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Participants' perceived utility of motivational interviewing using Co-Active Life Coaching skills on their struggle with obesity

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The purpose of this qualitative study was to investigate the impact of Motivational Interviewing (MI) using Co-Active Life Coaching skills as a treatment for adults (age, 35–55 years) struggling with obesity. Eight women (BMI $\geq$30) who reside in London, Ontario, received 18 coaching sessions over six months with a Certified Professional Co-Active (CPCC) coach. Participants engaged in semi-structured pre- and post-interviews, along with a focus group six months after the last coaching session. The study's CPCC was also interviewed post-intervention to gain an understanding of what it was like coaching this population. All interviews were analysed using inductive content analysis. Following the intervention participants credited increased self-confidence; learning to cope with life in a healthy manner; putting self first; increased emotional healing; the importance of social networks in weight loss; and learning to step outside their comfort zone to the coaching intervention. During the focus group, the following themes emerged: weight was a symptom; increased self-care; life coaching and weight loss as a journey; support required as a motivator; and importance of the coach/client relationship. The study's CPCC provided insight into the styles and skills most often used from the Co-Active method as well as suggestions for future coaches working with this population. MI using CALC is an effective intervention in supporting individuals in dealing with life factors that may impede weight loss.

Keywords: obesity; motivational interviewing; life coaching; behavioural treatment; obesity

Overview

Obesity is a global epidemic afflicting over 400 million adults (World Health Organisation, 2006). According to the most recent Canadian Health Measures Survey, from 1981 to 2007–2009, the number of obese females aged 40–59 doubled. If these trends continue for another 25 years, 50% of Canadian males and females aged 40 and older will be obese (Shields, Tremblay, Laviolette, Craig, & Janssen, 2010). Katzmarzyk and Janssen (2004) reported that the health care costs associated with obesity represent 2.2% ($201.3 billion) of the total health care costs in Canada. Coronary heart disease ($1.3 billion), hypertension ($979 million), and osteoarthritis ($881 million) were listed as the three most expensive diseases related to obesity. An increase in adiposity also contributes to an increased risk of colon, breast, endometrium, kidney, oesophagus, gastric cardia, pancreas, gallbladder, and liver

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cancers. Similarly, it has been estimated that 15–20% of cancers in the United States are due to increased rates of overweight and obesity (Calle & Kaaks, 2004). These trends are daunting and impose detrimental consequences on individuals and countries at large for an avoidable non-communicable disease (Shields et al., 2010).

Perhaps the most underestimated consequences of obesity are the psychological problems that contribute to and result from obesity including negative self-esteem, increased anxiety, and elevated depression levels (Warschburger, 2005). Adults struggling with obesity are less likely to marry and have lower household incomes than non-overweight adults (Gortmaker, Must, Perrin, Sobol, & Dietz, 1993). Negative attitudes towards those who are struggling with obesity are accepted in mainstream society and, in some cases, even encouraged (Wang, Brownell, & Wadden, 2004). Society often views obesity as a condition that is the fault of the obese individual (Wang et al., 2004). Wang and colleagues examined the stigma of obesity and overweight individuals and found that those who were obese had negative attitudes towards others who were obese and believed that overweight people were lazier than thin people. These researchers demonstrated that even adults struggling with obesity believed the negative stigma associated with obesity.

Women, more often than men, are affected by depression due to obesity (Hasler et al., 2005; Linde et al., 2004). Increased incidence of depression has been linked to low weight-control self-efficacy and reduced self-esteem resulting in increased binge-eating and an inability to make positive health behaviour changes. Lau, Douketis, Morrison, Hramiak, and Sharma (2006) outlined the need for a comprehensive treatment plan that includes nutritional therapy, physical activity, and cognitive-behaviour therapy. Shaw, O'Rourke, Del Mar, and Kenardy (2007) reported the need for and utility of behaviour therapy and cognitive-behaviour therapy as a way to help individuals facilitate weight management. One increasingly promising form of such behaviour therapy for weight management is Motivational Interviewing (MI) administered using Co-Active life coaching (CALC) skills (Newnham-Kanas, Morrow, & Irwin, 2010).

Research using MI via CALC as a intervention for obesity has demonstrated decreases in waist circumference (WC), increases in self-esteem, and increases in functional health status (Newnham-Kanas, Irwin, & Morrow, 2008; van Zandvoort, Irwin, & Morrow, 2008, 2009). Used on their own, both MI and life coaching have received positive attention as health-related behaviour change methods. For instance, MI has been studied for its use within smoking cessation (Butler et al., 1999), HIV (DiIorio et al., 2003), and youth dietary issues (Berg-Smith et al., 1999). Similarly, an annotated bibliography of 72 articles outlines that life coaching (in many different coaching formats not exclusively CALC in style) has been used for an array of health problems including but not limited to diabetes, mental health, depression, and cardiovascular health (Newnham-Kanas, Gorczynski, Morrow, & Irwin, 2009). It is imperative to note that not all 'life coaching' approaches are similar, and the lack of specificity regarding the type of coaching approach used was a major criticism of the studies outlined in the above-noted annotated bibliography. Similarly, the non-standardised approach to administering the tenets of MI has been criticised for its use within health arenas (Mesters, 2009). Due to their complementary philosophies, the use of CALC tools to apply MI principles has been deemed theoretically sound and clinically appropriate (Newnham-Kanas et al., 2010). MI is a flexible approach that may be used alone or in conjunction with another approach. It is an interview

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style that works to resolve ambivalence in order for the client to move towards change (Arkowitz, Westra, Miller, & Rollnick, 2008). CALC uses MI principles to work with the client to foster meaningful behaviour change. Within the coach/client relationship, the client is the 'expert' and is not presumed to be broken, but rather 'naturally creative, resourceful and whole'. In turn, the client is perceived by Co-Active coaches (similar to MI practitioners) to be the expert in his/her own life. The coach's job is to help the client find answers while practising self-management of the coach's own thoughts, opinions, and beliefs. As a result, the coach, by being fully present and attentive to the client's needs, works to deepen the client's learning and/or put into practice some action that the client chooses. For a full review of the model, please refer to Whitworth, Kimsey-House, Kimsey-House, and Sandahl (1998, 2007). This paper provides the qualitative component of a single-subject, multiple-baseline research study to assess the impact of a six-months one-on-one MI via CALC intervention for adults (aged 35–55) struggling with obesity. In addition to the quantitative findings that support this intervention for adults with obesity (Newnham-Kanas, Irwin, & Morrow, in press), it was also important to understand the personal experiences of the participants who engaged in the intervention and follow-up lasting a total of one year. Specifically, using one-on-one interviews and a focus group, the research team sought to gain an understanding of what it was like: living as an individual struggling with obesity; completing the intervention; and six-months after the final coaching session. We also explored with the CPCC what it was like to work with this population.

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Methods

Participants and recruitment

Eight English speaking women (aged 35–55) living in London, Ontario who presented with a BMI $\geq$ 30 were recruited using a local newspaper. Participant eligibility, process for inclusion, and profile descriptions are provided elsewhere (Newnham-Kanas et al., in press). The mean age of participants was 47 years. Ethical approval was received from The University of Western Ontario's Office of Research Ethics. A Certified Professional Co-Active Coach (CPCC) known to the research team volunteered to administer the coaching intervention.

Procedure

Once participant eligibility was confirmed, participants met for individual interviews with the lead researcher (CNK) at the host University for an introductory meeting. During this meeting, the researcher explained the nature of the study, received signed consent, and confirmed BMI and WC by direct measurement. At the end of this meeting, a semi-structured interview was conducted to gain insight into the lived experience of the women struggling with obesity. Prior to the interview, participants were told that information provided during the initial meeting with the lead researcher would not be shared with the CPCC. Participants were asked to respond as honestly as possible to ensure accurate reporting (Bates, 1992) and were assured that publication of their responses would not contain any identifying markers. The five primary questions used during the interview included: *What is it like being you?*

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In your wildest dreams, what would your life look like? In what way would it be different from now? What does your weight represent? What would you have to say yes and no to, to make your ideal weight come true? What is the story you tell yourself about your weight? Member checking as described by Guba and Lincoln (1989) was used after each question to ensure the researcher accurately understood the information presented. Each interview lasted 10–15 minutes and was audiotaped and transcribed verbatim.

As noted above, one CPCC who was certified through The Coaches Training Institute volunteered her time for the study. The coach was not involved in any other aspects of the study (i.e., the coach had no involvement in or knowledge of the meetings between the researchers and participants, data collection, or data analysis procedures). In addition, the researchers were not privy to information shared between coach and each participant. The first meeting between the coach and each participant was done in person and lasted approximately one hour; the remaining 17 sessions were done once per week by phone and lasted approximately 35 minutes. During the initial in-person session at the University, the coach explained the nature of coaching, worked together to create a designed alliance (goals and desires for coaching outcome) with each participant, and established the primary agenda for each client. Following the initial session, clients phoned the coach once a week (the coach called one participant due to a phone-plan-related agreement with this particular participant). Missed sessions were rescheduled and all eight participants received a total of 18 coaching sessions over 6 months. In compliance to the Co-Active coaching model and format, clients came to each session with their own agenda identified, and that agenda may or may not have been directly related to their weight and health. The majority of questions asked by the CPCC were unscripted open-ended questions, characteristic of the Co-Active coaching method. As per the model's key principle, it was assumed that the client 'knew' all the answers; the coach helped guide the client to her own answers using a variety of techniques. Some of those techniques included: asking powerful questions, championing, holding accountabilities, deepening their learning and/or getting them into change-action, and experiencing what the client felt in the moment. For a full review of Co-Active coaching, please refer to Whitworth et al. (2007).

Within one week of completing the intervention, participants returned to campus for a final in-person meeting with the lead researcher where they participated in a final one-on-one interview. Participants were told there were no right or wrong answers and were reminded that their responses would remain confidential in that the publication of their responses would not include any identifying markers. The final interview served as an opportunity for the researchers to gain an understanding, from the perspective of participants, about their experience of the intervention. The eight questions used during this final interview included: *What is it like being you? How has this changed since you started the program? Tell me about your experience being in the study/program? What have you learned from your coaching experience? What actions have you taken and which do you attribute to coaching? What life challenges or other situations took place throughout the study that may have impacted your body-weight goals? How do you see what you have learned impacting you in the next six months? What else would you like to tell me that I have not already asked?*

Each participant's interview lasted approximately 20 minutes. The interviews were audiotaped and transcribed verbatim.

Six months after their final coaching session, participants were invited back to campus to participate in a focus group led by an experienced moderator (JDI) and trained assistant moderator. The purpose of the focus group was to gain an understanding of participants' perspectives of the longer-term impact of the intervention, their weight-related challenges/facilitators since the intervention ended, and study-related advice that could be used in future work. Six participants agreed to participate in the focus group with one participant leaving half way through for a family obligation. Participants signed an informed consent form, were told that there were no wrong answers, and encouraged to provide honest and frank replies to each question. The six questions used during the focus group included: *What did you get out of being in the study? What have you done since the end of the study? What supports have you put in place to help you on this journey? What do you need to help facilitate your needs/goals/desires? What are you willing to do to make these happen? What advice do you have for us for future studies?* The focus group lasted 1.5 hours. The focus group was audio-recorded and transcribed verbatim. Methods to ensure data trustworthiness were employed throughout the data collection and analysis processes, as advised by Guba and Lincoln (and adapted from Irwin, He, Sangster Bouck, Tucker, & Pollett, 2005) (see Table 1).

After the study was complete, one of the study researchers (DM) who was not involved with participants or the CPCC during the study interviewed the CPCC. The purpose of this interview was to gain insight into the CPCC's experience in working with individuals with obesity. The seven main questions used during this interview included: *What was it like for you to coach in this study? What surprised you about working with these individuals? What were the tools/techniques you used most often? How did you know, as the coach, that the client got what she was looking for? What insights did you gain coaching individuals struggling with obesity? What advice do you have when working with this clientele? What would you do differently if doing this study again?* The interview was done over the phone and lasted 90 minutes. The interview was audio recorded and transcribed verbatim.

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Data analysis and interpretation

Inductive content analysis, as described by Patton (2002), was performed on the transcripts from the one-on-one interviews implemented at the beginning and end of the intervention as well as for the focus group. This technique was used to identify main themes that emerged from participant answers regarding obesity, the study's effect on participants' lives, and participants' experiences with the coaching intervention. The researcher and another experienced qualitative researcher, who was not in any way associated with the current study, separately analysed the pre- and post-interview transcripts and then came together to compare themes and determine which themes were most prominent in expressing the lived experience of struggling with obesity and of being coached. Two researchers (CNK and DM) analysed the focus group transcripts and two researchers (CNK and JDI) analysed the CPCC's transcript using inductive content analysis.

Table 1. Measures to ensure data trustworthiness.

Credibility	Member checking was done between questions and at the end of each interview to ensure the researchers correctly understood the responses from participants. During the focus group with participants, the moderator provided her perception of participants' responses prior to moving on to the next question, and the assistant moderator summarized participant responses at the end of the focus group to ensure accuracy.
Confirmability	Inductive content analysis was performed independently and simultaneously by two researchers, who later met to compare their analyses. Data were examined for similarities and differences across the interviews and emerging themes were identified. A summary of the analysis was prepared and discussed.
Dependability	The plan of study and its implementation are documented. Data gathering and analysis are described in detail. Reflective appraisals of the project are shared in the discussion of this paper.
Transferability	The research process has been documented in detail, thus enabling potentially interested parties to determine whether our results are transferable to other settings.

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Results

The results for this study are presented by division into four sections. The first three sections include themes from the pre- and post-interviews as well as the themes from the focus group with participants. The fourth section reveals findings from the CPCC's interview.

Pre-intervention interview themes

Pre-intervention interviews were designed to gain an understanding of what it was like struggling with obesity for these participants. Six main themes emerged from the pre-intervention interviews: (1) weight as a barrier/disconnect in relationships with others; (2) not recognising self; (3) excuses for weight; (4) lack of control over weight; (5) awareness of steps to weight loss; and (6) desire to be healthy. Illustrative comments that embody the majority of responses by participants for each theme are presented in Table 2.

Post-intervention interview findings

Post-intervention interviews were employed to gain an understanding, from the participants' perspectives, of what had changed since the beginning of the study and to gain insights into their coaching experience. Six main themes emerged from the post-intervention interviews that reflect what participants attributed to the impact of the intervention: (1) increased self-confidence; (2) learning to cope more effectively with life; (3) giving self permission to put self first; (4) continued emotional healing; (5) the importance of social networks; and (6) learning to step outside of comfort zone. Illustrative comments that exemplify the majority of responses by participants for each theme are presented in Table 3.

Table 2. Quotes supporting each theme from pre-treatment interviews.

Weight as a barrier/disconnect in relationships with other
'[My weight] represents a barrier or wall that I hide behind. It represents a wall that stops me from doing things I want to do'. (Participant 7)
'[My weight] represents withdrawal'. (Participant 8)
'And then I even take it a step further where sometimes, I think I'm hiding behind [my weight]'. (Participant 1)
Not recognizing self
'When I look in the mirror, I can see myself but I don't always recognize myself as being me. I'm not a fat person'. (Participant 3)
'I still think of myself as a thin person and when I look in the mirror I don't recognize myself'. (Participant 2)
'Who you are inside is not who you become outside. I've been in shock whenever I look at a window or a mirror, just a glance that that might be me and so I think it's more just, it's sometimes disbelief'. (Participant 8)
Excuses for weight
'Sometimes I justify [my weight] with genetics, metabolism being slowed down by medication I was on, whatever'. (Participant 1)
'I'll make excuses. Excuses why I've continued to put weight on instead of, and not making a really good effort to do something to get rid of the weight. Excuses like, "oh, it's the medication I am on" or "I can't exercise because it hurts too much" '. (Participant 4)
'I guess a few excuses. My Mother was overweight even though all the children weren't but as we got older we tended to gain weight and keep it on. You know I can make up excuses'. (Participant 5)
Lack of control over weight
'[My weight represents] loss of control. Not able to follow a plan. . .loss of control is where I'm eating indiscriminately and seeing it in the weight gain'. (Participant 4)
'I'm not quite in control of [my willpower and weight] as I used to be or what I would like to be'. (Participant 5)
'I think I'm addicted to food. . ..Every day I think how am I going to fix this? That's the only thing that's in my head as I have to get this under control and how can I?' (Participant 6)
Awareness of steps to weight loss
'[To make my ideal weight come true] I would have to say yes to a commitment to eating right and exercising right. Say no to eating wrong and not exercising'. (Participant 2)
'I would have to say yes to increased exercise and no to junk food. And yes to time for myself'. (Participant 3)
'I'd have to say yes to an exercise machine that I can do. I'd have to say no to a fair amount of eating habits and I definitely would have to say no to the times I eat, the late night snacking'. (Participant 4)
Desire to be healthy
'I would like to be, I guess I would like to be fit. I would like to be completely healthy. No, I don't want to be thin. I want to feel strong, be strong, and look strong. I want to be strong and healthy'. (Participant 2)
'I'd like to have more energy. . ..I'd love to travel and have the energy to travel and be more active'. (Participant 3)
'I wouldn't have this body and I would be able to be physically active and out there and doing things'. (Participant 7)

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Table 3. Quotes illustrating each theme from post-treatment interviews.

Increased self-confidence

'I feel a lot better about who I am and I learned to stand tall in my own shoes'. (Participant 1)

'If I don't [take control of my life], who's going to? So [my life] has changed in the sense [that] I have that confidence and that go-to again. You know, I've started volunteering again and I'm already making a return to work . . . for next January'. (Participant 7)

'So [working with the CPCC] gave me the confidence to know that what I was doing is right and the eating, and especially the exercise, gave me the mental ability to cope with my issues'. (Participant 6)

Learning to cope with life

'I'm more active, I'm also having more pain but I'm able to deal with it a little bit better because I'm feeling better about myself'. (Participant 1)

'I'm more able to tackle things where as before it was, I was so overwhelmed with existing that the thought of thinking about what I was going to eat. . .no that was just too much that day or most days'. (Participant 7)

'I have a much better handle on my stress. I guess [that] would be part of what I learned so that I can get perspective on what's going on around me. Perspective on what I'm doing or what I'm not supposed to be doing or how to turn things around to a more positive aspect for me'. (Participant 4)

Giving permission to put self first

'My priority now is really about me and that's huge, where it was [before the study] always about my kids. And I'm able to make it more about me because they're older and they respect that I've changed, that it's all about me, and they benefit from it like with the [healthier] food and that sort of thing and they're really supportive and happy'. (Participant 6)

'I've got to put myself first, you know, my children are old enough. They don't need me as much and my husband too. I'm willing to say no, not right now, and you know, period'. (Participant 5)

'I've learned to set boundaries and say, "you know what? My time is important for me too, not just for you"'. (Participant 1)

Emotional healing

'I had been sort of dealing with my issues with [family members] for the first couple of sessions with [the CPCC]. I just sort of finished that off. . .so that was nice, it's really nice to not have that . . . that painful feeling inside me sometimes when I think about [my family] I'm used to having a painful feeling and it's the first time in my life. . .that I've been without that painful feeling, so that's new to me'. (Participant 2)

'[It was] so life changing working with someone [the CPCC] who stepped beyond just the physical part because what was holding me back was real emotional stuff'. (Participant 8)

'The things that were the more emotional healing were, I definitely attribute that to the coaching'. (Participant 1)

The importance of social networks

'I'm definitely not a gym person, there's got to be a social benefit, so it has to be fun social for me, which boot camp was perfect for because we bonded with girls'. (Participant 3)

'Having somebody else to turn [the CPCC] to was really, really important, so seeking support is really good'. (Participant 8)

Learning to step outside of their comfort zone

'I'm stepping out of my comfort zone and becoming more social than I would normally feel comfortable with. I have a tendency to isolate myself a little bit and I'm kind of pushing myself to call old friends, make new friends'. (Participant 2)

'I think sorta the fact that to do that sort of [self] work, is to just get back, step back in life and I was not really out but I think I was observing more than I was being. Stepping in and being part of your life in an active way'. (Participant 8)

'Instead of sitting back as I kind of decided to play the victim role or the poor, poor me role or whatever, I've decided that if something is going to change then I'm going to do something about it'. (Participant 7)

Focus group findings

The focus group was utilised to understand what happened since the study ended and how participants were planning on moving forward. Six main themes emerged from the focus group: (1) weight was a symptom; (2) increased self-care; (3) life coaching and weight loss as a journey; (4) support required as a motivator; (5) relationship with coach; and (6) increased awareness. Illustrative comments that represent the majority of responses are displayed in Table 4.

Participants also discussed suggestions for future studies during the focus group. Half of the participants would have preferred sessions in person to help increase accountability. The other half of participants preferred sessions over the phone because it was very convenient. All participants wanted the study to continue past six months and agreed that one-year or longer would have been preferred. In their view, increasing the number of coaching sessions over a longer period of time would have kept the momentum that was just beginning to start for some participants and would have aided in the continued change in behaviour leading to greater weight loss. Three participants wanted the opportunity to connect with other participants during the study. Finally, participants craved an outlet to report their successes throughout to people in addition to the study's CPCC.

CPCC interview results

The purpose of the CPCC's interview was to gain insights into her coaching experience in service of understanding the coaching competencies that were particularly useful when working with these participants. Suggestions for future coaches working with individuals struggling with obesity are also provided.

All three styles of CALC (fulfillment, balance, and process) (Whitworth et al., 1998, 2007) were used during the coach's sessions with participants. Balance (used to help shift clients' perspectives and facilitate making behavioural choices) and process (addressing the internal emotional experience of the client in the present moment) were used more frequently than fulfillment (exploring what it means for clients to live true to their values). However, fulfillment coaching was used at the beginning of the coaching relationship to help participants clarify their values, envision their future self, and complete the wheel of life to identify areas that were not being lived to their full potential. In the CPCC's view, two of the most powerful tools that were used included powerful questions and 'outrageous' homework (e.g., asking a client who is desperate to find work to make ten cold calls to employers and deliver ten resumes to potential employers in five days). Both of these tools, especially the 'outrageous' homework, provided a safe environment for participants to practice saying 'no' and negotiating with the coach in service of fulfilling their over-arching agenda. Becoming aware and working with the participants' inner saboteur (i.e., negative

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Table 4. Quotes supporting each theme from the focus group.

Weight as a symptom

'I was attracted to getting into the program when I read [the ad] in the [local newspaper]. But I was so so so so stuck but weight wasn't the issue. The weight was the symptom, not the issue of all the other things that were stopping me...so for me, [the study] was about returning and finding me'. (Participant 8)

'I think for me, [the coaching] was more of an impact on other parts of my life than weight....For me, [the coaching] showed me how much how other things were impacting – that my weight wasn't just about food – that it was a lot more than food, a whole lot of other things and really, [the coaching] kick-started that part of me'. (Participant 3)

Increased self care

'So making choices. I'm on the treadmill every morning; I'm like 'ok, I have to make a choice... I don't get to get that piece of dessert that I want'. I do make those choices now. But as far as the other parts of it [weight management] are concerned, one of the big things for me was to learn to say no, and, uh, we [the coach and I] went into that really early on, real early on. To say no to others'. (Participant 4)

'I have to be a priority, and taking time during my day to make me a priority. Whether that means mindfulness techniques, spending time doing mindfulness stuff. You know, incorporating stuff like taking 15 minutes when I'm feeling really overwhelmed and I'm thinking "well, I gotta get this done and that done and whatever" and saying "but you know what? Right now what I need is 15 minutes in a tub or 10 minutes to close my eyes and just deep breathe"'. (Participant 5)

Weight loss and life coaching as a journey

'I'm working out. In terms of goals and such, I've got things, we did the [wheel of life – a task for clients to determine how satisfied they are with their life]. It's your blueprint of where you want to be. It's all a process, so you're getting some of those things done and I'm on track [to a healthier life]'. (Participant 7)

'Yeah, I've had to start and re-manage [my exercise routine], and starting and stopping is really difficult. So, but this time I took [exercise] really slow and I incorporated pilates so I think I've got the pain stuff managed. I'm well into the weight [training] and now I'm building towards the upper [body], so I really got a good base for [an exercise routine]. Now I've got to start on my nutrition'. (Participant 2)

'It took me a lifetime to get to this [weight]. I don't expect to overcome it completely'. (Participant 3)

Support required as a motivator

'I need to go [to the gym] because I really feel I need – sort of like the buddy system thing – I need to be around people who like to do that sort of thing. I have my husband and my son, both don't want to exercise... I want for me to have people around me that are interested in improving [their physical fitness]'. (Participant 5)

'Well, I get great support from my husband. In the winter, he'll say 'I'll scrape the snow or I'll get the car started for you' and that's great because if he's at it that means I get to go [to the gym]. That's special to me'. (Participant 4)

'I got the feeling that [people at the gym] are going through this [weight struggle] together, I mean, I value people that who are going through this [weight struggle] together with me. I mean, I value the information that I'm being [taught], I try to suck in all of the knowledge that I'm learning, but I enjoy and I feel motivated by the people who are [exercising] with me'. (Participant 8)

Relationship with coach

'[The coaching] is serendipitous for me. It's me and [the coach] having to face a health issue and having to get real with the [weight problem]....And being able to say anything to [the coach] was like talking to a best friend. Or hoping that she was your best friend, though not always!' (Participant 8)

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'And part of [the ease of the study] was that you knew you could talk to [the coach] about [anything]. So you had another sounding board as well, so I went into it as planned: 'I'm going to take every speck of [the coaching session]'. So I wasn't quitting for a second'. (Participant 4)

Increased awareness

'On the, [wheel of life – a coaching tool] that [the coach] had us do first, one of the things that I had was that I needed more fun in my life. I basically hung out with one friend, and I didn't manage and nurture my friendships that well, so people kind of fell away over the years, and I had regrets about that. What I've been doing since the study is trying to stay in contact with people, you know, saying 'hey, let's go for a coffee', and being more involved, and that's a big change for me, and I finally realized [the importance of nurturing friendships]' (Participant 7)

'In addition to the vegetables, I'm also allowing myself to have desserts. [The coach] and I talked about the smoking/drinking thing, and for me, a couple of glasses, 3 or 4 glasses were [too much]. But, chocolate, that tastes equally good, something small, being able to [still enjoy treats], enjoy [the chocolate], [and still] keeping track of the weight [works for me]. I'm allowing myself to enjoy things in small doses'. (Participant 8)

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self-talk) was also prominent throughout the coaching relationship and seemed to strengthen participants' ability to say 'no' which helped clients become centre stage in their own life. True to the Co-Active model, the agenda had to come from the client – even if it didn't necessarily align with the participant's ultimate agenda or the agenda of the study to lose weight. The CPCC also used acknowledgement (a skill used to identify who the client is rather than complimenting or praising his/her action or story) as a competency throughout the coaching experience. However, it was noted that the CPCC used this tool sparingly and it was only employed when definite action had been taken. The purpose of Co-Active coaching is to deepen learning and/or forward action; if one of these main purposes is not used, then coaching is deemed not to be taking place, merely an interesting conversation. The CPCC perceived that if she acknowledged on a regular basis or as a form of comforting, it would keep participants stagnant and defeat the purpose of coaching. Finally, the CPCC viewed clients as naturally creative, resourceful, and whole as exemplified when she said, '... it was amazing to me, their inner strength, their fortitude, how they were able to juggle so many different priorities, so many different challenges, so many different agendas'. Even during times when participants may have been struggling, the CPCC maintained that they were not broken and had the power to find their own answers and make the changes they desired.

The CPCC in this study shared some insights that may be useful to coaches who would like to pursue a practice with this population. Specifically, the study's CPCC recommended that: each programme or course of action be tailored to each client; the CPCC should remember to drop assumptions on what the client may or may not be ready for; when participating in a research study, CPCCs must be invested in their clients and not the outcome of the study; the CPCC should remember that the agenda must come from the client who may or may not want to focus on weight-related issues; CPCCs should be fearless and transparent with their reflections to clients; and a strong sense of empathy is needed when working with this population. Quotes supporting the coach's feedback are presented in Table 5.

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Discussion

The purpose of this study was to assess qualitatively the impact of MI using CALC as an intervention for adults struggling with obesity. Specifically, using pre- and post-interviews as well as a focus group, the researchers of the current study were interested in what it was like living as an individual struggling with obesity; what it was like being involved in the study; and how participants were planning on moving forward with their lives. At the end of the intervention, the CPCC of the study was interviewed to shed light on the tools and techniques used predominantly with these participants, as well as to provide suggestions for coaches interested in working with this population in the future.

Prior to starting the study, participants reported not recognising themselves anymore, using weight as a barrier to relationships with others, using excuses to justify their weight, lack of control over their weight, and a desire to be healthy. At the conclusion of the study, participants conveyed a new or increased self-confidence, new and effective ways for coping with life, putting self first, continued emotional healing, an increase in social networks, and learning to step outside of their comfort zone. Six months after the conclusion of the coaching sessions, six participants returned for a focus group where they discussed how integral the relationship with the coach was to their personal success, how weight was just a symptom to other challenges in their life, how changing lifestyle behaviours is a journey that takes time, how they have maintained their ability to put themselves first and say no to others, how support is needed to make changes that affect their weight, and how a new awareness about the choices they make will affect their body and mind. Participant feedback at the end of the intervention suggests that MI using CALC skills is an effective intervention that supports clients, who are struggling with obesity, in making changes that align with their goal of living a healthy life. Although it is known that weight gain is due to an imbalance of calories in compared to calories out, participants in the current study shed light on the important point that there are far more emotional factors that influence an individual's behaviour.

The overwhelming difference between pre- and post-intervention was that participants were feeling empowered following the intervention. Prior to the start of the intervention, all participants reported in the pre-interview that they had lost control over their weight. For some, this lack of control led them to not even recognise themselves anymore as they continued to create obstacles that resulted in an inability to make any changes that would benefit their weight. Wallerstein (1992) contends that powerlessness serves as a risk factor for disease. However, empowerment serves as a health-enhancing strategy and an important promoter of health. Whether their weight decreased significantly ($n = 6$) or remained stable throughout the intervention ($n = 2$) (see Newnham-Kanas et al., in press), these participants ended the intervention empowered to make choices that validated and supported their desire for a healthier body and mind.

Prior to the start of the intervention, participants demonstrated perceived powerlessness through their low self-confidence and struggle to connect back with others in their lives. It is well documented that self-esteem is lower in adults struggling with obesity compared to non-obese individuals (Ackard, Neumark-Sztainer, Story, & Perry, 2003; Linde et al., 2004; Starky, 2005). Social isolation is often linked with obesity and is thought to augment weight by increasing the psychological vulnerability that may result in over-eating and sedentary behaviour (Puhl & Brownell, 2001). Participants at the end of the intervention and throughout

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Table 5. Quotes supporting CPCC's feedback.

Styles of coaching
'. . . .when I look at the three types of coaching, the fulfillment, the balance, and the process, I would say in this client group, the two that were really used most often were the balance and the process coaching'.
'I used fulfillment initially in order to get, you know, to get a future-self perspective, but the balance, [was used for] understanding that wheel or using that wheel for choice'.
Powerful questions and homework
'So the really powerful questions allowed the clients just to really [learn] and make good use of each and every coaching experience'.
'. . . .as a coach I see myself fulfilling two really important functions – one is to ask incredibly powerful questions and the other is to give outrageously difficult homework'.
Saboteur
'I mentioned the wheel of life, um we did a lot of values clarification, we did a lot of work on discovering the gremlins [inner critic] um and, and how to handle that self-sabotaging'.
'. . . .I really think that this technique [learning about the client's inner critic] played a good part in that. Interestingly enough, I spent time teaching them about their gremlin [a coaching term for the internal judgemental voice of the client]'.
Agenda
'So I would often look for an agenda in what they would tell me about, but what they were really um, what I became involved in, as a coach, was more listening to their story and attempting to get them to have an agenda, if you would'.
'I guess that's a point I'm trying to make is that from, from the researcher's point of view, they have a certain agenda, but you as a coach don't'.
Acknowledgement
'And I had to self-manage to make sure that I used it very sparingly, used acknowledgement very sparingly, and only when um definite action had been taken. Um and then it was interesting for me, and surprising for me, to see how quickly, throughout the process, how quickly, or how much more frequently I was able to acknowledge more quickly as the process went on because they started really making significant change and gain'.
'I was very on alert for any small amount of gain or action that I could acknowledge, I had to make sure that I didn't acknowledge as a means of comforting. . .'.
Transparent reflections
'. . . .I realize that I should have, um I should've confronted them far sooner than I did in the study about the fact that we were [having a conversation and not a coaching call]. And um, I think their end result would've been significantly better had I done that sooner and more effectively. So I learned that'.
Invested in outcome
'And the . . . piece of advice is recognize that the ownership, revise with both the coach and the client, that you cannot, absolutely cannot become invested in [the client's weight loss]'.
'As, as opposed to, you know, teaching the whole student, and I guess that's a point I'm trying to make is that from, from the researcher's point of view, they have a certain agenda, but you as a coach don't'.
Empathy
'And you have to have a great deal of understanding and empathy for people who are struggling with pain and suffering'.

the six-month follow-up period experienced an increase in self-confidence and actively sought out social contact. For example, participants who put themselves first and said no to members of their family and friends whose needs would normally trump their own, demonstrated and reported an increase in self-confidence. Participants also

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connected with friends they had not seen in years and joined clubs and groups to fulfill their desire to develop a social network. Aiding participants to shift their attitudes, beliefs, and behaviour, will ultimately lead to weight loss. With this shift of thinking, participants' definition of success expands with the ultimate goal that any changes made will remain sustainable (Kausman & Bruere, 2006). For participants in this study, clinically significant increases in self-esteem were also measured and reported in Newnham-Kanas et al. (in press). These pre- and post-results align with previous MI via CALC studies by the research team, thereby reinforcing the relationship between MI and increased empowerment (Newnham-Kanas et al., 2008; van Zandvoort et al., 2008, 2009). The increase in self-esteem and self-confidence at the end of the intervention highlights the impact of MI using CALC skills can have when working with individuals who are struggling with their weight.

Six months after the last coaching session, six participants returned for a focus group. Many of the points discussed above were re-iterated; however, specific emphasis was placed on the relationship each participant had with the CPCC and how fundamental that was to her personal success. Whitworth et al. (1998, 2007) and Miller and Rollnick (2002) underscore that the power of coaching/MI lives within the coach/practitioner and client relationship. Whitworth et al. (2007) explain that the reason coaching is a powerful medium for change is because it is 'inherently dynamic' (p. 15). In other words, it creates an empowered relationship for change where the coach and client work together, as co-creators, to enable clients to make changes in their lives. As a result, these changes are expected to be integrated into their daily living and actually have an impact on their lives (Kausman & Bruere, 2006).

Support was reported by participants as critical to their success in managing their weight. Support for participants in this study included the CPCC, family, and friends. It has been reported that support for individuals struggling with their weight plays an important role in maintaining weight-loss (Perri, Sears, & Clark, 1993; Wolfe, 2004). Prolonged treatment and professional support are also key factors in increasing weight maintenance (Elfhag & Rossner, 2005).

According to Whitworth et al. (2007) asking powerful questions rather than telling answers is a cornerstone of the model that encourages clients to self-examine their own choices and behaviours. Specifically, 'powerful questions invite introspection, present additional solutions, and lead to greater creativity and insight' (p. 77). This same skill was found to be used most frequently by CPCCs in a study conducted by van Zandvoort et al. (2008) where the impact of Co-Active coaching was assessed as an intervention for University students who were obese. According to Kausman and Bruere (2006) and Foster, Makris, and Bailer (2005), this form of questioning empowers clients to find solutions that will actually garner results that work best for them.

Acknowledging participants was another skill used in this study and used frequently in the study conducted by van Zandvoort et al. (2008). Acknowledgement is used in the Co-Active model to highlight the inner character of the client (Whitworth et al., 2007), not to praise what clients do. In turn, this tool may aid in increasing clients' self-efficacy, or a belief in their ability to complete successfully a given task (AbuSabha & Achterbert, 1997). If individuals perceive that they are capable of completing a task, they are more likely to engage in that task (Donnelly, Eburne, & Kittleson, 2001).

It is important as coaching becomes more niche related, to have suggestions and feedback from CPCCs who have experience working with a particular group of

individuals, to share that information with new CPCCs in the area to strengthen their effectiveness in meeting the clients' goals. It became evident very quickly to the CPCC that each programme or course of action had to be tailored to each client. As a result, she had to drop her assumptions regarding client readiness to/for change. The CPCC, especially when working in a research study, cannot be invested in the study's outcome but instead must be fully invested in the client's agenda. Specifically, even if a participant has joined a research study to help him/her lose weight, the participant may not realise that he/she is not ready to start losing the weight. Rollnick, Heather, and Bell (1992) explain that it is important for the counsellor to determine the client's degree of readiness to change and then select a course of action that is most suitable to the client. If there is a mismatch on what the client is ready for and what the CPCC believes the client is ready for, resistance may ensue thereby halting any chance of change for the client. Even if moving forward does not elicit making a decision, let alone changing behaviour, it is considered a suitable outcome for clients.

From the coach's perspective, at times, it is imperative that the CPCC elicits the agenda for the coaching session from the client. Although this is explicitly part of the Co-Active model (Whitworth et al., 2007), often times the client will not have an agenda at the start of a coaching session and it can be very easy, without being aware, that the purpose of the study is now the agenda for the session. Without even realising it, this shift may form a power imbalance where the CPCC is telling the client what to do which may risk the client feeling disempowered and precluding them from finding their own answers and solutions (Kausman & Bruere, 2006).

It was also noted by the CPCC that in service of participants, the CPCC must be fearless and transparent with his/her reflections, even if those reflections may risk losing the participant from the study. This touches again on the point that the CPCC must be invested in the participant and not in the study's outcome. Finally, the CPCC expressed that a strong sense of empathy is needed when working with this population. All of the participants in this study had been struggling with their weight for years. Behaviours that have taken years to develop do not disappear quickly and require deep routed empathy to create a safe environment for participants to explore their behaviours, decisions, and lived experiences (Kausman & Bruere, 2006). As well, given the stigma associated with individuals struggling with obesity (Puhl & Brownell, 2001) and the reported frustration these individuals have when working with health professionals that has resulted in preventing clients from seeking help, empathy is crucial in putting individuals struggling with obesity in a comfortable environment where they can explore their situation without fear of being judged (Foster et al., 2005).

Limitations and conclusions

A limitation of the current study is the small sample size ($n = 8$). However, given that the study used a single-subject multiple-baseline design and had one volunteer coach, increasing the number of participants was not feasible. Although the researchers used a recruitment method that reached a variety of individuals, the sample obtained cannot be assumed to be representative of the entire population of women struggling

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with obesity between the ages of 35–55. In future studies, it may be helpful to ensure the same number of spots for male and female participants. Another limitation includes having just one coach, as it may be the coach herself that was associated with the reported findings and not necessarily the coaching techniques. Using more coaches in future studies may make findings based on the coaching techniques more generalisable. This limitation along with the small number of participants, determined by the study's design, reduce the generalisability of the study's results.

Despite these limitations, several important conclusions and recommendations can be derived regarding the coaching experience as an intervention for losing weight and the experience of coaching individuals who are struggling with their weight:

(1) Coaching was associated with increased empowerment resulting in greater self-care, increased social networks, greater awareness of choices and consequences, and greater emotional healing.
(2) Social support is needed for individuals to maintain their weight.
(3) Powerful questions and homework were coaching skills used predominantly in this study.
(4) Acknowledgement on behalf of the CPCC was used for supporting clients when change had occurred – not as a comforting tool.
(5) Balance and process coaching was used more frequently than fulfillment coaching to impact clients' learning and forward their action.
(6) The agenda has to come from the client.
(7) The CPCC must decrease his/her assumption on what the client is ready for; readiness must be the client's readiness not the CPCC's aspiration for the client.
(8) When involved in an obesity study, the CPCC has to remain invested in the client's outcome – not the desired outcome of the study.
(9) The coach-client trust and transparency is fundamental to the client's success.

It is suggested that future research increase the number of participants to increase generalisability. As recommended by participants, it is suggested that a similar study be conducted with coaching sessions lasting a full year. Additionally, we recommend adding a physical activity and nutrition programme in conjunction with coaching to determine whether those programmes along with coaching would provide a greater impact on weight-loss and maintenance.

Although the relationship between psychological disturbance and obesity reveals inconsistent results in published research (Fabricatore & Wadden, 2003), the results of the current study must be taken into consideration regarding the impact that obesity has on an individual's life and the effect MI via CALC skills can have in helping to resolve or change behaviours that affect an individual's health. This type of qualitative research is an integral part of developing effective treatment options for individuals who are struggling with obesity. As echoed by Kausman and Bruere (2006), if researchers and clinicians concentrate strictly on the changes in weight, WC, and BMI, we lose the ability to understand the factors that play an important role in determining an individual's behaviour that ultimately affects his/her weight.

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