chapter number

Mental-Health Issues and Challenging Clients in Executive Coaching

Michael Cavanagh

Coaching is emerging as one of the major forms of personal and professional development used by executives. Organisations and individuals use coaching to develop skills, enhance performance, develop leadership and personal functioning, and to remediate unhelpful patterns of behaviour. As such, coaching and therapy share some ground and some techniques. It is often said that one of the key differences between coaching and therapy is that coaching deals with nonclinical populations, whereas therapy is designed to address the needs of people suffering from diagnosable clinical disorders such as depression and anxiety. While this is an important distinction and one that coaches need to take seriously, the task of determining the boundaries between psychopathology and the normal range of human functioning can be difficult. When is a person simply sad, and when are they depressed? When is the worry an executive feels over delivering a key presentation just the normal butterflies associated with public speaking, and when is it a symptom of a more pervasive case of social phobia? These are complex questions for coaches, particularly those untrained in psychology and the behavioural sciences. Nevertheless they are important issues, because coaches are inevitably faced with the problem of significant mental-health problems in some clients.

A considerable body of research tells us that over 20% of the general population will suffer from some diagnosable mental-health problem at some point in their life, and that 10% to 15% of the population suffer from some form of personality disorder (Svrakic et al., 2002). Who are these people? It is easy to think of them as "other" — the unfortunates who inhabit the mental-health facilities of our society, or people from other socioeconomic classes, occupations, or areas. But the truth is that they are not "other". They inhabit our workplaces, our suburbs, our social circles

and our families. For example, with respect to socioeconomic status, Timonen et al. (2001) found that psychiatric disorders were more severe among suicide victims of higher socioeconomic status. Further, in one US study 11% of lawyers in Carolina were found to have seriously considered suicide at least once a month (Dolan, 1995). In general, professionals and managers have higher rates of stress, anxiety and depression than skilled, semiskilled and unskilled individuals (Eaton, Anthony, Mandel, & Garrisson, 1990; Moss, 1991).

Although coaching is oriented to nonclinical populations, it should not be surprising that some might turn to coaching to overcome significant mental-health problems. Acknowledging to one's friends and colleagues "I am seeing a coach" may appear more desirable that admitting "I am seeing a therapist". Indeed this tendency to seek help for psychological distress in coaching appears to have been borne out by the only two studies so far conducted to investigate the efficacy of life coaching. Both screened applicants for mental-health problems using the Hopkins Brief Symptom Inventory (Derogatis & Melisaratos, 1983). In the first study 52% of the respondents reported symptoms found in only the most distressed 2% of the population (Green, Oades, & Grant, 2004, p. ??). In the second study, Spence and Grant (2004) found 26% of their respondents similarly reported symptoms of significant mental distress (p. ??).

It might be argued that coaching is a benign intervention. Its solution-focused approach preferences the client's choice of goal and action plan, thereby maximising client control and minimising any damage that could occur from a failure on the part of the coach to recognise mental-health problems. However, it is simply not the case that coaching is always a benign activity. This has been pointed out by a number of authors. For example:

> I believe that in an alarming number of situations, executive coaches who lack rigorous psychological training do more harm than good. By dint of their backgrounds, and biases, they downplay or simply ignore deep-seated psychological problems they don't understand. Even more concerning, when an executive's problems stem from undetected or ignored psychological difficulties, coaching can actually make a bad situation worse. In my view, the solution most often lies in addressing unconscious conflict when the symptoms plaguing an executive are stubborn or severe (Berglas, 2002, p. 87).

One example of where coaching may cause harm is the case of depressed clients. Coaching involves goal-setting, often using stretch goals. However, depressed clients face significant difficulties in initiating and maintaining goal-directed behaviour. The coach can unknowingly encourage them to set goals beyond their current capability — indeed, such clients may seek to set such goals unprompted, hoping this will help them overcome their lack of energy and motivation. Failure to achieve these goals can further entrench a sense of despair and hopelessness, and these clients can leave coaching significantly worse off. If their depression and hopelessness is severe enough, failure in coaching could even be life-threatening.

When a coach does not have sufficient knowledge about mental-health issues, they are unlikely to notice the subtle signs of mental disorder in their clients. It can be difficult even for coaches with mental-health training, as clients often attempt to disguise their distress. The clinically depressed client may put on a public display of enthusiasm and happiness, and the anxious person may feign indifference or downplay their worries. Nevertheless, as identified in the code of conduct of the International Coaching Federation (and similar to other professional codes of conduct), two central ethical imperatives in coaching are for coaches to know the limits of their abilities and services, and to always act in the best interest of their clients. These require coaches to ensure that they make informed judgements about the nature of the emotional and mental issues their clients are grappling with, and about their ability to help them with these.

Professional education and ongoing supervision of coaching practice can be enormously helpful in ensuring coaches adequately assess the limits of their abilities with regard to the issues their clients bring to them. I am suggesting here that a standard, basic coach training should include training to recognise the presence of mental disorder, and an understanding of the appropriate evidence-based treatment options for these problems. In saying this, I am not suggesting that coaches should be fully fledged mental-illness diagnosticians, nor am I suggesting that coaches should attempt to treat mental illness. Rather, I am suggesting that coaches should be familiar with the key features of the most common mental disorders they are likely to meet among their clients, and be well informed about the referral options available.

Categorical Approaches to Mental Illness

Awareness of categorical approaches to diagnosis of mental-health problems can be particularly helpful for coaches in the process of determining whether the client would be better served by a qualified therapist. One commonly used categorical diagnostic system is that used by the fourth edition text revision of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (DSM-IV-TR). This describes the common features and presentation of mental disorders, and gives clear diagnostic criteria associated with each. It is useful for coaches to become familiar with the features of the more common mood and anxiety disorders seen in coaching. These include depression, dysthymia, bipolar disorder, social phobia, general anxiety disorder, panic disorder and obsessive-compulsive disorder. This chapter will not outline the features of these disorders; there is a large body of literature to which the reader is referred. A multitude of treatment-outcome studies have shown that there are good quality evidence-based treatment programs available for these conditions. Coaches should familiarise themselves with the types of treatments available for these disorders along with their efficacy. In particular, cognitive-behaviour therapy (both with and without pharmacological therapies) has been shown to be beneficial for depressive and anxiety disorders.

Dimensional Assessments: Assessing Suitability for Coaching

Aside from a familiarity with the general criteria for identifying common mental disorders, it is important that coaches have a process for deciding when the difficulties faced by their client warrant specialist intervention. There are no easy, sure-fire solutions; informed judgement and experience, along with an honest appraisal of one's own skills and abilities are necessary. However, the following five questions can be helpful in eliciting the information to make this decision.

How long has the client been experiencing this distress or dysfunction? If there is a persistent pattern of distress or dysfunction over a long period of time, then consider referral to a mental-health specialist.

How extreme are the behaviours or responses of the client? If the client's behaviours and responses (emotional, cognitive or physiological) appear to fall outside the range expected of an average person, it may indicate the presence of psychopathology. For example, this may include the client who becomes depressed or needs to take stress leave following relatively minor negative performance feedback. Another example would be the client who finds they cannot speak up at meetings, or has to endure great anxiety to do so.

How pervasive are the distresses and patterns of dysfunctional behaviour? Is the problem limited to a certain situation or aspect of the person's life, or does it seem to be operating in many areas and many times? For example, is the person's anxiety only around public speaking at important occasions, or does any situation in which they might be evaluated provoke anxiety?

How defensive is the person? Does the person actively seek to avoid addressing the unhelpful behaviours? Do they deny the problems in the face of significant evidence? Do they become overly aggressive, defensive or passive when appropriately challenged by the coach? Such responses may indicate that the client's problem may be deep-seated.

How resistant to change are the dysfunctional patterns of behaviour, thinking or emotions? Do the negative or unhelpful patterns persist despite the client's apparent willingness to address them? Is homework regularly not done, or done poorly? These things may indicate that the person is having great difficulty in addressing the unhelpful patterns of behaviour.

Working with Challenging Personalities in Coaching

Using the broad principles outlined above can help coaches deal appropriately with clients who appear to be suffering from significant personal distress. But what about those clients who are not so much distressed themselves, as seeming to be a source of distress to those around them?

Such clients may be suffering from a personality disorder. These disorders differ significantly from the mood disorders in that they represent persistent and enduring dysfunctional patterns of experiencing and interacting with the world. People with personality disorders are hard to live and work with — and they themselves can often find life hard. The way they interpret events and interact with the world often causes both themselves and others significant practical and emotional problems.

As with the mood disorders, having an awareness of categorical approaches to personality disorders can help the coach to notice the presence of problematic personality issues. The diagnostic system used by DSM-IV-TR is perhaps the one most widely used for personality disorders. It is only possible here to give the reader a summary of the central features of the main personality disorders (see tables 1 and 2). For fuller descriptions the reader is referred to the large body of literature on these disorders.

Estimates of the prevalence of personality disorders suggest that between 10% and 15% of the population may meet criteria for a diagnosable personality disorder (Svrakic et al, 2002). The author is not aware of any studies that assess the prevalence of personality disorders among clients of coaching, either executive or life. Anecdotal evidence and personal experience suggest that the proportion of serious personality difficulties in executive coaching is probably greater than that in the general population, particularly if the coaches' clientele includes people sent to coaching to overcome "problematic behaviours" (see, e.g., Hogan & Hogan, 2001; Sperry, 1997).

When faced with a client who displays enduring patterns of dysfunctional behaviour, the coach needs to assess whether their skills match the client's need or whether the client should be referred to a qualified mental-health practitioner. For clients who show less severe disruption of functioning, the five key questions outlined above remain important for assessing their suitability for coaching.

Table 1
DSM-IV-TR General Criteria for Personality Disorders

A. Personality disorders are enduring patterns of inner experience and behaviour that deviate markedly from the expectations of the individual's culture and are manifested in:
   (i) cognition (i.e., ways of perceiving and interpreting self, other people and events)
   (ii) affectivity (i.e., the range, intensity, lability and appropriateness of emotional functioning)
   (iii) interpersonal functioning
   (iv) impulse control.

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

Table 2
Core Features of DSM-IV-TR Personality Disorders†

Personality disorder	Core behavioural indicator	Prevalence	Treatment amenability
	Cluster A — Odd or eccentric		
Paranoid PD	a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent	0.5 – 2.5%	low
Schizoid PD	a pattern of detachment from social relationships and a restricted range of emotional expression	< 1%	low
Schizotypal PD	a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, eccentric behaviour	3%	medium
	Cluster B — Dramatic, emotional or erratic		
Antisocial PD	a pattern of disregard for and violation of, the rights of others	male — 3% female — 1%	low
Borderline PD	a pattern of instability in interpersonal relationships, self image, and affects marked by idealisation and devaluing and marked impulsivity	2%	medium
Histrionic PD	a pattern of excessive emotionality and attention-seeking	2–3%	high
Narcissistic PD	a pattern of grandiosity, sense of entitlement or self-centredness, need for admiration and lack of empathy for others	< 1% (but high incidence traits)	medium
	Cluster C — Anxious or fearful		
Obsessive-compulsive PD	a pattern of preoccupation with orderliness, perfectionism and control	1%	high
Dependent PD	a pattern of submissive and clinging behaviour related to an excessive need to be taken care of	no reliable data	high
Avoidant PD	a pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation	male — 3% female — 1%	high
	Unclassified personality disorders		
Passive-aggressive PD	A pattern of negativistic attitudes and passive resistance to demands for adequate performance.	—	—

Note: † Descriptions adapted from DSM-IV-TR. Estimates of prevalence and treatment amenability taken from Sperry (1995).

Not all "problematic personality features" indicate frank personality disorders, nor do they immediately indicate unsuitability for coaching. By a dimensional approach to personality, the expression of personality runs along a continuum from "disordered" to a "healthy expression of personality style" (see Figure 1 and Table 3). Challenging clients are those whose style and behaviours cause them difficulties, but who are not so inflexible or severely dysfunctional as to be considered personality-disordered. Such clients can usually benefit from either therapy or psychologically sophisticated coaching, or both.

Each of the personality types in Table 3 has a healthy and dysfunctional expression. While all the personality types are represented in coaching, experience suggests the most common challenging executive clients fall along the Narcissistic–self-confident, Histrionic–dramatic, Borderline–passionate and Antisocial–daring continua. Let us use the Narcissistic–self-confident continuum as an example. At the dysfunctional or disordered end of the spectrum, narcissistic executives can be charismatic, motivating and highly successful.

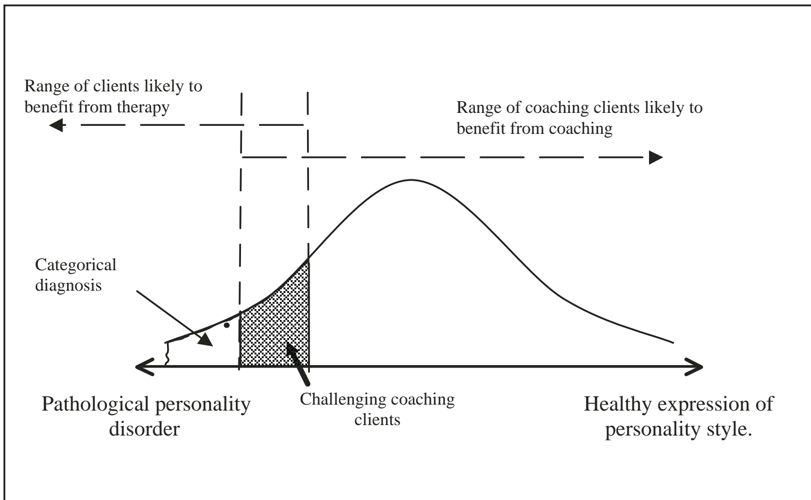

Figure 1
Coaching within the dimensional approach to personality.

They draw people to themselves with their confidence, excitement and grand visions. At the same time, however, they are often dismissive of others, arrogant, even contemptuous. They excel at promoting themselves, their projects and successes, but often fail to recognise the contributions of others. They may downplay or even misappropriate others' contributions. They are apt to rationalise failures and seek to blame others or the environment for poor performance. As team leaders they often do not foster independence and creativity; rather, they can develop dependency and acquiescence in their teams. It is not unusual for their direct reports to feel undervalued, used and

Table 3
DSM-IV-TR Personality Disorders and Corresponding Healthy Personality Styles.

DSM-IV-TR Personality disorder	Healthy personality style
Paranoid PD	Vigilant*
Schizoid PD	Self-sufficient
Schizotypal PD	Creative
Antisocial PD	Daring
Borderline PD	Passionate
Histrionic PD	Dramatic*
Narcissistic PD	Self-confident*
Obsessive-compulsive PD	Conscientious*
Dependent PD	Loyal
Avoidant PD	Socially sensitive
Passive-aggressive	Leisurely*

Note: *Descriptor of healthy personality styles taken from Sperry (1997).

resentful. Narcissistic executives typically find it very difficult to receive feedback when it suggests need for improvement. They also often find it difficult to engage in calm discussion when viewpoints different to their own are being expressed. In such situations, narcissists are apt to aggressively dismiss and devalue both the other person and their viewpoint or feedback. For this reason, they often do not get clear unambiguous feedback about their negative traits. This lack of corrective feedback feeds their overblown sense of their skill, intelligence and invulnerability.

At the healthy end of the spectrum, self-confident executives can also be charismatic, motivating and highly successful. Their vision, self-confidence, and strong sense of purpose contribute to their charisma. They are able to back their own judgement, while also being able to listen to the opinions of others, recognising and incorporating valuable suggestions. They are able to value themselves appropriately, while recognising and valuing those around them. As team leaders they are able to share the glory of success with the team, and act as advocates for their team. They recognise that success requires attention and effort be paid to the growth, satisfaction and development of the team members. They are able to promote themselves and their goals effectively and actively seek to do so. At the same time they are able to reflect on their performance and take appropriate responsibility. They expect others to respect them, and are able to be appropriately assertive when others fail to do so.

These descriptions are caricatures — neither exists in the real world. Individuals both express more than one personality dimension simultaneously, and occupy different places on those dimensions over time. Some days and in some situations we tend more toward the healthy end of the spectrum, and sometimes more toward the dysfunctional. Nevertheless, over time we do show preferred styles and repetitive patterns of interaction. These are our "comfort zones" and our habitual responses.

Considering executive's personalities solely from a categorical perspective can lead to a very problem-focused and pessimistic frame of reference concerning the possibility of change. While it is generally true that personality features tend to be enduring, most people are able to regulate their behaviour and responses so that they usually operate in healthy, flexible and productive ways. Generally, we are capable of moving outside our comfort zones and modifying our habits when the situation demands.

A more useful and realistic approach is to understand the underlying factors or dimensions that make up personality, and how these may be harnessed to create more useful responses to the difficult situations our clients face. Such understanding is particularly important when working with clients who, while not personality-disordered, show problematic patterns of behaviour and responses to stressful situations. These executives can be challenging to coach; the coach requires a relatively sophisticated understanding of these clients' needs, values and propensities.

Making Sense of Personality in Coaching: Cloninger's Psychobiological Model

Many factorial or dimensional models of personality have been proposed. For example, Eysenck's three-factor theory and Costa and McCrae's five-factor theory have been important in the study of personality for several decades (Eysenck, 1967; Costa & McCrae, 1990). Systems such as the Cattell's 16 Personality Factors (Cattell, Eber, & Tatsuoka, 1970) and the Myers–Briggs Personality Type Indicators (Myers, 1962) have enjoyed popularity in organisational and community settings. Cloninger's (1993) seven-factor model is a relatively new model of personality with promising application to coaching.

In this model, personality is made up of four temperament factors and three character factors (see Figure 2). The temperament factors are the heritable or biologically determined features of personality. They represent the person's biases or predispositions in the way they are likely to interpret and respond to novelty, danger or punishment, and reward.

Character factors, on the other hand, are the result of learning. Three important aspects of this learning involve the extent to which a person identifies the self as (1) an autonomous, responsible, worthwhile individual (self-directedness), (2) an interdependent part of a human society made up of other valuable individuals (cooperativeness), or (3) part of a wider unified and valuable universe (self-transcendence).

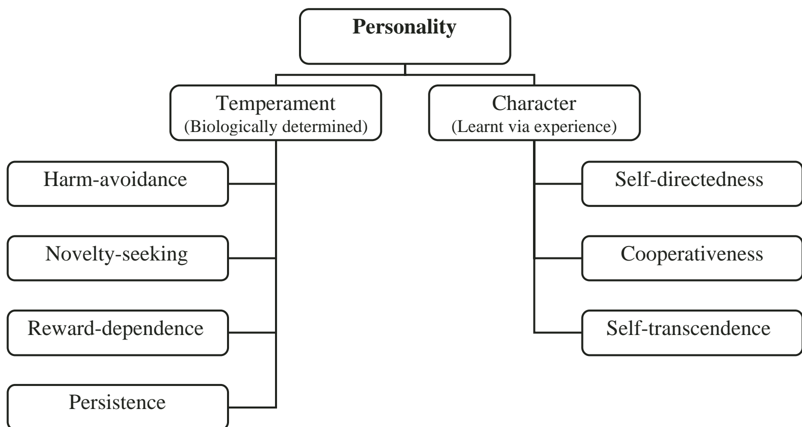

Figure 2
Cloninger's (1993) Psychobiological Model of Personality

According to Cloninger, the character factors

> relate to acceptance of the individual self, acceptance of other people, and acceptance of nature in general. Individuals with mature personalities (i.e., effective adaptation and self-satisfaction) are self-reliant, cooperative, and possibly self-transcendent. In contrast, those with personality disorders have difficulty with self-acceptance, are intolerant and revengeful toward others, and may feel self-conscious and unfulfilled. This suggested the hypothesis that subtypes of personality disorder can be defined in terms of temperament variables, whereas the presence or absence of personality disorder may be defined in terms of the character dimensions of self-directedness, cooperativeness, and self-transcendence (Cloninger et al., 1993, pp. 980).

In other words, temperament determines the types of experiences and events that will most attract or repel the person, and the general type of responses they are predisposed to make (see Table 4). Character determines how functionally these preferences and needs are expressed (see also Table 4). Temperament indicates personality type while character determines its health, that is, where one falls along the disordered–healthy personality-style continuum.

Svrakic et al. (1993) found empirical evidence for Cloninger's assertion that temperament factors are associated with personality styles. In a study of 136 psychiatric patients using scores on the Temperament Character Inventory (TCI) they found that character factors, (particularly self-directedness) predicted the presence of personality disorder, while the pattern of temperament factors predicted the type of personality disorder present. A range of studies using both clinical and nonclinical samples have supported Cloninger's model (e.g., Brandstrom, Richter, & Nylander, 2003; Mulder, 1996; Parker et al., 2003; Peirson et al., 2000; and Casey & Joyce, 1999).

A later study (Svrakic et al., 2002) further identified the pattern of temperament factors associated with the different personality disorders (see Table 5).

One of the key features of dealing with problem personalities is that many of the levers normally used to encourage behaviour change are ineffective, or even counterproductive. For example, the narcissistic executive is apt to interpret silence from their team following a suggestion for action as a lack of competence or motivation rather than disagreement. The boss who encourages a passive-aggressive employee to collaboratively develop solutions to problems is likely to find the employee engaging in even greater withdrawal and negativity.

Having an understanding of Cloninger's temperament and character factors can help the coach identify which needs and values are likely to motivate their client, and which are likely to be ineffective. For example, Cloninger's model indicates that personalities that fall along the antisocial–daring dimension are high in novelty-seeking traits and low in harm-avoidance and reward-dependence traits. Such people are likely to find extravagance, novelty and excitement motivating, but will be relatively unmoved by the suffering of others, sanctions for breaching rules, or the

Table 4

Descriptors of Individuals with High and Low Scores on TCI Temperament and Character Subscales†

Temperament factors	High	Low
Harm-avoidance:		
fear of negative outcomes	Pessimistic Fearful Shy Fatigable	Optimistic Daring Outgoing Energetic
Novelty-seeking:		
a need for stimulation and excitement	Curious Quick-tempered Impulsive Extravagant Disorderly Easily Bored	Reserved Deliberate Thrifty Stoical Ordered Boring
Reward-dependence:		
a need for interpersonal acknowledgement	Gregarious Perhaps needy Sentimental Open/Warm Appreciative	Detached Reserved Cold Independent Loner
Persistence:		
a need for achievement and completion	Industrious Determined Enthusiastic Perfectionistic Stable	Inert Spoiled Underachiever Pragmatic Easily frustrated
Character factors		
Self-directedness:		
the ability to accept oneself and to control, regulate and adapt behaviour in accordance with chosen goals and values	Responsible Purposeful Resourceful Self-accepting Disciplined	Blaming Aimless Inept Vain Undisciplined
Cooperativeness:		
the ability to identify, accept and work with other people	Tender-hearted Empathic Helpful Compassionate Principled	Intolerant Insensitive Hostile Revengeful Opportunistic
Self-transcendence:		
acceptance and identification with the wider world. Includes the ability to accept ambiguity.	Unselfconscious Intuitive Acquiescent Spiritual	Self-absorbed Contrived Controlling Materialistic

Note: † Adapted from Svrakic et al (2002)

possibility that one might not be successful. Indeed, appeals that emphasise risk and bending the rules may be challenging to the daring executive and trigger impulsive action, rather than give reason for pause. At the same time, connecting adaptive behaviours with personal gain and achieving material goals can be used to motivate behaviours that are more cautious and respectful of others. Table 6 outlines the key needs and behavioural

Table 5
Pattern of Temperament Traits Expected of Different Personality Subtypes[†]

Disorder	Harm-avoidance	Novelty-seeking	Reward-dependence
Passive-aggressive	High	High	High
Borderline	High	High	Low
Histrionic	Low	High	High
Antisocial	Low	High	Low
Avoidant	High	Low	Low
Dependent	High	Low	High
Narcissistic	Low	Low	High
Schizoid	Low	Low	Low
Obsessive-compulsive*	High	Low	Low

Note: [†] Adapted from Svrakic et al. (2002)
* When associated with high persistence

vulnerabilities, and a few examples of motivating and nonmotivating values for each of the personality dimensions.

"Betty" is an example of an executive who is "challenging". A senior trader in a stockbroking firm, she presented at coaching as an extroverted, charming, witty and intelligent woman in her early 40s. She had been sent to coaching after being passed over for a more senior management position. Her performance at sales was outstanding and the reason given for coaching was that her people-management skills needed to be improved — specifically, she needed to improve her ability to develop her direct reports. She was very disappointed at being passed over for the promotion, and expressed some anger about it. She believed she was well-suited to the position and deserving of it, and was able to give numerous examples of her successes. She also expressed a suspicion that she was not given the job because the CEO might feel threatened by her. The impression was quickly gained that Betty liked to be in charge, and was not entirely comfortable with self-reflection.

Her 360° feedback suggested that her direct reports felt somewhat undervalued. During the initial session she referred to her team as "my team" and "they", but did not refer to specific members by name. She tended to avoid discussing performance gaps in detail but did acknowledge a need to "pay more attention to developing the team". When challenged by specific questions about the development strategies she employed with her team, she was able to point to a range of actions including encouraging members to go to conferences and set goals for their own development. When asked questions which highlighted gaps (such as, "Have you discussed each person's plan with them?"), she became somewhat prickly, and rationalised these failures rather than focusing on learning. She did, however, express a real willingness to engage with coaching in order to change.

Engaging Betty in the task of developing her direct reports was unlikely to be achieved by making direct appeals to her empathy for them or to her

Table 6
Key Reinforcers, Motivators and Derailers for Executives with DSM-IV-TR Personality Disorders

DSM-IV-TR Personality disorder	Key need or reinforcer (key temperament pattern)	Examples of appeals likely to motivate behaviour change	Examples of appeals unlikely to motivate behaviour change	Derailers[a] (key character flaw)
Narcissistic–self-confident	Need for personal admiration	Enhancement of public profile, opportunities for praise, potential to distinguish oneself.	Empathy for others; appeals to acknowledge deficiencies/failure; promotion of others' rights.	Arrogance
Histrionic–dramatic	Need for social recognition or prestige	Empathic appeals; opportunities for public performance.	Appeals to order, predictability and uniformity.	Melodrama
Borderline–passionate	Need for a secure relationship	Ideals such as loyalty, commitment, spontaneity. Appeals to idealised self.	Appeals to self-promotion, compromise, or self-sacrifice where disliked parties are perceived to benefit.	Volatility
Avoidant–socially sensitive	Need to avoid negative evaluation	Appeals which address acceptance and security needs.	Opportunities for public performance; appeals emphasise challenge, winning, excitement and risk.	Excessive caution
Paranoid–vigilant	Need to be assured	Appeals to measured vigilance.	Appeals that emphasise trust, openness and nonvigilance.	Habitual distrust
Schizoid–self-sufficient	Need for self-sufficiency and independence	Opportunity to work on solitary projects; development of self-sufficiency skills.	Social disapproval, empathy for others, opportunity to interact with others.	Aloofness
Antisocial–daring	Need for power, need to be "the winner"	Appeals that emphasise personal gain, challenge, winning, excitement and risk.	Appeals to empathy, social conformity, compromise and self sacrifice.	Mischievousness
Schizotypal–creative	Need for novelty	Appeals that emphasise spontaneity, newness and creativity.	Appeals to order, predictability and uniformity.	Eccentricity
Obsessive-compulsive–conscientious	Need for control	Appeals that emphasise efficiency, conformity, order, predictability and uniformity.	Appeals that emphasise need for flexibility, novelty or difference; social disapproval.	Perfectionism
Dependent–loyal	Need for affection and approval	Appeals that emphasise belonging, social cohesion and security, and social disapproval.	Appeals that emphasise challenge, winning, excitement and risk.	Eagerness to please
Passive-aggressive–leisurely	Need to resist control by others	Appeals that emphasise winning interpersonally, reduction in oversight, increased leisure or potential for negative consequences.	Appeals that emphasise compromise, self-reflection, opportunity for self-directed behaviour, accountability.	Silence/passive resistance

Note: [a]Derailers taken from Dotlich and Cairo (2003).

sense of the moral rightness of this task. Similarly, challenging Betty with her failure to effectively develop her team, exhorting her to become more aligned with company policy, or even presenting this as a opportunity to increase her skills in, and knowledge of, staff development were unlikely to be effective ways of engaging Betty with these managerial responsibilities.

Rather, engagement for Betty came about when the coach acknowledged the real attempts she had made to develop her people, affirmed her stated commitment to this task, and asked her what she would need to change in order for this commitment to be perceived clearly by all the important stakeholders. This included identifying what she would need to change in order for her direct reports to experience a greater sense of her commitment to their development. By externalising the problem in this way, and addressing her need for social recognition and an enhanced public profile, Betty was able to disengage from the defence of her correctness and engage with the task of developing her team (including developing the empathy to understand their needs). In this context, Betty was eventually able to identify patterns of behaviour which undermined both team cohesion and her own reputation and credibility as a manager.

For those whose personality persuasion differs from Betty's, (e.g., "passionate" or "conscientious" executives), such obvious appeals to self-interest would be likely to be ineffective. Indeed, they would probably appear shallow and somewhat offensive. Berglas (2002) has called such utilitarian appeals "Machiavellian" (p. 88). However, according to Cloninger's theory, individuals come to a more self-directed, cooperative, self-transcendent character via the insights gained from life experience. In bringing about positive change, albeit for less than perfectly altruistic reasons, it is possible that clients will come to experience themselves, others and the world in a new way, and thereby come to value these adaptive behaviours in themselves.

Conclusion

There is clearly much research needed to understand the prevalence of psychopathology in the clients of executive coaching and its impact on the process of coaching them. Nevertheless, there is no doubt that coaches will be faced with clients suffering from significant mental-health problems, both mood and anxiety disorders, and personality disorders. Coaches are not mental-health clinicians; however, professional practice does require informed attitudes about mental-health issues and therapies. Having sufficient knowledge to be able to identify clients for whom therapy is the appropriate option, and the skill to refer them to an appropriate qualified therapist should be core coaching competencies.

For those clients who do not need therapy, but whose pattern of behaviour and personality make them challenging to coach, a psychologically sophisticated understanding of personality, and the common ways it is

expressed in organisational and work settings, can be enormously useful. A basic goal of developmental coaching for challenging executives is to help them shift their behaviours by increments toward the healthy end of the spectrum for their personality type. By understanding our clients' needs, motivational preferences and values we can help them develop more useful and adaptive patterns of external behaviour and, hopefully, more integrated, satisfying and mature inner experience.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. text revision) Washington, DC: Author.

Berglas, S. (2002). The very real dangers of executive coaching. *Harvard Business Review, 80*, 86–93.

Brandstrom, S., Richter, J., & Nylander, P. (2003). Further development of the Temperament and Character Inventory. *Psychological Reports, 93,* 995–1002.

Casey, J.E., & Joyce, P.R. (1999). Personality disorder and the Temperament and Character Inventory in the elderly. *Acta Psychiatrica Scandinavica. 100*, 302–308.

Cattell, R.B., Eber, H.W., & Tatsuoka, M.M. (1970). *Handbook for the Sixteen Personality Factor Questionnaire (16PF).* Champaign, IL: Institute for Personality and Ability Testing.

Cloninger, C.R., Svrakic, D., & Przybeck, T. (1993). A psychobiological model of temperament and character. *Archives of General Psychiatry. 50,* 975–990.

Costa, P.T., Jr., & McCrae, R.R. (1990). Personality disorders and the five-factor model of personality. *Journal of Personality Disorders, 4,* 362–371.

Derogatis, L.R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine, 13*, 596–605.

Dolan, M. (1995, June 28). Disenchantment growing pervasive among barristers. *Houston Chronicle.*

Dotlich D., & Cairo, P. (2003). *Why CEO's fail.* San Francisco: Jossey-Bass.

Eaton W., Anthony J., Mandel W., & Garrison R. (1990). Occupations and the prevalence of major depressive disorder. *Journal of Occupational Medicine*, *32,* 1079–1087.

Eysenck, H.J. (1967). *The biological basis of personality*. Springfield, IL: Charles C. Thomas.

Green, S., Oades, L. & Grant, A.M. (2004). An evaluation of a life coaching group program: A waitlist control study. In A.M. Grant, M.J. Cavanagh & T. Kemp. Evidence-based coaching (Volume 1): Contributions from the behavioural sciences (pp. ??). Bowen Hills, Australia: Australian Academic Press.

Hogan, R., & Hogan, J., (2001). Assessing leadership: A view from the dark side. *International Journal of Selection & Assessment, 9,* 40–51.

Moss, D.C. (1991). Lawyer personality. *ABA Journal*, *77*(2), 34.

Mulder, R. (1996). Towards an understanding of defence style in terms of temperament and character. *Acta Psychiatrica* Scandinavica, *93*, 99–104.

Myers, I.B. (1962). *Manual: The Myers–Briggs type indicator*. Princeton, NJ: Educational Testing Service.

Parker, G., Hadzi-Pavlovic, D., Parker, K., Malhi, G., Mitchell, P., Wilhelm, K., et al. (2003). An Australian validation study of the temperament and character inventory. *Acta Psychiatrica Scandinavica*, *108,* 359–366.

Peirson, A.R., Heuchert, J.W., Thomala, L., Berk, M., Plein, H., Cloninger, C.R. (2000). Relationship between serotonin and the Temperament and Character Inventory. *Psychiatry Research*, *89*, 29–37.

Spence, G.B., & Grant, A.M. (2004). Individual and group life coaching: Findings from a randomised, controlled trial. In A.M. Grant, M.J. Cavanagh, & T. Kemp (Eds.) Evidence-based coaching (Volume 1): Contributions from the behavioural sciences (pp. ??). Bowen Hills, Australia: Australian Academic Press.

Sperry, L. (1995). *Handbook of the diagnosis and treatment of DSM-IV personality disorders*. Bristol, UK: Runner Mazel.

Sperry, L. (1997). Leadership dynamics: Character and character structure in executives. *Consulting Psychology Journal: Practice and Research*, *49*, 268–280.

Svrakic D., Draganic S., Hill K., Bayon C., Przybeck T., & Cloninger C. (2002). Temperament, character and personality disorders: etiologic, diagnostic and treatment issues. *Acta Psychiatrica Scandinavica*, *106,* 189–195.

Svrakic, D., Whitehead, C., Pryzbeck, T.R., & Cloninger, C.R., (1993). Differential diagnosis of personality disorders by the seven-factor model of temperament and character. *Archives of General Psychiatry*, *50*, 991–999.

Timonen, M., Viilo, K., Hakko, H., Vaeisaenen, E., Raesaenen, P., & Saerkioja, T. (2001). Psychiatric disorders are more severe among suicide victims of higher occupational level. *British Medical Journal*, *323,* (232).