statements that included not merely multiple self-descriptions, but descriptions that could not easily co-exist with one another. For example, one of my interviewees said, "I see myself more as a health coach with….clinical expertise," and then not thirty second later said, "I see myself more as…a clinician who has health coaching expertise" (Interview # 43). As another example, one coach described her sense of identity by comparing health coaching with the medical profession, saying, "We're not doctors obviously. It's a... I didn't know that it would be... It's like pretty much like being like a nutrition counselor or something. Some people even call it that….For me, a health coach has to be able to solve medical problems even though I'm not a physician" (Interview # 42). In the same interview, however, this same coach described her identity as follows: "I wouldn't say it's that I'm going to solve [my clients'] medical problems. No….it's just encouraging them... People have to have the motivation to want to get better, or to want to clean up their diet, or whatever they need. But it's kind of guiding them and educating them, and just being a support" (Interview # 42). Such contradictory statements are perhaps to be expected if the identity itself is ambiguous and/or temporally-unstable, yet these expressions are nonetheless another way in which coaches demonstrated a lack of identity clarity.

To reiterate, each of these specific identity challenges—identity ambiguity, low self-confidence, temporal instability, and logical inconsistency—are indicators of the larger identity-related outcome—*occupational identity clarity*—that many health coaches are struggling with. See Table 3 for additional data examples of this central struggle.

Facing the Void: Identity Work Tactics and Compensatory Identity Resources

The third stage in the conceptual model is called "Facing the Void." In short, this stage involves *dealing* with one's identity challenges—namely, by cobbling together different kinds of available identity resources to achieve identity clarity. Of course, identity clarity may not be a desired end-state for every single person. Some individuals may prefer the flexibility that comes with less clarity; others may simply have accepted that their identities may never be clear to them. However, my interviewees repeatedly expressed a desire to clarify their identities. As one coach put it, recalling her early days in the career, "My mission was to make [my identity as a coach] not ambiguous by finding things that I thought would help me be more successful and help define what I wanted to do" (Interview # 38). Similarly, another coach who just recently completed her training program said, "In 3 to 6 months' time, I really want to be clear on what I'm doing….I don't want to be just all over the map" (Interview # 22). Yet another coach reflected on her early days as a coach, saying, "confidence is competence....someone said to me a few weeks ago it's embodied competence, and I wanted it. I wanted that feeling" (Interview # 48).

To this end, interviewees described and demonstrated a number of agentic tactics that help them clarify their identities. Each of these agentic factors involves drawing on some kind of "compensatory" identity resource—a conceptual or material entity that facilitates the construction of a clear sense of "who one is" and thereby helps individuals compensate for identity resources that are currently absent or in short supply. Although certain of these compensatory resources may also be found in stable, well-defined work contexts, they nonetheless represent the few options available to individuals seeking identity clarity in less-established fields and roles. In the case of health coaches, I found that some of these resources

have been provided, to a certain extent, by the training program in which the coach enrolls. In the following sections I draw attention to this fact when applicable. However, it is important to point out that training programs often can only attenuate the identity challenges coaches face—individual coaches, no matter the program, all mentioned struggling with identity clarity at some point in their careers, despite their training program's efforts. One coach said, for example:

> When I went through the program, the message that [our instructor] kept touting is that you guys can go out now and be coaches as a career....and it's like, what does that mean?....I didn't know...even though that program is two years long, I got to the end of it, and I still didn't know what being a coach meant or what it would look like. So there was lots of ambiguity. (Interview # 51)

Thus, although training programs can serve as important mediating forces in the professional lives of coaches, the nature of the occupation is such that many individual coaches nonetheless must face a tremendous number of identity challenges more or less on their own. It is to these individual tactics and compensatory resources that I turn in the following sections.

Relying on identity anchors. The first compensatory resource is an identity "anchor." Anchors include one's prior (or a different concurrent) occupational role, or a material artifact such as a product, a verbal script (for client sessions), or a website template. These anchors effectively relieve health coaches of some of the pressure to develop a unique sense of occupational identity. Indeed, these anchors do not directly clarify the content of the coach's identity—that is, they do not help clarify what it *means* to be a health coach, as captured by a coach's values, motivations, and beliefs about tasks and responsibilities—but they do promote clarity indirectly by serving as a foundation. For example, many of my interviewees came into health coaching from a prior career in the healthcare industry—for such coaches, their prior identity as a healthcare professional often serves as the basis for their emerging identity as a health coach. Sometimes this is purely a conceptual exercise. For example, one coach described

how reflecting on her background as a psychotherapist provides a starting point to work with: "it's what [health coaching] is and what it's not, and that's why I love the background because I can see clearly what [health coaching] is not" (Interview # 33). Other times the prior occupational role can provide something more tangible. One coach, for example, illustrated how her prior career as a registered nurse grounds her coaching identity by shaping her interactions with clients:

> I am a nurse – so I explain that to [my clients] as I can give them information and education as they need it, but I can also put the brakes on right away that's totally unsafe, inaccurate or out of whack. So it's sort of – the R.N. for me becomes sort of the back-up cushion. They recognize the parameters of that. They're willing to go into the fuzzy zone of coaching, but in my case, sometimes knowing the R.N. is the outside fence that keeps them safe in that fuzzy zone. (Interview # 16)

Using an occupational role as an anchor point is fraught with contingencies, however. For example, the degree of perceived similarity between the other role and health coaching is a significant factor in how well such anchor points promote clarity. This similarity becomes especially problematic when the roles are concurrently held—e.g., the coach works part-time as a coach and part-time in a closely-related occupation, such as personal training, nursing, or psychotherapy. When the perceived similarity between these roles is high, the coach is required to be clear—for themselves and for their clients—about where health coaching ends and the other role begins. The coach's level of identity clarity is thus influenced by the extent to which they can keep these roles separate. Coaches repeatedly described how such distinctions are easy to understand in theory, but difficult to sustain in practice. For example, one coach who also works as a personal trainer said the following about the differences between these roles:

> It gets muddled at times because a lot of coaching goes into being a personal trainer as well, but certainly the wellness coaching can stand on its own and be just that…That's kind of what I'd like to develop and that's where I'm kind of at right now in my journey with it all, is to be able to offer services to do the wellness coaching and also have the

> personal training and have people see the separation of the two and the conjunction with each other. But because I think it's so new and it takes a lot of clarity on my end to keep that separate and not muddy the waters for either my job or for the client….I think somebody could be okay with [the muddling]. I'm not. (Interview # 9)

Another contingency is the level of expertise associated with the other occupational role. A recurring theme in the interviews was that previously-held roles associated with high levels of professional expertise can leave coaches feeling qualified to do more for their clients than the "average" health coach. Although these qualifications might be useful in some ways (e.g., by comforting certain clients who are looking for a highly-trained coach), they paradoxically create a scenario where the coach is unsure about where to draw the boundaries around his or her coaching role, precisely because he or she has the tools to go beyond those limits. For example, one coach with PhD in a health-related field said:

> Absolutely they were some moments of ambiguity, and I mean, there still are I suppose because….some of the other coaches had carved out their role, their identity, what they were capable of doing, saying, giving, or how they perceived themselves, and I guess, I'm still in the process of doing that….The label of health coaching....I mean, there are so many aspects to it, right… So finding the boundaries of where a health coach might be able to go. How far can a health coach go before they start to step on other people's toes like a registered dietitian, for example. And in my case, it's been a little more difficult because I think I have academic qualifications that go beyond most other typical health coaches. So for me, it's been difficult to like figure out, "Okay, I'm capable of reading scientific papers and understanding them and so on and so forth, and I've had a lot of academic training. Where does it stop for me," you know? So it's, even now, it's just been difficult to kind of sort that out. (Interview # 50)

Not only is this line difficult to draw, but the stakes are much higher for people who come into health coaching from a prior professional career. Specifically, such coaches talked about how high-level qualifications bring with them a higher standard to which they are held accountable. In particular, coaches with professional licenses can be held legally accountable if they misrepresent or otherwise fail to make these role distinctions clear for their clients. As one coach, a former nurse practitioner, explained:

> If you're a physician, and you're practicing, or you're a nurse practitioner, and you're practicing as a nurse practitioner, and you want to add health coaching to your skill set, that's awesome. You know, that's great, but if you're a retired physician...if you're say a radiologist...I know a woman who happens to be a radiologist, and she was a physician, and she went to medical school. She can diagnose and treat, but she's been a radiologist her whole life. She's going to now do health coaching, you know, you just legal wise and just looking at what you want your model to be, you have to be really, really clear about what do I want to offer? Do I want to offer integrative medicine, or do I want to suggest, you know, supplements, or vitamins, or you know...and where does that cross the line? If you're a professional, where does that cross the line of diagnosing and treating, you know, what does your malpractice have to look like? You know, all those kind of issues. If you're a nurse practitioner, and I'm doing something like that, then depending on what state you're in, you've got to have….if you're doing any kind of diagnosing and treating, then you've got to have a physician, a collaborating physician, or a supervising physician. It just opens up this whole can of worms. So it can be really tricky not to cross those boundaries. (Interview # 47)

Beyond role-based anchor points, material artifacts can serve as identity anchors as well. For example, coaches mentioned that using a script for client sessions—that is, a verbal script outlining what to say to clients—can promote identity clarity by clearly defining one's workflow. As one coach who uses program-provided scripts said, "my internal way of thinking about it is that the program…tells me what to do and tells me in a sense who I am…So it's very well defined" (Interview # 26). Using a verbal script is not always straightforward, however, even if it is developed and provided to the coach by his or her training program. Indeed, coaches talked about having to tailor the script to their personal circumstances, which can require significant individual effort and ingenuity on the coach's part. One coach, for instance, said the following about the script given to him by his training program:

> On a visit, [the script tells] you to ask about the patient's highlight or the best thing that's happened to them. Then go over their goals from last time. But then, the middle part, before you get to setting new goals, they just structure it as the "generative moment." And that's the structure, and to me, not being from that background, "Okay, that's great, but how do I get there or get the patient there? And what does that really mean?" You know, it's so ambiguous. I didn't know what that meant. So it took me forever to figure out. And now, I actually have, if I'm on the phone with a patient, like a flowchart that I go through that helps me get there in more of a structured way. It helps me….It took me

> time to, and drawing on other resources, listening to different webinars….I listened to... a psychiatrist at Yale but also he also used to work, or maybe he still does, at a hospital in New York. And his webinar was just on motivational interviewing, and that gave me some of the structure on how to identify barriers or help a patient identify barriers. And then, once it's identified, how to take them to, you know, coming up with ways to get past those barriers. So that was really helpful. And then, there's a book I read….it was a book on coaching questions….what questions to ask and when to ask them. That was huge for me. (Interview # 30)

Other material artifacts, such as vitamins, health shakes, or other health-promotion programs, can also serve as identity anchor points for health coaches. One coach, who eventually left coaching precisely because he was unable to clarify his identity as a coach, related his observation of how other coaches have successfully developed a clear occupational identity:

> I think they either have a product or a program that backs them up…They say, "I'm a health coach." They lead that into, I think – people ask, "What does a health coach do?" They can introduce, "We sell vitamins and shakes to help improve their health". Or [another health coaching program], I'm involved with that organization…Those people take so much pride in telling people that we're health coaches because they also have this line of [health shakes and foods] and they have [a health-promotion program]...I really think those products and programs help define yourself when you're a health coach, to fall back on. (Interview # 3)

The final type of identity anchor is a website template—a pre-packaged space for professional self-presentation. This kind of artifact provides a very real foundation upon which a sense of identity can be constructed. For example, included with the price of tuition at one particular training program is a website package—specifically, a webpage and URL address that the student can use to attract clients as they progress through the program and beyond. In the course of reading through various coaching websites, I discovered a trend—the websites of coaches from this particular program all looked and sounded very similar. In fact, a large portion of the self-descriptions were identical from one coach to the next. The following block of text, with its many confidence-boosting details, was common to every single one of these websites:

> I received my training as a health coach from the [coaching program's] cutting-edge Health Coach Training Program. During my training, I studied over 100 dietary theories, practical lifestyle management techniques, and innovative coaching methods with some of the world's top health and wellness experts. My teachers included Dr. Andrew Weil, Director of the Arizona Center for Integrative Medicine; Dr. Deepak Chopra, leader in the field of mind-body medicine; Dr. David Katz, Director of Yale University's Prevention Research Center; Dr. Walter Willett, Chair of Nutrition at Harvard University; Geneen Roth, bestselling author and expert on emotional eating; and many other leading researchers and nutrition authorities. My education has equipped me with extensive knowledge in holistic nutrition, health coaching, and preventive health. Drawing on these skills and my knowledge of different dietary theories, I work with clients to help them make lifestyle changes that produce real and lasting results.

Each of these identity anchors—other occupational roles and material artifacts—thus contribute to clarity by providing a tangible starting point from which to craft an identity.

Employing identity devices. The second compensatory resource is an identity "device." The term "device" here refers to not a mechanical device, but a literary device—a literary technique used to produce a particular effect in the reader. I found that health coaches use a variety of such devices to clarify the content—values, motivations, beliefs about tasks and responsibilities—underlying their emerging sense of occupational self. One example of an identity device is an identity archetype. This kind of archetype is best understood as an idealized, abstract form (of a person or a role) whose basic values, motivations, attributes, behaviors, and beliefs are widely, if generically, understood. Archetypes, when applied to an identity, can thus provide insight into the content of that sense of self. Coaches talked about themselves in terms of various archetypes. For example, many coaches talked about seeing themselves as healers, facilitators, or teachers. One coach described himself as a healer as opposed to a businessman, which has implications for how he wants to spend his time as a coach. He said, "one of the issues is being a business person versus just being a healer. I almost wish that I had a partner who was a business person who could just focus on all of that marketing for me, so that I didn't have to do

it" (Interview # 36). Another coach described a process of moving between these and other archetypes, leading to the current clarity he has as a coach.

> I was for awhile seeing myself as a healer. But I've also...you know, coming from the background of being an attorney and very left brain, I've also been very analytical about this process, and I see myself at the cutting edge of some thinking that is transcending from the whole idea of being a healer back to being a teacher showing people how to heal themselves, and I see myself right now as a teaching skill sets, rather than as offering healing. (Interview # 46)

These archetypes can thus be combined in novel ways, leading to a unique sense of self. As another example, one coach said she defines herself as "a writer, but a writer who.... I think of myself as, if you want to get archetypal, I feel like I'm an artist. That's the writer but also a healer" (Interview # 34). To be an "artist" was also described by some coaches as an aspirational identity goal. One coach described a well-known and well-respected health coach in these terms, saying, "Listen to [her] when she coaches a client. It's like a symphony. It's a beautiful painting….It's drawing out of that person. It's beauty in motion" (Interview # 15).

Certain coaches also talked about seeing themselves as something akin to a prophet—specifically, as an enlightened individual with a responsibility to warn people about impending health-related calamities. For example, one coach, reflecting on his sense of identity as a coach, referred to a prophetic figure in the work of philosopher Friedrich Nietzsche:

> One of the stories he wrote about Zarathustra, his mythical character from Zoroaster….was the story of this old man that went up to the mountain and discovered like the truth about everything, and had all these warnings to give the people about how their beliefs, their weaknesses, and their desire to be sheep and follow the master, and follow what everyone else was doing, and follow the guidance and teaching of governments and corporations, and military, and churches, and organizations that were basically using them to promote their own agendas were causing the destruction of the human race and kind of the de-evolution of our species. He wasn't the only one saying that. I mean, there were other, many great writers, de Tocqueville, different people were warning, but the image that he got, this old man coming down out of the mountain with a lantern trying to tell everyone this message, and everyone is turning away. Everyone is literally... and to the point where they start calling him a crazy old fool. He's just a crazy

> old fool. Just don't even listen to him. He's just nuts. And what's really ironic about this is that, for the last 11 years of his life, Nietzsche became that man, actually became certified insane, and he was put in an asylum, and he spent the last 11 years not speaking to anyone. And so I've always... His example has been sort of a specter to me because it was in college where I was reading it. I thought to myself, "Wow, if I really say what I really want to say, and if I say it with the force and the power that I really feel it inside me, people are going to think I'm a quack, and I'm going to wind up in an asylum sitting there staring at a wall, if they don't put me down first." You know, because of the controversial stuff that I see, and that I feel, and that I believe. So I feel like I'm always having to water down my message, and simplify it, and be very careful about all the political ramifications of what I say. I mean, have you noticed that all these health movies that are out, these alternative health movies, these alternative health books, there's always a disclaimer in the front of the book that says, "This advice is not intended to be the advice of a physician. If you're going to make any changes in your health, please consult with your physician before doing so." Blah, blah, blah, blah, blah. (Interview # 36)

Another coach mentioned drawing on a well-known military archetype—the no-nonsense drill sergeant—to define himself as a coach. He said:

> In 2005 I gave myself the tag…."wellness sergeant," because I'm 10 years ex-Air Force, and the reason I say that is I do keynotes speaking at safety and health conferences. I'm a cross between Dr. Phil and Dr. Laura….So I tell people how it is, and again, not in a one-on-one type setting, but I mean in a group setting, is I just lay it out. This is how it is. For example, one out of three children are going to be type II diabetic by 2050 if you keep going to Costco and buying cases of Oreos. The average 65-year-old will be on five medications by 2050 if you continue to eat processed foods. That's just how it is. I'm going to tell you how it is, and if you cry easy, you probably don't want to listen to me. (Interview # 44)

Another device used by coaches is analogy—specifically, metaphor and simile. Metaphors are figures of speech wherein an image is used to convey something essential (values, beliefs, behaviors) about an unrelated image with which it is conflated (i.e., one image "is" the other), whereas simile accomplishes the same effect by comparing the two images rather than conflating them (i.e., saying that one image is *like* the other). For example, a common theme among my interviewees was the metaphorical use of images such as guideposts—or objects such as GPS (global positioning system) machines—to describe their identities to themselves and their clients. Such metaphors clarify the contours of the identity by association, which promotes

confidence in both coaches' and clients' understanding of how exactly the coach views him- or herself in the context of the health coaching role.

Analogies were also used by coaches to clarify the uniqueness of who they are as professionals. For example, one coach described her distinct identity as coach with an elaborate metaphor about different approaches to teaching someone to ride a bicycle:

> If you were learning to ride a bike, an educator would show you pictures of a bike and maybe have a bike and explain the parts. A therapist would talk about are you afraid to get on the bike, why don't you know how to ride one yet, what happened in the past. The coach would maybe briefly say how to pedal and balance, put you on the bike and run alongside you until you could ride it on your own….More currently, I would throw in that a consultant would just get on the bike and ride for you and do the errand and come back. (Interview # 16)

My interviewees also talked about the value of an antagonist—a device that entails someone or something, either real or imagined, that provides resistance and in the process strengthens the core values and beliefs informing one's sense of identity. One coach described the basic logic behind this tactic while reflecting on early negative experiences with her peers not understanding and doubting the value of her coaching career:

> It definitely caused some self-doubt for a little while….So it was hard to like feel like...I mean, everything felt kind of nebulous….So it ended up now I feel...I mean, now I don't let things like that affect me, and in a way, it's kind of like the yin yang, you know, you sort of have to...just like anything in life. If you experience a little bit of the opposite energy, then it can just clarify things for you. (Interview # 34)

Although skeptical peers and family members are often the antagonists in coaches' lives, this resistant figure need not be an actual person. For example, one coach talked about a guided imagery exercise that helped her develop greater confidence in her identity as a coach:

> So this was an exercise... This one was the most prominent in what I've done, and it was taught in one our lectures by a woman….she's a fellow health coach, and she took you through an imagery of being in a boardroom. And so, you're in the boardroom, and sitting around your table is your board of directors. So they're all those people in your life who were very influential in some way in how you have developed your life. So maybe it was

> a friend, a spouse, a pastor, a teacher, anybody like that. So she asks you to envision your board of directors. And then, somewhere in the room was that part of you that says, "I'm not good enough," and it's called "I'm not good enough." So envision where in the room is "I'm not good enough." What does "I'm not good enough" look like? What is it wearing? What's its posture? And then, ask "I'm not good enough" why they're there. What are they trying to do to serve you because that part of you is there for a reason. Maybe it's there for protection, security. There's different reasons for every person. So ask it, "Why is it there?" And then, ask it, "What does it need from you in order to feel better?" And so, for me, my not good enough said, "I came to you because your dreams have always been too big and everyone around you does not understand them, and they don't understand you. So I came to make you smaller, so that people would not be intimidated by you." So I had to then say, "Well, what do you need from me?" And she said, "I need you to surround me with people who can handle how big you want to be." And the interesting thing for me is other people said that their "I'm not good enough" was sitting off in the corner, you know, huddled. Mine was a mirror image of me at the other head of the table completely sharing power in my life, and it wasn't until I promised to surround myself with people who could understand how big my dreams were that she got up from the table and went and sat to the side. (Interview # 40)

In this way, my data suggest that individuals can use a variety of devices—archetypes, analogies, and antagonists—to develop a better understanding of the values, motivations, and beliefs underlying one's emergent identity, thus promoting identity clarity.

Seeking identity supports. The third compensatory resource is an identity "support." An identity support is a resource that helps protect and nurture one's developing sense of identity, reducing ambiguity and increasing confidence in that identity. These supports can come in many forms. For health coaches, a dyadic relationship with a supportive colleague, mentor, or even a successful client is one such form. Some coach training programs, in fact, require trainees to work with a mentor coach; many others do not, however. Some programs set up alumni events or online message boards and encourage participation; others do not. In either case, coaches must show initiative and seek out mentors and colleagues to help them work through the identity challenges they are dealing with—the training program cannot force this kind of fruitful

interaction. For example, one coach talked about how frequent meetings with a therapist colleague are helping him deal with identity ambiguity and "move forward" toward clarity:

> I mean, what's coming up for me….is just the importance of community and relationships. So, like, even this meeting today is with another colleague who's also a therapist, who has this credential, but also I think has some value around coaching. So, just meeting with him, I think, offers some energy and encouragement….it offers more kind of energy and support, and knowing that you're not in this alone so to speak. It allows you to hold the ambiguity, I guess.... It helps me hold the ambiguity, even as I keep moving forward. (Interview # 27)

Interviewees also reported that a successful relationship with a client can be a boon to identity clarity. When clients begin to achieve their goals, this not only builds self-esteem for the client but it also helps the coach feel more confident and self-assured in their identity as a coach. One coach, for example, said the following about how success helped him overcome his early inability to even call himself a "health coach":

> [It] probably took me six months to... to just have [the word "health coach"] flow off the lips instead of...and feel legitimate about it instead of saying, "Well, it's just a little thing I'm trying that's, you know, that I hope works." It's like, by then, it was really working. I had other health coaches on my team who were getting a lot of people healthy, and I had the rhythm of it, and I could legitimately call myself a health coach. (Interview # 26)

Although client success is of course partly under the coach's control, it is often the product of a complex interaction between aspects of the coach, the client, and the circumstances of their meeting. For example, one determinant of success that repeatedly came up in the interviews was "alignment" between the coach and the client, an interpersonal feature that is rather mysterious and difficult to control. One coach described, for example, how such alignment led to success and thereby helped clarify his sense of identity as a coach:

> My first couple clients, it was a struggle because I hadn't defined myself….I hadn't defined me, and I was trying to...I guess, where I was talking about earlier about defining yourself and I thought, "Well, maybe in this profession, a little bit has to define who you work best with." Like, I guess, my first client thought I was a dietician, and I'm not a dietician. I don't….set up meal plans and this and that. That's not really what I do, so we

> struggled with that because I tried to do that. Oh, I wanted to keep this client, and I wanted to be successful, so I tried. It didn't end up working. She wasn't satisfied because…. I wasn't clear....I had to find and become clear about....who was ideal to work with me. So anyway, when I did hit that first session with someone that just was....an alignment with the type of client...that I can best serve and contribute to, it was so easy. And then, it was totally easy. So you'll know that's legit because you're legitimate and the whole profession.....it goes hand in hand because I just had that validation like, "Wow! Okay, I am legitimate. This is something that works," because I just had that major breakthrough with this person. (Interview # 32)

Beyond this notion of coach-client "alignment," coaches also often talked about how their success as a coach is dependent on the client's level of buy-in and commitment to the coaching process. When clients are somewhat less committed to the process, coaches often find the clients harder to "connect" with. Many coaches related having trouble with clients who did not subscribe to the very idea of being coached, thus hampering their own success. In particular, coaches working in corporate wellness centers were likely to have had to deal with defiant clients (since, of course, the client's visit is not entirely voluntary in such cases—the client is incentivized by the company or their insurance company to schedule the wellness visit). For example, one former corporate wellness coach (who worked for a trucking company) talked about the role of success in the evolution and clarification of his identity:

> So early on, it was sort of tough wondering what my role was and what my identity was. Am I supposed to be their friend, or am I supposed to be a representative of….corporate to make sure their health is good, their blood pressure is down, so they don't have a heart attack and take out a city block? So that was sort of tough early on, but as I started gaining successes and getting people on the right track and helping people, then other people saw it, and I'm just a popular kind of guy with a pretty varied background….There was 45 coaches across the….freight terminal for my company, and some of the younger ones, you know, they come out of college with a master's degree in kinesiology or exercise physiology, and they don't know how to talk to a 50-year-old, 200 pound overweight truck driver who is missing half his teeth. It's just hard to connect, but I've done a lot of things, so I'm able to talk about fly-fishing, or working on the car, or whatever, and that's what you've got to do, but it was tough. For the first six months, I didn't know how I was going to be able to handle it because you come in there, and you're supposed to give topics, you're supposed to give monthly presentations. Some of them would take them, crumble them up, and throw them. Some of them would look at me and

> just turn around and walk the other way. They're sort of challenging your self-esteem so to speak. It just took time, and then I finally found one person, I got them to do a triathlon, and then it ended up to be three, and then it got to be teens, and then it got to be dozens. Then I got the director of operations to lose 45 pounds and 10% body fat, and then he became my biggest ally. Then the safety manager, the same thing. Then I got two freight managers that are doing triathlons. Now their wives are doing them with them. So it started out slow, but now even though I'm not there, I still communicate with all these people, and their life is just completely changed. So as far as me thinking... I think I'm the best wellness coach in the USA, personally. (Interview # 44)

This kind of identity-clarifying interpersonal relationship can also come in the form of a larger group of people—one's "tribe," so to speak, that helps the individual work through the challenges of crafting a sense of self. Such groups can accomplish this by, among other ways, reaffirming one's core values. For example, one coach said:

> The sense of community that's come with being part of [my program's] alumni network. I remember the first set of training that I was like, "Wow, I've found my tribe." You know, you're finally like connected to your set of like-minded people for the first time in your life. You know, people who have that kind of sense of like, We all...share...like just certain values about healthcare and life in general. (Interview # 21)

Such intimate groups can also provide guidance in the identity construction process, confirming for an individual whether or not their developing identity is consistent with how others view them. One coach related the following about a weekly group meeting she has with other entrepreneurs, including her health coaching business partner:

> My partner….and [I] do a Monday motivation hike. Every Monday morning, we get other women entrepreneurs together, and we go hike a mountain….and the whole time that we're hiking we all talk about these kinds of things and really reaffirm for each other kind of how we see that person because what we see in ourselves is not always what is true. And so, sometimes we need other people who are positive and supportive to tell us, "No. This is what I see you are. This is what you do for people." And you go, "You're right. Okay, yeah." So then, what I tell myself is not right. So it's really...I love at least once a week I get together with them, and we hike, and we just talk and share that positive communion with each other. (Interview # 40)

A "tribe" can also facilitate individual identity clarity by reminding a struggling individual that there are others out there who believe in what they are doing, thus reducing that person's feelings of confusion and self-doubt. As one coach said:

> I think confidence is a big [way I influence other coaches]. I get asked all the time about that, and I kind of just naturally fall into it now. On our [online] forum, [my program] has a big forum where there's 500 of us, I think, alumni now….A lot of this swirls around where people are like, "Where do I go? What do I do?" So I try to be as active as possible on that. Coaches will email me all the time and just say, "Hey, how do I do this?" I just say, you know, wing it, or you can do this, you've got it. That's what they want to hear a lot of the time, like everybody. You know, you just want somebody in your corner. So….I feel like it's a responsibility. For a profession that is emergent, it's a responsibility. (Interview # 23)

These kinds of "tribal" supports are not, as noted earlier, automatically given to health coaches. Certain training programs do maintain online message boards and alumni events, but not all coaches are active participants—either because they are limited in some way (by geography, for example, making it difficult to travel to events) or they choose not to participate. One coach lamented the latter problem as it pertains to online social interactions among coaches:

> I think one of the visions that [my program] had was sort of an online community, because they're all over the country. And we have about a half-dozen coaches here in [my city], who get together occasionally….and what we're trying to do there is create resources for alums to continue skills and also network. I think one of the frustrations for a lot of people, it might be that my expectations are a little lower, but one of the frustrations for people working with the newsletter and with the website and with the continuing education stuff, and all that, was the lack of interaction on the website. But I think it's really hard, and it does get into that sense of community. I think it's really hard to... You have no physical structure to define community. You have a certification, but you don't have the regular interaction. Is sort of like, you know, how many of your high school class do you still really hang out with? I think it's really hard, and it's still really young. So, you know, you've got 500 alum, or whatever. It's really not that many, so if you've got like a dozen hanging out on the website, to me, that's probably kind of good, but I think the expectations have been higher (Interview # 24)

In such cases, identity supports need not be made up of other people. Coaches also talked about the role of independent research and education in helping them come to a clear sense of

identity. These outlets could be considered "informational" supports. For example, one coach said the following about how she clarified her identity:

> I think, for me, I just did more research and just sought more training. So I did research on my own like, "What is wellness coaching?"….Wellness coaching has gotten really...that's a big enough subject as it is, so I think for me the solution anytime for doubt, for me, is just to….I just do research. I just look for answers and things….I guess that was my solution was just to...I guess I look for either information or inspiration. (Interview # 34)

In various ways, then, my data suggested that individuals can draw on dyadic, tribal, and informational supports to help them compensate for missing identity resources and gain clarity.

Imposing identity constraints. The fourth type of compensatory resource is an identity "constraint." A constraint is a resource that functions as a limiting boundary on one's identity, reducing and streamlining the content of one's sense of self and thereby promoting clarity. One example of such a constraint is a specialized professional service, which many independent health coaches offer, improving their sense of identity clarity as a result. Specialization, for coaches, often begins with a realization—either in the beginning of their careers or in the wake of failure—that they should focus their services around a particular health condition or population. One coach recalled her transition from "general" health coaching to a more specialized focus, saying, "When I first started the practice, for the first six months I was doing the generic health coaching…. and I realized within six months that this wasn't working for me at all…it was hard for me to let go of the other things and just kind of [get] boxed in to being a coach [who specializes in a certain condition], but I also understood that…it really helped me define myself" (Interview # 41). Specializing promotes clarity because it transforms the coach's identity from multivocal to univocal, making the coach's services much easier to explain to current and potential clients. This ease of explanation fosters an underlying confidence in the

identity as well. As one coach said, “If you get your target audience, and you get your little niche, then explaining what you do becomes super easy” (Interview # 22). Finding one’s niche is not always easy, however—it often takes consistent effort to understand how to best focus one’s services. For example, one coach mentioned finding helpful advice in a marketing book after a period of self-reflection. As she tells it, the book asked her to consider, “’What are you known for?’ And then it really started to click with me, ‘What do people ask your advice about? What do people email you about,’ and I was thinking healthy eating. So I think that it's going to be my focus moving forward” (Interview # 22).

In addition to a bounded, specialized service, identity constraints can also come in the form of a mental representation of the boundaries of one’s work role vis-à-vis other work roles. As noted earlier, such boundaries are difficult for coaches with additional similar roles to sustain. However, this kind of constraint can promote clarity by reducing the actual scope of one’s role, which enables a more consistent and confident understanding of the core features (i.e., beliefs about tasks and responsibilities) underlying one’s identity. Because health coaching does not have a regulated professional jurisdiction or a defined role in an industry, these boundaries are often arbitrarily drawn but nevertheless useful. For example, coaches talked at length about the value of developing a sense for what health conditions they were qualified to help their clients with, as well as for the types of clients they were qualified to treat. For example, one coach related the following about how she draws these boundaries:

> There are some common things and then some things are a little grey, so it’s better to err on the side of not. So if a person was having struggles with alcohol, if they were having struggles with eating disorders – I had someone come highly stressed….very, very stressed. His wife was having an affair with someone else, he discovered, and he was very upset about it and wanting to keep their marriage together. I said, “I’m happy to help you on how you handle yourself and your stress but you guys would need to go to a therapist for marriage counseling.” (Interview # 8)

Another coach described in more detail how this internal sense of boundaries shapes what he can and cannot say to his clients:

> There are limits….People will come to you. They'll ask you questions like, "Do you think I should get off my meds?" You just have to be real careful and answer...like I've learned several techniques….One which is like, "What do you think?"….You know, circular kind of questions or, "How do you feel about that?" Or, "Why is it important to get off your meds? Tell me more about that." Or, "Well, let's see, I'm not a doctor, so I could never tell you to get off your meds, but I think I could help develop enough health in your body, so that maybe you and your doctor together could decide that you don't need as many of these meds that you're taking or maybe you could eventually get off of them." But it's a process. It's not like I just say, "Yeah, go off your meds, and let's just wing it," because it can be a very dangerous process to come off of meds quickly and without any medical supervision. (Interview # 36)

As is evident in these quotes, creating boundaries around the health coaching role often brings to mind comparisons with other healthcare professions, many of which will necessarily be more qualified to treat the conditions coaches' clients are dealing with. However, many coaches described how these boundaries can in fact highlight the unique positive features of health coaching, thus promoting confidence in their identities. For example, one coach commented on the dividing line between himself as a coach and doctors, saying, "But I know, at a foundational level, that there is dialogue that I can have with people that they might not get from their doctor…I know that I can help people fully understand their health on a more holistic level and get them more excited about it then maybe your average physician who maybe that's not their primary role" (Interview # 39).

My interviewees mentioned another kind of constraint as well—a simplified narrative about the purpose of one's work. This kind of constraint promotes clarity by reducing the *perceived* scope of one's work role, which enables a more consistent and confident understanding of the tasks and responsibilities (now defined in more manageable terms)

informing one's identity. To be sure, some coaches subscribe to a grandiose vision of the purpose of their role, which creates lofty expectations that are difficult to demonstrate progress toward. For example, one coach said the following about his training program cohort:

> We're all different, but we all have kind of the same mission, which is, you know, the greater collective...you know, the population is like in a...we want to make a difference in a respect and do what we can, so we can create a healthier population which serves the highest good, really. You know, it helps the population with more higher productivity, fulfillment, satisfaction factor, all that…. But like, a health coach, we're not experts in any one thing. We're kind of adaptable. (Interview # 32)

With grand missions such as "changing the world" comes a natural tendency to want to spread one's message to anyone and everyone who will listen—this creates ambiguity around the exact boundaries and limits of the role. As one former health coach said about his past identity struggles he had as a result:

> It was fuzzy all the time. I loved trying to motivate people and I could certainly count their pushups and I could measure their cholesterol and give them guidelines, but I never felt I could really nail my exact role because I was helping individuals and then I'd go to companies also and promote healthy eating and teach lectures. But it's so much stuff that it's hard to focus. (Interview # 3)

In place of a grand mission, other coaches talked about their role in simpler, narrower terms. This strategy can help promote a more limited and consistent sense of identity. For example, one coach talked about how his role as a corporate wellness coach is simply to make his client's day better:

> I think my philosophy is whether I get Joe Dumbbell that comes to the door, or Nancy who needs to lose 100 pounds and is stressed and hasn't had much successful health standpoint, my goal is that I make their day better, and a lot of times it's really not about coaching. If somebody comes in....and they're just really stressed because it's a hard work environment here…And they're just happy to sit in a nice office and for 30 minutes and maybe just talk about their kids and the stressors a home….I give them 30 minutes to kind of forget about work and leave feeling better about themselves or the day. And so, in my experience….I feel like I can have every person come in here and leave... gain some further understanding of how to improve their health. And so, it might not always be a pure coaching session in terms of, "Okay, where are you at? Let's define your wellness

> vision. Let's set some goals. Let's get you out the door. Let's check in with you in a week or two." It's not always that, but it's like, "Okay..." and I know that a lot of the same clients that I'm going to see on a year-to-year basis, you know, good feedback I'll get from them is, "Yeah, you know, I'm doing really well, but I like coming in and seeing you because you always give me something to think about." So, I guess, I kind of look at my role as A.) There's some people I really need to help, and B.) If I can make the campus, the environment, more conscious about taking care of themselves, then that's essentially my role. (Interview # 39)

Thus, identity constraints—although sometimes difficult to impose given one's personal characteristics and professional background—can facilitate identity clarity by bounding and sharpening one's sense of the tasks and responsibilities that inform one's identity.

DISCUSSION

Although organizational behavior scholars have produced a wealth of insight into identity construction in and around organizations, this study began by asking a different question than previous identity studies: how do individuals construct occupational identities in the relative absence of identity resources—i.e., in a resource "void"? This question is important because extant theory does not speak well to the circumstances of many workers in today's volatile and rapidly-evolving economy. Indeed, as I noted earlier, prior research, particularly that which focuses on occupational and professional identity, has tended to focus on stable, well-understood professions, wherein individuals use various strategies to come to terms with the professional identity into which they are socialized (Pratt et al., 2006; Van Maanen & Schein, 1977). Thus, prior studies tend to emphasize the various interpretive strategies people can use to navigate their professional contexts (Kreiner et al., 2006b); in my study, however, there is very little existing professional structure to navigate. Instead, health coaches are collectively creating this context at the same time they are trying to individually create themselves as professionals. In other words, health coaches are in the peculiar, yet increasingly common, position of having to craft an

individual occupational identity in the absence of a clearly-defined occupation with which to identify. My conceptual model suggests ways that this task is accomplished, a process that involves three non-linear stages : 1) "encountering the void," where the social context's lack of identity resources becomes apparent to the individual; 2) "experiencing the void," where the individual struggles with various identity challenges—together denoting a lack of identity clarity—as a result of this encounter; and 3) "facing the void," where the individual deploys various identity work tactics to overcome this key identity challenge and gain identity clarity.

In the course of data collection and analysis, I uncovered other potential dimensions to the model that were suggested but not fully captured by my grounded theory methodology. For example, health coaches can be grouped along various dimensions (e.g., training programs, employment circumstances), and these different factions are likely to encounter, experience, and face the "void" somewhat differently. For example, my data suggest that health coaches with prior careers in healthcare professions are not only likely to struggle with imposing identity constraints, but that they are also perhaps more likely than individuals without such backgrounds to rely on another occupational role as an identity anchor, even though this latter strategy can further complicate their identities, as I noted. Indeed, individuals without a prior healthcare career are less likely to see their prior role (e.g., trucker or lawyer—two examples from my data) as a relevant starting point from which to craft an identity as a health coach, even though the clear distinction between such prior roles (e.g., trucking) and health coaching would likely make these roles effective identity anchors. Furthermore, health coaches who work in an organizational context (e.g.., as an onsite corporate wellness coach) are perhaps less likely to impose identity "constraints" by, for example, providing a specialized service or mentally constructing boundaries between health coaching and other professions. This is because such coaches have

the benefit of working in a nominally-defined role, one provided to them by their organization. Although such coaches seem to be a minority in the universe of health coaching, my data also tentatively suggest that these coaches likely experience less day-to-day pressure to construct a clear sense of identity, because their clients will show up either way. By contrast, coaches who own their own businesses and/or work as independent contractors are under different economic pressures, and thus are likely to be more intent on clarifying themselves internally (to themselves) and externally (to the market).

Another relevant factor that was hinted at in my data is the extent to which the coach views their work as a calling versus as a career or a job (Wrzesniewski, McCauley, Rozin, & Schwartz, 1997). The overwhelming majority of coaches I spoke with described their work as a calling, as one of the defining passions of their lives. Yet a few coaches did say they were mostly interested in the career-aspect of the work, that is, the fact that it would allow them to have a nice career with attractive perks (e.g., feelings of independence and achievement, relatively high pay while also "making a difference" in the world). Based on sporadic examples in my data, it seems that this individual difference—calling versus career versus job— is likely to impact the extent to which the individual coach is able to *endure* the void. Indeed, coaches who believe they have been called to do this work seem more likely to remain health coaches even if they must persist through various challenges, whereas coaches who are simply looking for a nice career seem less likely to be patient (and thus more likely to exit the profession). However, to reiterate, the preceding points are speculations based on both my experiences with health coaches over the past eighteen months and select instances I uncovered through data collection and analysis. Having now discovered the potential relevance of these distinctions, however, future research could provide a more fine-grained analysis of their effects, perhaps using survey or quantitative

methodologies. In a related way, future research could employ cluster analytic methodologies (Powell & Sandholtz, 2012) or quantitative comparative analysis (Greckhamer, Misangyi, Elms, & Lacey, 2008) to understand how different combinations of identity resources relate to different levels of identity clarity. For example, my data indicate that identity devices and identity supports may perhaps be the most common strategies among individuals with high levels of identity clarity. Yet quantitative cluster methods could provide a better window into such resource bundles, while also leaving the theoretical explanations underlying *why* certain bundles lead to certain clarity outcomes to future qualitative endeavors.

Implications for Organizational Behavior Research

This study makes a number of contributions to organizational behavior research. For identity researchers, I introduce and develop the concept of identity resources by providing examples based on a grounded theory analysis of the emerging profession of health coaching. I also introduce to organizational behavior the micro-level notion of identity clarity, which could potentially be extended to the macro-level. Indeed, organizational identity researchers have devoted attention to the ramifications of organizational identity ambiguity (i.e., multivocality) and strength (i.e., consistency across organizational members) (Gioia, Schultz, & Corley, 2000; Kreiner & Ashforth, 2004), but the implications of organizational identity *clarity* have yet to be explored. Instead, these macro scholars have often treated clarity as a specter that exists only in its absence—thus, the tools, tactics, and factors that help directly facilitate clarity have received little attention (Corley & Gioia, 2004; Patvardhan, Gioia, & Hamilton, 2013). This study thus contributes to organizational research, broadly speaking, by proposing a number of identity resources that could be useful for not only individuals but also organizations, in particular identity devices (e.g., archetypes and antagonists—"we are the little guy, and everyone doubted

our success") and identity constraints (e.g., specialization—"we do not diversify, we focus on a single product market").

In addition, I develop a conceptual model that suggests clarifying tactics for individuals who work in contexts that lack readymade identity resources, such as in new or otherwise ill-defined organizational roles (e.g., sustainability officer), ambiguous organizational types (e.g., hybrid for-profit/non-profit organizations) and rapidly-evolving and emerging industries (e.g., big data). Individual members of each of these collectives are likely to encounter, experience, and then have to face some kind of identity resource "void." The transferability, then, of my conceptual model could be assessed in future research. Moreover, future organizational behavior research might also consider the specific benefits of identity clarity. Although the benefits of role clarity have received attention from organizational scholars in the 1970s (Lyons, 1971), *identity* clarity—whether occupation-based or organization-based—has not yet been addressed. Based on findings in psychology, however, it is reasonable to assume that individual work identity clarity would be associated with many positive outcomes of interest to organizations, namely, employee self-esteem and subjective well-being (Campbell, 1990; Stinson, Wood, & Doxey, 2008; Usborne & Taylor, 2010). By developing my conceptual model, I also contribute to existing psychological research by theorizing about the passive factors and agentic tactics that can influence such clarity. Indeed, extant psychological research on identity clarity has not developed theory around *how* people can achieve it, instead focusing on the emotional or cognitive states that are associated with it.

Although my conceptual model is likely to be transferrable across different occupational contexts, there are also benefits to studying occupations in and of themselves. Indeed, "organizational" life is often experienced by people *in terms of* their occupations (Vough, 2011),

perhaps increasingly so given the continuing growth of contingent work (Bidwell & Briscoe, 2009; Kunda, Barley, & Evans, 2002; Tolbert, 1996), virtual work (Thatcher & Zhu, 2006; Wiesenfeld, Raghuram, & Garud, 2001), professional associations and occupational groups (Copeland & Kelleher, 2007; DiNatale, 2001), and globalized marketplaces and horizontal organizations (Standing, 2010). All of these trends are symptomatic of the changing employment relationship, which, as scholars have argued, can make more salient one's role-based, rather than traditional "organization-based," identities (Ashforth et al., 2008; Okhuysen et al., 2013). Even workers in conventional bureaucratic organizations may in some cases identify more strongly with their occupation (Thatcher, Doucet, & Tuncel, 2003), because occupational framings can offer a stable point of reference (e.g., "I am an engineer") in the face of fluctuating organizational realities (Ashforth et al., 2008). Among knowledge workers, for example, commitment to one's occupation, rather than one's organization, has been shown to more greatly impact work outcomes such as effort (May, Korczynski, & Frenkel, 2002), suggesting that loyalty to the organization might be a challenge for managers to foster in "knowledge-intensive organizations" (Alvesson, 2000).

Not only, then, is occupational identity a concept highly relevant to the working lives of many people today, but the concept also dovetails with recent efforts among organizational behavior scholars to extend our thinking beyond the confines of organizations, to understand "the broader effects and sites of work activity" (Okhuysen et al., 2013: 492). Indeed, scholars continue to fruitfully consider various aspects of the experience of and effects of work beyond organizations—including, for example, the influence of cultural identities on occupational dynamics (Ashcraft, Muhr, Rennstam, & Sullivan, 2012), or the influence of work identities on the non-work domain and vice-versa (Ramarajan & Reid, 2013). The present study thus

contributes to these efforts by focusing on the identity-crafting efforts of workers who, in the present economy, have very few options for cultural and institutional support on which to rely for clarity about their occupational self-definitions.

Implications for Health Coaches

This study offers practical insight for health coaches as well. First, this study lays out in great detail the different experiential stages involved in becoming a health coach. And each of these stages suggests a number of action items that leaders in the profession could take on. The "encountering" stage suggests, for example, that health coaches might benefit from collectively clarifying the ideology behind the profession. Is health coaching primarily a science-based profession with service-oriented professional goals? Or is health coaching better suited to remain outside the mainstream healthcare industry, instead emphasizing personal empowerment and lucrative business opportunities? The "experiencing" stage suggests, moreover, that health coaches are currently challenged by identity clarity and other correlated problems, such as a lack of confidence and temporally-unstable identities. This knowledge is in and of itself useful, since health coaches must at very least present a unified, confident front if their work is to be recognized as a healthcare profession. Finally, the "facing" the void stage provides an overview of the many different ways that health coaches can gain clarity around their identities. To my knowledge, no such catalog of useful strategies currently exists in the field. Instead, I have found that most programs spend very little time on how health coaches can craft and stabilize their own identities, and when programs do, the advice tends to be general rather than specific. My conceptual model thus contributes to health coaching by providing a snapshot of the different tactics that can help individual coaches develop a more confident, consistent, and stable sense of self. Although certain of the compensatory resources associated with these tactics are no doubt

already common knowledge to many coaches (e.g., specialized services can help reduce ambiguity and clarify one's identity), most of these resources are less obvious. Indeed, many of the different kinds of identity "devices" and identity "anchors" were not explicitly referenced by my interviewees. It was only after talking with many people in the field that I realized these trends in the data. For most coaches, then, I would expect that these devices and anchors have been operating at a less-conscious level. Bringing these concepts out into the daylight, so to speak, is thus likely to be useful for coaches as they strive to develop a deeper sense of individual professional identity.

GUIDE ON THE SIDE OR SAGE ON THE STAGE? HUMANIZING STRATEGIES AS A PATHWAY TO LEGITIMACY FOR HEALTH COACHES

"We're not the sage on the stage. We're the guide on the side. So….in a session, I'm not going to ….lecture to a client. That's not what coaching is."—Interview # 29

"It's a way of being human, this coaching."—Interview # 49

How do authority figures—leaders, professionals, managers—gain legitimacy? This question is at the heart of many literatures in the social sciences, where many answers have been proposed, particularly within social psychology. Among these scholars, the consensus view is that individuals view authority figures as legitimate to the extent that the latter have a track record of positive results—that is, the authority figure has demonstrated his or her procedural fairness and/or ability to generate favorable outcomes (Tyler, 2000; Tyler, 2006; Van der Toorn, Tyler, & Jost, 2011). Another contributing factor is the extent to which subordinates and stakeholders feel dependent on the authority figure for resources or desired outcomes (Johnson, Kaufman, & Ford, 2000; Van der Toorn et al., 2011). In addition, research suggests a crucial role both for authorization by other legitimate authorities and institutions (Hegtvedt & Johnson, 2000;

Weeden, 2002), as well as legitimating myths and ideologies (Chen & Tyler, 2001; Hammond, 1989; Jost & Major, 2001; Tyler, 2006). Such tokens and narratives make audiences feel obligated to defer to the decisions and judgment of the individual in authority.

However, there are various authority figures who find themselves in scenarios that do not allow for the above approaches to gaining legitimacy. For example, newly-appointed organizational leaders—such as new CEOs—may lack a track record with their organization and/or relevant credentials and industry experience (Beal & Yasai-Ardekani, 2000; Weng & Lin, 2012). Likewise, individuals in newly-created leadership roles—such as those due, for example, to a shift in power within an otherwise stable power hierarchy within a work team—may also lack a track record, not to mention their subordinates may question the extent to which they are truly dependent on the new leader for resources (e.g., expertise) (Aime, Humphrey, DeRue, & Paul, 2013). Furthermore, individuals in emerging or otherwise ill-defined professional roles—e.g., sustainability officers, social media managers, or ethics and compliance officers—often lack clear indicators of their effectiveness, recognized credentials, and/or a well-defined expertise on which their subordinates must depend in order to achieve certain desired outcomes (Treviño et al., 2013).

In light of these conditions, this paper considers the following question: how do authority figures gain legitimacy in the absence of standard legitimating factors—e.g., a proven track record of positive results, subordinate dependence, institutional authorization, or a legitimating ideology? To answer this question, I took an inductive, grounded theory approach to understanding the legitimating strategies of individuals in a new professional role—health coaching. Health coaches are striving to become recognized voices of authority in the general public and the healthcare industry, though by many accounts the profession does not yet have a

fully-validated track record of success, widely-recognized credentials and professional expertise (on which clients would be dependent), or a legitimating ideology. Moreover, health coaching—like other forms of "expert service work" such as personal training and life coaching (George, 2008, 2013)—requires the coach to take a leadership role vis-à-vis his or her clients, empowering and motivating them toward high performance. Health coaching is thus not only a fitting context for my research question, but one that also allows for transferability to broader issues concerning leadership more generally.

This study makes a number of contributions. First, I contribute to organizational behavior research by developing theory around how individuals in positions of authority can gain legitimacy when they lack demonstrable evidence of positive outcomes and other markers of legitimacy. Second, I contribute to research by focusing on the proactive, agentic methods through which authority figures can *create* their own legitimacy, rather than focusing on the more commonly-studied reasons that legitimacy is attributed to them (Tyler, 2006). Third, I contribute to research by using the interpersonal strategies of health coaches—which I term *humanizing strategies*—to open up new ways of thinking about leader effectiveness. And fourth, I contribute to practice by drawing out the actionable aspects of my theoretical model—that is, by discussing specific action items for health coaches (and professionals in similar roles), health coaching programs, and practicing managers. I provide an in-depth account of each of these contributions in the Discussion section.

Given my emphasis on induction in this study, I do not provide an in-depth literature review below; rather, in the following section I provide a brief review of relevant literatures, recognizing that these literatures provide clues but do not fully provide answers to my research question. The remainder of the paper is spent unpacking the research context, methods, and

findings. I replicate the inductive, grounded-theorizing process by leaving the bulk of explication to later sections of the paper.

LEGITIMACY AND AUTHORITY FIGURES: A BRIEF LITERATURE REVIEW

Defining Legitimacy

Sociologists, social psychologists, and organizational scholars have defined legitimacy in myriad ways over the years (Deephouse & Suchman, 2008; Scott, 2007; Weber, 1947). However, Suchman provides perhaps the most broadly accepted definition: "a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions" (Suchman, 1995: 574). For the purposes of the present study, I consider both the "internal" and "external" legitimacy of authority figures as the key outcomes of interest. The former refers to validation and acceptance by direct subordinates (e.g., clients, employees), while the latter refers to the authority figure's "acceptance and validation by external stakeholders" such as industry gatekeepers and institutional agents (Drori & Honig, 2013: 346).

The Legitimacy of Authority—Management and Organizational Research

Legitimacy has long been treated as a crucial, often more cost-effective mechanism of social control than power, the latter understood as the capacity to influence others based on one's ability to reward or punish (French Jr & Raven, 1959; Tyler, 2006). By contrast, legitimacy operates through a subordinate's internalization of a feeling that the authority figure "ought to" be obeyed (Hurd, 1999), meaning that the authority's decisions and rules are more likely to be willingly accepted and followed (Weber, 1978). Such voluntary acquiescence can be facilitated by the authority's positive track record (i.e., favorable and/or procedurally-fair outcomes), access

to resources or outcomes creating subordinate dependence, authorization by other authorities, or legitimating myths and ideologies (Hegtvedt & Johnson, 2000; Tyler, 2006). Yet, as noted, not all authority figures have such tools at their disposal. For instance, new leaders often do not have a proven or relevant track record they can point to to generate feelings of obligation in their followers—how, then, can authority figures in such uncertain conditions convey viability and credibility and thereby gain legitimacy?

In management and organizational studies, scholars have given a name to this conundrum— the "liability of newness"—but the focus has been almost entirely on the organizational level of analysis (see, for example, Bruderl & Schussler, 1990; Freeman, Carroll, & Hannan, 1983; Singh, Tucker, & House, 1986; Stinchcombe, 1965). These macro-level studies draw on signaling theory to propose various ways that new organizations can convey their viability and credibility to outside audiences (Bird & Smith, 2005; Pollock, Porac, & Wade, 2004). Recent work in management, drawing on institutional and social psychological research, has sought to balance out this macro-tendency, focusing on how individuals in new professions legitimize themselves and/or their role (Goodrick & Reay, 2010; Reay, Golden-Biddle, & Germann, 2006; Treviño et al., 2013). Despite the many incisive contributions of these latter studies, each of the chosen professionals roles—nurses, nurse practitioners, and ethics and compliance officers—were from the beginning embedded in an organization or industry, which suggests authorization from authorities (e.g., executives) or at least a widely-accepted cultural ideology supporting the role (e.g., ethic and compliance officers and the increasingly widespread cultural belief in the importance of ethics in organizations). Thus, although prior work has shed some light on the question of this study, I contribute by exploring the "liability of newness" not only at the individual level but, moreover, in a context largely devoid of legitimating resources.

The Legitimacy of Authority—Sociology of the Professions

Professionals—physicians, lawyers, accountants, priests—are key authority figures in contemporary society. And indeed, sociologists have long been interested in how professions come to be seen a legitimate sources of authority, with a focus on the social dynamics that allow these collectives to achieve exclusivity over their work, providing them social and economic power—a key step in the professionalization process that Weber called "social closure" (Saks, 2012). Sociological studies thus tend to explore the macro-structural factors, internal political strategies, competitive dynamics, and institutional resources (e.g., legal rights) that facilitate the construction of these exclusive professional jurisdictions (Abbott, 1988; Larson, 1979; Ritzer, 1975). The assumption, then, is that the individual professional benefits from a kind of "trickle-down" legitimacy as their profession achieves social and cultural dominance. As a result, the legitimacy "work" of the individual professional—i.e., his or her individual efforts to legitimate themselves and their role—has largely been overlooked by sociologists (Treviño et al., 2013). To be sure, some scholars have been interested in "image-building," or "efforts to display the [profession] as essential, exclusive, and complex to the public"—in other words, to persuade others of the legitimacy of the role—but the emphasis has been on the efforts of the collective (e.g., professional associations) toward that end, not on those of the professional him- or herself (Forsyth & Danisiewicz, 1985: 64). Thus, although sociologists have provided many insights into the legitimation of the authority of a profession, few have explored how individual profession*als* can legitimate themselves when they lack a proven track record, well-defined expertise, and/or institutional authorization (e.g., widely-recognized credentials) to draw on for legitimacy (e.g., George, 2013; Goodrick & Reay, 2010; Nelsen & Barley, 1997; Sherman, 2010), as is inevitably the case in the early stages of the professionalization of an occupation

(Etzioni, 1969; Macdonald, 1995). Put differently, sociologists have paid scant attention to how members of an aspiring profession can legitimate themselves *individually* when their profession is not yet widely-viewed as legitimate (George, 2008, 2013; Nelsen & Barley, 1997; Sherman, 2010).

Thus, the above literatures speak to but do not fully answer the question of how authority figures can establish legitimacy in the absence of standard tools toward that end. Before continuing, I should note that this study did not begin with a focus on authority figures and legitimacy *per se*. Instead, the study was originally designed to explore how individuals strive to legitimate a new profession in a highly-institutionalized industry. In the course of data collection, however, it became clear that, although the data did speak to how health coaches are creating legitimacy around their role (i.e., their profession), the emerging theoretical model also spoke more generally—and perhaps more forcefully—to issues of legitimacy for unproven or "unauthorized" authority figures who do not have access to standard markers of legitimacy.

METHODS

Research Setting— The Emerging Profession of Health Coaching

The research setting for this study is the same as in the previous paper (health coaching). For brevity's sake, I will not discuss the details of the profession again here.

Methodological Approach—Grounded Theory

The methodological approach and data collection for this study was the same as in Chapter 3 (grounded theory). For brevity's sake, I will not discuss these details again here.

FINDINGS

Before getting into the details of the findings, I first provide an overview of the grounded theoretical model, as pictured in Figure 2. As noted above, health coaches are not only striving to become respected authorities in the healthcare industry, but they also perform many of same functions as leaders in teams and organizations. Specifically, coaches guide the efforts of their clients (i.e., subordinates) toward a specific, often shared, wellness goal (i.e., high levels of performance), doing so by inspiring them and eliciting intrinsic motivation. However, as I discovered, most health coaches would object to the term "subordinate" for their clients. To stay close to the data, then, I use the terms "coach" and "client" in the grounded model; in the Discussion section, I explore the transferability of the model to other kinds of authority figures (e.g., leaders) and subordinates (e.g., employees).

The model details a series of theoretical linkages between three "humanizing strategies" that are used by health coaches (see the left side of Figure 2)—namely, *embodying authenticity*, *establishing relatability,* and *elevating clients*—and internal and external legitimacy (on the far right side of Figure 2). These humanizing strategies can have a direct, positive effect on internal legitimacy by creating an alternative basis for expertise claims—the coach's lived experiences (past or present)—and by improving clients' overall impressions of the coach (see Path A of Figure 2). These humanizing strategies also effectively neutralize any status differences between the coach and his or her clients, thereby empowering the latter and promoting their well-being (see Path B). Such emotional benefits lead to improved client performance, which outcome can help increase both the internal and external legitimacy of the coach (see Paths C and D). It is important to note that these strategies are more abstract, and thus distinct from, the actual health coaching techniques that coaches draw on in client sessions (e.g., motivational interviewing,

appreciative inquiry, etc.). However, the logics and motivations behind these humanizing strategies are likely informed by many of the concepts underlying these techniques.

In the next section, I unpack the theoretical model using the two-order approach used in previous published articles (Gioia & Thomas, 1996; Kreiner et al., 2006b; Van Maanen, 1979). Thus, the sub-headings in the text are the "second-order" abstract conceptual themes, which function as boxes and/or arrows in the model. These "second-order" themes were aggregated from various interview data ("first order data") and secondary data. Supporting data examples, taken from interview data and secondary data sources, are thus included under the sub-headings of their respective themes. Further data examples are included in Table 4. In the next section, I begin by describing the humanizing strategies—embodying authenticity, establishing relatability, and elevating clients—all of which came out of responses from interviewees to my questions about how they create legitimacy for themselves in an emerging professional role.

Embodying Authenticity

The first humanizing strategy is what I refer to as *embodying authenticity.* This strategy, which can be implemented in various ways, involves the coach foregrounding his or her essential humanity, which both neutralizes the status differences between the coach and the client as well as helps coaches acquire "internal" legitimacy (i.e., legitimacy with clients). In this way, "embodying authenticity" is similar to but distinct from the notion of "authentic leadership," which centers on leaders' development of self-awareness and self-regulation yet preserves the status differences between leaders and their followers (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2007). In this section, I discuss only the ways in which coaches embody authenticity; in later sections I will discuss how this strategy helps with legitimacy. Indeed, early on in the data collection process, this strategy seemed to me counter-intuitive (perhaps even

counter-productive) in the context of gaining legitimacy, but over time its usefulness to coaches became apparent.

One example of this strategy involved coaches highlighting how much they simply could *not* know related to improving a person's health and wellness. In other words, they emphasized the human limitations of their knowledge. Specifically, they accepted the fact that they did (and could) not know what exactly each client should do to become more well. The frankness with which they described this epistemological limitation was striking. For example, one coach noted how these limitations have become more apparent over time, saying, "In the early days, it's easy to [act like you know everything] because you're avid and you're passionate and you feel you have the answers. The longer I go, the older I get, the more I realize I really don't. I would have no idea what is true for you. I have a ton of really advanced skill level in asking questions to help you find it but I would never know" (Interview # 8). This perspective was echoed by others, including one coach who said, "You know…I don't have all the answers. I'm there to lend my expertise based on…the values that I hold, and the principles that I feel have worked well in my life or with clients" (Interview # 38). In addition, interviewees also mentioned that not only do they not know everything, but the biomedical knowledge that many of them *do* have is often not at all applicable to the fundamental objective of health coaching, namely, eliciting behavioral change in clients. As one interviewee, whose father was a physician, told me:

> Because of my, I guess, paramedical or faux-medical background with growing up in a medical household, and having been partially premed, always interested in physiology and medicine and biology, and all that stuff, I have a built-in knowledge base for how the body works, how cells work, how nutrition works, what the vitamins, stuff like that…. I can put down the carbon atom and the hydrogen atom, and I can show you the difference chemically. But so what? That's not going to help somebody get healthy. (Interview # 26)

This openness about epistemological limitations found similar expression in coaches' views on traditional sources of professional authority. For example, many coaches mentioned their disdain for credentials—within health coaching and related industries —and their preference for more "authentic" sources of credibility such as "walking the talk," as this quote illustrates: "To me, when people say I'm a nutritionist with a degree from Maryland State or whatever, you know what? That don't weigh nothing to me. To me, if you're going to be a health coach, you've got to walk the talk and provide those other things in balancing your lifestyle" (Interview # 31). This idea emerged in different ways throughout the interviews, but the devaluation of formal credentials in favor of more "human" sources of credibility was a constant. As one coach put it:

> I think the credibility is really the person rather than just the credentials or what they've got behind their name.... You can go through the program and have a whole host of certifications and not be great, and you can go through a program and really practice what you preach and really help a lot of people. I think the credibility of the person matters most… I think you can have any series of credentials behind your name, and it doesn't mean you're good at what you do. You can have a bunch of bad doctors who went through medical school and have a residency behind them that suck. So I don't really focus on that. I think what I really focus on the most is what type of experience people have with me, and do they feel like they can tell what type of person I am by the way I talk, the way I share on social media, or am in person. That's what I focus on. (Interview # 38)

Often this emphasis on "walking the talk" results in a situation where coaches interact with people in the same way—i.e., they are always promoting wellness—whether that person is an official client or not. Thus, the coach is effectively a health coach no matter what setting he or she is in. As one coach said, "it's more a way of being in the world than something I turn on and off, or I'm doing or I'm not doing" (Interview # 49). Another coach expanded on this idea, saying:

> The basis for all of my work is well-being, and well-being stretches across the entire health profession, and the advocacy of well-being—it's almost a science of well-being—

> if you're not doing it yourself you cannot coach. So as I walked that out in my own life…it's in all my conversations in all the environments I'm in. I can't do anything with others (or exposes me to others) that has to do with well-being that doesn't promote a conversation that starts me going…. I'm a health coach with my kids. I'm a health coach with my family. I'm a health coach with my clients. (Interview # 19)

Another related way many coaches embody authenticity is by not creating a separate, standardized professional persona they can "put on" when meeting with clients. For example, physicians can speak sometimes as one's physician, sometimes as one's friend—the former persona is imbued with special authority and legitimacy on account of its distinction from the latter. By contrast, coaches often let their personality shine through in professional situations, thereby disregarding the idea of a separate, vaunted, sterile professional persona. For instance, coaches mentioned being careful to not dress in a way that is too "professional," which would make them into something they are not and convey the wrong impression to clients. As one coach said, "I've thought about toning down my business...because I want to seem more warm versus professional" (Interview # 28). Another coach noted the importance and rarity of such an authentic approach, saying, "You have to be yourself…. I know my photographer friends always struggle with people and photo studios because they want to come across as somebody else, somebody they're not" (Interview # 41). Interestingly, one coach suggested that this rejection of a discrete, formal professional persona is further facilitated by prevailing economic conditions in U.S., where many people are deciding that the only way they can be successful in their careers is to be authentically true to themselves. When I asked this coach about the distinction, then, between who she is as a person and who she is as a coach, she said:

> There's no difference. Except that I'm either at work or I'm not. I am who I am all the time, and there's just certain pieces of information I'm going to charge you for because I've spent a lot of money to learn them. So this aspect of me is my business….I am who I am no matter where I'm at, but I feel like since, you know, 2008 when the economy just went flop, I think that you have this whole group of people that have really had to try to figure out, "Okay….how do I make a living? How do I create a life for myself again

> when everything was destroyed and taken away," and the only thing we can consistently rely on...because we know.... so many people have spent so much money on their education and after that time frame couldn't use it, or now they're in that job but they're making less than half of what they used to make, and it's difficult. It did not guarantee us anything. So we have this group of people, like myself, who have had to say, "Okay….What is important to me, and how do I create my job from that?" (Interview # 40)

Embodying authenticity thus involves a variety of beliefs, attitudes, and behaviors that foreground the basic humanness of the authority figure. As the above quotes illustrate (see also Table 4), many coaches eschew any personal or professional quality that would detract from this mission.

Establishing Relatability

Related to the strategy of "Embodying Authenticity" is a humanizing strategy that involves coaches viewing and presenting themselves to others from a position of vulnerability. I label this array of beliefs, attitudes, and behaviors "Establishing Relatability." This strategy, although it can be implemented in various ways, always conveys the idea that the authority figure understands—through either current or past lived experience—the challenges facing his or her audience, thus making him or her relatable while also creating an alternative basis for expertise claims (i.e., the lived experiences themselves). In this section, I discuss only how health coaches create relatability, however, leaving the discussion of the linkage between relatability and legitimacy to a later section.

One way that health coaches pursue this relatability strategy is by projecting *imperfect* physical wellness. For example, many coaches described the importance of looking good (i.e., radiant and healthy) but not "too good." As one coach said,

> You know, health comes in many forms. There are different aspects to health, so you can look any way you want and still be healthy, or you can look really healthy and be pretty sick. So I don't feel like that is, in terms of a health coach, necessarily...I mean, I think

> you should be... You should be clean. You should be well groomed. You should have a nice look about you. You should always have a very positive, healthy attitude, but I don't think that you have to fit into you have to weigh this much, wear this size, you know. I don't think that matters. I think that does turn people off if you're too perfect. (Interview # 40)

The reason it is important to not look "too perfect" is because it allows the coach to be a comforting presence to the client. As one coach said:

> I have yet to see an obese health coach, but having said that, somebody who is overweight and is losing weight could be very comforting for some people to work with….So I don't feel like I need to be buff or... I mean, I...You don't know me, but I'm a small person….Do I look healthy? Yeah. Am I fit? Pretty much. Am I overweight? No. I have a BMI in a healthy range. So, I would personally be somewhat intimidated... if someone's not a trainer, you know, you want your trainer to look healthy and fit, and be kind of aspirational. I don't feel that kind of pressure as a health coach. (Interview # 28).

In the event that the coach *does* look too "aspirational," and therefore less comforting for clients, the coach can explicitly share their past or present struggles as a way of compensating for their apparent physical perfection. For example, one coach said:

> But I think I use vulnerability and show people I'm human, and I'm not perfect, because I think if someone was struggling with food, and they never knew that I struggled with food myself, they would look and say, "Oh, who's this skinny bitch who's going to try to tell me how to eat." Because I think that's how people would look at me, but I'm not that. I'm not a person who's always been skinny my whole life and never had issues surrounding food. So I'm vulnerable about that. I have people who come to me because they feel stuck in their career. So I tell people, "I spent six years in industry I hated, and these are the steps I took to get out." (Interview # 38)

Many of my interviewees mentioned that talking with their clients about their own past or present struggles is an effective method of helping establish relatability, and not only in situations where the coach might look "too good":

> I found that the other thing that's important is to share with them, "Hey, I'm not perfect." So I hear all the time... My biggest population is obese, middle-aged women, and they don't want to see a dietitian because they are going to go see a nice, thin girl to tell them exactly what to eat, and they're going to feel... I hear that they feel bad about themselves, or they can't relate. So I try to convey to my patients too that sometimes that I don't eat perfect, and I don't exercise every day, and kind of get that out there too. Versus, I'm the

> expert, and I do everything perfect. That, "Hey, you know, I have weeks where I'm not great or there are things that don't go well for me. This is how I've overcome them, or this is how I got back on track." I think that helps. (Interview # 30)

Certain coaches have gone so far as to integrate this vulnerability and relatability fully into their coaching "message," as indicated in the following quote:

> Part of my whole…message is I'm also very open about my own health challenges and telling people that this is a journey. Like, your health is a journey, and sometimes you get on top of one thing and then three months, six months, or whatever, one year down the road you might discover that you've got now a problem with estrogen or whatever even though your thyroid is fine now, and that happened to me as well. And so I'm never afraid to be vulnerable. (Interview # 41)

In this way, coaches take a different tack than many professionals seeking to establish their authority—instead of hiding their negative experiences in order to present an impressive facade, coaches openly share these experiences. In contrast, then, to embodying authenticity—which highlights the coach's humanity—this strategy more specifically highlights the coach's flaws.

Elevating Clients

The third humanizing strategy is called "Elevating Clients." This strategy involves coaches viewing their clients as whole people who have unique knowledge and insight to bring to bear as they strive to accomplish their goals—indeed, clients are viewed as the "experts" in this regard, knowing themselves and their skills better than anyone else.

For example, at the same time health coaches embody authenticity through their openness about their limitations in what they can know about their clients' health and wellness, they also often couple this stance with a recognition that their clients, in fact, hold these very answers. In other words, coaches shift the locus of content expertise to the client—the "content" here referring to the obstacles and blockages preventing the client from reaching their goals, and the

reasons underlying the desire to reach those goals. This perspective on clients was apparent in many of the interviews. For example, one coach described how she broaches this topic in her coaching sessions, saying, "I talk about how the client is the expert, I'm not the expert and that my job is to ask questions that help them understand what they already probably already know but just aren't aware of or aren't operating under" (Interview # 14). A different coach noted that clients hold knowledge beyond what they know but maybe are not aware of, stating that in her conversations with clients she tells them, "You know things you don't think you know. I'm going to help you find it" (Interview # 13). Given this assumption that the client possess a built-in trove of knowledge, coaches can approach sessions with the expectation that the client will be the source of the answers to their own problems. One coach said, for example, that coaching is about the "patient coming up with the answers as compared to the nurse saying, 'You must get your medicines filled and if you can't drive, you'd better get your neighbor to do it or you better find somebody'" (Interview # 15).

Through this elevation strategy, coaches not only effectively shift the locus of expertise from themselves to their clients, they also shift all the trappings of such expertise. In other words, if, as health coaches believe, the client holds the solutions within them, then the client is also the one who should be doing the majority of the work toward accomplishing their wellness goals. One interviewee described how she talks about this with clients, saying, "I'm not an expert in you. But my goal would be more mindful, to listen to what's going on within yourself into changing behaviors that you don't want through particular strategies. You're the expert, not me. If I'm working harder than you, there's really something wrong" (Interview # 10). One health coach shared a similar sentiment, saying:

> The client drives the agenda. The client drives the speed. The client drives the desired outcomes. It's very much an evocative practice, so it's very much about the coach drawing out from the client what's important to you? What do you value? What are your priorities? What do you want to accomplish? It doesn't matter what the doctor told you you needed to do. What do you want to do? What have you been able to successfully do in the past? What are the strengths and skills that we can draw on and augment? What are the barriers that you need help with learning how to overcome? What kind of resources do you need? So a health and wellness coach would never put together a health plan for someone else, but they would help that person develop that plan for themselves. (Interview # 2)

Interestingly, because clients are the experts and thus put in the majority of the work, health coaches can sometimes absolve themselves of responsibility over client outcomes, especially in cases when the client does not succeed in achieving his or her goals—the client then fails on their own and will likely cease taking sessions or be phased out by the coach. For instance, one coach said, "With [my health coach training program], the one thing that was really outstanding to me was to think that it wasn't my responsibility whether these people succeeded or not. That is freeing. To an extent, it is their deal. It is their deal" (Interview # 1).

Coaches also described this elevation strategy in terms of a more generalized respect for the decisions of others even before they commit to becoming a client. For example, one coach described his marketing approach as follows:

> If I can engage that person in a conversation, or they engage me in a conversation about it, I feel that it's up to me to try to explain to them in a way that they get without sounding like I'm selling my services. In other words, I don't want to come across as a 'you need to hire me.' I don't know that they need to hire me. You know, only they would know that they need to hire me…. I think, if you allow them to really make that decision without being pushed in a direction, they become a much stronger client, and a much more committed client. (Interview # 35).

Closely related to coaches' perspective on the client as the expert over themselves is an increased need to try to see the world from the client's perspective. In other words, as coaches fully embrace the notion that the client holds the answers for their own wellness, then the coach is compelled to try to view the world from the client's perspective, in order to best know how to

facilitate the client's efforts. Thus, although coaches need not feel responsible for the client's failures, they are still compelled to try to show empathy toward them, i.e., to fundamentally see the world from the client's perspective. The client's perspective on the world thus takes precedence over the coach's own. For example, one coach noted how developing empathy as a health coach is more nuanced than simply feeling "sorry for" or "understanding" the struggles of others. She said, "For me personally, it might translate how I would, at a funeral, saying something like, 'Oh, I'm so sorry for your loss'. That's focusing kind of on me because I'm saying I'm sorry, rather than saying, 'It must be very difficult for you'. That's focusing on the other person. Until I learned that—I don't think I really understood what [empathy] meant so much" (Interview # 1).

In sum, the above three humanizing strategies result in a scenario where the traditional professional-client status hierarchy has been dismantled. As one coach explained:

> [Health coaching] works because….I can come to you as who I am, and you are my equal. I'm not superior to you because of training, or status, or profession. I am a person and you are, and that creates a very nonthreatening comfortable environment to interact and be open and dialogue. And so, if I'm approaching you that way as a person fully….then….the way I'm interacting with you is eye to eye, we're the same height, my chair is not higher than you, etc., and that is what creates a human equal that provides the space to fully interact not as a supplicant or some subservient patient. (Interview # 45)

This neutralization (or equalization) of status is central to the client having a successful experience and achieving their wellness goals—the details of which I explore in a later section.

Facilitators of Humanizing Strategies

Next, however, I turn to the various factors that influence the extent to which any particular health coach subscribes to the above humanizing strategies ("facilitators" and "constraints" on the far left side of Figure 2). Although a critical mass of coaches are fully engaged in the strategies I've described, not all coaches are entirely convinced that these tactics

should be a primary focus of their work. Thus, the theoretical model in Figure 2 must include the different facilitating and constraining factors that shape the degree to which the coach implements this humanizing approach with clients. In my data, I considered a theme to be a "facilitator" or a "constraint" if it was described by my interviewees as something that was not necessarily under their control; these factors are thus less agentic than the humanizing strategies.

Coach's professional training program. The training a coach receives is an important factor that influences the extent to which he or she embraces a humanizing approach. All of the coaching programs I encountered teach practices that are compatible with this approach, yet certain programs emphasize humanizing strategies more strongly than others, and to my knowledge no program comprehensively covers all of them. For example, one faculty member of a leading health coaching program said the following about training new coaches to reject a separate, one-size-fits all professional persona and instead "be themselves":

> The self-awareness piece is really, really critical, and then authenticity. Every single person that we train, we tell them….there's six different faculty total that they get to see. We all practice very differently. We all have different styles, different personalities, and we always emphasize to them it's a matter of them finding their own way with this within a certain agreement of core principles. But the way they practice, how they practice, is going to look different than each one of the faculty members. They need to be authentically themselves in a comfortable way with themselves. (Interview # 2)

I found, as suggested by the above quote, that this belief in the importance of letting each coach be authentically themselves does often trickle down to the coaches themselves. One graduate, when reflecting on the "four pillars of coaching" that were taught to her in her program, said the following about authenticity:

> There is a Swiss psychologist who divided all stories into what he called universal tales and folk tales. The universal tales are the ones we all have. Everybody's got a creation story. Everybody's got a coming of age story. The folk tales are how different cultures interpret those different stories. That's sort of what these pillars are. These are the universals and we all – each coach works with them differently. I listen differently from

> the way you listen, but the person working with us would say, "Oh, that person really knows how to listen" (Interview # 11)

Another coach from a different program responded in similar terms. She reported, "I think that during the certification process, going through the classes, we talked about being authentic, walking the walk, talking the talk, it really comes out in your coaching and really makes you – I don't want to say a better coach but a more authentic coach and people feel that when you're actually working with them" (Interview # 4). Certain training programs provide a positive influence on trainees beyond simply instructing them on the benefits of humanizing strategies. For example, some programs, as part of the training process, have their coaches observe experienced coaches demonstrating the process. As one coach indicated, this modeling experience can positively influence the new coach's own willingness to embrace humanizing strategies:

> As part of the course, they….bring on some really masterful coaches. I've had the opportunity to listen to Coach X [name removed] actually coach somebody. When you listen to a really good coach coaching somebody, that's really cool. That makes you really want to do it….I think when I'm observing somebody do that, I see the impact it can have on somebody and I become a believer, more of a believer. You begin to get more of a sense of how cool it is to help somebody, not just by putting them in a fitness class and making them move, but helping move their mind in a different place. (Interview # 17)

The coach's chosen training program can thus leave an imprint in ways the coach may not fully anticipate before entering the program. These experiences are integral, however, to the coach's views on the viability of humanizing strategies.

Coach's negative experiences with an expert approach. Many coaches mentioned having (or continuing to have) negative experiences with health professionals who subscribe to the expert-based model of healthcare, which assumes an unequal, directive relationship between the professional and the client/patient. Coaches described how these experiences positively

influenced (and continue to influence) their desire to embrace humanizing strategies. Indeed, the expert-based model is a foundational aspect of training in numerous professions, including the medical and nursing professions. One former nurse, now working as a coach, lamented this fact, saying, "All the clinicians, practitioners, anything in medicine, we were all taught the same way, 'I'm the expert. You're the patient. I have what you need. I tell you what to do. You go do it, and you'll have optimal recovery or health and so forth. If you don't do it, then you're non-compliant, and you're bad'" (Interview # 43). This expert view is founded on the idea that the professional has exclusive access to the answers to a problem, and many coaches have had experiences as patients where professionals in fact failed to help them, creating distaste for the whole paradigm. For example, one coach said, "I've had so many health problems, and I've gotten over them, and I've conquered them, which no doctor could do. No doctor even knew what was wrong. I was just kind of done right away with doctors" (Interview # 42). Another coach, who formerly worked as a physician, related her less-than-satisfying interaction with her physician after being diagnosed with a serious health condition:

> The most telling thing was I was sitting in my [physician's] office, and he said to me, "[Coach's name], we don't know what causes this. We don't know a lot about your condition, but one thing we do know is that stress worsens the whole thing." And so he said to me, "Whatever you do, limit your stress," and he walked out the door, and I just looked, and I just thought to myself, "Okay. Well, I have small children….I have been told stress worsens this and that's all he could say to me." You know, he had no...yeah, stress worsens it. Don't get stressed and walked out. So I just thought, "Well, I need to learn how to not get stressed, and that's ridiculous".....it so highlighted the limitations of traditional Western medicine in the treatment of chronic conditions. (Interview # 51)

Not only did coaches talk about coming up against the inherent shortcomings of medical experts, but they also described experiences which led them to believe that the expert-driven medical model is fundamentally misguided, creating even further antipathy toward that particular

approach. As one coach, who once struggled with serious health condition, said about mainstream medicine:

> The problem with the Western medicine in my world is that they don't address the root cause of problems. And so, for example, if you have a thyroid condition. If you have any opinions, they will just give you steroids, or they'll give you medication that is the type of thing of that thyroid hormone you're not producing, but...it's never asking the question, "What is causing it in the first place. Why is it that you're own body is turning against yourself and destroying its own tissue?" (Interview # 41)

Among my interviewees, these negative views also sometimes originated in actual prior experience with *being* the professional expert telling clients what to do. In particular, interviewees coming to health coaching from other healthcare roles often mentioned how playing the all-knowing expert was often ineffective, causing frustration with the whole paradigm. One coach recalled:

> I trained as a clinical exercise physiologist. And after graduate school, when I was working, and mostly those types of physiologists, we work in cardiology doing secondary prevention whether it's in cardiac rehab or heart healthy programs. They also work in endocrinology, diabetes education, and that sort of thing, or in more of a corporate wellness center area. So I was working, before I came here….in cardiology and doing the typical, you know, what I was trained to do. So give patients...you know, just throw a ton of education at them and expect that that would change their behaviors and get them healthy. And under the setting where they would have to have an event or have heart disease before they could work with me because that's what insurance paid for. So like most health and wellness coaches, at that point, I realized this isn't working. I'd have multiple patients that would come in, and they had memorized all the educational packets and know exactly by the book how they should be eating, exercising, taking care of themselves, and just weren't doing it. Often times they'd graduate. I'd see them back in six months. They'd have another, MI or something. So needless to say, it was frustrating. (Interview # 30)

Among coaches, this distaste for the expert-driven medical model was often reinforced by ongoing frustrations with the perceived damaging effects of this approach to wellness. For instance, one coach related the following:

> When a person right off the bat tells me their story, says, "I've got a thyroid condition, my doctors said," and I immediately say "Do you feel you're always going to have a

> thyroid problem," and if she says "yes" well, guess what? The medical expert has told her that. He's holier than thou. He's next to God on the right-hand side, and they believe it without a shadow of a doubt that they'll always be fat. Can I help that person? I might be able to help them little bit with their diet or their thinking, but I'll probably never be able to get past that medical doctors expert. That's why in this country Deepak Chopra said that doctors should actually get sued for....mental malpractice. You tell a low self-esteem person that they've got stage I or II cancer….and there's an X percentage of a chance to live. That person will die just because they were told. But in other countries they don't tell people that, okay? Because they believe that the power of healing.... If you focus on your disease and how bad it is, you're going to get more of it, and you're going to die. If you focus on getting well, you'll move that direction…. So that weighs on me. (Interview # 44)

In various ways, then, coaches' negative experiences with expert-driven approaches to patient care can leave the former feeling more intent on embracing an alternative approach—namely, the humanizing strategies I have outlined.

Constraints on Humanizing Strategies

Just as there are facilitators of humanizing strategies, there are also constraints. In this study, I found two in particular: 1) whether or not the coach had a prior career in an expert-oriented field, which influences his or her level of comfort with minimizing the traditional professional-client status hierarchy; and 2) the client's level of comfort with this same situation.

Coach's prior embeddedness in an "expert"-oriented field or industry. None of the coaches I spoke with began their careers as health coaches—all of them left a prior career to become a health coach, and the type of career they left has an important influence on the challenges and opportunities they face as coaches. For example, if a coach had spent time working in a highly professionalized, credentialed field (e.g., academia, healthcare), then, as the person transitioned into health coaching, he or she tended to resist fully embracing to the humanizing strategies presented in Figure 2. Importantly, this constraining factor appears distinct from coaches' negative experiences with playing "the expert," as described above. Indeed, many

coaches talked about how playing “the expert” was in fact very difficult for them to let go of if it was something they were used to, independent of how they felt about it.

This dynamic became most apparent as coaches described how they define their expertise, given that they are often “elevating” their clients and treating clients as the experts. The notion of coaching expertise—what it is and how to determine who has it—is indeed a lively topic of debate in the health coaching profession. According to one coach, “The expertise of the coach is being the expert at actually letting the person figure out the journey themselves, but just being there and kind of give them cues and tools and whatever they need in order to figure it out on their own” (Interview # 4). In other words, as the coach, “You are the expert at making each client being the expert” (Interview # 16). One way this can be done is through simply reflecting back clients’ concerns to them. As one coach explained:

> So you're thinking in your own mind, “Okay, how do I connect with this person? How do I make it so that they are going to be receptive and hear me because I can hear what they are saying.” And probably the best way to do that is to sort of mirror what they're saying back to me. In other words, they tell me something, and I say, “Well, if I'm hearing you correctly, you are saying to me X.” and they can say, “Yes, that's what I'm saying.” (Interview # 36)

Not all coaches necessarily buy into this idea, however. For example, one coach said:

> I think that my experience with the clients that I've had is that they do want more than just….somebody to sit there and hold up a mirror and say, “Okay….so what do you see in the mirror?” You know, I mean no offense to health coaching, but you're supposed to, usually they use this exact word "reflect," you restructure the sentence of what your client just said and then you say it back to them. Okay, that's cool, but yes, that can be huge and most actually the client says, "I need to stop smoking.” or “I need to figure out a way to get knee surgery so I can exercise blah blah blah.” Whatever his challenge is, finally come out and say, “Boom. You know, this is it. This is what I need to do.”….I’ll shine the flashlight and help them get their little path through the woods till they get to where they need to be (Interview # 18)

As these statements suggest, defining health coaching expertise can be a rather contentious and confusing endeavor. As one coach noted, "it seems to me that coaches have conflicting ideas about what coaching is. And it's for the non-expert. … We're a facilitator. And we may be experts in coaching, right? But we're not there to tell people what to do? I think a lot of coaches struggle with that" (Interview # 24). Coaches talked about how this tendency to continue telling people what to do is even more likely if the coach has a high level of prior credentials or has previously worked in an expert-oriented field. In such cases, coaches often resist equalizing the coach-client hierarchy through humanizing strategies. This resistance is often most apparent as the coach enters his or her training program. For example, as one faculty member in a training program (and practicing health coach) told me:

> The typical thing is we have a lot of nurses, often, doctors and pharmacists and those people are so steeped in the way that we were….trained, too, which is a medical model, a medical thinking, an expert model that it is really challenging for them to let that go. The first year of our….program it seems we have to keep unhooking them from that. Then there are some people with personalities that are fix-it people. They just want to fix things. That is similar. I might even say with many other kinds of professions, if we got psychology in there, they're probably a little bit more used to listening better but they still may want to diagnose and figure someone out, which is not the point of coaching at all…. So….that is the key issue that we run into. (Interview # 8)

This difficulty can continue beyond the training program as well. For example, one former nurse who struggled with this aspect of health coaching said the following about trying to suppress her "inner expert":

> I think, that was part of my difficulty, and I don't know if there's a real black and white way to say it or delineate it, and I think that's part of the difficulty is how do you go, "Okay, stop! So you're asking me a question, and I have the answer, or I can help you, you know, provide you with some answers to your questions, but we're no longer health coaching now." And so, yeah, I think to me the easiest way to be a health coach is to try and turn that part of yourself off and say, "I don't want to offer that. I only want to offer health coaching in the coaching form." And because I'm so passionate about prevention, you know, all that goes into that, and I feel like I've got so much knowledge that was a really hard, really hard kind of thing to wrestle with is, "Do I really not want to do that?

> Because that's really what I'm passionate about, and I love educating people. So what's that going to look like?" And I never really figured out what that was going to look like. (Interview # 47)

Although passion combined with content knowledge can make it difficult to fully embrace humanizing strategies, other reasons may include a strong personal belief that coaching a client to better wellness *requires* a coach to have content expertise (e.g., knowledge of biology, physiology, etc.). And if the coach does have such content expertise, they are likely to resist not using it with clients. For example, one coach who was first trained as a physician said:

> There was this message [in my health coach training program] that it's nice that you know about some medical stuff and understand people's diseases, but....in order to be a health coach, there was this message too that you don't need to know any of that…..You don't need to know the details of people's medical experiences to coach them to make healthier choices.... I never bought fully into that at all. …. It's [like] being told, 'No, you can only receive information auditory. I don't care if you can read. We're only going to receive information from recordings from now on. Even if you can see the banner, don't read it.' Do you what I mean? It was a little bit crazy making. (Interview # 51)

Of course, expertise can also be a source of personal pride for highly-trained professionals as well, which can be difficult to let go of. As one coach said, "Actually, being able to take the ego out of your profession is kind of a talent, I think, not wanting to be the expert and wanting all the recognition or whatever it is that you get for it, some of your work, that you're really just doing it because you want to help improve someone's life" (Interview # 4).

Client resistance. One surprising constraining factor I found was that, according to my interviewees, clients are not always quick to embrace the humanizing approach offered by health coaches. As one coach explained:

> It's hard for the client because they just want you to give them answers. "Just give me an answer. Just tell me what to do." And it depends on the client, but there's certainly a lot of that. But I think it is the way you have to present to them that they're in the driver's seat and they're going to formulate what their lifestyle is. This is about them creating a life that they want. So you're empowering them to take control of it and try things out and experiment. (Interview # 9)

This propensity to look for "quick fixes" from an expert is, as many coaches maintained, a symptom of perhaps a larger societal issue. In other words, it is not entirely the client's fault that they do not go willingly into this new type of relationship with a health coach. As one coach said, "[Clients] will want to say '[Coach's name] just tell me what to do'. That's what we're used to in our society. People aren't used to being encouraged, to listen and trust themselves, to seek out and respond to that innate sense that they have, along with other things. It is a learning process to help people be in that kind of a relationship with you" (Interview # 8). As one coach noted, however, the central difficulty with this learning process is that it involves the health coach "bringing people from a place of victim to responsibility" (Interview # 19). Thus, it is not simply that clients have been denied a proactive position with respect to their healthcare professionals, although that is often true. Instead, for a client to fully embrace the coach's humanizing approach, the client must be willing to take on new responsibilities that require high levels of patience and commitment, both of which are challenging for many people in today's society. As one coach said:

> I think our bigger challenge….is the instant society that we live in. You know, we want to fix things right now. And coaching it's going to take you... 90 days to six months for you to see lasting change. Can you stick with it? You know, this isn't P90 X where you're going to see results in like one day. You really have to stick with it to get there. I mean, you'll see...you know we get the euphoria after the first two weeks, and then they go through a cycle...they'll go through a hill and a valley over the course of their . . . I don't want to call it treatment because, again, we're not medical. But over the course of their cycle of coaching, you know, there's ups and downs of this. You have setbacks. You have great weeks. And as long as they can stick it with it, then they can do it. But again our biggest challenges living in a society that wants to take a pill and make it go away. (Interview # 23)

Another recurring theme in the interviews was that clients are often overwhelmed with their access to health information online—this can be another source of resistance to coaches'

attempts to give the client more responsibility over their health. As one coach said, "I think people are actually in information overload. They have so much information they don't even know what to do with it or even know how it applies to them" (Interview # 4). Understandably, then, if clients seek out a health coach for help navigating this information but are then told that they are the "experts" over themselves, certain clients will misunderstand and then resist this transfer of expertise and responsibility. For example, one coach said this about her clients:

> If they want to know about certain components of nutrients and foods or whatever, they could find that one-line, but I think sometimes they just don't know how to develop that skill of finding things or they want to have that support system of somebody that works with them. Same with fitness routines. They have access to all that information but they need help getting it….And misinformation everywhere. Maybe that's part of it, too, what do you believe, what don't you believe? What should you believe, what shouldn't you believe?....I have a….coaching session that I do right now and I do tell people there's a lot of information out on the internet and there's a lot of misinformation on the internet. People get on the bandwagon with certain food kicks and certain fitness kicks and I think maybe there's some confidence instilled in them if they know they have someone they can ask questions to that has an area of expertise. (Interview # 17)

In sum, clients can for a variety of reasons resist the transfer of authority and responsibility that underlies humanizing strategies. This contingency is often largely out of the coach's control yet can shape the degree to which the coach can embrace these strategies.

Effects of Humanizing Strategies on Clients

Broadly speaking, the humanizing strategies I've outlined have two specific effects on clients: they produce feelings of empowerment and encourage feelings of well-being (see Path B in Figure 2).

Feelings of empowerment. The first of these primary effects is that health coaches' humanizing strategies empower clients to take charge of their health. Many of the coaches I spoke with had at some point been a client themselves, going through coaching sessions. In fact, certain training programs require (or at least encourage) coaches to experience the coaching

process in this way. As one coach described, the underlying philosophy for this practice is the idea that "You can't be a coach unless you've been coached…You have to go through the same kind of training you would put somebody else through…if I have my client journal about certain things, I should be journaling…so I know how effective it is and why somebody should do that" (Interview # 10). One coach mentioned the positive experience she had going through coaching sessions and how she describes it to others, saying, "What I can say to other people is that I felt my best when... I had a coach. I mean, I made a lot of positive changes in my life when I did have a coach" (Interview # 37). One reason why these experiences are positive is because health coaching makes clients feel highly driven, sometimes described as "inspired," to take control of their health problems. By respectfully treating clients as the key source of knowledge (thus "elevating" them), coaches cede to clients control over the resources most essential for changing their behavior (i.e., knowledge of how to succeed, and knowledge of why they've failed in the past), which generates self-efficacy and internal motivation. This view was widespread among my interviewees. As one coach noted:

> People will meet your expectations no matter how high or low they are. So if you set somebody up to be just this nonfunctional, food addicted, whatever you want to describe. Well, that person is going to, "Oh, this guy thinks I'm a five out of a 10 as a human being goes. Well, yeah….why would I perform higher than a five. You already see me as a five." If I come to you and say, "You're a 10. I don't care what goofy stuff you've got going on. I have goofy stuff going on too. I just have a different set of skills than you do, so here's how I can benefit you by you interacting with me and receiving the benefits of those skills." The person says, "I would like the benefit of those skills. This is worth it. I'm really open to that space. Let's do this." (Interview # 45)

To be sure, this approach to empowerment is distinct from many other healthcare professions, where patients often "feel disempowered" because too often their physician or nurse "tells them they're bad and wrong and need to change" (Interview # 49). As one coach said:

> People that come to [me] for help are missing something that they want….I think part of what's gone on is that in this evolution of expertise, the experts have been condescending and disempowering with their clients, which doesn't help because people do need to be empowered and without being empowered they won't and can't take responsibility for their own outcomes, and I think until people do take responsibility for their own outcomes there will be no meaningful change in anything. So for the coaching industry to say, "Look, I'm just another human being here, and I've got this little set of skills that will facilitate you taking charge of your own outcomes." I think that's a positive step, and I think it's a way that coaching has distinguished itself from the rather paternalistic industry of psychology and particularly psychiatry and mainstream medicine. (Interview # 46)

Indeed, without such humanizing strategies, health coaches would become just another healthcare professional that struggles to create intrinsic motivation and self-efficacy in their patients.

Feelings of well-being. In addition to feeling empowered by coaches' humanizing strategies, clients also often feel an increased sense of well-being. One coach, describing health coaches collectively, said, "we're not therapists, okay, but we are a therapeutic conversation" (Interview # 19). One reason health coaching has such a therapeutic effect is simply because the coach is listening carefully, in a non-judgmental and empathetic way, to the client's concerns. To be listened to can be a great source of relief, yet, again, one that many people do not experience often with their healthcare providers. A coach who is a former nurse said, for example:

> When you think about it, what is the one area that people complain about with their physicians is they don't listen to me. And whenever you do your physician follow up evaluations, that sort of thing, [it] is always huge on 'I believed my physician or nurse listened to my concerns, they listened and they took them seriously and blah, blah, blah,' because they don't. They already have their minds made up when you walk in the room. (Interview # 15).

Because clients rarely encounter good listeners among healthcare professionals, the experience of being listened to by their coach often comes as surprise. As one coach said when asked about how clients respond to this situation:

> First of all, the first time they're taken back because they usually have never been listened to. And they're like, "Oh, yeah, you did remember that I'm 30, and that I have anxiety problems and that's why I drink a big Coke when I get to work. So, wow," you know. But I think what it does is they really feel that a healthcare professional, and that's what we call ourselves, that they've been listen to, and were going to put together a plan based on….their schedule, their agenda, their goals, their strengths, their vision, and their goals (Interview # 44).

Thus, to be listened to creates feelings of well-being because clients feel that their ideas and concerns are valid, that their view of the world and themselves has merit. This helps clients fully buy into the coaching process and commit themselves to their goals. One client suggested as much when describing her experience with her health coach, noting that this sense of validation was just as satisfying to her as making progress on her health goals:

> My goals when I started (her) program were to lose weight and get a handle on how to be healthier when I was on the road for work. While we have certainly made excellent progress on those fronts, (she) has also helped me in so many other incredible ways I never would have imagined. First, she is an incredible listener, kind, warm and someone you can really talk to. I had been so frustrated that my doctors last year didn't take my health concerns/questions seriously, but (she) did immediately and genuinely and worked with me on how best I should tackle those health challenges – in an individual way, not in a cookie-cutter "one size fits all" that many other health programs/professionals do. Feeling validated and listened to would have been worth it alone. (Testimonial # 2)

To be sure, listening to client concerns in a non-judgmental and empathetic way is not always easy, however. One coach said, "I still struggle with the person that will not let go of their story of, 'I'm this way because of this, and it's not my fault'. If you can't look at the mirror and say, 'I created that, and I can fix it', then you're already starting two steps back" (Interview # 44). One coach shared a similar sentiment, noting that such listening skills can take a long time to develop:

> But I would say that being a good listener and empathy and the ability to hear – this is a skill. Who knows how to develop it, to listen to the degree that you've lost yourself and that you really hear the nuances of a language, what a person's really saying versus words that are coming out. Those are advanced skills. I think you have to really care about people to even begin with this and…. feel that people have the answer within them to

> believe that. Sometimes that's kind of hard and they're making really bad decisions. (Interview # 1)

Indeed, my interviewees often mentioned that this particular ability to listen takes much practice to master and its origin is rather mysterious. For this reason, many of my interviewees said that good listening skills are a hallmark of health coaching excellence.

Consequence of Client Empowerment and Well-Being: Improved Client Performance

Perhaps the most fundamental tenet of health coaching is that clients can achieve superior results and make lasting changes in their lives to the extent that the coach creates a safe psychological space in which the client feels able to move toward change. Indeed, to the degree that coaches' humanizing strategies lead to feelings of empowerment and well-being in the client, these conditions positively influence the amount of effort the client is willing to put toward making the necessary changes to improve his or her health. One client, for example, recalled how her coach's patient and "subtle approach" of listening with kindness eventually led her to make these improvements:

> I have been working with [my health coach] for a little over a year now. My life was going through a major transition, but my only thought in working with her was to lose weight. My life was stressful and barely manageable without large doses of coffee and erratic eating. Skipping meals and then eating my children's leftovers was not uncommon. The first 4 months I didn't do anything she suggested! Each appointment she treated me with kindness and she listened. I continued to get educated and listen to what she was suggesting, but found that I still didn't embrace the idea that I really wasn't there to lose weight as much as nourish myself. Through her subtle approach, I have transformed the way I was treating my body and made the connection between foods and my mood! Since then, food is no longer an issue and it is very easy for me to make good choices. (Testimonial # 9)

Coaches, too, recognize that positive results come about only as the client has a transformative positive experience; the coach cannot compel these results, no matter their skill level. For example, one coach said:

> Again, it's the empowerment of...ask any coach who's had successful outcomes from their clients...because, again, it's not about us….it's not successful coaching—it's successful outcomes. The desired outcome happened…..And so I think you have this innate drive in all of us who've had that happen with clients where...we've seen it ourselves because this happened to us in training. So we're like, "Oh, my gosh. We figured out the secret. It is this." You know, this is the missing link in healthcare. If we could just train everyone to do this and get off of pills and do, you know, whatever. But we don't want to sound too woo woo. So we have to do it one person at a time right now. But yeah. Absolutely. It's that empowerment. (Interview # 23)

The antecedents of superior results—empowerment and well-being—are characterized differently by different coaches. For example, these emotional states can be described as a catalyst that sets in motion a series of realizations that lead to ever-increasing health improvements—a virtuous cycle of high performance. One health coach portrayed this cycle in terms of the client's biological response to feeling empowered:

> You get this little feel-good burst of chemicals. You go and do something different. That lead to another insight, another action, another insight, and that upward spiral eventually becomes a new brain network and that becomes a default network. So the product of the coaching is our insight and the insight has to happen in our clients' minds, the small insight where you discover maybe if you did exercise, you'd actually be more creative, you'd have more energy. Oh, my goodness. I never thought about that. I thought I was just supposed to do it for my heart and my cardiovascular health. And then you do it and then you go, "Oh my goodness, I just made a new friend out there and now I'm helping them and that's making me feel like I'm making – ", and on and on and on. You can't do it in a makeover because you can't change your brain fast enough in a few months. You have to change your mindset and your behavior over time and then you have some hope for lasting change and that's what we're good at. (Interview # 5)

Thus, although the exact mechanism by which empowerment leads to improved performance is admittedly difficult to pinpoint, my interviewees described a number of ways in which this effect could plausibly occur.

Humanizing Strategies: Pathways to Legitimacy

Humanizing strategies help create legitimacy for health coaches in two ways—directly and indirectly (see Figure 2). I will address each of these pathways in the following sections.

Direct pathway to internal legitimacy. As noted above, health coaches' humanizing strategies help empower clients to reach their goals (see Path B in Figure 2). Yet these strategies can also *directly* lead to increased legitimacy with clients (see Path A in Figure 2). First, being vulnerable with past and present struggles and "walking the talk" can lead to more favorable impressions of the coach as an "expert"—indeed, these lived experiences (past and present) become an alternative basis for expertise claims, one which does not rely on institutional authorization (e.g., recognized credentials). As one interviewee explained, "I've rehabbed myself so many times that people can appreciate what you've done and you come across as more of the expert and more of the authority person because you've lived through so many things and you've been able to come out at the other end. So I really try to do that with my coaching" (Interview # 10). Another coach said that projecting vulnerability is "one thing that I've learned, because I decided that you don't ever come across as weak" (Interview # 41). This dynamic is further illustrated in the following quote, spoken by a coach who holds a PhD in a health-related field but chooses not to highlight this credential with clients, instead focusing on past health challenges:

> I've found through my own experience, when I meet someone for the first time, and I talked to them, and I try to understand what they're going through, what they're struggling with, and I say, "Well, look I went through that similar process myself, and I went from a stressed out, burned out, unmotivated person to now a very achievement oriented person, but in an easy way. Like I'm not stressed out about it anymore, and I have plans for life, and it's great." So it's like having that story, that I think, inspires people to want to work with you rather than the credentials themselves. And I haven't even mentioned that I'm a PhD and blah, blah, blah. You know, I haven't even mentioned it at that point, but that gets their interest in it already. It is kind of fuzzy because in this kind of profession, I feel like experience matters more. Like if you look at a lot of the coaches online, a lot of their about pages are like, "I healed myself using food and all these techniques, you know, mind body medicine. Like, I went from A to B," where A was really bad and B is really good. So I think that's what really speaks to people when they hear about what you do for the first time, and that fixes them more, that story fixes them more than the actual credentials themselves. (Interview # 29)

Another coach reiterated this point, highlighting how this openness about her own challenges has led to a more welcoming response from potential clients:

> It does build credibility because it's true a lot of people tell me, "I want to work with you because you know what it feels like. You've gone through this before." So that's for sure...and I do draw a lot on my story. I don't do it all the time because I don't want everything to be me me me, but it certainly helps. And you know, I have ongoing health challenges. Like, I was diagnosed with [a health problem] just six months ago. I had terrible hair loss and going on in spite of everything else being fine, and we found out that with my doctor that my [chemical] levels were through the roof.…So that became part of my story. I certainly draw on all of those tremendously into my practice. (Interview # 41)

In addition to the benefits of relatability, my data suggest that "walking the talk" also improves client perceptions of the coach. For example, one client said, "For me, [my coach] represents the epitome of wellness. She lives what she talks about and that holds more credibility with me than anything else. She exercises, eats right and is genuinely concerned for the health of others. I told my husband at the beginning of this year that I was most thankful for Jesus being my Savior and saving my soul, and for [my coach] saving my life" (Testimonial # 45). Another client talked about how such authenticity proves that the coach is not peddling an illegitimate product, saying, "As a health coach, one has to walk the walk, and not just talk the talk. When you get advice from a person like [my health coach], you can rest assured that this is not a fad, unbalanced diet. She is a vibrant, healthy, energetic person" (Testimonial # 27). Indeed, client perceptions of legitimacy are sometimes expressed through increased trust in the coach's advice. One coach, who had once been a client herself, said the following about coaches who fail to be authentic:

> How could you tell me to live a certain way, and you're not living it. How can you tell me to be healthy, when you're not healthy? I think it's about building trust. Like, how can I trust you, when you don't seem to be doing what you're telling me? I mean, someone's counting on you to guide them in a better direction, so they need to see that you're a

> walking example….You have to be a walking example of what you're saying you are. I mean, it seems very false to not be. I wouldn't trust someone. (Interview # 38)

Finally, as coaches elevate the client as the locus of content expertise and then listen heedfully to them, clients see that the coach understands that their challenges are not due to some inherent flaw or inferiority, thus conveying that the coach truly does have their best interests in mind. This experience increases the coach's credibility in the eyes of his or her clients. One coach recounted how this played out during his time working as a health coach for a trucking company:

> You [the client are] being listened to and every time you call, and if somebody isn't on track because they had a bad week, and a lot of blue-collar people have bad weeks….The people that are less educated seem to have more crap in their life based on socioeconomic conditions, and you have to work with them. And if they are having a bad week, then you don't load them up with, "Alright, Monday Wednesday and Friday. Let's get back to the water aerobics." No, you go, "Well, hey, maybe next week you need to take it a little easy." Yeah, it tends to build a lot of credibility, and I had to learn that working with these truck drivers day in and day out, watch them come in to work half dead with the flu, with the cold, no vacation time left.. They've got to go to work anyway. They're getting yelled at. You can't ask them to stop at 24 hour fitness and go to a spin class after work when they're in that kind of state. So it just builds credibility. (Interview # 44)

One client shared a similar sentiment, pointing out how being treated like a whole, capable person—rather than a marketing opportunity—improved his coach's credibility:

> [Many independent health professionals] take advantage of peoples insecurities about their weight, their lifestyle, and they look to profit off of that. [My coach] is not one of those people. That was the first and most eye opening aspect when I started on as [his] client. When you work with someone who is in his industry to help people more than to make a profit, it adds to that person's credibility. [He] believes in people and has faith in people's ability to change for the better.

That treating clients this way has a tangible, positive effect on the credibility of the coach is not entirely surprising—this process has analogs in other professions as well. For example, one coach described the image benefits of good listening—and the consequences of not being a good listener—in the following way:

> We've always said the best doctors are the ones who listen, the ones who had a good bedside manner, the ones who would come in and make you feel safe and loved and hold your hand. So this whole matter of being present non-judgmentally to somebody has pervaded all of the fields of expertise, and the reason we don't really care for experts now so much, is that less and less of them have this ability to be present and to wish to empower their clients. So I think that ability to be present is a skill in and of itself, and it's something that requires some expertise. It requires training. I don't think people can be nonjudgmental listeners just because they decide to go to a weekend coaching course. So I think that is an expertise, and I would say it's the foundational expertise of coaching. (Interview # 46)

In sum, humanizing strategies not only create an alternative expertise base (i.e., lived experiences) for health coaches, they also convey to clients that the coach has their best interests in mind, namely, by affirming coaches' belief that their clients are knowledgeable, capable individuals—a fact which is often lost on many other healthcare professionals.

Indirect pathway to internal legitimacy. Internal legitimacy with clients can also be *indirectly* impacted by coaches' humanizing strategies (see Path C in Figure 2). Specifically, coaches' humanizing strategies set the stage for positive client results, which results can then be parlayed into increased legitimacy perceptions for the coach. These results are thus especially crucial in getting new clients, because most health coaching is not yet reimbursable from insurance, meaning that clients must pay for sessions out-of-pocket. Clients must believe that they will get their money's worth. Testimonials are one common way these results are disseminated, thereby projecting the credibility of the coach. For example, one coach said:

> I started recording my testimonials. If you go to my success stories on my website, I have video testimonials of talking to my clients via Skype, and it's not made up. I mean, it's real people with real stories, right. So people watch these and that helps me tremendously to build credibility. I came to a point where I was comfortable in dropping these 30 minute free consults that I used to do. And, you know….when people write to you and you just respond in a very brief way saying, "This is what I think is going on. If you want to have a further conversation, I would love to help you with this, this, this. Book my session, and that's [dollar amount]," and it works. It works so much better. (Interview # 41)

Highlighting positive outcomes to current or potential clients can be credibility-enhancing even if those clients are themselves healthcare professionals. Indeed, such outcomes can in effect *become* the health coach's credentials—the results speak for themselves, in other words. As one coach, who works at a clinic in a medical center, said:

> Most of our patients work at the hospital, so I'm working with nurses, doctors, researchers. They want some of that, right? So at the beginning, certainly, I got some of that kickback, "Hey, I'm a doctor. What are you going to tell me that I don't know?" That's the beauty of coaching. They get here, and I don't have to tell them anything. I just have to help them make a plan and give them some accountability. Well, I guess, that upfront-- this is what I am, here are my credentials. And then once I can get them in the room, then, I think they start to get the sense of, this isn't going to be like going to see a dietitian, and I even contrast that in my email, "Hey, this isn't going to be like going to a trainer or a dietitian. I'm not going to tell you what to do." So I guess, I do say that upfront anyway. So the expectation is already kind of set there. And then, now, luckily enough, I have all these numbers, right? So I can say... A patient might come in and say, "Hey, I want to lose weight. What do you think I should do," and I can say, "Well, here's what 20 of my patients who have lost over 50 pounds or more have done. Here's a list of their behavior changes. Where do you think, off of this list, is the best place for you to start?" So I actually have... For those researchers, they love it. And of course, all of these medical professionals, they like to see the scientific proof. Now I kind of have that to be my credentials at this point. (Interview # 30)

Other coaches described more specifically how positive outcomes with prior clients can take on a credibility-enhancing life of their own. In other words, if one client achieves his or her goals, then that person can become a walking testimonial. As one coach said about former clients who have seen success, "Those people are like, you know, it's like a good referral in any profession. You know, good marketing happens. If one person's happy they'll go and tell 20 people. Success in coaching...those people it's like you turned on the light bulb... They are now manifesting what they want to manifest in life, and they get it. And so if we touch one, we touch ten" (Interview # 23). This domino effect was mentioned by many coaches as the key to bringing the benefits of health coaching into wider public consciousness. As many coaches see it, the

general public does not necessarily oppose the idea of health coaching—they simply don't know that it exists and can offer positive benefits. For example, on coach said:

> I think just people becoming aware of the benefits of it. It just takes a long, slow road for people to decide that they're going to spend $60 for a personal trainer, and the same with a wellness coach. They're just going to have friends that have done this and had benefit. It is a pretty small world. It's a big world, but what makes people change is people around you who have had a positive experience. (Interview # 1)

Thus, humanizing strategies can contribute to internal legitimacy not only directly but indirectly, namely, by generating positive client results which can be leveraged to improve clients' legitimacy perceptions of the coach.

Indirect pathway to external legitimacy. Humanizing strategies are most likely to reflect favorably on coaches in localized circumstances (i.e., with clients), while demonstrable performance outcomes will likely be more convincing to external stakeholders, such as industry gatekeepers (e.g., investors, analysts). Thus, when it comes to being accepted into the healthcare industry in the U.S., the effect of coaches' humanizing strategies on such external legitimacy is most likely an indirect one (see Paths B and D in Figure 2). Indeed, professionals such as coaches that emphasize their relatability and authenticity, rather than their scientifically-supported credentials, are not likely to be welcomed by a highly institutionalized and professionalized healthcare industry. Thus, coaches' humanizing strategies—which do not spotlight the expert skills or laudable education of the coach him- or herself—is not likely an approach that would convince gatekeepers of the healthcare industry, namely physicians, of the value of this new role. As one coach with years of experience working with physicians said:

> What I call pure health coaching, which is just helping, you know, motivational interviewing, helping somebody identify goals and identify the barriers, and help them reach those goals doesn't necessarily include education. It may help...it includes maybe helping them find resources possibly, but it doesn't include educating them on what the best diet is or what the best, you know, whatever is. So I think that really confuses a lot of

> physicians who might otherwise refer to a health coach. I think it decreases the legitimacy even of [coaches] who have a medical background. (Interview # 47).

Many coaches recognize that gaining legitimacy with the healthcare industry is thus likely going to depend on viability of their outcomes—that is, whether or not they can demonstrate that their work leads to improved benefits for clients. For example, one coach recalled a recent experience with his physician, who was impressed by this coach's own incredible health improvements:

> I'll go back to my story about meeting with my doctor. Well, my doctor was the...He was inspired from me because he saw me progressing through the years where when I was 270 and down to 170 he said, "[coach's name], you are phenomenal." He said, "What the heck have you been doing?" I said, "I went to school," and I gave him my pamphlet. So now, he sees me he goes, "Wow. Are you still coaching this? Man, I got to..." He's all happy with the things that I've done. I've inspired my own doctor. So if anything, I've radiated ripple effects to him. (Interview # 31)

Although health outcomes like this may be somewhat persuasive to the healthcare industry, they may be even more persuasive if they can be achieved by saving resources at the same time. One such resource is money—if health coaches can demonstrate a cost savings for their services, then this will likely go a long way with the healthcare establishment. As a physician at a medical institution who has started selectively using health coaches said:

> [Health coaching] would seem to me to have application if it is shown to be effective and there's a standardized approach. I think it would be helpful anywhere. It does have the potential of providing a lower cost. For example, we have health coaches who help with smoking cessation. It's a very cost effective approach compared to some of the more expensive clinical services that they may use. So I think from a cost savings perspective, it could be a powder on the wall. (Interview # 7)

This idea was echoed by a health coach who works on research projects that are trying to demonstrate the potential cost-savings of health coaching:

> I think what it will take is for research to be able to show that this saves money, and it takes time to show that. Right? Because this is preventative care for the most part. So I think that's a motivation for doing research is figuring out how can this save insurance

> companies money….And one of the studies that I've been working on is a study on [a particular health condition]. So, you know, if we can prove that health coaching.. . . can help with this. Then with this huge problem that a lot of money is being spent on, then maybe people start to come around. I think a lot of it is being able to show that it's financially feasible, not only feasible but wise. (Interview # 21)

Similarly, one coach with extensive prior experience in the healthcare industry suggested that getting superior outcomes while saving physicians' *time* could also be effective, even more effective, in fact, than trying to convince the healthcare establishment that health coaches are "experts" at some unique skill:

> If they (doctors) think that this person (the health coach) can actually help their patients reach their goals, if they see this person as a time saver….I worked in family practice for many years, that's how we get paid by how many patients we turn through. If they see this person as a time saver because, you know, the people that come in that are chronic, you know, diabetics, and the people who want to lose weight, and the people who smoke, and you know, that kind of stuff. The people they really should be spending a lot of time with, and we don't, they're the people that keep coming back and keep coming back and keep coming back. And if physicians saw that health coaches could actually help them kind of...you know, help them get their patients to where they want to be and help save them time and help them be a healthier population, I think they could totally be sold on it. I think...I mean, it's like [certain coaching programs] lend a little less credibility, honestly, to them in that aspect because it's like, "Oh, come on. You can take this online course, and now you're going to be an expert in nutrition?" Which they're probably way more of an expert than most physicians because they really don't take any nutrition courses. But, you know, I think physicians could totally buy into that if they understood it. (Interview # 47)

Thus, these data suggest that coaches can potentially make inroads with the healthcare industry (and its gatekeepers, the medical establishment and insurance companies) by embracing the humanizing strategies present here, whose effect on external legitimacy is based on the client results that can be had through these strategies' neutralization of the professional-client status hierarchy.

DISCUSSION

Although much prior research in social psychology and management has addressed the intricacies of legitimacy as applied to authority figures, this study began by asking a different question than prior studies: how do authority figures gain legitimacy in the absence of standard legitimating factors—e.g., a proven track record of positive results, subordinate dependence, institutional authorization, or a legitimating ideology? I developed a theoretical model addressing this question based on an inductive study of the emerging profession of health coaching, in which individual health coaches nominally serve in an authoritative role vis-à-vis their clients but do not have the standard tools (e.g., recognized credentials) to secure legitimacy. The theoretical model thus suggests that authority figures facing a liability of newness—and authority figures more generally—can exert influence, convey credibility, and secure legitimacy by serving as a "guide on the side" rather than acting as a "sage on the stage." This inversion of conventional ideas about authority has been the subject of many debates in fields such as higher education and the learning sciences, where the notion of a "top-down" approach to educational training has been criticized as ineffective (King, 1993), particularly as learning continues to take place in virtual, collaborative environments (Mazzolini & Maddison, 2003). However, this particular idea has been scarcely considered in social psychology and management research; instead, in these fields, the social dynamics that underpin and bolster such "top-down" authority structures have received the most attention (Emerson, 1962; French Jr & Raven, 1959).

As noted earlier, this study did not begin with a focus on authority figures and legitimacy *per se*. Rather, the original intent of the study was to explore how individuals working in emerging professional roles establish credibility for themselves (and their role) in a highly institutionalized industry. In the course of data collection, however, it became clear that the

emergent theoretical model was applicable to questions regarding the legitimacy of authority figures more generally, particularly under conditions where the authority figure must overcome a liability of newness. Such liability-prone conditions include new individuals in established leadership roles (e.g., incoming CEOs) (Beal & Yasai-Ardekani, 2000; Zajac & Westphal, 1996), individuals taking on newly-created leadership roles (Aime et al., 2013); or individuals in new organizational or professional roles that involve a strong leadership component, which I will discuss in more detail below—namely, roles that require client/customer/subordinate buy-in and/or motivation in order for the authority figure to be successful (Treviño et al., 2013).

As depicted by the model in Figure 2, I have attempted to theorize about the relationships between an authority figure's humanizing strategies and legitimacy outcomes. But the model also hints at other types of theoretical relationships that are worth discussing. First, the model mostly centers on how *individuals* can achieve legitimacy, but if the role itself is new or unproven (as is the case with health coaching), it is reasonable to assume that these pathways to legitimacy likewise spillover to the role—and vice-versa, as the role itself becomes more legitimate. Second, the humanizing strategies presented here are likely to be related to, but still independent of, one another. For example, by establishing relatability, the coach is likely to also be improving his or her perceived authenticity, though this relationship may not necessarily work the other way around. Indeed, at a more abstract level, it is plausible that an authority figure could "walk the talk" without necessarily also being relatable to subordinates. In fact, if the authority figure "walks the talk" to an excessive degree (in this specific case, if "walking the talk" leads the coach to believe they are superior to their clients), then this could in fact make him or her less relatable. In other words, authenticity is just one piece of the puzzle—authority figures likely must couple this authentic stance with sincere vulnerability in order for

subordinates to feel empowered and have a greater sense of well-being. The model also suggests a compensatory relationship between results (i.e., a proven track record) and humanizing strategies. Specifically, as authority figures facing a liability of newness continue to gain experience and success, they will eventually have the option of simply relying on their track record for legitimacy, ignoring the left side of the model in Figure 2. As the model suggests, however, this option should be resisted—it is only on account of the humanizing strategies that the positive track record was achieved in the first place, and thus such strategies must be continued in order to maintain the results. Future research might fruitfully consider all of these issues in more depth. For example, do certain humanizing strategies more directly affect the legitimacy of the role rather than the person in the role? If so, why? In addition, the interrelationships between different parts of the model could be further explored. For instance, do humanizing strategies and positive results have an additive positive effect on legitimacy? Or are there cases where positive results can hamper legitimacy perceptions—e.g., if they are ascribed by followers to luck, chance, or unfair practices—but humanizing strategies can compensate for that deficit?

Implications for Organizational Behavior Research

As noted earlier, health coaches can be considered not only types of authority figures but also types of leaders—their mission is to motivate individual clients or small groups of clients to achieve a shared vision of greater wellness, though one tailored to the client's needs and desires (Armstrong et al., 2013). And indeed, leadership is best understood as an act, often by a person in a position of authority (i.e., a "leader"), which enables followers to move toward a particular goal (Hemphill & Coons, 1957; Locke, 1999). Health coaching becomes further appropriate for studying leader dynamics when one takes a behavioral, rather than a title-based, view of leaders

and leadership. Such a view suggests that leadership is rooted in the *behaviors* used to influence others toward a goal, rather than in the official title or designation of the person doing the influencing. Given this, I suggest in this study that health coaching can be a fruitful context for thinking about leadership more generally, thus contributing to various discussions in organizational behavior and social psychology.

Indeed, the first contribution I make is the application of the interpersonal dynamics of health coaches to our understanding of the act of leadership. Coaching, of course, is not a new topic in the world of leadership—indeed, since at least the 1990s, a cottage industry has sprung up around the topic (Joo, 2005; Tobias, 1996). However, the dominant trend has been to consider how coaching can help leaders, such as executives, become more effective in their own work. In other words, the leader is often assumed to be the *client* in need of coaching, not the *coach* him- or herself (Goldsmith, Lyons, & McArthur, 2012). As such, scholars and popular writers have given less attention to the possibilities of applying the interpersonal dynamics used by coaches—humanizing strategies, in the case of health coaches—to the act of leadership itself. Moreover, although the executive coaching literature discusses concepts such as authenticity and empowerment, there is scant consideration of what these concepts look like in practice, much less how they are theoretically linked to one another (Popper & Lipshitz, 1992). My theoretical model thus provides a new direction for thinking about the relevance of coaching to employee and organizational success (Boyatzis, Smith, & Beveridge, 2012). Specifically, the model suggests that leaders can better empower their followers by neutralizing the status differences that separate them—namely, by 1) the leader deemphasizing his or her non-human sources of credibility (e.g., credentials) in favor of "walking the talk"; 2) by interacting with followers from a position of vulnerability; and 3) by actively considering followers "experts" in their own right.

Among leadership scholars, the topic of leader legitimacy has received little attention in recent years—my model attempts to redirect this trend as well. Indeed, recent leadership scholars have tended to study concepts that connote legitimacy but do not explicitly address legitimating dynamics, such as charismatic (Conger & Kanungo, 1987), authentic (Avolio & Gardner, 2005), and ethical leadership (Brown, Treviño, & Harrison, 2005). Many such leadership concepts are rooted in well-known sources of legitimacy, such as personality (referent power) and procedural fairness (French Jr & Raven, 1959; House, Spangler, & Woycke, 1991; Tyler, 2000). Authentic leadership, for example—which clearly shares my model's interest in the notion of "authenticity"—does not explicitly theorize about the link between authenticity and legitimacy perceptions of the leader; rather, such perceptions are considered a boundary condition to the efficacy of authenticity (Eagly & Karau, 2002). Moreover, "authenticity" is understood in this literature to be a function of the extent to which a leader is "in tune" with him- or herself, "in tune" with his or her followers, and acts in accordance with those perceptions (Avolio & Gardner, 2005; Walumbwa et al., 2007). However, whether or not this process involves a *humanized* of view of the leader and followers—which is central to my definition of authenticity—is not specified. Rather, what matters is simply *congruence* between the leader's thoughts, beliefs, and actions (Owens & Hekman, 2011). My theoretical model thus suggests new directions for leadership studies by developing theory around how leaders can secure legitimacy when they lack demonstrable evidence of positive outcomes such as fairness, and by explaining why such alternative strategies lead to improved leader legitimacy. In addition, this study contributes to social psychology by focusing on the active, agentic methods through which leaders can create their own legitimacy, rather than focusing on the reasons that legitimacy is attributed to them (Tyler, 2006). Few studies in social psychology (or in management research

broadly) have viewed legitimacy from this perspective, instead often zeroing in on the factors and the content of outsider perceptions of legitimacy (Tost, 2011; Treviño et al., 2013).

To be sure, leadership scholars have indeed provided insight that resonates with my theoretical model. Foremost among these is recent work on leader humility (Owens & Hekman, 2011). In this stream of research, Owens and colleagues pinpoint a number of way in which leaders can exhibit humility, as well as the associated behaviors and effects of these expressions. "Humble" behaviors include acknowledging limitations and mistakes, modeling "teachability" (i.e., being open to learning new things), and spotlighting follower successes and contributions. However, despite the fact that such expressions are theorized to drive positive organizational outcomes, these expressions are often just that—social displays of modesty that are not necessarily rooted in any fundamental beliefs leaders have about themselves, their followers, and the capabilities of each. For example, spotlighting an employee's contribution to a project is not equivalent to the leader believing that the employee holds within him or her an expertise that exceeds the leader's own. Thus, my model suggests that work on leader humility could benefit from integrating leader vulnerability and the true elevation of subordinates. Indeed, as Owens and colleagues point out, many of the business leaders they studied believed that admitting weakness was only acceptable *after* they had proven they were able to achieve good results—otherwise such vulnerability was a liability. Yet my theoretical model suggests just the opposite: humanizing strategies are together the key to achieving results and thus must necessarily come *before* these results. Moreover, leader humility has not yet been connected to perceptions (e.g., legitimacy) followers have of their leaders. My theoretical model thus contributes to prior work on leader humility by, first, shifting from humble behaviors that may amount to simple social modesty to those that effectively neutralize the leader-follower status hierarchy; and second, by

linking these humanizing strategies to the internal and external legitimacy of the leader. Future studies could consider in more depth other ways that the leader-follower status hierarchy can be neutralized and this legitimacy effect achieved, many of which likely extend beyond leader attitudes, behaviors, and beliefs (e.g., organizational design).

In addition to exploring leader legitimacy, this study also builds on prior research by providing theoretical insight into how individuals in new professions can contribute to the legitimation of their role (Goodrick & Reay, 2010; Reay et al., 2006; Treviño et al., 2013). In particular, my theoretical model speaks to how individuals can legitimize certain kinds of new professional roles through local action, namely, through a specific way of being *human* with one's clients. This localized, interpersonal path to legitimacy is brought into sharp relief in this study largely because of the idiosyncrasies of health coaching. Indeed, many scholars have previously studied new professions and professionals (e.g., nurses, nurse practitioners, ethics and compliance officers) that from the beginning had access to certain legitimating resources, such as a defined role in an organization or industry—which suggests authorization from other authorities (e.g., executives)—and the deep knowledge and social networks that come from such embeddedness (Goodrick & Reay, 2010; Reay et al., 2006; Treviño et al., 2013). Health coaches lack many of these resources. Moreover, prior work has shown how these legitimacy efforts are undergirded by a logic of exclusion (Ashcraft et al., 2012). In fact, the very notion of a "professionalization" relies on the idea of establishing the superiority of the profession's knowledge base, its inaccessibility to all but the initiated (Abbott, 1988). As has been well documented, this is most often accomplished by establishing a body of abstract, expert knowledge (Larson, 1979). Yet, although the health coaching profession is making efforts toward such "social closure" (Macdonald, 1995; Weber, 1978), the individual health coaches I

spoke with tend to take the opposite approach—for many, the idea is not to create a body of knowledge that leads to barriers between the coach and the client, but to break down those barriers, turning the client into an equal partner rather than a dependent. The paradox of this approach is that, as my theoretical model suggests, it can sometimes help create legitimacy around not just the individual professional, but also the role itself. Future research could consider the intricacies of this paradox and the conditions under which it holds true. For example, it may be the case that this deliberate "breaking down" of professional-client barriers is only effective in creating legitimacy to the extent that it represents an attractive alternative to a proximate professional system that relies on high barriers to entry—such as is the case with health coaching and the many healthcare professions, namely the medical profession, that serve as counterpoint to coaches' "humanizing" approach.

Implications for Health Coaches, Health Coach Training Programs, and Managers

My theoretical model suggests a number of practical recommendations for three groups: 1) professionals, such as coaches, who are striving for legitimacy in unproven roles; 2) health coaching training programs; and 3) practicing managers.

First, the transferability of my theoretical model to other new professions (and new professionals in established roles) must be considered carefully. Path A, because it describes a pathway to personal legitimacy for authority figures, is likely to hold for any new profession. However, the applicability of the rest of the model (Paths B, C, and D) to another profession appears to depend on the extent to which the client's investment in the interaction with the new professional is relevant to the eventual results. To be sure, for certain professions, client empowerment is unnecessary at best and unhelpful at worst. On the other hand, other professionals arguably function best when their clients, customers, constituents, or employees are

deeply engaged and committed to a positive outcome: managers, professors, teachers, politicians, "expert" service workers such as personal trainers, consultants, and so on (Boyatzis et al., 2012; George, 2008). In such cases, individual professionals might benefit from the entirety of the theoretical model I have outlined here.

Second, this study shines a light on various issues of interest to health coaching training programs. For example, as noted earlier, coaches with prior backgrounds in healthcare often struggle with letting go of their expert mindset. In such cases, training programs might help these coaches understand that it is not as if health coaches give *all* authority away to clients and thus possess zero expertise. Instead, as I discovered through data collection and analysis, health coaches *do* claim an expertise, but a particular kind of expertise that may be unfamiliar to certain trainees. Health coaching expertise is not based in an abstract set of facts ("know-that"—a "content" expertise) but, rather, in a series of processual activities that assist clients in their own self-discovery ("know-how"—a "process" expertise). As one coach put it, "The expertise in a coach is the art of really being able to listen well and ask questions in such a way that it moves someone forward to themselves… So the expertise is really in process, it's not in the solution" (Interview # 8). Certain coaches come to this realization and understand that it is not as if the client is the expert at *everything*; instead, both coach and client bring different kinds of expertise to the table. As one coach said, "We come as equals to a conversation where we both bring important expertise. [The clients'] expertise is them….They know everything that they are capable of and really what they want, so that's what they bring….What I bring is some expertise in behavior change" (Interview # 48). However, as many coaches described it, this notion of "distributed" expertise is somewhat difficult to grasp. Thus, it is perhaps not surprising that coaches with other credentials in a highly professionalized field may initially be resistant to this

approach, since their prior professional livelihood depended on the very practice of *not* distributing their expertise, instead maintaining an exclusive boundary between themselves and their clients. Thus, to the extent that training programs are able to help their trainees grasp the idea of distributed expertise in the client session, then the likelihood of coaches fully embracing the humanizing strategies in Figure 2 is likely to increase.

Finally, practicing managers can also benefit from the findings of this study. In particular, managers might strive to take a more "humanizing" perspective on themselves and their employees. Doing so would not lead to diminished perceptions of the manger. On the contrary, the manager stands to gain not only favorable impressions from employees but also increased performance from them. In addition, practicing managers might usefully adopt the label of "process expert" in their organizations, especially when they are surrounded by many other content experts in the organization. Such a distribution of expertise could allow the manager to feel as if he or she is contributing a specialized set of skills without suggesting that employees are less capable than or subservient to the manager.

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APPENDIX A: FIGURES

FIGURE 1

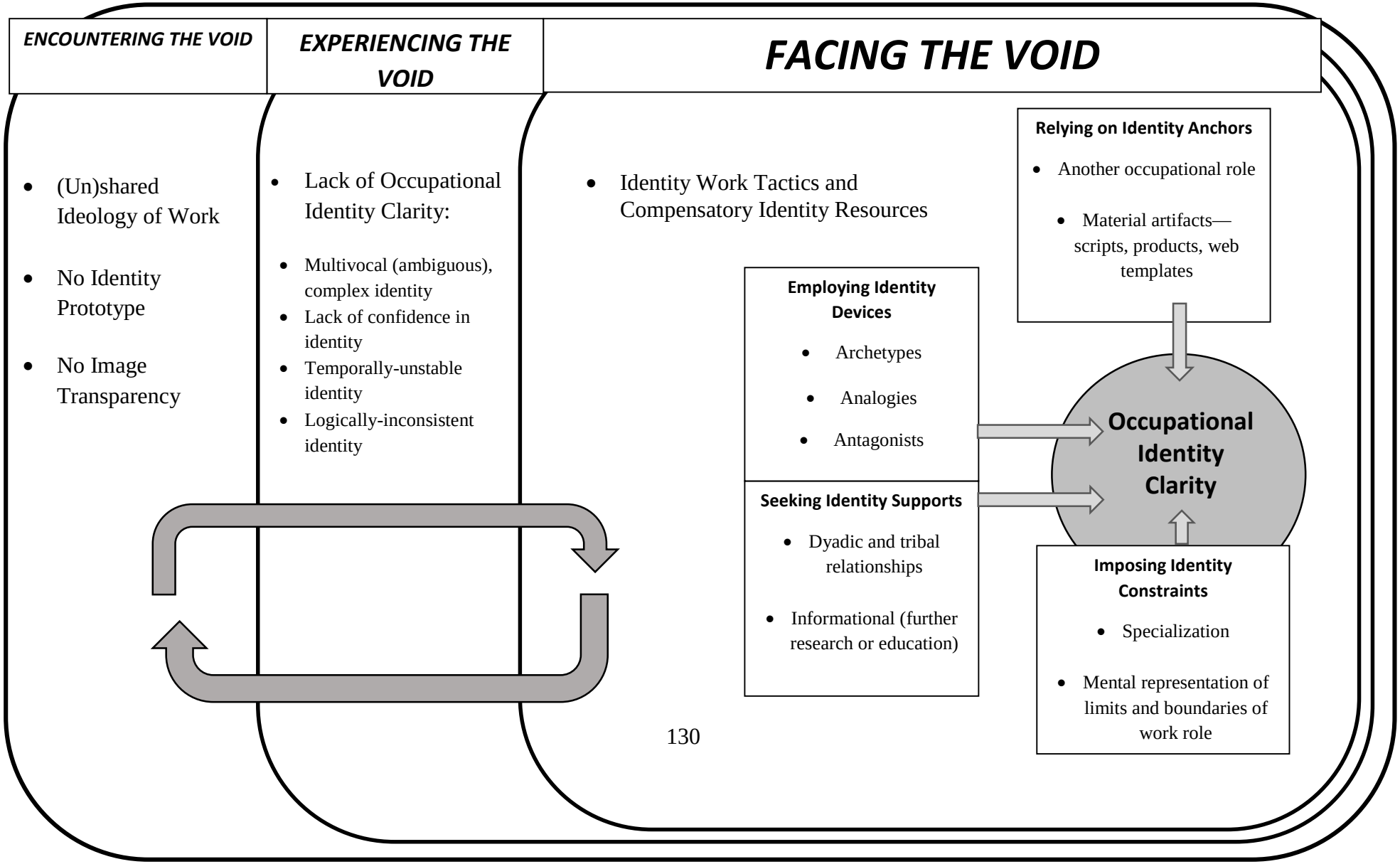
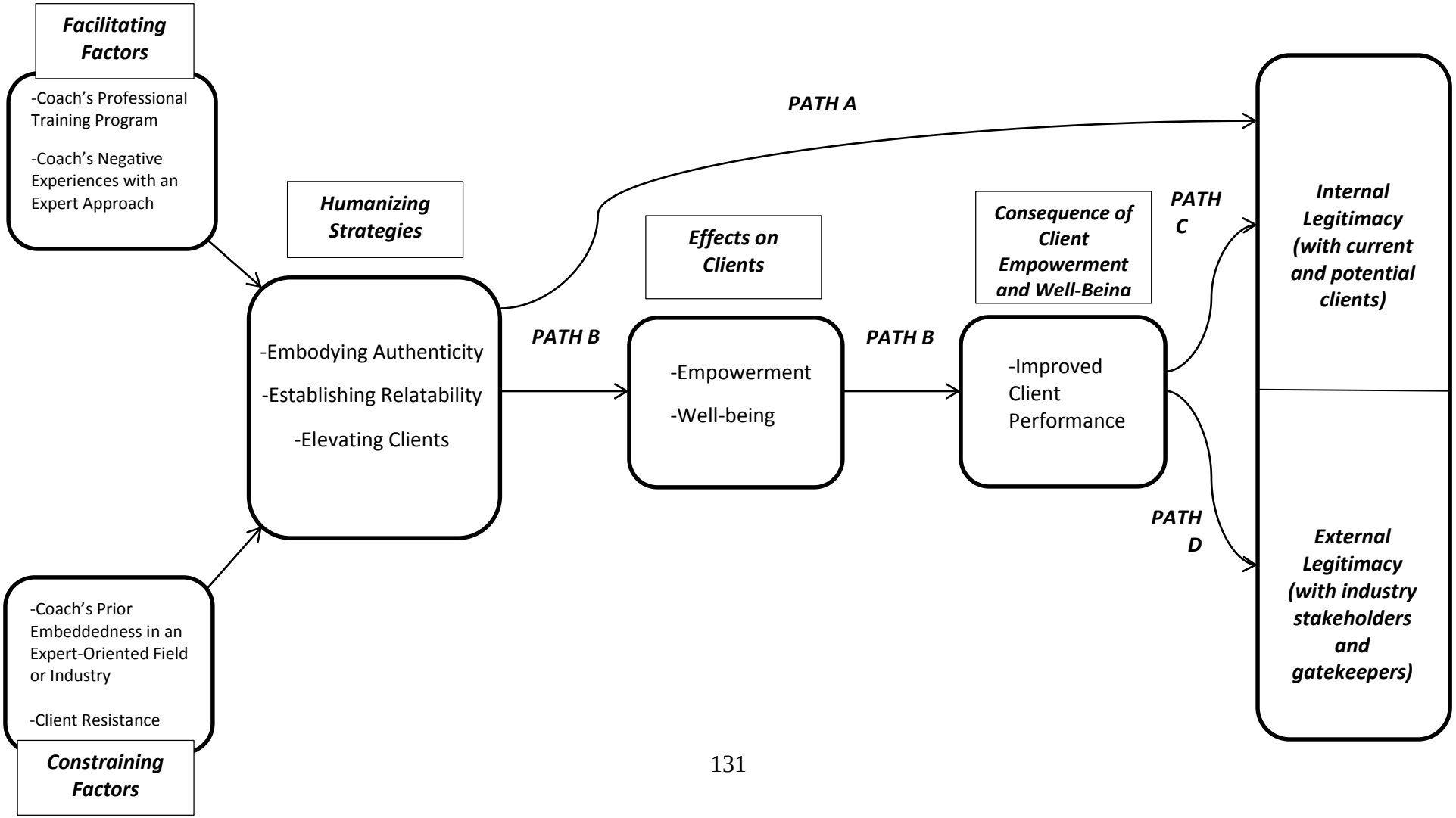

ENCOUNTERING THE VOID
EXPERIENCING THE VOID
FACING THE VOID
(Un)shared Ideology of Work
No Identity Prototype
No Image Transparency
Lack of Occupational Identity Clarity:
Multivocal (ambiguous), complex identity
Lack of confidence in identity
Temporally-unstable identity
Logically-inconsistent identity
Identity Work Tactics and Compensatory Identity Resources
Relying on Identity Anchors
Another occupational role
Material artifacts—scripts, products, web templates
Employing Identity Devices
Archetypes
Analogies
Antagonists
Seeking Identity Supports
Dyadic and tribal relationships
Informational (further research or education)
Occupational Identity Clarity
Imposing Identity Constraints
Specialization
Mental representation of limits and boundaries of work role

FIGURE 2


Facilitating Factors
-Coach's Professional Training Program
-Coach's Negative Experiences with an Expert Approach
Humanizing Strategies
-Embodying Authenticity
-Establishing Relatability
-Elevating Clients
PATH A
PATH B
Effects on Clients
-Empowerment
-Well-being
PATH B
Consequence of Client Empowerment and Well-Being
-Improved Client Performance
PATH C
PATH D
Internal Legitimacy (with current and potential clients)
External Legitimacy (with industry stakeholders and gatekeepers)
-Coach's Prior Embeddedness in an Expert-Oriented Field or Industry
-Client Resistance
Constraining Factors

APPENDIX B: TABLES

TABLE 1: KEY MILESTONES IN THE EMERGENCE OF THE HEALTH COACHING PROFESSION

1983*:* Motivational interviewing (MI), a core concept in health coaching, introduced.[1]
1992: Institute for Integrative Nutrition founded by Joshua Rosenthal. MI elaborated upon.[2]
1994: Further evidence found for the efficacy of motivational interviewing.[3]
1995: International Coach Federation founded by Thomas Leonard.
1998: International Coach Federation establishes core competencies, code of ethics, IRB.
1999: Association of Coach Training Organizations founded.
2000: Duke Integrative Medicine founded. Wellcoaches founded by Margaret Moore.
2001: Bark Coaching Institute founded by Linda Bark.
2002: Wellness coach training program launched by Wellcoaches.
2003: Health coach training program launched by Take Shape for Life.
2005: Health coach training program launched at the University of Minnesota.
2007: National Society of Health Coaches established. Key articles using the term "health coaching" written by Melinda Huffman, founder.[4] The Coaching and Positive Psychology Initiative at Mclean Hospital (a Harvard Medical School affiliate) founded.
2008: Health coach training programs launched at Duke Integrative Medicine, Spencer Institute
2009: 1st Health Coaching Summit (genesis group for the National Consortium for Credentialing Health and Wellness Coaches). Institute of Coaching at McLean Hospital established through a merger of the Foundation of Coaching and the Coaching and Positive Psychology Initiative.
2010: 1st Summit for Credentialing of Coaches in Health Care. Health coaching textbook written by Margaret Moore and Bob Tschannen-Moran of Wellcoaches.[5] Health coaching program launched by the California Institute of Integral Studies.
2012: Health coach training programs launched by Dr. Sears Wellness Institute, American Council on Exercise. Health coaching textbook developed by the National Society of Health and Wellness Coaches.[6] Health coach training program launched at the Maryland University of Integrative Health.
2013: *Global Advances in Health and Medicine* dedicated two special issues to health coaching (May and July). Health coaching textbook written by Meg Jordan.[7]

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[1] Miller, W. R. 1983. "Motivational interviewing with problem drinkers." ***Behavioural Psychotherapy***, 11(02): 147-172.
[2] Miller, W. R., & Rollnick, S. 1992. ***Motivational interviewing: Preparing people to change addictive behaviors*** New York: The Guilford Press.
[3] Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. 1994. ***Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence***. Rockville, MD: DIANE Publishing Company.
[4] 1) Huffman, M.H. "Traditional patient education is out... health coaching is in!" ***Beacon Health Homecare Administrator Perspectives***. Beacon Health: Mequon, WI ; and 2) Huffman, M.H. "Health coaching: a new and exciting technique to enhance patient self-management and improve outcomes." ***Home Healthcare Nurse*** (25)4: 271-274).
[5] Moore, M., & Tschannen-Moran, B. 2010. ***Coaching psychology manual.*** Philadelphia, PA: Lippincott Williams & Wilkins.
[6] Huffman, M. 2012. ***Evidence-based health coaching for healthcare providers***.
[7] Jordan, M. 2013. ***How to be a health coach: An integrative wellness approach***. San Rafael, CA: Global Medicine Enterprises.

TABLE 2: EVOLVING DEFINITIONS OF HEALTH COACHING

- "The practice of health education and health promotion within a coaching context, to enhance the wellbeing of individuals and to facilitate the achievement of their health-related goals" (Palmer, Tubbs, & Whybrow, 2003: 92).

- "A service in which providers facilitate participants in changing lifestyle-related behaviors for improved health and quality of life, or establishing and attaining health promoting goals" (Butterworth, Linden, McClay, & Leo, 2006: 358).

- "Professional coaches provide an ongoing partnership designed to help clients produce fulfilling results in their personal and professional lives. Coaches help people improve their performance and enhance the quality of their lives. Coaches are trained to listen, observe, and customize their approach to individual client needs. They seek to elicit solutions and strategies from the client, and they believe the client is naturally creative and resourceful. The coach's job is to provide support to enhance the skills, resources, and creativity that the client already has" (International Coaching Federation, 2007).

- "Health and wellness coaches are professionals from diverse backgrounds and education who work with individuals and groups in a client-centered process to facilitate and empower the client to achieve self-determined goals related to health and wellness. Successful coaching takes place when coaches apply clearly defined knowledge and skills so that clients mobilize internal strengths and external resources for sustainable change" (National Consortium for Credentialing Health and Wellness Coaches NCCHWC, 2010).

- "Professional coaching is an ongoing professional relationship that helps people produce extraordinary results in the lives, careers, businesses, or organizations. Through the processes of coaching, clients deepen their learning, improve their performance, and enhance their quality of life. In each meeting, the client chooses the focus of conversation, while the coach listens and contributes observations and questions. This interaction creates clarity and moves the client into action. Coaching accelerates the client's progress by providing greater focus and awareness of choice. Coaching concentrates in where clients are now and what they are willing to do to get where they want to be in the future. ICF member coaches and ICF credentialed coaches recognize that results are a matter of the client's intentions, choices and actions, supported by the coach's efforts and application of the coaching process" (International Coaching Federation, 2010).

- "A patient-centered approach wherein patients at least partially determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach…." (Wolever et al., 2013: 52)

TABLE 3: IDENTITY WORK IN THE ABSENCE OF IDENTITY RESOURCES—ENCOUNTERING, EXPERIENCING, AND FACING THE VOID

Code	Description	Example Quotes
Key Outcome: Occupational Identity Clarity		
Occupational identity clarity	The key identity-related outcome, defined as a clear sense of "who one is" in one's occupation as evidenced by univocality, confidence, temporal stability, and logical consistency in one's identity	"There's no ambiguity…it's wellness care. It's a new paradigm. So when you're doing health, you're doing wellness. You're not doing illness" (Interview # 25) "A lady approached me and she was just sincerely asking me questions on what she needed to do and I just felt like, for the first time, I had the education to help her. It just dawned on me, 'Man, I think people really would listen to me because I guess I do know.' That was kind of the turning point where I thought, 'I am a health coach. This is what I can do'." (Interview # 3) "When I'm in that [health coaching] role, it's clear for me. So like on a scale of 1 to 10, I would say it's an 8//9, definitely probably even close to a 9 in that role" (Interview # 9)
Encountering the Void: Identity Resources Become Conspicuous in their Absence		
Shared ideology of work	An identity resource that consists of a shared understanding of the meaning and purpose of the occupation. This resource is not yet available to health coaches.	"And I think there is a sense of...I can think of several health coaching colleagues who the way they are marketing themselves sort of comes across that they identify themselves as health coaches slash saviors like out to save the world like we know the truth and it's our job to deliver it to everybody. To me that's a very different approach than what I would like to uphold, and what I think [my coaching program's] model, at least, really stands for, which is, "We'd like to help people achieve what they want," rather than, "We know what people need, and we're going to give it to them." So I do see an identity forming in the entrepreneurial world, and it's certainly not representative of the whole of it, but there's a certain culture that's there." (Interview # 21) "It's going to sound arrogant perhaps, but that's okay. I don't relate to a lot of health coaches. If you've gone to [one health coaching program's] meet ups in New York, I find that people's knowledge is very superficial. It's very on the surface, and many of them do not have the same intensity of wanting to acquire knowledge and be a really sound professional in what they do the way I am. So I don't really relate to that so much. I'm definitely in the functional medicine world for sure. I do attend a lot of

		conferences. You know, I do spend time with doctors who are in that space. I'm a sponge for information and knowledge, so it's always good to be plugged into that world." (Interview # 41) "What I believe about wellness coaching is right now, it's just like what I believe about personal training. It's marketing. It's business side. If you can't market yourself and you can't self-promote, you're not going to be successful. It's not like you're just going to put out a shingle and say, 'Hey, I'm a wellness coach' and people are going to come to you. And nobody is going to refer to you either. Why would you refer to you if you don't get out there and beat the bushes and promote yourself?" (Interview # 6)
Identity prototype	An identity resource that consists of a collective understanding of who constitutes an ideal member of a particular group, as facilitated by a standard credentialing and licensing system, curriculum, and a standardized role. This resource is not yet available to health coaches.	"I'm discovering there are lots of different types of... You know, I talk to people a lot that say, 'I'm a health coach too.' 'Oh, really? When did you get into [my health coaching program]?' 'No, I'm not health coach [with your program]. I'm just a health coach.' 'Oh, that's interesting. Well, what do you mean?' So….anybody can call themselves a health coach. It's not regulated. I can't call myself a doctor, but I can just snap my fingers and call myself a health coach." (Interview # 26) "I can see why people question it though since there is no uniformity with it, national certification, or licensing, or anything like that. Like, anyone can call themselves a coach, and I definitely wouldn't want to work with somebody that I didn't feel like couldn't help me." (Interview # 34) "The wellness coach concept of helping people to be healthier these days is a really good concept but it's really hard to define, maybe hard to standardize and validate, and I think it's going to be a matter of a few years before the profession does come up with some sort of a standard training protocol and a way to be certified by one body that certifies the health coach business." (Interview # 7) "There definitely is some ambiguity. And because the role is still in process, and in particular the health and wellness coaching role at this point is a huge spectrum of training for people that are calling themselves health and wellness coaches." (Interview # 49)
Image transparency	An identity resource that consists of a basic comprehensibility of the occupation from the outside looking	"I'm still to a certain extent struggling with [my identity], but I think it's in part because it's what the population's perception is or is not of health coaches. That is a cross to bear. There's no doubt about it. If I said to you, 'Hey, I'm a licensed social worker.' Chances are you have a feeling that you knew what that was, most likely. So then if I say to someone, 'I'm a health coach.' They say, 'Yes, but what do you do?'" (Interview # 18)

	in—what it means, what its members do, why the work needs to be done. This resource is not yet available to health coaches.	"I know that outside of these walls your dialogue with somebody that you just met, and they ask you what you do, and you just say wellness coach or health coach. Usually, I've been using the word wellness coach. It kind of seems more appropriate from my standpoint. And then, there always has to be, 'Okay. Well, let me explain that,' because, you know, I think even if you said a business coach or even a life coach, I think a good amount of people would be like, 'Oh, okay, yeah.' You know, it's funny the way that I've always kind of described it to a lot of people is when they kind of give me the look like, 'Hmm, what's that?'" (Interview # 39) "The ambiguity comes in that not being a known fact out in the world in terms of 'I'm a welder,' or 'I'm a garbage collector,' or 'I'm a teacher.'" (Interview # 49)
Experiencing the Void: Key Identity Challenge—Lack of Identity Clarity—Becomes Salient		
Lack of occupational identity clarity	A multi-dimensional identity challenge in which one's occupational identity is beset by ambiguity, low self-confidence, temporal instability, and/or logical inconsistency	"I'm a health coach. I help women (or families, or whatever the group is that I'm speaking to) figure out...You know what? I'm totally not prepared….and I need to have...and this is part of my deal, is that it's not smoothly rolling off of my tongue. Let me. I can pull something out here. I can get you one. But that's part of it, is that I'm not comfortable being in fluid saying that. So I just don't…. maybe it's just that I don't have enough clarity what the heck it is that I do to enjoy that" (Interview # 28) "It's really about how do I present myself, how do I – actually….I did some groups for a women's clinic at [a U.S. university] this fall and that kind of made me feel legitimate. And I'm on the programming committee for [a medical association] and that makes me feel legitimate. But honestly, in my conversations, like I said, it's all within me. Some days I feel like I'm a hack and other days I feel like I know what I'm doing. So it's kind of how you present yourself to the world." (Interview # 13) "I'm still, I think, making changes as I go along because everything is so new, and the clients that I get, everyone is different. Yeah, I think it will be a... It will constantly be an evolving thing, the identity part. Right now, I see myself as someone who wants to help women in need who are.... I see myself as a, I guess, my definition of a coach is someone who can empower clients to rediscovery and make the changes that they want. It really depends on what their true desires are." (Interview # 37) "I think [coaching] is broader [than psychotherapy]. It's less restrictive in many ways…. With coaching, you're not setting a label, and I think psychotherapy is far broader. I mean, broader in its application

		because you're looking very deeply at a lot of behaviors. Whereas, with coaching, you're looking at some behaviors attached to some goal. So it's not always as comprehensive." (Interview # 33) "If you get in front of a client, and you're doubting yourself, then they're not going to have much confidence in you and health coaching." (Interview # 32)
Facing the Void: Identity Work Tactics and Compensatory Identity Resources		
Relying on identity anchors	A cognitive or behavioral tactic that involves relying on identity "anchors"—different occupational roles or a material artifact. Anchors do not clarify identity content, but promote clarity indirectly by providing a foundation for one's identity.	"For me, I like to empower people. I think that's what it is, not from, like, a groundless place. Like, from real experience and also theory and research. That's why I love being in [a] counseling program because I feel a lot more secure and grounded as a coach now, ironically." (Interview # 34) "People tend to bundle coaching with other skill sets like being a yoga teacher, so that's one thing...and I'm working on, too...and I think that happens a lot more often in the entrepreneurial world. Someone will be not just a health coach, but a health coach, and a yoga teacher, and a meditation teacher, or they can do reiki as well, so bundling it as part of a skill set that includes other healing arts or health related skills. So I do see that happening a lot. And it kind of gives you a sense of being more useful." (Interview # 21) "If you look at the [program's] 'wheel of health,' and I do direct people to my website it's got the wheel of health on there, which really does help. It's really about looking at the wheel and creating balance in your life. Whatever part of the wheel we go through, whether it's nutrition, or whether it's movement, or your professional life, whatever that is, whatever part of the wheel that you want to start moving with, it ends up touching base with all the other aspects of the wheel. You know to shorten all of that, and basically I just say that a health coach is one that works with the whole body approach and the integrative health coach is a whole body approach to wellness." (Interview # 20) "Even our nurses [in this medical facility], they struggle with that, because they are trained, not like I am, but in some nursing coaching form they've got some training. They know how to be a nurse, and they know how to be a coach, but they don't know how to mesh those when they are something and when they are not. And luckily, for me, I've been given the opportunity to not have to fight that. I just can be a coach, and I don't have to try to be a physiologist. I do get to have opportunities here. We have a little gym, and there's times when I get to take off my coaching hat and go in there and show people how to lift weights, or check their pulse, or whatever it is. So, for a half hour, I may be able to be a physiologist, but I kind of have that black and white, and I try really hard not to mix the two." (Interview # 30)

		"I think one of the things that makes it very difficult, you know, there's physicians, and PAs, and NPs, and nurses that do it...for me, one of the things that made it difficult for me is, 'Okay, what do I offer?' You know, if you're somebody that's...even a therapist, I think. You know, a speech therapist or something that's gone. You're really probably going to offer just what I call pure health coaching as opposed to how much education, um...you know, I mean, I've got a lot more tricks in my bag than somebody who maybe doesn't have as much of a health background, so delineating what your package is and the legalities of that I think also make it...sometimes can be more difficult for somebody who is already a healthcare professional like a doctor or physician. You know, somebody that could get in be tricky areas saying, 'You know, I don't have malpractice, so I need to make it really clear that I'm not diagnosing and treating.' You know, how much educating am I doing, and am I...you know what I mean? It can be very...much more gray than somebody who's...say a physical therapist even. You're doing physical therapy. You're doing health coaching. They're not really crossing over." (Interview # 47)
Employing identity devices	A cognitive tactic that involves employing an identity "device"—an archetype, an analogy, an antagonist—to provide or clarify the content of one's identity	"I really try to help people create an overall balance in their lifestyle so they are getting the most out of life that they can get and that they're truly living the way they want to live and they're going after the dreams they want to become a reality and I'm just kind of their cheerleader to help them make that happen" (Interview # 4) "A wellness coach, I'm more of a mentor and a cheerleader….I don't really give myself a mightier than thou job description. I just think I'm a coach. I mean, I'm a cheerleader for a person working towards their best self." (Interview # 44) "I'm your positive behavioral guide post. We are going to help you out here, because it's not just about the weight, and you don't need therapy…. And boom, you know, I mean it's that simple…. I don't fault [my coaching program], and I don't fault other programs, but I don't think anyone's come out with a really concise definition and said, 'You're a positive behavioral guide post for life change and behavioral change.' It's really simple." (Interview # 23) "The coach is there just to ask questions to kind of be the guidepost or showing the client, 'Well, there's this sign that points in this direction. What you think it would be like if you followed it and so on?'" (Interview # 50)

		"What it means to be a coach to me is to empower a patient by helping them see what they need to do to change and then allowing them to figure out how to do that without being the one to do that. I struggle with how to describe this, so I just say, when I meet with them, 'You're going to drive this. This is your thing. I'm going to be the GPS. I will keep you on track or help you if you're puttering out,' and patients at least seem to really identify with that analogy." (Interview # 30) "I'm still kind of struggling with, 'How to market myself in a way that's attractive to people and actually winds up with people wanting to work with me, but also kind of still feel genuine, and still feel like I'm projecting, you know, the person that I want to be, which is a helper, and a healer, and a teacher." (Interview # 36) "And people love to get it, and you just have to let it go, because….as many people who will be naysayers, others will support you. So, you know, I believe every great person has come up against some opposition, and they just said, "Screw you. I'm going to do what I want to anyway." (Interview # 38). "My friends, you know, might raise an eyebrow here or there, but they're like, 'Well, [he] seems to know what he's doing, and he seems really passionate about this so, you know, I hope it works out.' So the only resistance, really, was from….my elderly friend. But other than that….I think everybody just sort of gave up on trying to pigeonhole me" (Interview # 26) "The identity is important to me….to compare it to an athletic coach at times, wellness or fitness coaching, and people do certainly identify with a coach in the athletic world and that coach doesn't necessarily have more skill than the athlete. In most cases, they don't. The athletes have more skill in the field than the coach, but the coach is able to guide and direct." (Interview # 6) "If we [as health coaches] can reflect back to [our clients] and just kind of be there as a mirror for them and ask the right questions at the right time, then you know, an aha moment might take place or some new insight for them might take place." (Interview # 50) "I have my own personal identity that ends at the end of my skin or my little or aura. It's this, and this is my history…..And then simultaneously, we all carry an archetype. We all have some identifications and archetypes whether it's our zodiac sign or, you know, whatever profession that's more broad—a healer, a teacher, a leader, and those qualities inform us. They are alive in use. They have a life, and the more we are aware of those as we identify with them, the more effective I think we can be in our personal delivery

		of those qualities, and the more we develop those qualities, the more effective we are. And then for me, there's also a third layer so to speak of reality which is the infinite where we're all divine spirits having a human life kind of thing. And if...I think that people that can move effectively between those, or in my experience, even more satisfying being a human is to hold all three of those in this particular model simultaneous realities of ourselves at the same time, then it really illuminates our capacity to coach and be present with someone and not take things personally and be where they are, meet them where they are and what's the most useful for their own progression for their own growth and development. So I really enjoy and appreciate people who understand that more archetypal role that they carry and play as well as that they are pure spirit bringing that through into human experience at multiple levels" (Interview # 49)
Seeking identity supports	A behavioral tactic that involves seeking out identity "supports"—like-minded people (e.g., colleagues or clients) or additional research and/or education–to help nurture the content of one's identity. These supports can be "tribal," dyadic, or informational	"I went to another, I guess she's more of a career/life coach, just this past, no this week….and her big thing, she's holding my feet to the fire, which is great. I mean it is a little painful, when somebody's just sitting there, 'Well, come on, what is it that you're trying to do. I still don't know what you're doing,' and they're sitting there saying that to you, and you're like, 'Oh my gosh,' you know….which is awesome, which is back again to coaching at it's best, holding your feet to the fire, accountability, 'Come on, what the heck are you really doing?' (Interview # 18) "[My program's alumni group is a] pretty tight knit community. They have….once or twice a year there's like a different event. Once a year they have one on the West coast, and the other time they have one in New York City where, you know, a big conference. They have lots of speakers and stuff. You get together and….it's very rejuvenating to go to those because then you're just refreshed and fired up to just create...be the change" (Interview # 32) "There is sort of a mutual thing just being with your tribe….So there's validation and being understood. I also think there's the practical side of other people being able to say, 'Well, I've done this, or I've tried this, or I speak to this, or I recommend these people, or I recommend these resources or this website,' again building resources. I also see them, as I was talking about us capacity to reflect and understand my own reactivity, I see my peers and my cohorts as my mirror, as an external mirror. Well, they might challenge me on something and say, 'Well, you kind of mentioned that pretty casually that you had a run in with your brother-in-law because he doesn't really understand what you do with your coaching, and it's not covered by insurance, and its way out of the box. You kind of mentioned it, but I could tell it had a sting to you. Go back and tell me more about that.' You know, where they're a witness. They will challenge and hold accountable. And also on the other end where things that are really fantastic or feel good or there are successes, they're there to celebrate and be...I don't know. Consistent….is the word that

		comes to me. But you know, 'Take a minute and reflect what worked really well about that workshop. You had a ton of people, and that's the most people you've ever had at a workshop. Was it the one day? Was it the two day? Was it the topic?' You know, and to really help me almost mind more not only identity but also ways of expressing myself in the world with different techniques" (Interview # 49) "I think within myself that, for me, when I...what helps me, I think, mentally is when I identify and when I do a lot of research, which I do, that helps me...you know, for me." (Interview # 33) "I went into the program knowing that they do it very unstructured, so I kind of braced myself for that to some degree. So in terms of the ambiguity, I would say I'm pretty much a self-starter, so I kind of prepared that that program would lend me everything that I really needed to have a successful business, and I had to really created it on my own. So I sought out other additional training, business related trainings, and then my background had a lot of business knowledge." (Interview # 38) "And it's been a growing sense....and I think, what's helped me grow as a coach is what has helped me grow in my own sense of myself as a coach. So I've gone on for a lot of additional training. I'm certified with the Coaches Training Institute and by the International Coach Federation….So I continue to expand my own learning and my own sense of what it was that I did and how it pertained to me in my life….So it wasn't enough for me to know that I was certified with [my health coaching program] and stop there. You know, it wasn't enough for me to even stop with CTI when I discovered there was a certification that the International Coaching Federation had, and all the coaches that I admired had that. So, for me, it was how to be at the top of my game, so that I felt good" (Interview # 48) "I think not only is there a process of coming to an internal point of clarity but, at least in my experience maybe because I love the growth and development part so much, that my internal clarity can be radically different every six months as I've taken another class….So the research I've delved into, which I've already been interested in, neuroscience for instance, and all the new cool things we're learning in quantum physics again changes my identity in terms of being able to speak more clearly to the to this mind body connection and research and all that kind of stuff." (Interview # 49) "I went into my internship, and you talk about ambiguity and confusion, and I didn't know whether I was coming or going because I was asked to forget this huge part of myself in order to be any good at what I was doing now, and I was really having a hard time doing that. And then, I had this mentor….who said,

		‘Stop listening to them. You don't need to do that. You just need to figure out how to incorporate everything.’ And that was a great experience. That was a great experience because if I hadn't had that experience or been with her, I was in a pretty bad place by the end of the coaching program in that I didn't know how to be a coach and completely forget the [prior healthcare professional] part of me. It was hard. I was being told I had to, and yet, that was a hard thing to do.” Interview # 51) “So I have confidence in knowing that I think I'm fortunate because I have those actual documented outcomes that I can refer to. I can't show them the report because that's proprietary, but it gives me the confidence that I can help people.” (Interview # 37) “I think throughout this process of beginning to orient myself to helping other people, I have always experienced that ambiguity. And ultimately, the only way in which I have gotten any clarity about that is from the feedback I get from the client's. My observation is that it doesn't matter what certificate or credential you have….and I think it's true for licensed therapists, is that your identity is always in question until you get somebody coming back and saying to you that really helped, and so you can get direct linkage between something you're doing, the way you're doing it, and the outcome.” (Interview # 46) “In our….leadership development programs we have embedded a wellness portion of those programs. So I and my colleague….we facilitate the wellness portion of that. We individually coach all of the cohort of those teams….and those people, those participants going back to their leadership saying, ‘This is a really valuable part of the traditional leadership development program that's been put in.’ Like, that in itself is a great...I want to use the word comforter, I guess, because it a sense of validation of a tool, a resource.” (Interview # 45)
Imposing identity constraints	A cognitive or behavioral tactic that involves imposing an identity “constraint”—a resource that bounds one’s identity by reducing the scope of or streamlining its	“I'll begin with the first question about establishing the distinction between coaching and therapy. It's part of my informed consent process, and so it's right up...it's really...it's very clear to the perspective client that it's for coaching, and there's only coaching. So it's very...for me, it's a critical, critical process to outline up front exactly what that relationship is going to be. So that is part of the informed consent process with the client, and it's very, very clear because that's a value.... so I believe that that's very clear for coaches to do.” (Interview # 33)

	content (i.e., beliefs about what one's role constitutes). Examples include seeing oneself as a specialist, developing a mental representation of the boundaries of one's work role, or constructing a simplifying narrative about the purpose of one's role.	"One thought that comes to mind is kind of sitting with when someone needs therapy or might be open to therapy versus just coaching alone. Because we're working obviously a lot around behavior, but kind of the mind and beliefs are related to that as well. So I think this is an issue for me, because even in this research study that I'm a coach on, and we're looking at mindfulness. Health coaching for people with higher levels of hostility and depression, who also qualify as pre-diabetics. So trying to offset them becoming diabetics. So, I've sat with these questions of, 'Okay, I'm working with a set that is more generally hostile or depressed, but I'm working with them as a coach, not as a therapist.'….This has also led me to think, 'Well, maybe to be an effective coach, I need more training in, I don't know, mental health.' So, yeah. I guess, that line can feel a little... You know, and being able to judge someone's progress, or not." (Interview # 27) "I think for me a nurse has a more global perspective than a wellness coach. Remember, the wellness coach focuses on five or so aspects of your life, right, health, stress, sleep, exercise and nutrition." (Interview #15) "I have come across clients who have worked with health coaches, for example, who asked them to get off of medication. I mean, like, are you absolutely out of your mind? You cannot….and this is one of the things that [a health coaching program] teaches you. You cannot be asking people to get off meds. We're not qualified to do that" (Interview # 41) "I'm still trying to understand it myself. Like, 'What exactly am I doing here?' So I'm more comfortable with just saying, 'I'm a listener. I listen to my clients.' You know they're the ones with the hands on the wheel. They're the driver of the vehicle, and I'm there along with them, and most of the times they make the right turns, but sometimes I'll chime in and say, 'Maybe you should turn left here. Let's explore that a little bit' and so on (Interview # 50)

TABLE 4: HUMANIZING STRATEGIES—FACILITATORS, CONSTRAINTS, CONSEQUENCES FOR CLIENTS, AND PATHWAYS TO LEGITIMACY FOR HEALTH COACHES

Code	Description	Example Quotes
Humanizing Strategies		
Embodying authenticity	Coach's beliefs, attitudes, and behaviors that include recognizing limits to one's knowledge, valuing "walking the talk" over credentials, and being oneself in every situation rather than switching into an authoritative "persona"	"I could go to Harvard Medical School and get a degree, but it…is tiny. Yet, you got away with a, 'Oh, I got a degree from Harvard in nutrition,' yet those people don't even know how to freaking eat. They're sucking down coffee and donuts. 'Well, wait a minute. You graduated with a Harvard degree, and you're eating that stuff. You didn't learn anything as far as I'm concerned'." (Interview # 31) "I don't focus too much on credibility. I think where I build my credibility is through….the way I communicate my message, and the way I live my life…I think that that's what I lean into is my ability to communicate who I am. I think that I don't focus as much on credentials." (Interview # 38) "For me, it's more of a personal journey and just taking that personal journey and driving it into my business. I think it's more that I really strive to live my life in the most authentic way possible and really trying to scrap those ideals of who I should be, or what I should like, at what age I should feel a certain way, or decisions I should make, and then doing what feels right and what feels like me. And then, that really....because it's a personal journey, it's carrying over into every aspect of my life." (Interview # 38) "I'm not an authority. I don't know any better than anybody else. I don't see anybody as broken. I see everybody as on a path going somewhere, and it happens to be in the realm of health and wellness, and I'm just here to enjoy the ride with them." (Interview # 44)
Establishing relatability	Coach's beliefs, attitudes, and behaviors that include projecting imperfection and verbalizing past or present struggles (i.e.,	"In the beginning when I first started going to school, I did struggle very much with, 'Oh my gosh, but I'm overweight. How can I be a health coach if I'm overweight?' Now I was in the process of losing a lot of weight, but I'm still not completely there yet. You know, I've got an extra 25 pounds on. So I struggled with, 'Oh, I'm going to look like a slob. How can I coach people around weight issues if I still have a weight issue?' What I realized is people don't need you to be perfect." (Interview # 40) "I'm a pretty lean guy, and you know….I stay in pretty good shape. So, I...you know, I definitely...I mean, if I go hire a personal trainer, and they're out of shape, there's certainly a loss of credibility, and

	being vulnerable)	that's just...I mean, if I go meet my banker, and he's got a T-shirt on and jeans, you know, I'm not feeling real good about the situation. So I feel that's huge. That's just the reality of people, you know, and it's our culture….That can work against you though. If you have somebody that's clearly not healthy…they don't think that you can identify with them. This skinny, lean guy, you know, whatever, and they're 100 pounds overweight. But I have a way of kind of detecting that they are feeling uncomfortable like that, and once we kind of break the ice, I'll usually go into some kind of realm of... Because they'll just be honest in saying, 'You know I really struggle with my weight,' and you can tell that they're embarrassed, or they're ashamed about it. So you know, 'Everybody's got an issue. Whether it's marital issues, or work issues, or financial issues, or weight issues, or substance abuse issues. Like everybody's got an issue. Your issue may be weight. The next person may be relationships,' and so really kind of getting them to calm down and accept the fact that, you know, especially the weight thing can be really personal and sensitive. My mom's always struggled with her weight, so I try to find some way to kind of identify with them, so that they feel more comfortable. They see that even though I'm not in their shoes, I can empathize with them and understand." (Interview # 39) "The way that I interact with my clients isn't like from an ivory tower or in any kind of distanced way." (Interview # 50)
Elevating clients	Coach's beliefs, attitudes, and behaviors that include shifting the locus of content expertise to clients; considering clients to be the repository of the "answers"; believing that clients should be putting in more work to achieve their individually-chosen goals; empathizing with clients while also feeling less	"I think what I most focus on is I will say something to the effect that 'I will not provide answers for you. I won't direct. I won't – in terms of here's this plan or, any of those types of things'. I want them to understand that they're not coming me to get answers. They can come to me and discover answers but I can't give them answers. That's, I think, the big, important part of it for me, that there's a respect for who they are and what they have and what they're bringing, all the things they know, that part of it that's important to me." (Interview # 14) "I like the idea that we are not the experts. You know, that every client has the answer within them, and it's just a matter of helping them create a space to figure it out because usually people are in a frenzy…or have no time for themselves that they can't even figure out a plan when they actually know all the answers. And so that takes the pressure off me." (Interview # 37) "For me, kind of the number one thing is being someone's partner and not being—doctors like to think of themselves as experts, but not defining yourself as experts, not saying you're the expert, but the client is the expert and really the client holds all the answers for their own healing." (Interview # 13)

	responsibility for their failures	"Within the context of their lives, [the clients] are the expert. They know….the greens are good for them. Now it's up to them to figure out how to put that and fit that into their lives in a way that matches up with whatever their particular goals are. So in that sense they are the expert." (Interview # 50)
Facilitators of Humanizing Strategies		
Coach's professional training program	The facilitating influence of the coach's professional training program—certain programs will encourage humanizing strategies	"A sort of a light went on for me was they talked about, 'Yeah, this is definitely a modeling profession. You're definitely...you are being a role model.' So it's not just about, like, how you can sit there with somebody and hopefully help them through the process of the relationship that you guys have, of like, empower them to, you know, like maybe switch their mindset at some point. It's literally about you being a reflection of what they are trying to become. You have to hold that space, so you can't just...you have to walk the walk. You can't just pretend to be." (Interview # 34) "The quote that [a training program says] is like, 'We're not the sage on the stage. We're the guide on the side.'So….in a session, I'm not going to like lecture to a client. That's not what coaching is. It's more about asking them the right questions and listening more than talking. And when you ask the right questions for the client, they come up with their own answers, and they come up with their own... Like, they realize certain blocks that they've had in their mind that prevent them from doing that, and it's through that process that they know what to do next." (Interview # 29)
Coach's negative experiences with an "expert" approach	A facilitating influence stemming from the coach's prior negative experiences with some aspect of an expert-based, less "humanizing" approach to subordinates	"I gradually got more and more dissatisfied with the whole disease management aspect of medicine. My original background was in [a hospital] setting and when you get repeat customers in that setting, you know that there's something really wrong with their lifestyle. From there, I went to outpatient work and thought it was an education problem, went back and….realized it wasn't an education problem on the part of the patient at that time, because I was still in nursing, but it was a doing problem, and moved over into community education and speaking and still kept being confronted by this. People knew what to do but they just wanted that magic pill or that magic surgery without taking any ownership. So I ended up quitting nursing to figure out what I wanted to do." (Interview # 16) "The medical community just gives lip service to nutrition. So Americans are like, 'Oh, the doctor didn't tell me to stop eating Cheetos. Well, I'm not going to stop eating Cheetos.' Well, you're going to keep being a type II diabetic. 'Well, the doctor didn't tell me that. It wouldn't be on the shelves if it was bad for you.' I hear that all the time. I want to reach through the phone, you know what I'm saying?" (Interview # 44)

Constraints on Humanizing Strategies		
Coach's prior embeddedness in an "expert"-oriented field or industry	A constraint on humanizing strategies—extensive prior experience as an "expert" makes coaches less likely to neutralize status differences through humanizing strategies	"I'm thinking particularly of one woman who was a doc, who was very resistant at the top. She was saved because she was also extremely curious and I think her curiosity served her well as a doctor and it was the thread that made it possible for her to be curious about what would it be like if I didn't have to be the only person who held that information. She was willing to jump off that cliff because of her curiosity. But she was, and she was the very first one to say she was very resistant and resistant specifically to the place that said there's not a right or wrong way to do that, because she had spent many years and had great success being right, and being wrong meant that somebody would die, so it wasn't an option. And to say well, this is an arena where it's not right or wrong really snatched from her a whole lot of who she was as a professional person." (Interview # 11) "Our program….is not full-time. It's part-time, but it's [many] hours of training. It takes time for people to learn how to engage in a different process and a different kind of relationship with a client. And the longer that they've worked in conventional healthcare, the longer it takes to deprogram them." (Interview # 2) "It's definitely a change for people who have been working with patients or are used to, like you said, in the expert field and being the experts as far as being the teacher or the counselor or someone who's actually giving clear directions on what to do next and kind of taking a back seat and taking an approach to the actual coaching, I think it's hard. I think it's hard to change your mindset and, like you said, kind of just let the person evolve based on their own speed rather than what you want them to do." (Interview # 4) "So when you have a traditional, and you have a MD, and you have a nurse practitioner, and you have this education in which you are the expert in the room, and usually you come from a practice in which you don't let the patient say anything because you have 10 minutes, and you have to hit all of these benchmarks in order for insurance to pay for the visit, and you don't want the visit to go into areas that you can't control because you won't stay on time. And then, the education is so...the medical education is about closing the conversation. It's about narrowing things down, and that's not what coaching is about at all. It's about opening things up and looking at the possibilities and trying to make connections between seemingly disparate things…..So that is the challenge to not slip into old ways....I really had to learn the dance about how to be a physician and how to be a coach at the same time, which even though I've said that I think they do go well together and now it feels really good. I really had to consciously

		work at not going into that old pattern of narrowing things down, narrowing things down, narrowing things down so that I could be open and listen to the connections, and listen to the metaphor, and listen to people, and have people work on their intuition about what they think is the root cause. So that was a hard dance at the beginning." (Interview # 51)
Client resistance	A constraint on humanizing strategies—clients occasionally prefer to be told what to do rather than take on the commitment and responsibility of being the "expert" over themselves	"It's difficult from the coach's perspective as well as from the client perspective because I think a lot of people want a quick fix answer and they want you to tell them what to do. They come in and say, 'This is the problem. What should I do?' You can give someone a quick fix answer, but it doesn't mean it's going to be right for them because it's such – I don't know. You really have to work through the process in order to figure out what is best for them. So I think sometimes the clients do get frustrated from that point of view because they want a quick fix answer." (Interview # 4) There's just too many people turning their power over and saying, "Give me a pill to make it better" (Interview # 13) "I'm trying to educate people that coaching is much more than just helping you lose weight. In fact, focusing on losing weight is actually not the path toward success and holistic health. And trying to deal with that right up front is difficult because it's the driving motivation that gets people in the door to actually do the work…So you don't want to be so confrontational with people that you say, 'Well, look, you're here for the wrong reasons.' That's very discouraging to them, and it may turn them away. It may cause them not to be a client. It may cause them to go on some other fad diet and fail at that. So it's kind of... It's confusing, and it's challenging because, on the one hand, you want to embrace people who are motivated to change. But on the other hand, you want to make sure that they're prepared for significant, lasting change in their lives in. (Interview # 36)
Consequences of Humanizing Strategies for Clients		
Feelings of empowerment	As a result of the coach's humanizing strategies, clients feel empowered and motivated to perform at a higher level because they believe they now have control over the means to put	"In that session, everything was so positive and inspiring, and by the end of an hour and a half, I had specific goals and specific things that I was going to do to actually move forward on things that I had been putting off. I mean, I was... I'm pretty health-conscious, but when it came to exercise, for some reason, I just could not get started. I was just so impressed with how that whole wellness vision and how that whole process really wanting to make changes within the first session was pretty incredible to me." (Interview # 37) "I think [clients] end up feeling much more empowered and self-reliant and just confident in their own understanding or knowing of their health….people are so disempowered by the medical system as it is.

	plans into action.	They go in, they're confused, people are just talking at them telling them what to do, not giving them information. It's been my experience, and it's been kind of what I know from hearing people's stories over and over and over again. The feeling of disempowerment is huge….So my patients who want to do the traditional coaching, not traditional coaching, but who want coaching, who want to have me help them help themselves kind of thing, they end up....they have a feeling of empowerment about their health, and I think they have a feeling of empowerment about their lives too." (Interview # 51) "I mean, who wants to change if someone else is telling them what to do? They have no control over the situation. So what we work to do is A) give them control over something....A great example…is one that one of my professors told which was a guy was coaching someone who kept saying his whole goal or excuse me, his focus was, 'I have to take these eight pills every week, and that is my heart medicine in two or three different forms, and if I don't take them I will die.' And he wouldn't take them. And so that was why he was going to an integrated health coach. And it sounds so simple, but through the process the coach started uncovering some things, and he wasn't taking them, and he's like, 'I don't understand. This is so simple, and I'm so frustrated, and I don't know what's coming out of it.' And the coach asked all the right questions, and it came out of the conversation that... The coach asked, 'What do you want to look and feel like?' And he's like, 'I know what I don't want to feel like. I don't want to feel like my 80-year-old dad who is constantly taking pills, doing nothing. He was old, decrepit, and died in an assisted living facility.' And so they flipped it, and he said, 'What's your vision? What do you want to look like?' 'Someone who is not taking pills, completely independent and young...useful.' And so, what comes out of that is, it was never about the taking pills. It was all about not wanting to feel like his 80-year-old dad who he had always viewed as being old and not independent. And so that's what we uncover in the coaching process is what's behind the reason, or what is the reason why he didn't lose the weight. It's not the weight, you know. We're not therapists, but we come...we really skirt that line. Because that's it... The combination of the confidence level, and being able to name it and see it, and then also to say I want to change this, and I'm empowered and confident enough to make the change, because I see why am doing it." (Interview # 23) "The inherent belief of a coach is that the wisdom lies within the person, and they maybe don't have full access to it at the moment. And so what I do as a coach and what we coaches ascribe to do is to create a safe place….You know, where you really let them know, 'Yes, I absolutely see that piece of it. You mentioned it. I see that you have the wisdom around that...I don't know...overeating and that it's emotional based. Good for you. How often do you notice that?' 'Well, I never notice it at the time. I

		only noticed it in retrospect.' 'Do you notice it the same day? Do you...?'….all those different techniques that we use to be able to bolster their confidence that they really have the wisdom. And then once that gets exposed and once they get on that view, that perspective, that view of themselves, and begin to realize more and more that they are very empowered, then you know, we can make a choice to be very empowered, be aware that we are going to eat this half a pie, and it's totally about being about being pissed off at our boss. But then, it's at least with a bit more consciousness. You have to become aware before there's choice." (Interview # 49) "You have the client come up with the solutions through excellent questioning….that way, they feel that it's their idea, and when you feel that it's your idea your like, 'Well, I'm much more willing to go through with it.'" (Interview # 50)
Feelings of well-being	As a result of the coach's humanizing strategies, clients feel a general sense of well-being because they feel understood	"Even spouses don't listen, I don't think, sometimes, and I'm guilty of it with my spouse as well is we don't give people our full attention, and that something that's like the framework in wellness coaching is we become completely attentive and empathetic and we're all there. We're there and we're completely...we're looking at them eye to eye, we're giving them positive verbal feedback, we're paraphrasing. We learn all these skills of how to do different paraphrasing and open-ended questions, so they're talking the whole time, and you're listening." (Interview # 44) "Excellent listening. I think that is...it sounds boring, but it is so therapeutic for the clients to just have someone really actively listen to what they're saying just to be fully there with them. That in itself can be, not just a great stabilizer, but very therapeutic in and of itself." (Interview # 50) "In the course of a session, it's very free flow. It's all led by the client. I mean, I ask questions, and I'll sometimes direct the flow. To answer your question, in the beginning, I relied on certain questions, but now, it's more like just really understanding and listening to the person and what they're saying in between what they're saying. You know, getting underneath that emotional... Reading in between the emotional lines, I guess. Because they'll say one thing, but really it means something else, or there's something that they're not saying and expressing verbally, but I call them out on that. And when they feel understood, that's when we can start working." (Interview # 29) "When I describe what I said to you earlier about, you know, 'You, client, have expertise in you, and this is what I do, and we'll merge these together.' You know, they kind of say, 'Yeah, okay. That sounds great.' What I see is that they grow and flourish in that role in that very first hour. They start out

		very tentatively and as we move through that first hour and they get a sense of what it's like to answer questions to have questions put to them that really do get at things that they want to say, it's very exciting. You know, my initial appointments with clients are almost always an hour, and at the end of that hour, people have changed. You know, they have come in not really knowing what to expect, and they leave feeling really heard." (Interview # 48)
Consequence of Client Empowerment and Well-Being		
Improved client performance	As a result of the coach's humanizing strategies, clients feel empowered and feel an increase in well-being (which increases buy-in), thus motivating them to put more effort into their performance	"Her humility and acceptance has made me feel even more committed to her ideas, and her encouragement and guidance has pushed me to overcome every obstacle I've encountered." (Testimonial # 1) "Because patient engagement now, is what people finally understand, is what can help improve outcomes and reduce overall cost. In the past, our traditional method of 30-40 years prior, 'I will tell you what to do because you've come to me to get the medical expertise you need in the way of prescriptions, treatment plans, interventions to improve your health, to optimize your recovery, and so forth and so on,' but that we know today is not the best approach." (Interview # 43) "When you take motivational interviewing, which I think is very powerful and I'm just a novice at it, when they show in science they can say that one session with an excellent wellness coach people were better able not to drink than going through inpatient. That just speaks to me when you see how powerful that can be in the hands of a really expert coach, how it can be life-changing. And of course….we're in the business of helping people and caring about people. And there's been more and more research illustrating that this can make a difference in people." (Interview # 1)
Humanizing Strategies: Pathways to Legitimacy		
Embodying authenticity & Establishing relatability & Elevating clients	Humanizing strategies *directly* create (internal) legitimacy with clients by creating an alternative basis for expertise claims, increasing trust in the coach's advice, and conveying to clients that the	"Rather than it being like an academic credibility, I build a life credibility with people." (Interview # 38) "You have to just get to know people as a person, build a relationship, let them see how you live, and that instills credibility. I have a variety of groups that I belong to that are networking groups, but they're not the traditional networking group where you stand up and give your little commercial. We get together, and we go hiking, or we get together, and we go to happy hour. And through getting to know each other, they go, 'Oh. [She] is a health coach, and she understands this because she lives it. So everything she's going to teach you, she does. She's not going to just give you a list of things to do.' So that's the most effective here where we live is just be out there, get to know people, let them see really

	coach truly does have their best interests in mind	who you are as a person, and that's when credibility comes because they can read articles all day, you know, and that doesn't necessarily mean anything to them." (Interview # 40) "I think the piece that we really instill in our students that is critically important is, one, perpetual ongoing self-awareness….they can't help anybody else go any further than they've gone themselves. So they really have to be walking their talk all the time… People will resonate with that and the people that want to work with them will find their ways to them." (Interview # 2) "If [my past struggles] are appropriate, if there's a client who is going through a similar situation, of course, I would share what my experience was. Do I tell every client the story I told you? No, but it's there on my website. If they want to read about it, they can, and I know that for a couple of my clients that story just gave me tons of credibility. It's what made them want to work with me." (Interview # 50) "But maybe the most outstanding and telling aspect of your classes is that you *look* the picture of health and vitality so whatever you are doing must be working. 'The proof is in the pudding' and 'You are what you eat'-two food analogies that sum *you* up." (Testimonial # 29) "Because she has 'walked the walk' with her weight and health, she brings an extra credibility and trust to her tool kit. Her own success at weight loss and maintenance and her development of a high level of fitness has netted her a vitality and zest that genuinely motivate others in their own journeys towards optimal health." (Testimonial # 47)
Evidence of effectiveness	Demonstrated effectiveness creates (internal) legitimacy with clients—an indirect effect of humanizing strategies	"If the client is happy, then the client will probably go out and refer other people to that coach, which means the coach will over time be what we would regard to be successful. On my website, I have a long list of testimonials, and I elicit those from my client so that other people coming in who are curious about me can say, 'Okay. Well, other people have said nice things about him.' Now, whether that translates into...the second part of your question, whether that translates into 'will the medical profession accept coaches,' because clients say nice things about them? I don't know. I doubt it." (Interview # 46) "The holistic approach [my coach] brings ensures long-lasting results. The manner in which she delivers it is fantastic. She's real. She understands (yes, I keep my morning coffee and feel no guilt). She takes your life, in all its uniqueness, into mind. It's personal and achievable, and easy to stick with. One of the best things about [my coach] is she actually cares that I succeed. [My coach's] confidence in

		my ability gave me the confidence to continue on. She doesn't let me forget all the progress I have made, and simultaneously keeps pushing me to get to the goals I set at the beginning….I cannot recommend [my coach] enough. Signing on with her was the best thing I have done for myself. I guarantee [my coach] has single-handedly added many healthy, happy years to my life." (Testimonial # 49) "I think that's where the word of mouth thing is….If you can get testimonials out there, if you can get people that have had success that share their stories with somebody else then seek the services because they've seen it work for somebody else, because they don't see these things on TV or in the media, per se. They don't see that." (Interview # 17) "I have always had great respect for [my coach's] professionalism and dedication, not only to her work and clients, but also to her own self- development which enables her to offer the latest methods for ensuring that she has great success with her clients. She is dynamic and passionate about helping others. She gets results!" (Testimonial # 47) "To me, the mark of a great coach is someone who not only gets results, but gets them in the fastest and safest way possible. [My coach] does just that." (Testimonial # 48)
Evidence of cost-efficient effectiveness (good results at low cost)	Demonstrated efficiency creates (external) legitimacy with industry stakeholders and gatekeepers—an indirect effect of humanizing strategies	"Initially, [coaches are] going to be hired for the purpose of saving somebody some money. I overheard a physician say, 'Oh, with these new regulations, my patients aren't allowed to come back in the office and if they get readmitted to the hospital with the same diagnosis, I'm going to get penalized. I'm going to hire a coach and make these people just all see the coach'. So all he's doing is turfing his problem patients to a coach…. I think initially that's how they're going to probably be brought in unless you get a really forward thinking person who's much more about holistic, complimentary, integrated medicine stuff who either brings that in or has a private one that they refer out to." (Interview # 16) "I have a conversation going with a friend of my, she's one of the youngest...she's a hospital administrator in [a U.S. city]. And she's done several studies and pilots where they put health coaches on site as follow-up for patient care. Are you taking your medication? Are you losing the weight the doctors asked you to use? Not 'Are you?' 'Are you?' 'Are you?' for yes or no questions, but they're coaching them through any issues they have that they cannot get from the physicians, because of the way it's set up. They can't call the doctors and say, 'I really don't get this. How am I supposed to take this medication again? And I don't know why I'm not taking it but I missed it last night.' Individual

		questions like that. It doesn't necessarily take someone who's educated in the educational field to guide them through the follow-up care and the reduction in readmits...the financial savings from readmits became substantial enough where President Obama took note and they started to use the program." (Interview # 19) "I think that kind of thing—looking at patient outcomes, looking at patient ratings, looking at how it affects their overall. This is going to be unbelievably hard to do, but I think until...insurance companies don't reimburse for anything that they don't know is going to save them the money, right, or has been proven in their eyes. So there's got to be some research around outcomes like people going through certain cancer treatments and having coaching at the same time and having some tangible outcomes they look at whether it's reoccurrence, quality of life. Whatever it is, they're going to have to have send up some tangible outcomes and really measure that....and doctors are the biggest snobs on the face of this earth. I mean, they want...and sometimes it takes, especially with new things, it takes an enormous amount, way more than what should be, it takes an enormous amount of evidence to sway opinion." (Interview # 51)