Health Coaching is a practice in which accredited health professionals apply evidence-based psychological, counselling and coaching principles and techniques to assist their patients to achieve positive health and lifestyle outcomes through cognitive and behaviour change (www.healthcoachingaustralia.com).

There is a growing recognition that simply telling patients what to do is not effective in bringing about long-term behaviour change. This creates frustration for both patients and health professionals. Health Coaching interventions help health professionals to motivate patients toward readiness to change, assist them to change unhelpful thinking patterns and encourage self-regulation and self-management of lifestyle risk factors and treatment regimes associated with chronic illnesses.

The HCA Model of health coaching is a cognitive behavioural model for health behaviour change. It is applied at the individual level of health behaviour change (as distinct from community and society level interventions), and typically occurs in the context of a consultation with a health professional. It is useful in addressing issues of adherence to health behaviour change as outlined by the World Health Organisation (WHO, 2003).

The HCA Model is an integrated package drawing on evidence-based psychological theories, principles and practice techniques. This model was devised to assist health practitioners to elicit autonomous (intrinsic) motivation to change in clients required to change their lifestyle behaviours in order to prevent or manage chronic health conditions. It is based on a readiness to change framework (Rollnick, Mason & Butler, 1999).

Focus on Individual Barriers to Behaviour Change

The model instructs health professionals in how to assist clients to identify and address their individual barriers to change. Individuals are often not consciously aware of all the tradeoffs involved in a specific behaviour change, nor all of the barriers that impede them adopting desired health behaviours. Hence, it is necessary for health practitioners to develop the skills to help clients to identify and understand the beliefs, assumptions, expectations, thoughts, situational factors and conditioned associations that either drive or inhibit the desired behaviour change. Barriers can typically be categorised as behavioural, emotional, situational or cognitive in nature. Once these barriers have been identified, health practitioners and clients can engage in a collaborative problem-solving process to reduce or eliminate specific barriers. Part of the health practitioner’s role is to teach the client skills to support health behaviour change attempts, as well as reinforcing existing strengths and skills. These skills can then be applied by the client to maintain the behaviour change or make other health behaviour changes in line with medical recommendations. In this way the client is empowered to take a more active role in managing their health, and their self-efficacy for adopting healthy lifestyle changes is enhanced.

Communication Style and Intervention Techniques

Motivational Interviewing (MI) and Solution-focused Coaching (SFC)

In recognition that many clients will be resistant to changing particular behaviours, the HCA Model incorporates aspects of Motivational Interviewing (Miller & Rollnick, 2002). MI is used in a brief form (e.g., see Rollnick, Mason & Butler, 1999), rather than the full form of MI that was developed substantially in the context of drug and alcohol rehabilitation. In medical consultations for chronic condition prevention and self-management, while clients may have some resistance to particular health behaviours, particularly where addictions (including smoking and food) are concerned, many will not have such an intense level of resistance as commonly seen in the drug and alcohol rehabilitation field.
The HCA Model also incorporates Solution-focused Coaching (SFC) (Greene & Grant, 2003). It is argued that, while MI interventions are appropriate for clients in low readiness to change a particular behaviour, as readiness increases, the pace and style of the interview should change to reflect this. The Solution-focused conversation style is pivotal in assisting health practitioners to collaboratively work through the goal setting/action planning process without “telling the client what to do”. This inclusive interaction style engenders truly collaborative goal setting and action planning. It thereby increases self-efficacy and induces self-motivation in clients. SFC provides various models and techniques to guide the practitioner and client through goal setting and goal striving processes in a way that increases clients’ chances of success in making behavioural changes (see Stober & Grant, 2006).

The SFC approach helps clients to elicit personal solutions to their own problems using a specific style and structure of conversation. This interviewing style is useful to introduce following the point where the client decides that they are ready to pursue a particular General Goal (e.g., to increase activity levels). It enables health practitioners to guide clients to generate and evaluate options for achieving their General Goals by using the GROW model. Once an option has been chosen by the client it can be refined into a SMART goal and a detailed action plan can be constructed to address the identified barriers. Solutions developed in this way generate a greater sense of client ownership, are more likely to fit the client’s preferences and life circumstances. Therefore, the client will be more likely to initiate behaviour change and the strategies will be more likely to lead to success.

MI and SFC are philosophically aligned in that they both encourage a client-centred, curious, respectful and non-judgemental mind set to be held by the health practitioner. They are complementary models of communication and protocols that support client behaviour change processes. However each is ideally suited to different states of readiness to change. As a general rule, prior to the client deciding to embark on a particular behaviour change, brief MI would be the predominant communication style and processes recommended for use by the practitioner. After the client indicates that he/she is ready to work on a particular General Goal, the recommendation would be for the health coaching practitioner to move to a SFC approach in order to explore how the General Goal might be achieved. This relationship between the communication styles, processes and readiness to change is represented graphically in Figure 1, p 6.

Cognitive-behavioural Techniques (CBT)

Cognitive-behavioural change techniques are used to address cognitive barriers to change and can be blended as needed throughout the health coaching process. In the HCA health coaching model, CBT techniques are incorporated particularly at three points in the health coaching process:

1. CBT techniques are used as an adjunct to examining the benefits and costs of changing versus not changing a particular behaviour. Cognitive techniques can be used to uncover autonomous or intrinsic motivators for change, and thereby increase the perceived importance of behaviour change and the likelihood that the client will decide to attempt health behaviour change.

2. Cognitive-behavioural techniques are recommended in the action planning phase if the client anticipates or experiences cognitive barriers to implementing and maintaining their action plan. That is, they identify that habitual thinking patterns may undermine their good intentions of carrying out specific behaviour changes.

3. Cognitive change techniques are also an important component to include in relapse prevention plans, which are an integral part of action planning.
The Theoretical Model

The theoretical model is outlined in Figure 1. This model incorporates aspects of well recognised health behaviour change models and concepts, including:

- Therapeutic Alliance (Bordin, 1975; Luborsky, 1976)
- The Transtheoretical Model (Prochaska & DiClemente, 1984)
- Readiness to Change, Importance and Confidence (Rollnick, Mason & Butler, 1999)
- The Health Belief Model (Becker & Rosenstock, 1984)
- The Theory of Reasoned Action/Planned Behaviour (Ajzen, 1991)
- Relapse Prevention (Marlatt & Gordon, 1980)
- Self-efficacy (Bandura, 1977)
- Self-regulation (As in Grant, 2006)
- Barriers and facilitators to change

The model is built on the platform of a strong therapeutic alliance that encourages collaboration and mutual respect. The HCA theoretical model guides health practitioners through the health behaviour change consultation in a manner that monitors and reacts appropriately to the client's readiness to change throughout the consultation. Readiness to change is assumed to be behaviour specific and fluid. Within any one consultation, readiness is expected to increase as the client's importance attributed to a specific behaviour change increases and as barriers to change are addressed. Conversely, readiness to change is expected to decline as barriers are encountered and/or importance decreases as a result of issues arising during the consultation. These processes will not be limited to a consultation, but will continue to operate outside of contacts with health practitioners. The various back arrows in Figure 1 represent the often dynamic nature of the behaviour change process when using the HCA framework. It reflects practitioner responsiveness to changes in the client's state of readiness.

The major tasks for the health coaching health professional are:

1. To assist the client to engage in behaviour change for autonomously motivating reasons (facilitated by use of an MI focus);
2. To increase the client's chances of successful and lasting behaviour change when he/she has decided to make changes (facilitated by use of an SFC approach); and
3. To correct misinformation and provide professional advice as required, in a way that increases adherence and avoids creating resistance.

As indicated graphically in Figure 1, in order to complete these tasks the health practitioner must:

- build and maintain a trust-based relationship with the client (i.e., form a strong therapeutic alliance);
- increase the client's perception of importance through building awareness and understanding of:
  - chronic condition-related issues
  - the client's individual barriers and facilitators to change (including awareness and understanding of the client's personal strengths and weaknesses in this area); and
- increase the client's perceived confidence by building their self-efficacy.
Skills Training Components for Health Practitioners

The HCA Model prescribes six skills components for health practitioners to work effectively with their clients for CCPSM. These are:

1. Medical conditions and adherence knowledge - including the reciprocal impact of psychosocial issues and chronic health conditions
2. Behaviour change interviewing techniques - to engage clients in health behaviour change in a collaborative, empowering, client-centred manner
3. Psychological theory of health behaviour change - to identify potential barriers and facilitators to change
4. Behaviour modification and evidence-based coaching techniques – to support clients in acquiring self-regulation & self-management skills and to increase their likelihood of success
5. Cognitive change techniques – to identify and address cognitive barriers to change
6. Emotion management techniques - to identify and address emotional barriers to change

Each of these components contains various sub-components. These are:

Component 1 – Medical Conditions and Adherence Knowledge:
- Aetiology, symptoms and complications of major chronic illnesses
- Impact of chronic illnesses on health and quality of life
- Impact of lifestyle risk factors on health
- The role of health promotion in chronic disease reduction & management
- Adherence to medical and lifestyle prescription
- Common psychological issues associated with chronic health conditions

Component 2 - Behaviour Change Interviewing Techniques:
- Active listening and general communication skills
- Agenda Setting techniques
- Motivational Interviewing skills (particularly for lower levels of readiness)
- Solution-focused Coaching skills (particularly for higher levels of readiness)

Component 3 - Psychological Theory of Health Behaviour Change
- Readiness to change frameworks
- Health behaviour change models
- Cognitive, behavioural, emotional and situational barriers and facilitators to health behaviour change
- Theories of motivation
- Self-regulation and self-management models

Component 4 - Behaviour Modification and Evidence-based Coaching Techniques
- Goal-setting and goal striving theories, principles and models
- Action planning, Contingency planning
- Monitoring and accountability
- Learning and reinforcement principles, Adult learning principles
- Behaviour modification
- Behavioural relapse prevention strategies

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Component 5 - Cognitive Change Techniques

- Cognitive techniques to increase effectiveness of MI and SFC processes
- Cognitive techniques to identify and challenge automatic negative thoughts, beliefs, attitudes and expectations that may undermine behaviour change attempts
- Restructuring undermining cognitions into supportive thoughts, beliefs, attitudes and expectations
- Cognitive relapse prevention strategies

Component 6 - Emotion Management Techniques

- Techniques to assist clients to manage negative affect that undermines health behaviour change (e.g. depression and anxiety symptoms and fear-avoidance.)
- Recognising psychosocial issues & referring appropriately
- Assisting clients to build and use support networks

Using the HCA Model in Practice

Health Coaching Australia uses a specific structured framework to operationalise the theoretical model (not outlined in this paper). The Model was developed for use within health practitioner practice as usual (e.g., a Dietetic consultation or a consultation with a Diabetes Educator). There is a growing tendency for health organisations to included dedicated CCSM health coaching or case management sessions delivered by health coaching trained Key Workers or Health Coaches. Consultations are generally face-to-face or telephone based (e.g., The Good Life Club, Kelly, Menzies & Taylor, 2003).

There are a number of options available for integrating the HCA Model and intervention framework into clinical practice. These are:

1. Use the entire framework as a stand alone intervention for health behaviour change for CCPSM;
2. Use the framework in conjunction with other models of CCPSM such as the Stanford group education model (Lorig et al, 1999), or the Flinders model for CCSM (Battersby al, 2003).
3. Use of single components of the model within short consultations (e.g., use of a cognitive change intervention technique to address cognitive barriers to carrying out an action plan, or use of MI techniques to encourage a client to seek assistance regarding a psychosocial problem acting as a barrier to self-management).

The HCA Model complements other models of CCPSM. The HCA training, structural framework and tools provide health practitioners with micro skills that may augment the effectiveness of other CCPSM interventions. Feedback from organisations that use a combination of models suggests that this is the case.
Figure 1. HCA Theoretical Model

Therapeutic Alliance

Physiological Issues & Lifestyle Risk Factors
Medical & Lifestyle Recommendations

Beliefs & Attitudes  Social Norms  Self-efficacy

Agenda Setting
Desired Outcomes / General Goal Options

Importance  Confidence  Timing

(high)  Readiness  (low)

Decision Line
Ready to Change Something

Behavioural Intention / General Goal

(Barriers)  Behaviours
Emotions
Situations
Thoughts

(Facilitators)

Behavioural Process (Specific) Goals
Maintenance Strategies

Outcomes
Psychological  Physiological
Quality of Life

Opt Out

MI – Motivational Interviewing
SFC – Solution-focused Coaching

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