COACHING TO EQUIP AND EMPOWER CARERS TO MAINTAIN THEIR EMOTIONAL HEALTH AND WELLBEING FINAL REPORT AUGUST 2016

PROJECT FUNDED BY NHS GRAMPIAN CARERS INFORMATION STRATEGY
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EXECUTIVE SUMMARY

Introduction

This report is the result of a project funded by the NHS Grampian Carers Information Strategy (NHSG CIS) budget. In summary, the aim of the project was to

- explore the use of coaching as a method of support aimed at improving health and well-being for family/informal carers,
- to identify the benefits which can be gained and
- to understand more about achieving sustainability of those benefits.

The potential impact of caring on emotional health and well-being is increasingly recognised in policy documents at both national and local level. Coaching is one method of providing support and this project aims to build evidence about the use of coaching in this context.

Method

Thirteen carers participated in the project, each receiving 6 coaching sessions over a period of approximately 6 months. Evaluation of the benefits which resulted took place through the use of pre and post-coaching interviews. A field diary was kept by the coach and this data contributed to the conclusions and recommendations of the project.

Key findings

All carers benefitted from coaching and these benefits can be summarised as an increased ability to manage their emotions, increased acceptance of their situation, recognition of their own importance and needs and a sense of a future

All carers benefitted from coaching so the development of criteria to identify carers who would benefit was not possible. All the carers demonstrated a willingness to accept any support that was offered.

Maximum flexibility about timing of sessions was identified as important and the relationship between coach and carer was also seen as critical to the success of the coaching activity.

There was a lack of awareness generally about the use of coaching for carers and this was a factor in how the project progressed.

Recommendations

1. There should be a pro-active approach to sharing the findings of this project and to contributing to and developing the existing dialogue about support for carers both locally and nationally.
2. Formal contact should be made with the relevant Health and Social Care Partnerships through their Chief Officers to explore how to develop support for carers using coaching.
3. Consideration should be given to following up the group of carers in this project to explore the extent to which benefits have been sustainable.
4. Consideration should be given to the governance arrangements which would be required to provide assurance about the suitability of coaches and the quality of the coaching process. These arrangements should include processes for monitoring and review of any service which is established.

CHAPTER 1 INTRODUCTION

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- explore the use of coaching as a method of support aimed at improving health and well-being for family/informal carers,
- to identify the benefits which can be gained and
- to understand more about achieving sustainability of those benefits.

The full application for funding is contained at Appendix 1.

The context for the project is one of increasing recognition that family and informal carers are a critical component of the ability of modern society to cope with a population increasing in age. The ageing population is living with a variety of health problems some of which are very often complex in nature. The focus of the project is to look in some depth at one way of supporting carers in order to build evidence about the use of coaching in this context.

The pressure on carers and the numbers of carers are increasingly recognised in Scottish Government policy. This is made visible in many national and local documents responding to policy. A core principle in the Equal Partners in Care Project is that **"carers are supported and empowered to manage their caring role"**. Similarly, the sixth of the nine outcomes required by the recently established Health and Social Care Partnerships is that "**People who provide unpaid care are supported to look after their own health and well-being, including to reduce any negative impact of their caring role on their own health and well-being".**

For a number of years VSA, the organisation in Aberdeen contracted to provide services for carers for Aberdeen City Council, provided a one to one coaching service for carers. From 2009 to 2014 more than 40 carers received coaching. During the delivery of the coaching service for VSA between 2009 and 2014, it became clear that there was a widespread lack of awareness of the use and value of coaching for family/informal carers. This was both among those directly involved with carers and among professionals who may have significant amounts of contact with carers through their client/patient group.

Over the 5 year period of delivering the VSA service, feedback gathered informally indicated that the service was much valued by the carers themselves and was perceived by them to have a significant impact on their health and well-being. A number of interesting issues had already been identified. For example, there appeared to be no link between the scope and demands of the caring role and the extent of the impact on a carer. Another interesting issue was the observation that some carers seemed to have much greater motivation and capacity to effect change in their lives than others. Similarly, the gender of the carer did not appear to be significant in influencing the impact of the caring responsibilities. At this time, coaching for carers was not widely available but where it was provided there was a feeling that it was beneficial. The VSA work with more than 40 carers which involved the delivery of almost 300 coaching sessions indicated that significant benefit can be delivered to carers through coaching.

Following the cessation of the VSA service in 2014, it was clear that evidence of benefits would be necessary if coaching was to be made available to carers. Further, it would be necessary to understand how to identify those carers that are most likely to benefit as well as how to ensure or at least maximise the likelihood of sustainability of benefits. As a result of both the decision by VSA to cease the service and the lack of evidence about the use of coaching for carers, it was decided to seek funding to evaluate the use of coaching in this context.

CHAPTER 2 PROJECT METHOD

This chapter summarises the process which took place to establish the coaching service for the limited time of approximately 6 months and the coaching activity itself. The detail of the coaching approach and style is contained in Chapter 3.

There were a number of areas to be addressed in setting up the project. This chapter will address each of these areas as follows.

1. Defining the referral/request route for carers into the service
2. The location of the service
3. Preparation of materials
4. The coaching process
5. Administration processes,
6. Evaluation

Two of these areas were made significantly more difficult as a result of the fact that the service delivery was not part of an existing organisation.

2.1 Defining the referral/request route for carers into the service

The coaching service needed to be placed within the health and social care system in such a way that carers with a "need" could easily be signposted to the service.

Through discussion with some NHS contacts it emerged that the Clinical Lead in the South Cluster of GP practices was interested in exploring how to improve support for carers. It was therefore decided to work with two South Cluster GP practices. Discussion with the Clinical Lead led to conversations with Practice Nurses in these two practices. There was huge enthusiasm in both practices and their nurses were very readily able to identify carers who might be interested in and benefit from coaching.

It was entirely unexpected when, despite many phone calls and increases in publicity, requests for coaching did not materialise. Plans had been made for the eventuality of too many carers. Too few carers or none had not been considered as a likely risk. Approximately 2 months after the "go live" date of 30th March 2015, discussion with the Carers Information Strategy Programme Manager took place and an extension to the timescale was approved. An approach was then made to VSA to act as the request/referral route. VSA staff were willing and enthusiastic in the same way that Practice Nurses had been but again there were no requests. After personal contact was made with individual Carer Support Workers there were 2 requests to participate in the project.

However, at the end of June 2015, 3 months after the "go live" date, there were still only 2 requests for coaching. The route into coaching was now clearly a very important aspect of the project and the imperative remained to find a way to connect carers who would benefit from coaching to the service. Based on previous experience of delivering coaching there was confidence that many such carers did indeed exist.

Further discussion took place with the Programme Manager resulting in a decision to use personal networks in an attempt to bring appropriate carers into the project. Contact was made with Horizon's Rehabilitation Centre and Alzheimer's Scotland. Again willingness and enthusiasm were much in evidence. The necessary training/awareness for staff who would be making requests for coaching on behalf of a carer took place and very quickly requests for coaching were received. Chapter 5 on evaluation shows how carers came to the service in more detail.

Request routes for participants were closed at the end of September 2015 to avoid a situation of more requests and insufficient capacity to cope with them.

2.2 The location of the service

The Health Village in Frederick Street had been identified as a potential location for coaching before the project began. Discussion now took place with the Health Village Manager to explore this further. Practice Nurses had expressed concerns that there may be some reluctance among carers to attend the Health Village, thus creating a disincentive to participate in the project. In spite of this it was decided to base the service at the Health Village and ensure maximum flexibility about timing of appointments in an attempt to offset any negative views. Contingency plans were developed to deal with the possibility of reluctance to attend the Health Village but in the event these were not required.

The manager at the Horizon's Rehabilitation Centre offered to make a room available for coaching for carers who already had a connection with the Horizon's service.

Administration processes, paperwork and publicity material were discussed and finalised in readiness for the coaching service to "go live" on 1st April 2015. The engagement and enthusiasm led to huge confidence about the project and the inclusion of coaching for carers in the system.

Alongside these preparatory conversations the search for a physical location took place.

2.3 Preparation of materials

A briefing note (Appendix 2) for professional staff was prepared and distributed widely among professional staff who might request coaching, staff who would be involved in managing the booking of rooms, and managers who may have an interest.

An information leaflet (Appendix 3) was prepared with input from 2 carers who were later involved in piloting the evaluation framework.

Appendix 4 is a document aimed at helping those who might request coaching to assess whether or not coaching might be appropriate.

2.4 Evaluation of coaching service

The funding application made it clear that the evaluation of the coaching would be based on pre and post-coaching interviews delivered by an interviewer who was not involved in the coaching activity itself. The selected interviewer was familiar with the challenges facing carers as a result of previous employment at VSA Carers Services. Two carers who had received coaching through VSA agreed to pilot the evaluation interviews. This was done in February 2015 and led to changes which are incorporated in the final pre and post-coaching interview frameworks included at Appendix 5 and 6 respectively.

In order to avoid additional appointments for the evaluation it was decided that the pre-coaching evaluation interview would take place at the first coaching session and that the post-coaching evaluation would form part of the final session. It was acknowledged that this would lengthen both appointments and also create a risk of "contamination" due to the proximity to the coaching process itself. However, on balance it was felt that this was preferable to asking carers to attend additional appointments.

2.5 The coaching process

Following receipt of a request for coaching each carer was contacted by telephone

- to introduce the coach,
- for a preliminary discussion to confirm that the carer was making an informed choice to embark on coaching,
- to provide information about what coaching is and what participation in the project would involve and
- importantly to explain the implications of being part of a project to evaluate the use of coaching.

An initial appointment date and time were agreed and the carer was informed that a short interview with a colleague would take place at that session as part of the evaluation.

Requests were received for 15 carers. Thirteen of these progressed to participate in the project. For 2 carers, it was agreed that coaching was not the most appropriate intervention at this time. Their needs related more to information about services and they were referred on to VSA Carers Services.

The 13 carers who became part of the project began their coaching sessions between 4th August 2015 and 11th November 2015, their initial requests having been received between 2nd July and 22nd October. The pre-coaching evaluation interview delivered by the selected interviewer was included in the first appointment. Subsequent appointments were arranged at mutually agreed intervals and the day and time of sessions were always at the convenience of the carer. The intention was to arrange initial appointments at relatively short intervals and to space out later appointments so that the whole coaching process would take place over approximately 6 months. On some occasions the interval was as short as a week and in others, towards the end of the sessions, it was as long as 6 weeks.

At the final session the post-coaching evaluation interview, delivered by the same interviewer as the pre-coaching interview, took place after the coaching itself. By way of conclusion a further 10 minutes with the coach took place to close off the coaching activity.

More detail of the coaching approach is contained in Chapter 3.

2.6 Administration processes

All of the administration associated with the project was undertaken by the coach. While all appointments were arranged by telephone, text reminders were sent the day before each session and generally communication was via text messaging. Notes of sessions were sent by e-mail or hard copy depending on the preference of the carer.

Consent was confirmed with the consent form included at Appendix 7.

CHAPTER 3 COACHING APPROACH AND STYLE

Coaching is a recognised professional activity which differs from therapy, counselling and mentoring. It is focused on the future and involves listening, asking questions and at times challenging the person being coached (coachee). The aim is to help the person to find their own solutions to areas where they are seeking change. They may do this by setting goals, defining how they would like things to be different or simply by exploring how they manage their own life and situation.

A definition used widely by coaches is that coaching is "a collaborative solution-focused, results-orientated and systematic process in which the coach facilitates the enhancement of work performance, life experience, self-directed learning and personal growth of the coachee". (Grant 1999)

However, a more suitable definition when defining coaching in the context of this project is that “coaching is about enabling individuals to make conscious decisions and empowering them to become leaders in their own lives”. (Wise 2010)

A coaching session with a carer therefore takes the form of a conversation focused on helping them to discover for themselves answers to the challenges they identify and the changes they want to make.

The coaching approach used with carers is based on the same principles which underpin every other type of coaching. The context can vary widely between different types of work based coaching or between other specific topic based coaching eg career or interview coaching. There are however some aspects of the carer context which have a major influence on the coaching process.

3.1 Coachee considerations

The most significant characteristic which affects the coaching activity with carers is their vulnerability and the risks arising from that vulnerability. The components of a normal professional coaching process are all required but some have extra prominence as a result of risk and vulnerability. The potential for severe consequences for the carer and therefore for the person cared for must be recognised. It must also be recognised that the very act of pursuing possible benefits may bring the risk of damage to the caring relationship.

Overall the aim of the coaching activity with carers is to build their resilience and ability to deal with whatever situation might arise. This approach, focussed on resilience, has a great deal in common with business or executive coaching. However, many of the situations which might be described by carers can be very emotional and within coaching sessions there are frequent emotional moments. This ability to accept and learn responses to emotions has a prominence that may be less common in a business coaching session.

3.2 Relationship between coach and carer

Many carers have found ways to maintain a degree of equilibrium by avoiding any exploration of how they feel and what they think about their situation. Even though they may have decided to seek help, the reality of the experience of “receiving help” can be hugely challenging and may risk disturbing their equilibrium. The willingness to continue with the process once it becomes clear what it will involve requires a huge degree of trust in the coach. To some extent

the carer places themselves in the hands of the coach and holds a belief that the coach will protect them from damage during the process.

In normal day-to-day experience this level of trust takes time to develop. In a coaching setting not only is there greater urgency since there are a limited number of sessions, but a lack of trust or simply underdeveloped trust may lead the client to reject the process.

In order to overcome this risk, the establishment of the relationship between coach and carer must begin at the first interaction which in relation to this project was by telephone. The critical components of the relationship include respect, active listening, a non-judgmental attitude, empathy and support. Legitimacy and credibility of the coach are also important factors which can begin to be developed at this early stage.

3.3 Coach characteristics

If the coach is to be successful in this potentially risky and emotional situation then they must be seen as authentic, indeed they must not only be seen as authentic but they must indeed be authentic and behave with integrity. Congruence between their values and beliefs and their behaviour with the client are critical.

It has already been mentioned that coaching sessions with carers can be emotional at times. Self-awareness and the ability of the coach to accept and manage their own emotional responses are therefore crucial.

There is often significant risk to the carer of opening up situations or subjects that may be very difficult to deal with. While the usual processes of ensuring the person receiving coaching is in control and can choose not to continue with an area that emerges are established, in practice this may not be straightforward. A carer can be very vulnerable and sometimes desperate for their situation to improve. The coach must assess moment by moment how to work safely with them and make instant judgments about what to say or not say. In order to do this the ability of the coach to manage themselves is paramount.

Unlike business or executive coaching there is no expert body of knowledge related to caring on which the coach can base and interpret what emerges at a coaching session. This inevitably leads to a need to be able to tolerate uncertainty. There are frequent occasions when it is very unclear what to say or do. At these times the desire to help, a characteristic of many coaches, must be carefully managed.

3.4 Self disclosure by the coach

A further difference with other coaching settings is the extent to which the coach might share their own views and/or experience. For many coaches this is seen as wholly unacceptable but on occasions with carers this has been a valuable part of the dialogue. As long as the intention behind the sharing is legitimate within the coaching context i.e.it is to support the dialogue not divert it, then it can be very helpful. It can be a very visible demonstration that the carer's experience is shared by others and therefore does not indicate any deficiency in them. It provides evidence that the coach does understand their situation thus increasing confidence in the coach and the coaching process. This sharing or self-disclosure process is described in psychotherapy as providing “the illusion of hope”. It can create the sense that the carer is not alone in their experience which can be both comforting and confidence building.

3.5 The coaching activity itself

The factors described above mean that the coaching with carers is not simply a transactional i.e. cognitive, activity. The work with carers is often at a transformational level, meaning that it involves consideration of emotional and value based factors allowing work to take place at a deeper level. Working at a deeper level means that a carer considers the meaning which is attached to behaviour and events. It also involves considering their intentions in order to change their own behaviour. The likelihood of sustainability is increased as a result of working at this deeper level.

A number of tools were used to support the coaching. Some were recognised tools or frameworks whilst others were representations put together by the coach to help the carer see a different perspective or simply to make sense of what might seem like a confusing situation. These tools, diagrams, flowcharts were all personalised through the use of the carer's name on the diagram or inclusion of a reference to their particular situation and forwarded to the carers. A great deal of positive feedback related to these paper based records of sessions and several carers used them as reference material or reminders about what they were learning and attempting to achieve.

3.6 Managing the ending of the coaching sessions

Because of the strength of the relationship which is experienced by both the coach and the carer, the management of the end of the coaching sessions can present a challenge. Due to the level of investment by both parties in the coaching process, the ending of the coaching relationship can be associated with loss. In recognition of that, dialogue about feelings and thoughts associated with the ending and the offer of continued contact if required were all ways of lessening the impact and increasing sustainability and independence.

In summary, the coaching with carers which was delivered in this project was a relational activity working in partnership as equals both of whom are learning rather than with one, the coach, constituting the expert.

CHAPTER 4 DATA – DEMOGRAPHIC AND FIELD DIARY

4.1 Demographic data

A small amount of demographic data was collected in order to provide a profile of the carer group involved in the project.

While 13 carers commenced the coaching sessions only 11 are included in the evaluation data. One carer attended only 2 coaching sessions and although there were repeated attempts to arrange further sessions these were unsuccessful. Another carer suffered a bereavement after two sessions. The post-coaching interview was not appropriate for this carer's changed situation so while they did continue with the coaching sessions they were not interviewed at the end of their coaching sessions.

All 13 are included in the following demographic data.

There were 10 female carers in the study and 3 male carers. Their ages ranged from mid 40s to early 80s.

Figure 1 Age of carers

Between 41 and 50	4
Between 51 and 60	1
Between 61 and 70	4
Over 70	4

Four of the carers were working or employed, all of them female and all part time.

The length of time the carers considered themselves to have been undertaking a caring role ranged from less than a year to more than 20 years.

Figure 2 Length of time in a caring role

Between 1 and 3 years	5
Between 3 and 10 years	2
More than 10 years	6

Of the 13 carers there were 4 who cared for 2 people. However, 2 of these 4 carers had not considered themselves as carers for the second person until they began their coaching sessions. In the profile of those that were cared for there are therefore 17 cared for people. Four carers cared for their mother and one also cared for a daughter, three cared for their wife, four cared for their husband and one of these also cared for a daughter. One carer cared for 2 daughters, another for 2 grandsons.

Figure 3 Conditions of the cared for

Dementia	4
Behavioural/mental health problems with no diagnosis	3
Multiple sclerosis	3
Cerebral palsy	2
Parkinson's and dementia	1
Dementia and other chronic conditions	1
Downs syndrome	1
Mental illness	1
Head injury	1

When asked if their caring role was shared, the perception of 10 was that they were entirely responsible for the caring although 3 of them did say that there was occasional support from family members. Two felt they shared their role with other members of their family.

Three carers were receiving support from professional carers and 3 had some support from voluntary organisations. Only one was in receipt of respite and that was both on a weekly basis and also to allow the family to take holidays.

4.2 Field diary

Notes were taken by the coach at every coaching session and this "field diary" has been used to create a description of the coaching sessions and process which will be used with the formal evaluation data to generate some conclusions and recommendations.

The carers' first appointment focussed on developing a relationship of trust and support between the coach and the carer and identifying what they would like to achieve through the coaching. The language of goals and outcomes had begun at the pre-coaching telephone conversation. The pre-coaching evaluation interview further emphasised goals and outcomes so the goals generated by the carers, as well as their ability and willingness, must be seen in that context of focus and encouragement.

Every carer included a reference to managing emotions in their goals. For several this was a very emotional process. One described feeling "angry, resentful, frustrated, robbed of happiness". Another spoke of continuing feelings of guilt related to an incident around 20 years ago which had resulted in the caring relationship. A recognition of being short tempered most of the time, of "every day being a challenge and it's tiring", of the situation having built up over time so now "I feel resentment" are accounts for which words alone do not fully illustrate the depth of feeling. For some this was the first time they had spoken of how they felt resulting, in some cases, in further guilt and negative feelings about themselves. For others it was a huge relief to speak about themselves without fear of being judged. However, it was common for them to judge and be hard on themselves.

As well as describing their emotions others talked of the situation and its impact on them. Descriptions included hoping sometimes “that it would all go away” or from a different carer “I am not superwoman – not responsible for everything!” The desire to find a way to continue being themselves was also expressed in statements like “have I closed myself off” in order to cope, and “I want to feel better about the independent activities” that I like.

A number of areas emerged as the conversations progressed and these will be explored in a way that hopefully does not diminish the area described nor the carer’s experience. They are presented simply to reflect the impact that caring can have on individuals and families.

4.2.1 Managing emotions

For some carers there was a desire not to feel certain emotions but several realised from an early stage that they may be unlikely to stop feeling a particular way. However, they were clear that if they could find a way to avoid being overtaken or ruled by their emotions, that would be a significant benefit.

One carer said she felt that emotions “hug and strangle me” and described how she felt powerless at times. Another felt overwhelmed and acknowledged that what she wanted was to cope better. The level of emotion was compounded for one carer because, in order to protect her husband for whom she cared, she didn’t share how she felt. She thought he would not be able to cope if she shared how she felt with him. There were negative consequences for both as a result of this strategy but the risk of an alternative approach seemed too great.

4.2.2 Managing changed relationships

Feelings of a gradual loss of self, loss of the cared for and/or their relationship emerged for some of the carers especially for those that were caring for a partner or husband. One described feeling as though “I am losing him gradually”. There was recognition for another that she and her husband spent little time together as husband and wife and they had now become carer and cared for. This brought a great deal of sadness. After decades of being happily married one husband described his relationship with his wife as now being like parent and child. Similarly, there was significant stress associated with his wife’s childlike behaviour for one carer.

For offspring, role reversal and becoming the parent figure on occasions was sometimes easier in the short term, but there was acknowledgement that this brought potential problems, sustainability being one that was mentioned.

The motivation to put so much effort into caring was described by one as “paying back” for all the years they had been cared for or a continuation of a style of relationship that had begun when they were a child. Clearly these were longstanding aspects of their relationship and like many other aspects of the coaching process associated with deep seated values and beliefs held by the carers.

One carer told me at their final session that they had realised that their husband was more than his condition and that she was more than his carer and that this had opened up a valuable new way of seeing things.

4.2.3 Planning and levels of control

A discussion which often took place in the sessions related to attempts to make plans and stick to them and a desire to be organised and gain as much control over life as possible. Huge levels of frustration resulted from perceived failure so explorations of the need to plan

and be organised often took place. After several sessions one daughter, whose attempts to be organised were frequently thwarted, said spontaneously “You can’t change the situation, just change your response. But changing isn’t easy because it’s often very deep and it’s been that way for a long time”.

For one carer whose normal style was, by his own admission, not very organised there was a feeling that “I should be more organised, keep the house better and be less tired”. Feelings of inadequacy often resulted from this sense of what he “should” be doing but couldn’t quite manage to achieve.

The intensity of the anxiety which resulted from not being able to influence things was debilitating in one or two situations. An insight came to one carer regarding the ability of the person they cared for to actually make decisions and therefore contribute to the family unit. They said “I’ve remembered things about …….. that I had forgotten – he can make decisions!”

Learning to accept things and to “not try to change mum or negotiate with her” brought relief to one carer. A similar situation was described by a daughter who at times felt embarrassed about her mum’s behaviour, frustrated that she couldn’t influence it and then angry at herself for feeling the way she did. Another spoke of her mum’s refusal to do things “the way I think is best for her”.

The ability to “back off” from the person they care for and to “leave him to be how he is” was how one carer described the change for her.

Safety was a consideration mentioned by one carer with a realisation that safety could not be guaranteed and that the quest for safety might sacrifice quality of life on occasions.

4.2.4 Valuing and paying attention to self

There were many references to an inability or unwillingness to pay attention to one-self and one’s own needs. It was not always clear whether this was a longstanding characteristic but it certainly was evident and influential in the caring situation.

Expressions of what carers wanted – “I would love to have some time out alone with my husband”, “I want to be able to ask for what I need” - on occasions emerged for the first time in the sessions leading to discussions about why personal needs had not previously been expressed or even acknowledged. Fear of rejection or assumptions that needs could not or would not be met led to avoidance on occasions.

Two carers spoke of allowing others to treat them in ways that they felt were unacceptable but struggled to set boundaries. One of these carers said she “knows in her head what she should do but the old patterns kick in”. While she knew that she didn’t want to be spoken to in a certain way, the setting of a boundary was a very difficult option for her. Her familiar patterns of “It’s not fair and I‘m not going to let her get away with it” led to win-lose types of confrontation, which escalated and left her feeling bad about herself and her mother. However, at a cognitive level she knew that “if you don’t value yourself who else will?” Another example of cognitive recognition but inability to effect behaviour change was “I know what to do but I can’t find the switch.”

The carer who said at the outset that she wanted others to offer help rather than having to ask, gained an insight as the sessions progressed. She said she realised that wanting others to offer help indicated to her that she was valued. This allowed a discussion about the extent to which she valued herself and how valuing herself might lead to others valuing her too.

Comparisons with others were often made by the carers and it was common for them to judge themselves harshly – “I ought to be less lazy, more organised, not so short tempered, less annoyed, frustrated and irritated” was one carer’s verdict about themselves.

It was with extreme sadness that one carer told me “Sometimes other people don’t seem to see me. They are just interested in …………….(the cared for)”.

4.3 Key coaching contributions

Every carer was unique and their coaching activity quite different reflecting their character, situation and needs. However, there were many similarities in terms of what was offered to them and the areas of their experience which were discussed and challenged.

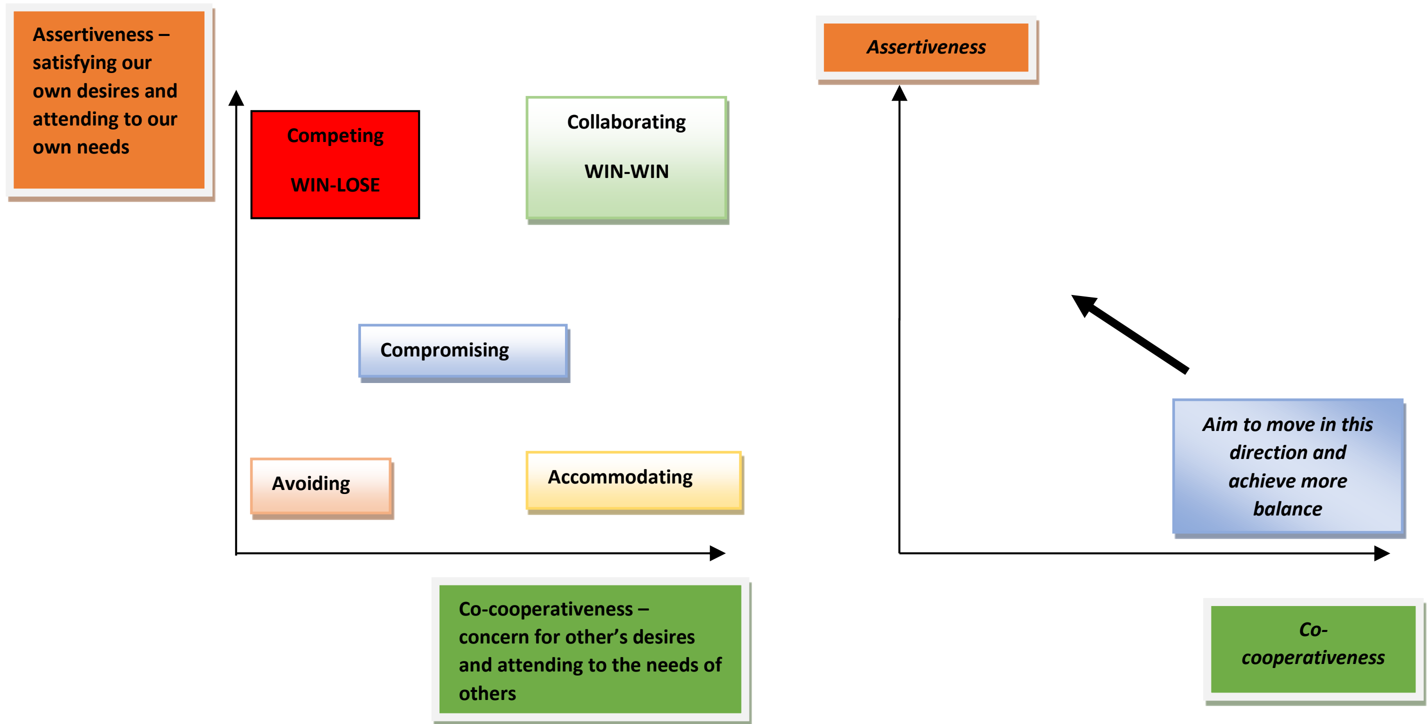
4.3.1 Choice and control

For several carers when their behaviours and experience were reflected back to them using the framework of choice and control, they realised that they had given away control, often to the person they cared for, and as a result felt they had forfeited any control of the situation. Once this was offered there was often a realisation that it was the lack of control and perceived inability to make choices that caused frustration and even resentment. As will be mentioned again later, this issue of awareness and looking at a situation through a different lens often led quickly to positive feelings. The awareness frequently led to a discussion of where some control could be taken and if the answer was that there was no possibility of exerting control this was often challenged again with a good outcome. So the issue of habit in interactions, the effort to change habits as well and the perceived risk of change were all topics which were explored as a consequence of opening up this issue.

Setting boundaries is a part of taking control and surfaced frequently. Again once a situation was reframed and re-described using the language of setting boundaries there was often a rapid change for the carer. Two tools were used frequently to assist these discussions. One was the Thomas Kilmann Conflict Mode matrix and the other was a simpler matrix offered by the coach to encourage awareness of a balance between paying attention to one-self (assertiveness) and paying attention to others (co-operativeness).

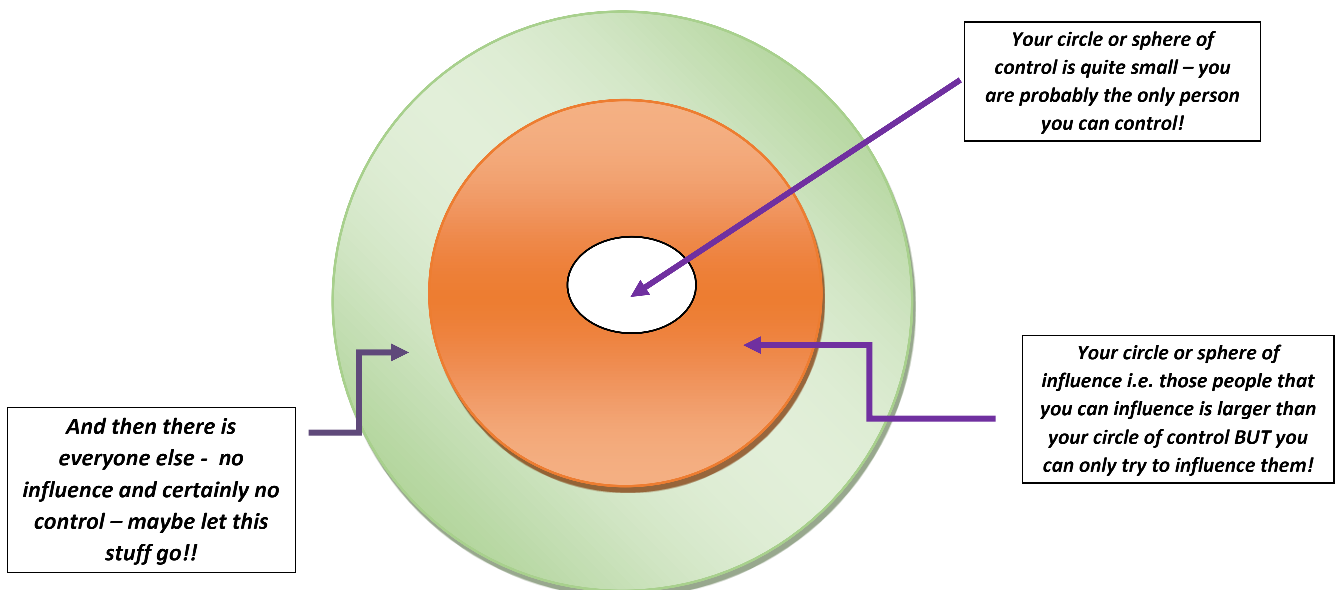
Figure 4 Assertiveness and co-operativeness

Thomas – Kilmann Conflict Modes ***Achieving balance***



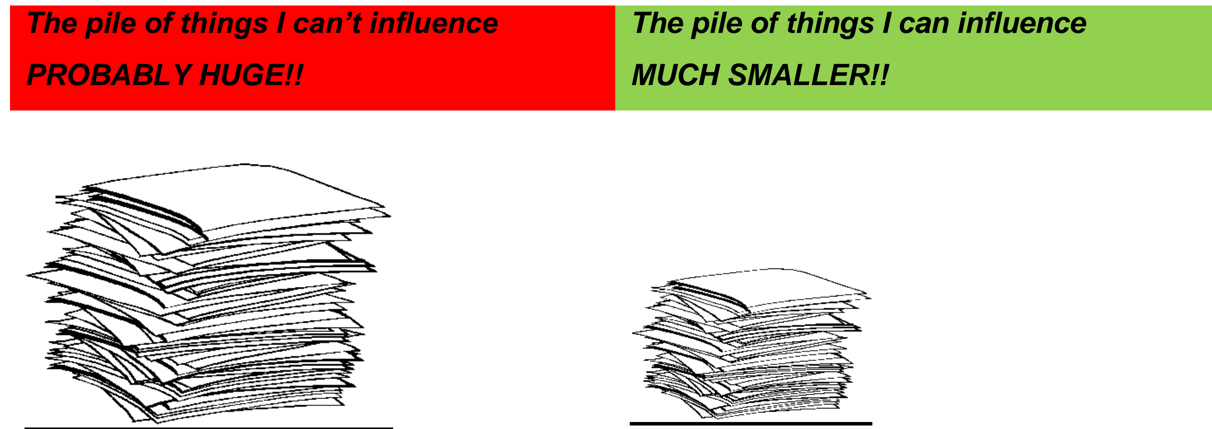
For many, there were attempts to take control of things that they really could not control, for example another person's behaviour, and this led to a great deal of frustration. The concept of Circle of Control and Circle of Influence provided insight for 3 carers. They realised that their ability to control was actually quite limited.

Figure 5 Control and influence



A very simple image of seeing themselves actively placing things on two piles – one they can do something about and the other they cannot have any impact on - resulted in an ability for several carers to focus on situations where they do have control and maybe even manage to achieve an outcome.

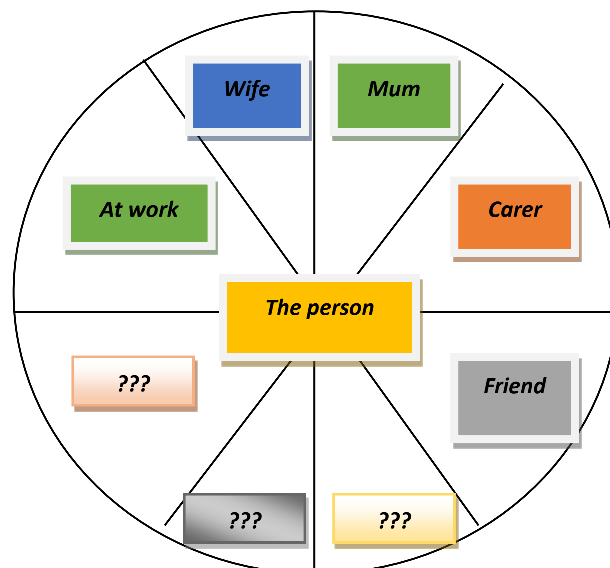
Figure 6 What can I influence?



4.3.2 Balance across different aspects of life

Balance across different aspect of life also occupied many of the sessions and the "Wheel of Life" model was used for this. Again the first step was often awareness that for example the wheel for an individual was divided unequally and the carer role might be squeezing out other aspects of a carer's life. This might lead to a realisation that the carer role had meant that the partner/wife/husband role had been largely sacrificed or it might result in thinking that gaining some balance might in itself lead to improved well-being which in turn might have a positive effect on the caring role.

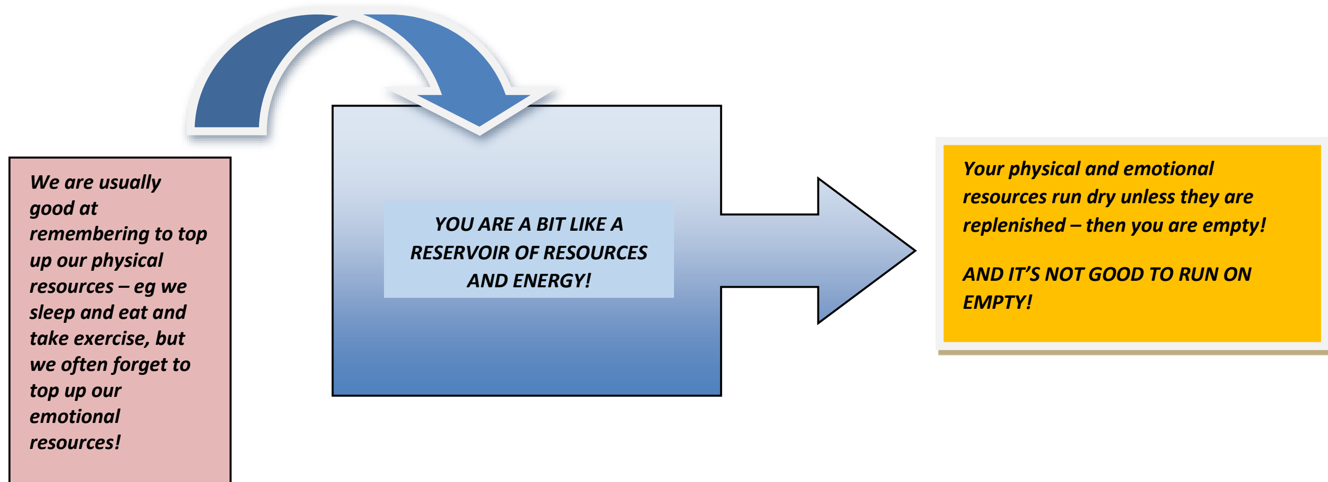
Figure 7 The wheel of life.



4.3.3 Maintaining emotional health and well-being

Closely associated with this area of balance was the use of another model developed by the coach for use with carers. This model helps carers see themselves as needing different types of “fuel” to allow them to continue to give of themselves in their caring role. The analogy of a car not being able to “run on empty” was frequently used and a comparison made with many of the carers who appeared to be able to run for a long time on “almost empty” but were probably paying a price which they either did not see or chose not to see for fear of the risks and consequences it might lead to.

Figure 8 Maintaining emotional health and well-being



All carers in the project faced at least one of the areas referred to above in their coaching sessions and half of them experienced several more.

The tools described above were principally about offering a new perspective to the carers and sometimes that was enough to enable them to change. For one carer in particular the post session thinking that she did and, as she described it, the converting them into her own language and mental images was sufficient for her to make personal change.

4.3.4 Mindfulness based concepts

For other carers, and again it was more than half, the use of some concepts based on Mindfulness brought very positive feedback. Figure 9 below illustrates the three areas that our mind might occupy and encouragement to spend time in the present was helpful. The ability to be self-aware and in the present was supported through the use of guided meditation for some carers.

A practical model (Figure 8) also based on Mindfulness which several carers used was what the coach called the NAP approach meaning ***notice, accept, and pause*** to enable them to make a conscious choice before taking action. This was practiced in coaching sessions with many carers and they were encouraged to try it in situations at home which were not too charged. Tricks to help with the pause element of this model like being “upright and dignified” (from Leadership Embodiment) and paying attention to the breath (Mindfulness) provided practical ways to develop skills.

Figure 9 Where do you spend your time?

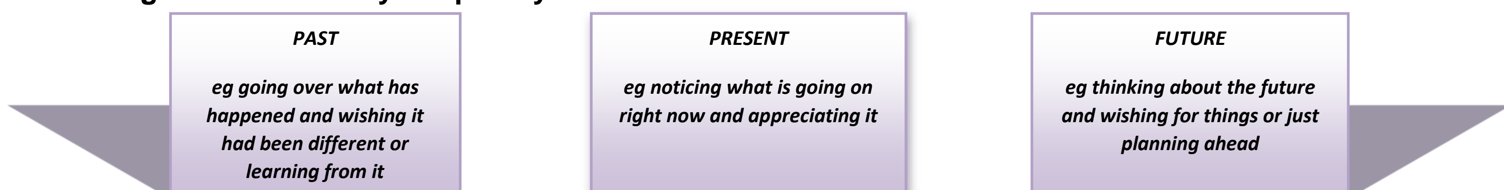
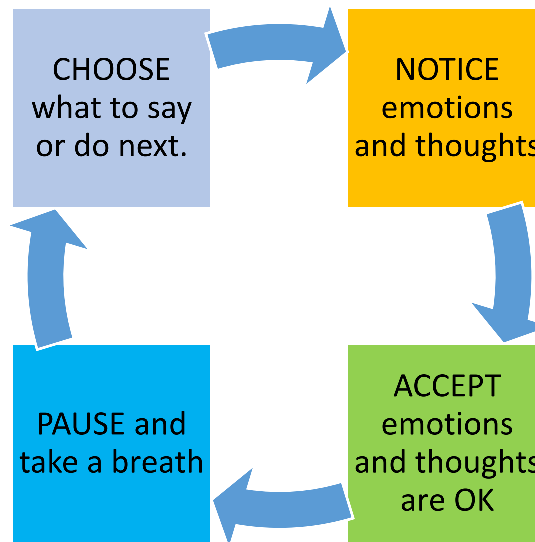


Figure 10 Equipping yourself to make a choice



4.3.5 Flow charts

Finally, there were several occasions when a situation described by a carer was drawn as a "flow chart". This allowed a consideration of "what if" they had done or said something different at the start of a conversation and what outcome might have resulted. The shift from thinking about "what I want to say" to "what I want to achieve" in order to gain a different perhaps less confrontational result in a conversation became possible.

Figure 11 Managing interactions

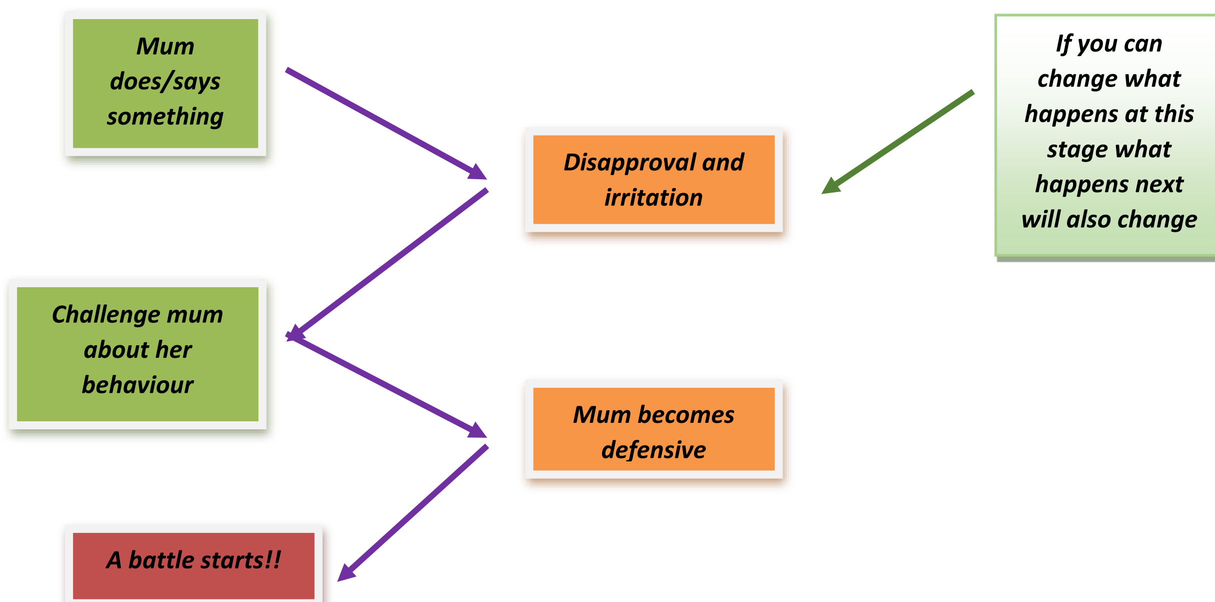
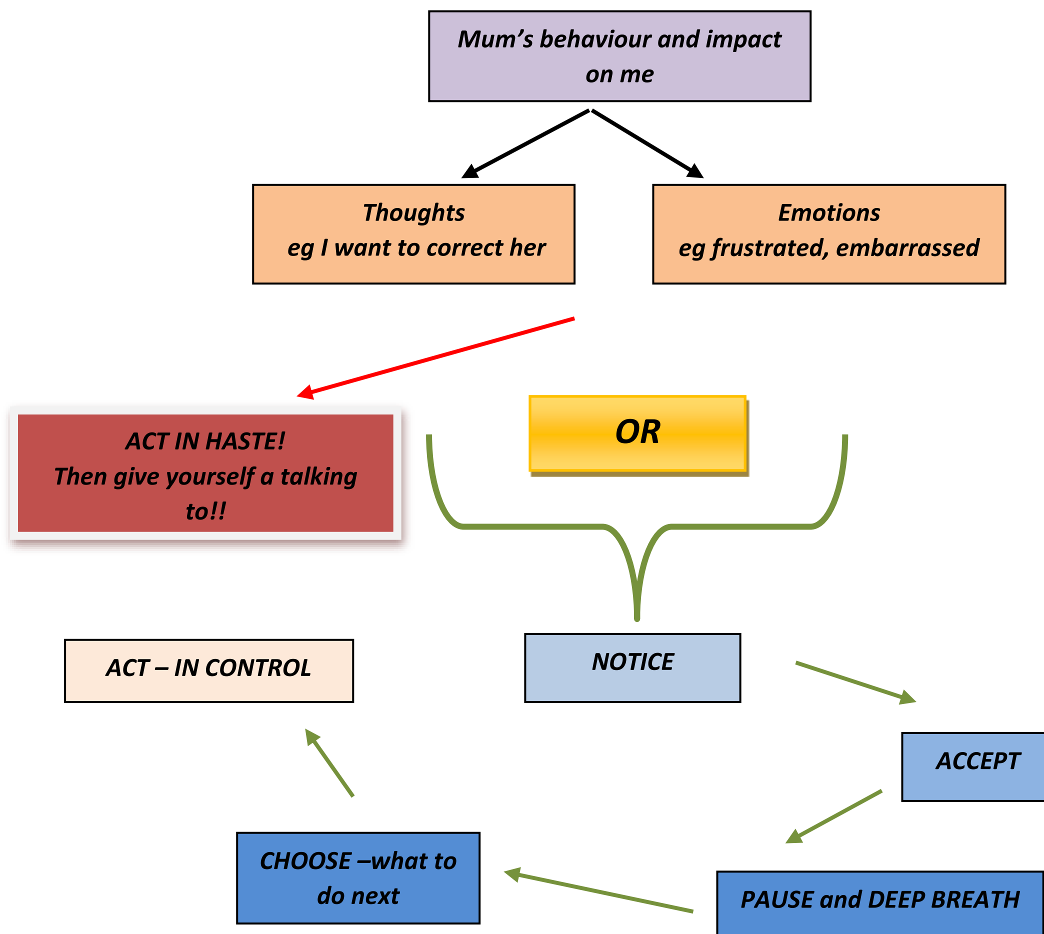


Figure 12 Managing emotions



4.4 Feedback and progress

While sustainability of the benefits achieved through coaching cannot be assumed there were some very quick, significant and positive changes made by carers. One said she had begun to have different kinds of conversations with the person she cared for, her husband. She had become more open and honest and shared some of what was "going on for her". For this carer there was little if any difference in the response from her husband but she felt she had been more honest with him which she described as a good feeling. Another had carved out time and made an effort to have a meal out with her husband on their own and the enjoyment in itself was an encouragement to repeat the process.

Other personal changes which were reported were a significant improvement in physical energy levels, holding back from trying to control everything and therefore less frustration when something blew her off course. Two carers set some boundaries fairly quickly and were surprised at the response from the person for whom they had set the boundary and also how good it made them feel to exert some realistic control.

Taking time for self and stepping back or out of the situation for a short time was also reported as bringing benefits. One of the most powerful illustrations of this was a carer who dressed slightly differently and changed her hairstyle slightly as she changed her level of attention to herself.

One carer said she had become more organised and was not putting things off to the same extent and indeed this was allowing her to play to her strengths.

Emotions did not always disappear but one carer said that the “guilt had not gone away but they were able to cope with it”. For another they were managing emotions in some situations but in others it was more difficult, for example in a crowded waiting room.

At a surprisingly early stage in the coaching process a carer said they had “less expectation of how it should be and more acceptance of how it is – I wish it wasn’t the way it is but I am more accepting”.

It was very humbling to hear from one carer that her husband, who she had been caring for over many years, had suggested that they go out to celebrate Valentine’s day. This may not be such a huge issue for many of us but for this couple it was significant because going out together requires enormous effort. Before the coaching process the carer would have and often did say “let’s not bother”. She believed that the change in her as a result of the coaching encouraged her husband to make the suggestion.

At the final coaching session, which included the post-coaching evaluation interview, a number of statements were recorded and these are simply listed here as spontaneous evidence of perceived benefits.

> “I’ve rediscovered myself”
>
> “I am calmer, bowling better and winning but less aggressive!”
>
> “I’ve got increased awareness of myself so I can make choices.”
>
> “I used to look ahead and just see more of the same, now I see a future”
>
> “I have told my husband; I can give you a lot but I can’t give you all of me. I need to keep something back.”
>
> “I used to want to please everyone all of the time, now I don’t need to.”

CHAPTER 5 EVALUATION

The formal aspect of the evaluation of the project was carried out using one to one interviews with each carer at the start and at the end of the coaching process. Inevitably there is some duplication of areas that have been covered in Chapter 4. It has been decided simply to acknowledge this and while it may be repetitive for the reader it may also help to emphasise key areas of importance.

A colleague of the coach with non-coaching experience of work with carers and of evaluation in a research environment delivered both pre and post-coaching interviews. The frameworks for both interviews were piloted with 2 carers and amended in response to their comments and the experience of the interviewer. Both the carers involved in the pilot had previously received coaching through the VSA service.

The interview schedules are included at Appendix 5 and 6. It was agreed that the interviews would be carried out as consistently as possible but that the interviewer would manage the interview in a way which was responsive to the carer, their emotions and the issues they wanted to raise. This led on occasions to the omission of some questions. However, since the carer group is very small and this was not a research project, it was decided by the coach and the evaluation interviewer to tolerate this.

As already highlighted, in order to avoid additional attendance of carers for evaluation the pre-coaching interview was carried out at the first coaching session following a short introduction by the coach. Similarly, the post-coaching interview was carried out at the last session immediately after the coaching had concluded.

Thirteen carers took part in the pre-coaching interview and 11 in the post-coaching. As has been noted previously one of the original thirteen left the project after 2 sessions and another suffered a bereavement during the project and was therefore not included.

5.1 Pre-coaching interview findings

5.1.1 Access to coaching

Six carers reported that coaching was suggested to them by someone else. The suggestion came from

- VSA Carer Support Worker (2 carers)
- VSA counsellor (1 carer)
- GP for the cared for person (1 carer)
- Horizons Rehabilitation Centre staff member (2 carer)
- Horizons Rehabilitation Centre therapist (1 carer)

Four carers reported that they chose to access the coaching project themselves based on information contained in a pack provided by an Alzheimer Scotland Nurse (1 carer) or an e-mail about the project from Alzheimer Scotland (3 carers). Another carer was unsure about the source of their information but thought it was through information from Alzheimer Scotland. One carer self-referred.

In addition to reporting the route to coaching, one carer indicated a level of “desperation” and another said the information about coaching “came at a good time”. There was surprise from another carer that their GP did not know about services for carers.

5.1.2 Expectations/attitudes to coaching

Six carers did not know if coaching would help them but indicated that they were “willing to try anything”, “keen to try something new” and appreciative that something was being offered. Four of these were “hopeful” that coaching would help.

Three carers thought that coaching would benefit them and expressed views about how they hoped it would help. Examples of their views included the possibility that it might assist them to gain some balance and some sense of priorities; they might gain increased understanding about their own reactions and as a result learn to deal with situations. Another example was that the experience and understanding of the coach would be valuable and might help to relieve some stress.

Two carers did not know how coaching might help but were optimistic, hoping that it would help, through “speaking to someone who understands” or helping them to accept how their life has changed.

5.1.3 Knowledge about coaching

Only one carer said that they knew what coaching was and how it could help. Five others answered no or “not really” and 5 said they knew “a bit”.

Lack of in depth knowledge about coaching did not appear to be a barrier but some carers were able to contrast coaching with counselling. Three said they knew that it was different with one expressing the view that counselling “didn’t suit me”.

For some, their information had resulted from their introductory telephone conversation with the coach and one highlighted that coaching was focused on the future rather than “dwelling” on the past. Another had previously received coaching.

One simply highlighted the value of being able to speak to someone outside the situation who is not involved.

5.1.4 Current state/how you feel generally

Negative feelings were expressed by 8 of the carers. The general state was described as feeling stressed, under pressure, overwhelmed, tired, exhausted, emotional and weepy, and sad. Specific emotions such as guilt, anger, resentment, frustration, bitterness, and hurt were highlighted. Anxiety, hopelessness, desperation and disappointment were also mentioned.

For some the situation was described as wearing and one had a feeling of having to “bite my tongue”. Another experienced feeling that they did not do anything well enough.

Interestingly 3 carers responded with generally positive feelings, in one case having learned to cope with the resentment and anger which they had felt in the past. One had found a way to protect themselves by not thinking about the past or the future.

5.1.5 How you feel about your caring role

Ways of describing the caring role included comparing it to a 24-hour job but without the ability to take time off. A sense of a lack of choice and control was evidenced with the term “feeling trapped”.

Feeling alone featured and was expressed as a lack of help and understanding, having sole responsibility and not knowing how to cope and having to learn.

Also mentioned were being overloaded and having to juggle, a metaphor which is often used.

The three carers who were more positive in relation to how they felt generally also provided more positive sounding responses to this question. One stated that they enjoyed their role though they did see it as a 24-hour job, another saying they coped, managed and were resourceful. The third simply said it was their job to look after their relative.

When asked if they felt they have a choice, 8 carers said they had no choice and one described that they had consciously made a choice to commit to the caring role. Two were not asked since the conversation progressed slightly differently.

5.1.6 Impact on other aspects of life

The issues of time for self and leisure time featured prominently. Nine carers made reference to these areas describing how they feel guilty taking time for themselves, anxious about the cared for person, difficulty relaxing when away and just the practical difficulties of getting away. The limitations on time for self and leisure, lack of ability to be spontaneous perhaps because of the need to plan in advance as well as needing to negotiate for respite, having to cancel plans, can all act as disincentives to making the effort for leisure time. Finding a way through this was evident for one carer who described prioritising time and social contacts.

Impact within the family through having to "work round" everyone and feeling "torn" as well as changes in their role and relationships were identified.

Sleep was affected for 3 carers with one saying they are "always listening".

Four carers were in paid employment, 2 of whom expressed concerns related to continuing to work. One had reduced their hours in response to their caring role leading to financial worries.

A negative impact on physical and mental health was mentioned by 2 carers.

5.1.7 Hoped for difference through coaching

Ten of the carers were able to identify outcomes they would like to achieve through coaching and 8 of these scored them on a scale of 0 to 10 reflecting their level of importance. The outcomes included dealing with emotions e.g. feeling less anxious, learning to cope eg "learn how to deal with things in a different way", and practical things like "to be able to take a break".

5.2 Post- coaching interview findings

5.2.1 Reflections on the coaching sessions

When asked for a description of the coaching sessions, carers used a variety of positive expressions such as informative and helpful, very valuable and beneficial, productive and enjoyable. There was reference to the coach as easy to talk to, understanding, professional and having empathy.

The value of a "safe environment", the opportunity to "off load" and the help to look at themselves were noted as was the stimulation and encouragement to "reflect, think and plan" with the result for one that they tried something they would not otherwise have attempted or achieved.

When offered a scale on which to rate the coaching ranging from "unhelpful" to "very helpful" all 11 carers rated it as "very helpful".

The way in which it was helpful was described variously as, not having solved problems but having provided tools to help manage, being able to see things from a different perspective and understanding that the situation may not change but "you can change yourself through how you cope and react which is less stressful".

One carer summed it up as "guidance through conversation" with "small ideas that resonate with you". A more concise description offered by 1 carer was it "made you stop and think".

Eight carers spoke of being provided with tools and strategies to deal with their emotions, thoughts and individual situations. When asked what was particularly helpful the various tools and diagrams were highlighted. (See Chapter 4 for some of the tools which were used/created.)

A very powerful description from 1 carer was that the coach helped her to look within herself and find herself again. Acceptance of emotions, managing own expectations, coming to terms with the situation were also highlighted as were techniques for relaxation. Similarly powerful

was the fact that the strategies tools and ideas were identified as helping the interactions with the cared for person as well as their changed approach improving relationships.

The question seeking to understand what was particularly helpful elicited responses including the coach being outside the situation and objective and non-judgmental; the coach being good at listening and understanding things; the coach being able to "help me to see from the other side of the fence".

With regard to outcomes, being calmer, more able to cope, seeing how to move things forward featured. Other significant outcomes included one carer who said "before I was just the carer and now I'm the partner" and another who said their own different, more positive approach has led to a more positive reaction from the person they care for.

All 11 carers said they would recommend coaching to other carers with some spontaneously adding words like definitely, undoubtedly and absolutely and saying "without question".

5.2.2 Comparison with pre-coaching - how you feel generally

Carers were reminded of their pre-coaching stage answer to this question with a view to identifying any change.

Changes in emotions and level of acceptance of the situation were mentioned by 6 carers and these were all positive. Feeling more even tempered and less weepy, guilt having been replaced with acceptance, less angry are examples. One said that sadness had previously been "close to the surface" but was now not so close.

Learning how to cope and to accept that feeling a bit resentful is OK was how one carer described what they had learned. Another used a metaphor saying that the coaching had stopped a "volcanic reaction" and it had now become more like a "controlled tremble".

Eight carers gave answers which related to strategies for coping, identifying that the emotions had stayed the same but they now had more strategies to cope with them. One said of their emotions that they are "still there, will never go away" but that they are "adapting to it in a more positive and proactive way". It was noted by one that they still have apprehension about the future but are able to "understand and control things".

One carer had gained the confidence to start caring for themselves more, stating "I do matter" and feeling more able to ask for help.

For 2 carers this was a difficult question to answer since other issues had arisen for them during the period of the coaching. It was highlighted at a later stage by one carer that they felt that the coaching had helped them to "stay away from more medical support" for dealing with their emotions.

5.2.3 Comparison with pre-coaching - how you feel about your caring role and impact on other aspects of your life

The answers to these 2 questions have been brought together reflecting how the carers answered in more free ranging conversations.

Six carers described how, whilst the role had not changed, they had developed coping skills. This was illustrated by feeling more in control through accepting that they could not control everything and as a result identifying what they could control; having better tools with which to manage; looking at things more positively and with perspective, and being better at prioritising.

Five carers provided a second category of answers which related to how well they looked after themselves and took advantage of leisure time. One of these 5 said that it is not possible to give everything and that “you’ve got to give enough for yourself”. Learning to focus on other things, being more relaxed when away from the caring role, feeling more natural going out, gaining more pleasure from things and simply being out a “couple of times” are illustrations of this.

Improvement in aspects of relationships were noted by 4 carers who said they could see a change in the cared for person. One felt that through coaching their explanation of respite was calmer and less confrontational therefore more accepted. Another described being happier to return home after being away.

In relation to emotions, 2 carers felt less resentful and more accepting through understanding they were not to blame for anything. Two others reported being able to discuss future care with the person they care for.

For one carer there had been no change because of other family issues which had “taken over”.

5.2.4 Outcomes and goals

After a reminder of the desired outcomes and goals which had been discussed at the pre-coaching interview, carers were asked if they had changed their outcomes and/or goals after the commencement of coaching. If they had made no changes they were asked to rate their current situation and the table below shows the change in the rating they gave to the outcomes.

Figure 13 Change in outcomes

Carer number	No. of outcomes set	Large change +ve	Moderate change +ve	Small change +ve	No change	Small change -ve	Moderate change -ve	Large change -ve	Changed outcome
1	3	2							1
2	3	1		1	1				
3	1			1					
4	2			2					
5	2		1						1
6	2		1	1					
7	3	3							
8	2	1		1					
Total	18	7	2	6	1				2

Figure 14 Amount of change in outcomes

The score/rating given by a carer was translated as follows:-

Difference in rating/score	Descriptor
4 or more points more	Large change +ve
3 or 4 points more	Moderate change +ve
1 or 2 points more	Small change +ve
Same points	No change
1 or 2 points less	Small change -ve
3 or 4 points less	Moderate change -ve
4 or more points less	Large change -ve

While the limitations of this tool are acknowledged, the attempt to measure the perceived impact of coaching is interesting. Eight carers were able to set and rate outcomes or goals and for all of those eight their rating changed in a positive direction. Six of the carers reported large or moderate change in their outcomes or goals through their ratings.

There were 3 carers who were not included in the ratings. Two of these were unable to set either outcomes or goals but one of these reported having achieved their goals. One carer set 3 pre-coaching goals but was unable to score them. However, at the post-coaching interview they described experiencing change between better and much better, “better than better”.

Two carers changed one of their outcomes at the post-coaching stage. For one this was an outcome which related to managing emotions and they no longer saw this as an outcome since coaching had helped to reach an acceptance of the situation. The second carer had set an outcome related to a practical issue and realised that this would not be covered by coaching. The coaching had however helped them to decide how to approach the objective.

Two carers offered the view that their desired outcomes had improved because they were approaching caring in a better and calmer way. A third carer said that the improvement was through learning coping strategies.

5.2.5 Attitudes and feelings related to coaching having finished

A number of emotions were mentioned including sad, nervous, scared, concerned, disappointed and frustrated. Carers described having looked forward to the coaching sessions and gained “comfort” from knowing there was a session every few weeks which they would miss when the sessions ended. One carer felt less negative since they understood from the coach that the “door was open” if required and that they had gained sufficient for the moment.

The intention to continue what had been gained from coaching was talked about by 4 carers. One felt they would be more open now to attending a Carers Support Group and saw it as a good way of remembering that “you are not alone”.

One specifically mentioned the new ability to reflect on situations and planned to continue with that, while another intended to use the techniques they had learned and discussed ways of making sure they remembered these.

In terms of level of confidence about the future, 7 carers felt confident or fairly confident about continuing with what they had gained with one expressing a hope that they might stay on an “even keel”. Two did not feel confident, one of whom had gained confidence during the coaching process from “knowing she (the coach) was there”.

A number of suggestions relating to the future were offered. Two felt that more sessions would be useful and one of these was a carer who had expressed a lack of confidence for the future. There was a suggestion from another 2 carers that a "top-up" or follow up after a period of 3 or 6 months would be useful.

Group sessions or a contact network of carers in similar situations were mentioned as was the possibility of coaching for a group of family members.

Finally, there was an important reminder that carers work and may therefore find it difficult to attend coaching sessions.

5.2.6 Comparison between coaching and other support

Coaching was recognised as different to other kinds of support by all 11 carers. The use of family and others for support sometimes led to a feeling of guilt and sometimes practical suggestions were offered when that was not what the carer wanted. They described coaching as more than "just listening" in that it was non-judgmental, separate, objective, professional, understanding, non-critical and realistic. In the words of 2 carers, coaching gave the opportunity to "let everything out" and to be "able to let it all go".

A strong sense of remaining in control of things came through for 1 carer – "It was me that did it, but she (the coach) helped me". Through "providing resources" and "knowing the tools" it was perceived that the coach equipped carers to make their own plans and way forward.

For another it was what they called the "one door" approach that was valued. The coach did things that were seen as helpful – "She flipped it round and made you look at it differently".

A view was expressed that contact with other carers is useful to exchange information but that coaching helped more to learn how to cope.

The value of the slow pace of coaching with gradual small changes over time was noted.

5.2.7 Timing and availability of sessions

All 11 carers were positive about the timing and availability of sessions.

Figure 15 Timing and availability of sessions

Number of carers	Comments
6	Six sessions were sufficient although some carers may need more
2	Would have preferred more sessions
8	Spacing between sessions was good
4	Sessions being spread out gives time for thinking and working on things between sessions
1	Would have liked more regular appointments but appreciated the need for time to put things into practice
1	A break with a follow up would be good
1	Appreciation for the prompt follow up by the coach on actions
2	Appointment reminders were useful
2	Appreciation of flexibility to fit appointments around caring commitments

5.2.8 Additional comments

"Like a cloud being lifted"

"Gave me my confidence back"

"Made me differentiate between being a carer all the time and me"

"Invaluable resource and hope its continued"

"Left us a legacy to fall back on"

"Can look forward better now"

CHAPTER 6 DISCUSSION

6.1 Pre-coaching interview data

6.1.1 Access, knowledge and expectations

There has already been some account of the work that had taken place to ensure that potential "referrers" for coaching were well informed about what coaching is and what it could offer as well as some possible criteria to help with the identification of carers who might benefit. These criteria had been tentatively identified through the VSA service which was provided from 2009 to 2014.

Most of the carers in the study came to coaching either through an agency with whom they had an established relationship (5 carers) or they "self-referred" as a result of the information being made available through an agency which was familiar to them and trusted (4 carers). One had previously received coaching through the VSA service and "self-referred" and it was suggested to the final carer at an early session with a VSA Carer Support Worker.

Behind all of the routes where coaching was suggested to a carer there was both an established personal or professional relationship between the coach and the "referrer". When this is looked at against the backdrop of several months of work to develop awareness to no avail it seems reasonable to conclude that on its own, knowledge of a service is insufficient. Working pro-actively in a professional network to establish a new service on the complex map of existing services is necessary. Another factor which had appeared in the early work to develop awareness among nurses was the perception that there would be another referral form to complete. When some referral forms (Social Work was highlighted) can take up to 45 minutes per referral any additional form to be completed can act as a disincentive, albeit sub-consciously to making that referral.

In terms of prior knowledge of coaching and expectations there seems to be little link to ability to gain benefit. However, all 11 carers either expressed hope that there would be benefit or showed optimism and/or a positive mind-set.

It is important to re-emphasise that when the pre-coaching interview took place there had been at least two contacts with the coach. The first was at a phone call made by the coach to respond to the coaching request and provide more information and the second was during the initial 10 minutes of the first coaching session. These two "interventions" were intended to begin the process of establishing the "container" in which the coaching would take place, a major aspect of which is the relationship with the coach. The pre-coaching telephone contact which may last even up to 30 minutes is normal practice for this coach.

While only one of the 11 carers admitted to knowing what coaching was and how it could help, it is acknowledged that there may be reluctance to admit to knowing anything in this interview setting. A perception or fear that knowledge might be "tested" could well influence the answer. However, the perception of the coach is that knowledge of coaching in this context is not widespread and this group is likely to be no different in that regard.

What was striking was that pre-existing knowledge did not seem to be a pre-requisite for this group to participate in the project. The desperation described by one and the feeling that the offer of support came at a good time may well be more important factors. As a result of a willingness to consider coaching, some hopefulness and some optimism may result very quickly from the initial contacts.

The coach had previously hypothesised that a willingness to take personal responsibility might be a factor in identifying which carers would benefit. There are some statements that might

indicate a willingness to take personal responsibility, for example the statements about helping them to gain balance, increased understanding and learning about their own reactions. However, these are insufficient to support the use of willingness to take personal responsibility as a criterion to be used to identify who might benefit from coaching.

There were some comparisons with counselling and this was used on occasions by the coach during the initial phone contact. Counselling is a more commonly understood service than coaching so the use of the term and some explanation of differences and similarities can be helpful. Coaching can sometimes follow counselling or it can be an alternative and seeing both services available on the landscape for carers may be worthwhile.

6.1.2 Descriptions of the current situation for carers

There was a strikingly negative account of the current situation for most carers with some of the words used apparently directed at themselves and their own ability to cope. Other words seemed more directed at the cared for person or situation and a third group of words related to hopes and expectations about the future. Very powerful words were used and these accounts were often very emotional which then influenced how the interview progressed, perhaps with a decision not to explore some areas any further.

The positive account of their current situation from 3 carers and the fact that they also benefitted from the coaching raises questions. The ability to remain positive or at least present oneself as positive may in itself be a coping mechanism and result from an approach of not allowing oneself to examine thoughts and feelings. Alternatively, rather than deliberate avoidance there may simply be a lack of ability to recognise emotions and to be self-aware.

Another area of interest is the reference to caring being like a job and the use of job-like statements to illustrate the situation, particularly in relation to the element of choice or lack of choice. For many, work is not a choice. It is necessary and for some it has to be tolerated. It would be interesting to explore further the use of the term "job" and how it may be used to convey other messages.

The wider impact of the caring role was expressed quite clearly but the sustainability of the situation and the risk of impact on the health of the carer are obvious concerns.

6.2 Post-coaching interview data

The project title – "Coaching to equip and empower carers to maintain their emotional health and well-being" - provides the backdrop against which the post-coaching interview data should be considered. The intention was to try to equip carers by offering them tools and strategies and to enable and encourage them to take responsibility for their own lives. On occasions this took the form of attempting to inspire them to bring about change.

6.2.1 Reflections on the coaching sessions

There is some evidence of carers gaining a feeling of being equipped in their references to the tools and strategies. The tools and strategies were useful for dealing with situations and dealing with emotions, the latter having figured very prominently at the pre-coaching interviews. It was also identified that the strategies, tools and ideas helped interactions with the cared for person as well as leading to a changed approach to wider relationships.

There were other aspects of the process which carers clearly found helpful but in relation to the title of the project the fact that 8 of the 11 carers spoke of tools and strategies indicates that to some extent the aim to equip them was achieved.

The second aspect of the project title which is worthy of note here is the intention to enable carers to maintain their own emotional health and well-being. The description offered by one

"you can change yourself through how you cope and react which is less stressful" is a good summary of how the tools and strategies worked for one carer. There were several other references to personal change related to acceptance of emotions and the situation and managing their own expectations. The results of the process and the personal change were particularly powerful for the two people who said they had re-found themselves and were once again their carer's partner rather than "just the carer" respectively. Both of these are powerful references to identity which is a very important aspect of well-being.

6.2.2 Comparison with pre-coaching situation

Before and after comparison revealed many references to changes in levels of self-awareness and ability to self-manage, even to the extent of being able to stay away from medical support. Compassion for themselves, scarce prior to coaching, was very evident in the person that reached the realisation that "I do matter".

When asked about the impact on the caring role and on wider areas of life the prominence of tools, coping strategies and perception of levels of control in the answers, again point to increased ability to take responsibility for themselves even though the caring situation may not have changed.

The recognition of "self" being important even if only to continue to care was a feature again and examples about going out, being more relaxed when away from the person they care for and even "happier" to return home, are more powerful indications of impact.

6.2.3 Outcomes and goals

The attempt to generate some quantitative data to support this project focussed on trying to define some goals or outcomes, to allocate a pre-coaching score to represent the severity/priority and then to allocate a post-coaching score to enable some measure of impact.

There are many well recognised limitations to this approach in terms of the value of any conclusions which can be drawn. However, the process of defining goals and of attempting to allocate a score to them may in itself be of value. The resulting tangible and credible recognition that there has been some change can provide confidence for a carer about personal ability to effect change.

6.2.4 Sustainability and comparison with other support

While the carers reported a reasonable level of confidence about their ability to maintain the benefits they had gained, the words used to describe how they felt were slightly inconsistent with the confidence levels. To some extent this is unsurprising since it has been clear from the carer's accounts that the relationship between coach and carer is very important. For this relationship to end could inevitably lead to the kind of responses they described.

Managing the end of the coaching is as important as managing the commencement and this was recognised. Managing expectations, increasing the intervals between sessions, the offer of a follow up at 3 months (suggested by one of the carers) and the offer of continued availability of the coach on an informal "over coffee" basis were all parts of the overall process aimed at reducing the negative impact of the end of the coaching sessions.

Coaching was recognised as different to other types of support. As well as sessions being valued in their own right there is yet again frequent reference to tools and strategies and the ability to remain in control. The statement "It was me that did it but she helped me" provides evidence of the value placed on personal change and the potential for longer term benefit.

Clearly the caring situation does not change and in several cases the situation deteriorated as the condition of the cared for worsened. The practical nature of coaching and its emphasis on building personal capacity to cope, to make choices about how to respond and to accept what

cannot be controlled or influenced and work with “what is” were recognised and valued by many of the group.

CHAPTER 7 CONCLUSIONS

This project has added both to the understanding of how carers view their situation and what can be provided to support them. The focus of the project was the emotional health and well-being of carers and understanding how to equip them to manage their own health and well-being in a way that does not require continuous input.

The objectives outlined in the funding application were

1. The identification of the benefits of coaching for carers and their perceptions about those benefits.
2. The development of criteria to identify which carers are most likely to achieve those benefits.
3. Increased awareness among funders and service providers of the use of coaching to improve the emotional health and well-being of carers.
4. Development of a protocol which will outline good practice for coaching carers.

7.1 Benefits of coaching

a) "Less expectation of how it should be and more acceptance of how it is"

The ability to accept and manage emotional responses to situations was major benefit for several of the carers in the study. Many of their goals related to negative emotions and wishing to find a way to cope better with them. While the negative emotions did not always disappear the increased ability to deal with them was noticeable.

b) "Increased awareness of myself so I can make choices"

Loss of control, inability to plan ahead and the resulting negative emotions were features prior to the coaching taking place. Reaching a position of feeling able to make choices and manage interactions differently was another key benefit. References to different kinds of conversation with the person they cared for, and making a choice about how to react in a situation are illustrations of this.

c) "I used to want to please everyone all of the time, now I don't need to"

The sense of being in a position where pleasing others, especially the cared for person, mattered more than taking care of themselves was very evident prior to coaching. There were many very practical examples of putting themselves first on occasions which led to an often immediate improved sense of well-being.

d) "I used to look ahead and see more of the same, now I see a future"

The sense of a future, in some cases a positive future, provided hope and a sense of purpose beyond the caring relationship for some carers.

7.2 Criteria to identify carers

While it had been hoped to identify some criteria by which to predict which carers would benefit most from coaching this was not possible. All the carers in the project benefited albeit in different ways, regardless of whether or not they knew anything about coaching. All the carers in the study had a hope for change and the insight that their situation was unlikely to change. The realisation that the only way for change to take place was through personal change was evident in most of the carers at the start. The only criteria that might be used therefore are that the carer has a positive attitude to the coaching and an openness to trying it.

7.3 Awareness among staff

The project itself has increased awareness of coaching in this context in those directly involved including clinical, administrative and managerial staff. The lack of awareness was a major factor in how the project progressed. This indicates that there is much to be done in this regard if coaching is to be offered as a method of support for carers.

7.4 Good practice protocol

Maximum flexibility around appointments, delivering coaching over an extended period, management of the ending of the coaching activity are components of good practice which were identified by the carers themselves. The use of visual tools and the practice of the coach making them available to the carers was also valued. Contact with the coach between appointments to confirm sessions as well as the relationship between coach and carer were also identified as important.

The relationship between coach and carer is core to the efficacy of the coaching process and attention must be paid to this from the first interaction between coach and carer however that initial interaction takes place.

7.5 General observations drawn from the study

"It was me that did it but she helped me"

A key element of successful coaching is the extent to which the person receiving coaching feels that they have been responsible for the changes they have made. Similarly, any feeling of dependence on the coach will have an impact on the ability to sustain the changes that have been made. The approach taken and the provision of tools and strategies was geared to developing independence and sustainability and the data indicates that this was broadly successful.

"You can change yourself through how you cope and react which is less stressful"

The insight that is illustrated above had a major impact on both the carer who said it and others who gained the realisation and acceptance that the only way they could make change was through their responses to events and situations. This awareness opened a door for many carers to a calmer situation and resulted in increased resilience.

"Made me differentiate between being a carer all the time and being me"

The identity of many of the group of carers in the study had over time been eroded to the point at which they had almost forgotten themselves and had begun to see themselves entirely as a carer. There were many examples of situations where the relationship between carer and cared for returned to its previous state of wife and husband or mother and daughter.

"I've rediscovered myself"

Rediscovering herself was how one carer described the change through coaching and led the way for them to gain more balance in their lives and therefore more fulfilment. The insight that "I do matter" sums up much of what was gained.

CHAPTER 8 RECOMMENDATIONS

It is imperative that there is increased provision of support for carers and it is clear from this project that coaching can make a significant contribution to the provision of support. Coaching is a relatively low cost way to support and equip carers to manage their own situation and consideration should now be directed towards increasing its availability.

It is recommended that coaching should become mainstream and that continuous on-going monitoring should take place to ensure it is being delivered in the best way. For coaching to become mainstream, increased awareness among staff and carers is necessary and this can be achieved through widespread promotion of the findings of this project.

The relationship between coach and carer is critical to success as are the specific attributes and skills of the coach. This means that care is required in the identification of coaches to undertake this work.

It is therefore recommended that

5. There should be a pro-active approach to sharing the findings of this project and to contributing to and developing the existing dialogue about support for carers both locally and nationally.
6. Formal contact should be made with the relevant Health and Social Care Partnerships through their Chief Officers to explore how to develop support for carers using coaching.
7. Consideration should be given to following up the group of carers in this project to explore the extent to which benefits have been sustainable.
8. Consideration should be given to the governance arrangements which would be required to provide assurance about the suitability of coaches and the quality of the coaching process. These arrangements should include processes for monitoring and review of any service which is established.