International Journal of Innovation and Research in Educational Sciences
Volume 2, Issue 6, ISSN (Online): 2349–5219

Life Coaching: A Method for Enhancing Patients' Emancipation

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***Abstract* – This paper presents a case study conducted as part of a PhD Thesis on testing Life Coaching as a learning method for fostering emancipation in vulnerable groups (adult patients), using a participatory-action-research approach.**

The lessons learnt provides empirical insights on the implications for the implementation of non-medical methods that could allow a shift from a situation of passivity (patient care) to a new one of participation to the definition of new objectives or projects of life (active citizenship).

This paper was conceived to fulfil an identified need to study and test innovative and non-medical methods for fostering adult patients' self-determination.

***Keywords* – Active Citizenship, Emancipation, Life Coaching, Self-Determination, Vulnerable Groups.**

I. INTRODUCTION

In this paper I will explore an empirical case study concerning the experimentation of Life Coaching applied in a medical context at the UOSi Multiple Sclerosis Unit of IRRCS Neurological Sciences Institute of Bologna[1] as a non-medical approach aimed at supporting processes of change and enabling patients' learning and emancipation.

This case study - realized with the voluntary participation of four patients and personally conducted by certificated Coach[2] - allowed the testing of Life Coaching, a method of intervention where the role of the person involved is central to the definition of her/his approach to life.

It highlights the role of the coaching in a different field, not only for corporate business or sports organizations, as well as the importance of sound coaching research able to be applied also in other contexts (e.g. medical) with different targets (e.g. vulnerable groups).

When I refer to the "vulnerable groups" I assume the definition provided by the Social protection and Social Inclusion Glossary of the European DG Employment, Social Affairs and Inclusion[3]. This definition – also adopted also by the European Quality Assurance reference framework for Vocational Education and Training (EQAVET) - considers as vulnerable "groups that experience a higher risk of poverty and social exclusion than the general population. Ethnic minorities, migrants, disabled people, the homeless, those struggling with substance abuse, isolated elderly people and children all often face difficulties that can lead to further social exclusion, such as low levels of education and unemployment or underemployment" (EQAVET, unpaged)[4].

The method tested turned out to be more maieutic than rehabilitative, more educative than medical. It demonstrated effective support in the processes of changing, learning and emancipation. This experiment covered a period of six months (from September 2013 to February 2014), starting with the identification of participants until the final evaluation of the experience.

Participants in the experiment represented a specific population, and not a sample representative of any conditions - or part - of vulnerable groups [11]. For this reason, the realized and observed study considers mainly the processes that people have directly lived and judged. This is especially in relation to the questions about "how and "how much" emancipatory approaches can make the processes of learning easier for vulnerable groups and improve their quality of life despite their health conditions.

The intention was to explore how persons in vulnerable situation can face everyday issues, through a non-medical method that focuses on each person's commitment, learning and level of activity in their role (capability), with a central focus on their needs, desires and objectives.

The analysis conducted was organized on three different levels:

1. The first level of analysis involved the development of a theoretical understanding of emancipatory approaches through a deep literature analysis.
2. The subsequent second level of analysis focused on formulating assumptions within an inclusive research approach, including:

- A focus on the shift from a system based on the medical model of interventions with vulnerable groups, towards a model based on the Civil and Human Rights approach to disability [15].
- The rejection of deterministic beliefs about disability and associated ideas that exclude the possibility of patients achieving their goals, and therefore shifting from a situation of passivity, sickness and patient care to a new scenario based on the person's commitment to learning and the elaboration of his/her own project of living.

3. The third level was characterized by interviews, focus groups, formal and informal meetings, coaching sessions and observations.

These levels of analysis were used to support a deductive approach to the preliminary analysis of the data [6]. Subsequently a further iterative process was used to reflect on practice through the lens of developing theoretical ideas. This combined a more inductive approach, involving further ideas and concerns relating to

[1] Available at: http://www.ausl.bologna.it/isnb/chi-siamo/lorganizzazione/le-unita-operative/riabilitazione-sclerosi-multipla
[2] ACC Certification provided by the International Coaching Federation (ICF). Available at: http://www.coachfederation.org/
[3] Retrieved from: http://ec.europa.eu/employment_social/spsi/vulnerable_groups_en.htm
[4] Retrieved from: http://www.eqavet.eu/qc/gns/glossary/v/vulnerable-group.aspx

the concepts of emancipation, as they emerged from interviews, observations, meetings, etc. which in turn helped to shape the themes of my analysis.

Therefore, the objective of the study conducted consisted of providing a complementary service and assessing its efficacy. It was not a substitute or alternative to those methods already provided by the UOSi Multiple Sclerosis Rehabilitation Institute of Neurological Sciences, but based on a different approach.

A more inclusive and less medical approach, which differs from the care relationship because it is based on the desire to improve and change, not on the need of assistance and medical care.

The reason that led to the choice of this method concerns the willingness to test an innovative tool. Able to support a shift from a medical model of intervention to one based more on concepts such as active citizenship; self-determination [20]; learning [9]; emancipation [13]; as advocated by many international documents and policies. These aspects, along with the concept of inclusion, have as primary purposes the education of all persons in social life regardless of any impairments, deficits or functional limitations, including all dimensions of life in which the person can live and fulfil his potential [8].

This case study was included in a wider project of doctoral research entitled "Social inclusion of vulnerable groups through participatory and emancipatory approaches. Implementing active citizenship and socially innovative actions in the framework of civil & human rights model of disability" [14].

II. FRAMEWORK OF REFERENCE

The concept of inclusion, as formalized with the Salamanca Statement [16], marks the beginning of a cultural renewal and the adoption of an approach based on a more social model of disability [12] - in opposition to the medical model - and in this work further expanded by adopting a Civil and Human Rights perspective in the intervention with vulnerable groups.

This model promotes the active involvement of patients, focusing on: the reduction of social and cultural barriers; the improvement of residual functions, learning capability and resilience [4].

This perspective also embraces the principles and theoretical constructs of the International Classification of Functioning Disability and Health [22] regarding: the person, holistic approaches, relational perspectives, the quality of processes and the systems of participation in social life.

Within this frame of reference, Life Coaching is proposed as a means of non-medical intervention.

This method is based on the assumption that the demand for a coaching path is not due to the need for care as traditionally conceived, but to the desire to improve one's quality of life or change it for the better through active learning, in accordance with the UN Convention on the Rights of Person with Disabilities - Article 24, point c) - in which recommended measures, practices and methods are able to provide a "reasonable accommodation to the needs of each individual" (UNCRDP, 2006). Where reasonable accommodation is defined as the ability to deal with problematic situations using appropriate resources [5], people can often discover that accommodation through learning and reciprocity, especially in situations of vulnerability.

This learning and reciprocity, that characterizes the coaching relationship, is strictly related to the concept of reasonable accommodation. The aim of this kind of coaching (to support individuals to discover their resources for achieving their objectives) it is also related to self-determination, learning and emancipation. These are the same principles that are contained in the UN Convention on the Rights of Person with Disabilities and other international documents [17]-[18].

Participants

The participants chosen for the experiment were patients already being assisted by the UOSi Multiple Sclerosis Rehabilitation Institute of Neurological Sciences.

The criteria for inclusion/exclusion, defined in collaboration with the team from the Institute, were:

- Voluntary participation;
- Cognitive functioning was not compromised;
- Ability to problem-solve was not compromised;
- Time elapsed from the diagnosis of the disease was1 to 12 months;
- Gender equality (considering that the population affected by the disease presents a greater case study of women);
- Age (25-55 years).

Motivation was another aspect added to this list of criteria, related to the fact that the participants, who were volunteers, had to be motivated by a desire to improve their life situation, and to reach new goals through actions aimed at change; change not necessarily related to situations caused by the disease, but to any sphere of life.

The participants attended a preliminary interview with the psychologist of the Institute, aimed at introducing the experiment and assessing the level of motivation and interest to take part as volunteers.

The individuals identified were:

- V.: 25 years old, female. Type of Multiple Sclerosis: relapsing-remitting.
  Years since diagnosis: 7.
- B.: 50 years old, female. Type of Multiple Sclerosis: relapsing-remitting.
  Years since diagnosis: 13.
- P.: 43 years old, male. Type of Multiple Sclerosis: relapsing-remitting.
  Years since diagnosis: 20.

Institutions involved

The institutions involved in the experiment of Life Coaching as an emancipatory approach in interventions with vulnerable groups (in particular adult patients affected by a degenerative illness, often leading to disability) in a medical context were:

- UOSi Multiple Sclerosis Rehabilitation Institute of Neurological Sciences of Bologna. The Institute provides day hospital and outpatient services through a

multidisciplinary approach to patients with multiple sclerosis, providing diagnosis, identifying therapeutic paths and taking charge of patients. The Institute provided a team of professionals to identify the participants, plan and monitor the experiment. The team included: one psychologist, one neurologist and one coordinator for supporting and monitoring the experiment.

- Department of Education Studies "G.M. Bertin" of the University of Bologna, which provided the pedagogical references to define the experiment, conducted observation and analysed the experience through interviews with the participants involved.

III. METHODOLOGY

Setting of the experimentation

The experiment was set in a medical context, structured in integrated health units within the Hospital Bellaria[5], which is located at the UOSi Multiple Sclerosis Rehabilitation Institute of Neurological Sciences.

The introduction of Life Coaching within a medical situation was an innovative element to the setting in itself.

Moreover, thanks to the open minded and holistic approach adopted by the Institute through multidisciplinary interventions, it was possible to put into practice what is argued in many international documents (such as the UNCRDP, European Disability Strategy, Europe 2020, EU Disability Action Plan), around themes such as: inclusive approaches, de-institutionalization and the active-role in learning processes.

From this point of view, the context and setting were key elements for the positive adoption of the new method of intervention.

These elements were not strictly focused on issues and problems related to the disease (clinical situation), but rather on a desire and willingness to change and improve the situation of the persons involved (active situation).

By remaining within a broader process of assistance and care the aim was to better qualify competences and strengthen synergies between the different participants and professionals involved.

Experimentation process

The experiment was carried out over 6 months, from September 2013 to February 2014. The preliminary phase included four meetings with staff from the Institute, whilst during the implementation phase 5 coaching group sessions were conducted with the participants (one session every 15 days, lasting 1½ - 2 hours). The psychologist of the Institute also attended these sessions and monitored the progress of meetings.

The experiment was designed to:

- Verify the complementarity of Life Coaching in relation to other services already present at the Institute, in accordance with a holistic approach.
- Explore the assumptions related to the effectiveness of intervention.
- Offer a non-medical approach, which puts the person at the centre of the change process, starting from her/his desires, aspirations and objectives.

The first coaching group session was aimed at presenting the initiative and introducing the Life Coaching method.

The other sessions focused on participants' situations; supported the definition of their objectives and their assumption of commitment; evaluated opportunities and identified challenges; detailed action plans and set out the specific results to be achieved (participants were also provided support by phone and via Skype).

For the duration of the experiment coordination meetings with the psychologist of the Institute were arranged in order to ensure continuous monitoring of progress, backed up through initial and final interviews and the completion of a questionnaire to assess the impact of the initiative on the quality of their lives.

During the different phases beliefs which may limit or open new scenarios were investigated; possibilities were evaluated and the levels of commitment were measured in achieving the defined goals.

The coaching model used is defined as "ontological-transformational". The ontological aspect considers language as a key to understanding human phenomena and is characterized by a "generative character that allows to create and shape the future" [7].

It is starting from language's acts or "performative verbs" [1]-[2] that coaching supports a person to plan actions that can be turned into reality. The transformational aspect of the intervention intends to move the patient from a "position of control to one of commitment" [10]. The theoretical assumptions refer to the constructivist theory, the systemic approach [19]-[3], linguistics and sociology. The constructs and principles drawn from these theories are therefore the basis of the definition of this method, which supports persons in dealing with a problem, a relationship, a project or adopting a different perspective. This allows the choice of solutions and decision making - emancipatory aspect - that are the best possible for the person, and for the whole ecosystem that surrounds her/him, so that all its members can enjoy the benefit [21].

IV. LESSON LEARNED

The lessons learned from this case study concern two main aspects. The first is related to the effect of the application of a non-medical method within a medical context, from the point of view of patients - especially the possibility of increasing their learning and emancipation - and from the point of view of the institution.

The second aspect concerns the effectiveness of Life Coaching when used with vulnerable groups.

Concerning the first aspect, it was very interesting to observe how people in a medical context often - if not always - assume a passive role in which they expect to be informed about "what and how to do everything". If from the point of view of diagnosis and treatment that makes sense, it doesn't when it comes to choosing how to deal with everyday life, even in the presence of functional

[5] Available at: http://www.ausl.bologna.it/applications/iap_app02/iap?id=15745&action=site

limitations, diseases or disabilities. In this sense, this experiment showed how patients became disoriented and taken aback when asked "what do you want to do with your life, now?" or "what do you wish for, what are your objectives or aspirations, with or without the disease?".

Through these and other questions - specific to the method used and focused on the patient's whole life, not only on the part affected by the disease – what emerged was how difficult is to open up to new projects or perspectives of life. It was shown how unusual it is for patients to come back to desiring, learning or to planning new objectives; this is especially the case for patients in medical contexts. However, at the same time it results as extremely useful for people to re-learn to use their potential, resilience and capability where they are supported to do so. This can include new strategies of action aimed at reaching new goals, regardless of deficiency or functional limitations.

The participants' point of view was investigated during the coaching sessions and through interviews. The feedback provided was very positive, especially if compared to the aims of the testing, including: to test the usefulness of a method more social and less medical, different from the care relationship because it is based on the desire to improve and change, not on the need of assistance; to provide evidence base of its emancipatory and maieutic features; to prove the assumption according to which coaching can be a method able to foster a shift from a situation of passivity towards new scenarios of active participation in the elaboration of one own project of life.

Some feedback of the persons involved (named coachee) are reported as follows:

V. stated "... the experience as very positive, I was able to put into practice and implement my action plan and I made some changes in my life ..."

To the question about "what are you going to take home (what have you learnt during coach sessions)?", the answers were:

B. stated "...the desire to try to change something that does not work in my professional life..."
V. stated "...new insights and new points of view..."
P. stated "...I have confronted my shyness, and now I am more self-confident..."

In terms of the goals of the method, the feedback shows how these were achieved, inasmuch as they supported the participants in dealing with their objectives and the definition of the action plans to reach them, providing different perspectives and allowing for new insights.

This aspect is closely linked to the emancipation of the individual from a passive role (as "receptor" of medical indications only), towards a more active and aware role, in order to improve her/his life or change it for the better. This is an interesting point of reflection that connects with the effect produced by the introduction of this method in a medical context.

The first effect has been in contributing to support a holistic and multidisciplinary approach in the interventions of institutes. That along with an attitude of openness has shown how the complementarity of medical and non-medical interventions represented a positive element for both patients and operators.

From this point of view, one of the outcomes of the experiment was a reflection on the opportunity to transfer some of the techniques and tools of Life Coaching to professionals and operators (such as neurologists, physical therapists, caregivers, educators).

V. CONCLUSION

The objective of this study was to analyze and test the Life Coaching as method of intervention with vulnerable groups (e.g. adult patients, in this case person with disability) in medical context.

The intent in transferring techniques and tools of this method is not to create a new job profile (i.e. a sort of Disability Coach), but to encourage the acquisition of new skills and competences aimed at providing the possibility of working with patients not only as people to be assisted, but also as pro-active agents for the improvement of their lives. This is an aspect that is often not addressed by therapeutic treatment, but it can help to define objectives and strategies to achieve improvement, based on motivation, self-determination and empowerment.

This point can be linked with the second important aspect that emerged from the experiment, which are the presuppositions of effectiveness of the method.

The presuppositions of effectiveness identified were:

a) For the person (named coachee by the method):
- Motivation for self-development.
- Commitment to the program (definition of objectives, action plan, monitoring of expected results, etc.).
- Accountability towards her/his improvement and self-determination.
- Intellectual honesty.
- Disposition to listen and to change/improve.

b) For the Coach:
- Confidentiality about the contents emerging during conversations with the coachee.
- Flexibility and willingness to support the coachee in the achievement of objectives and the meeting of their needs.
- Deep trust in the potential of the coachee.

These presuppositions of effectiveness form the basis of the results, which include:
- developing greater self-determination;
- fostering the capabilities to renew desire, to plan new life objectives;
- facing change - in personal or professional life - with greater self-confidence;
- improving interpersonal relationships;
- enhancing accountability (considered as the ability to respond);
- increasing emancipation for improving the quality of life.

After presenting the presuppositions of effectiveness, I want to show the possible limits of the method. Considering that coaching is a method that uses language to support people to undertake actions that transform reality, it requires good language skills and abilities.

Additionally, as it is based on the transformation of the system according to which a person lives, from a position of control to one of commitment, the patient's cognitive functions should not be compromised.

These aspects limit the possibility of using the method with every type of disability, restricting its use to some cases such as physical and sensory disabilities due to trauma or neurodegenerative diseases.

Considering which disabilities the method can be effective for - and in what contexts - I think it could be very useful and interesting to try to apply the method in rehabilitative contexts (such as AIDS support centres or institutes specializing in provision of prosthesis). This is because when people enter those contexts they often have to re-define their life, goals and challenges, starting from situations of trauma, impairment or functionality limitations.

Moreover, I think it could even be very interesting to try to use the method with people affected by mild-delay at the cognitive level, especially in order to research issues related to the involvement of families and a new approach for the participants in interventions.

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