

ORIGINAL RESEARCH

The Process of Patient Empowerment in Integrative Health Coaching: How Does It Happen?

综合健康辅导中的患者赋能流程：进行过程

El proceso de capacitación de los pacientes en la formación sanitaria integral: ¿cómo se produce?

Karen L. Caldwell, PhD, *United States*; Jennifer Gray, PhD, *United States*; Ruth Q. Wolever, PhD, *United States*

Authors Affiliations

Department of Human Development and Psychological Counseling (Dr Caldwell), Department of Communication (Dr Gray), Appalachian State University, Boone, North Carolina; Duke Integrative Medicine, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, North Carolina (Dr Wolever).

Correspondence

Ruth Q. Wolever, PhD
quill004@mc.duke.edu

Citation

Global Adv Health Med. 2013;2(3):48-57. DOI: 10.7453/gahmj.2013.026

Key Words

Health coaching, lifestyle behaviors, chronic disease, qualitative methodology

Disclosures

The authors completed the ICMJE Form for Disclosure of Potential Conflicts of Interest and disclosed no relevant conflicts of interest.

ABSTRACT

Emerging healthcare delivery models suggest that patients benefit from being engaged in their care. Integrative health coaching (IHC) is designed to be a systematic, collaborative, and solution-focused process that facilitates the enhancement of life experience and goal attainment regarding health, but little research is available to describe the mechanisms through which empowerment occurs in the health coaching process. The purpose of this qualitative study is to describe apparent key components of the empowerment process as it actually occurs in IHC. A sample of 69 recorded health coaching sessions was drawn from 12 participants enrolled in a randomized controlled study comparing two different methods of weight-loss maintenance. Two researchers coded the word-for-word transcripts of sessions focusing on the structure of the sessions and communication strategies used by the coaches. Three basic sections of a coaching session were identified, and two main themes emerged from the communication strategies used: Exploring Participant's Experience and Active Interventions. In IHC, health coaches do not direct with prefabricated education based on the patient's presenting problem; rather, they use a concordant style of communication. The major tenets of the health coaching process are patient-centeredness and patient control focused around patient-originated health goals that guide the work within a supportive coaching partnership. As the field of health coaching continues to define itself, an important ongoing question involves how the structure of the

provider-patient interaction is informed by the role of the healthcare provider (eg, nurse, therapist, coach) and in turn shapes the empowerment process.

摘要

新兴的医疗服务模型表明，参与自身护理对患者有益。综合健康辅导（IHC）是一个系统化、协作性、且专注于解决方案的流程，它有利于提升生活体验和实现健康目标，但鲜有研究对健康辅导流程中产生赋能的机制进行说明。本定性研究旨在说明 IHC 中实际发生的赋能流程的明显关键组成部分。从登记一项比较两种不同的减重保持方法的随机对照研究的 12 名参与者中抽取一份载有 69 次健康辅导疗程记录的样本。两名研究人员对疗程的文字记录进行编码，关注疗程结构和教练采取的沟通策略。确定了辅导疗程的三个基本部分，找出了所采取的沟通策略的两大主题：探索参与者的经历和积极干预方法。IHC 健康教练不会根据患者表现出来的问题进行预先准备的教育，相反，他们采用协调的沟通方式。健康辅导流程的主要宗旨是以患者为中心以及专注于患者自发的健康目标的患者控制，该宗旨通过支持性的辅导合作关系指导工作。随着健康辅导领域不断更新，医疗服务提供者（例如护士、治疗师、教练）的角色如何建立医患互动结构并反过来形成赋能流程，成为一直存在的重要问题。

SINOPSIS

Los modelos emergentes en cuanto a la prestación de atención sanitaria indican que los pacientes se ben-

efician de la participación en su propio cuidado. La formación sanitaria integral (FSI) está diseñada para ser un proceso sistemático, colaborativo y centrado en la búsqueda de soluciones que facilite la mejora de la experiencia vital y la consecución de objetivos relacionados con la salud, pero existen escasas investigaciones para describir los mecanismos a través de los cuales se produce la capacitación en el proceso de la formación sanitaria. La finalidad de este estudio cualitativo consiste en describir los componentes claves aparentes del proceso de capacitación tal como se produce realmente en la FSI. Se obtuvo una muestra de 69 sesiones grabadas de formación sanitaria de 12 participantes inscritos en un estudio controlado aleatorizado para comparar dos métodos distintos de mantenimiento de la pérdida de peso. Dos investigadores codificaron las transcripciones literales de las sesiones centrándose en la estructura de las sesiones y en las estrategias de comunicación empleadas por los monitores. Se detectaron tres secciones básicas dentro de una sesión de formación y surgieron dos temas a partir de las estrategias de comunicación empleadas: la exploración de la experiencia del paciente y las intervenciones activas. En la FSI, los monitores de formación no dirigen con una enseñanza prefabricada basada en el problema que presenta el paciente sino que adoptan un estilo de comunicación concordante. Los principios básicos del proceso de formación sanitaria consisten en centrarse en el paciente y en el control de este con

la mirada puesta en las metas de la salud originadas en el paciente que guían el trabajo dentro de una alianza de formación de apoyo. A medida que se va definiendo cada

vez más el campo de la formación sanitaria, existe una cuestión permanente importante que gira en torno a cómo la estructura de la interacción entre el profesional y

el paciente se ve influida por el papel del profesional sanitario (p. ej., enfermero, terapeuta, monitor) y da forma a su vez al proceso de capacitación.

INTRODUCTION

Lifestyle behaviors are considered the primary contributors to the chronic illness that underlies the collapsing infrastructure and economy of the US healthcare system.¹⁻⁹ Lifestyle behavior not only influences the development of these chronic conditions but also affects their progression and severity through treatment nonadherence. Multiple lines of work point to the need for greater patient engagement in healthcare as a necessary component of any approach designed to improve health outcomes and reduce costs. However, while the need for informed, engaged, and empowered patients is clearly established in trending healthcare delivery models,¹⁰⁻¹³ very little empirical work explores the process through which patient empowerment is actually developed within patient-provider relationships. The purpose of this study is to use well-established qualitative methodology to explore the process through which integrative health coaches actually empower patients to make lifestyle changes.

Emerging healthcare delivery models suggest that not only do patients benefit from being engaged but also that these models require patients who are knowledgeable and possess the skills to participate in their care.¹⁴ Clinical models such as the patient-centered medical home and prospective healthcare^{15,16} highlight the importance of patient engagement in achieving coordinated care, increasing rates of treatment adherence, and improving patient health outcomes. In terms of policy, multiple efforts have been made within the United States to underline the importance of the patient's perspective. For example, the Patient Protection and Affordable Care Act of 2010 (PPACA)¹⁷ created the Patient-Centered Outcomes Research Institute (PCORI) to promote and fund real-world outcomes research that accelerates patient-centered care.^{18,19} The PPACA identifies an engaged patient as central to disease management, prevention, and shared decision-making between provider and patient regarding treatment options.

Given that these trending healthcare models rely on a patient-centered approach, it is essential that patients themselves are empowered to communicate their needs, become highly involved in decision-making processes, and learn how to optimally care for themselves. Patient engagement theoretically allows patients to help prevent, manage, and cure disease through their involvement in the healthcare process and integration of evidence-based information, professional advice, and personal need.¹⁴ Theories exist about how to best engage, educate, and empower patients to

improve their own health and change health behavior as needed (eg, the Chronic Care Model or the Patient Engagement Framework),^{14,15} yet limited work has empirically explored the actual process. In fact, the majority of lifestyle interventions still utilize the conventional medical model of an expert educating or intervening rather than drawing from the science on human motivation to change. This "prescriptive" approach has limited impact and can even undermine the provider-client relationship.²⁰

It is well established that patient education is critical, yet education-based interventions by themselves are clearly insufficient.²¹⁻²³ Self-management that requires complex treatment regimens and lifestyle change must target intrinsic motivation. As the need increases for healthcare providers to become adept at empowering patients to elicit such change, it is imperative that the process of such interactions becomes more salient.

With attention toward a motivational approach that facilitates this process of change, the field of health coaching is rapidly emerging, and with it, a particular brand of coaching called integrative health coaching (IHC).²⁴ In development since 2002,^{24,25} IHC draws from decades of behavioral science focused on the motivation for change. The underlying theoretical model of IHC asserts that behavior changes are sustainable when linked to personal values and sense of purpose.²⁴⁻³⁰ The theoretical model aligns with patient-centered concepts in that the behavior change is directed by the patient and not the provider. While many healthcare providers recommend lifestyle changes, they are not trained to adapt their approach to the psychological and patient-driven nature of sustainable behavioral change. IHC, on the other hand, helps clients create a learning paradigm for themselves in which they can experiment with and refine new behaviors in a way that truly fits their own lives. Coaching outside of healthcare has been used to achieve a variety of goals, including career development, financial management, and relationship satisfaction.³¹ It brings about change through active participation of the client, a supportive alliance between the coach and client, exploration of the client's perception of the issue, and generation of solutions by the client.²⁷ In these empowering relationships, the coaches convey to the clients confidence in their abilities to make and sustain changes while also conveying a sense of choice in how to do that.^{24,25} IHC is designed to be a systematic, collaborative, and solution-focused process that facilitates the enhancement of life experience and goal attainment regarding health.^{25,32,33} A

better understanding of how the empowerment process actually occurs within the coaching relationship will inform efforts to develop and refine healthcare delivery models that engage and empower patients in a manner that improves health outcomes.

METHODS

Program Description

The health coaching interactions analyzed in this study were part of a larger two-site randomized controlled study comparing two different methods of weight-loss maintenance. Participants in the study had lost a minimum of 9% of their body weight in the previous 3 years. Detailed study procedures are reported elsewhere,³⁴⁻³⁶ but in short, eligible participants were randomized into one of two interventions: Enhancing Mindfulness for the Prevention of Weight Regain (EMPOWER) or a standard behavioral weight-loss maintenance (SBWLM) intervention. Both conditions entailed 2-hour psychoeducational groups that occurred weekly for 12 weeks with three booster sessions occurring at weeks 16, 20, and 24. Both groups received information about nutrition, physical activity, and the importance of stress management, values, and goal setting. Additionally, the EMPOWER group participants were taught meditation, mindful eating, and mindfulness strategies to reduce stress-related reactivity and refocus attention on their “true needs.” Both groups were structured to ensure parity on numerous factors such as time invested, peer and interventionist support, educational content, and positive expectancy. Participants were asked to devote about 30 minutes per day to reviewing and practicing lessons taught in group sessions. Participants in both conditions were also given a “maintenance partner” who held a prearranged 20 to 30-minute telephone conversation every other week starting at week 9 and continuing for 6 months. An additional call provided follow-up at month 15. At study entry, all enrolled participants provided their written consent to record the individual telephonic sessions (aka maintenance partner sessions). Those sessions used for this substudy included a random sampling of the recorded sessions from participants in the EMPOWER condition.

Participants

In the original EMPOWER study, a total of 95 subjects were recruited from two sites. For this qualitative substudy of the individual health coaching process, a subsample of 12 of the 32 participants who completed the EMPOWER intervention were randomly selected to include both men and women, the two locations of the study, and the two staff members who were the maintenance partners (health coaches) for this arm of the parent trial. A random sample of 69 recordings was drawn from the 156 sessions provided to these 12 participants. The sample was stratified to ensure inclusion of early, middle, and later sessions with 16 recordings from sessions 1 through 3 (early), 12 recordings from the four

final sessions (later), and the remaining recordings from the middle working stages of the coaching process. The recordings were then transcribed verbatim. Substudy participants include four men and eight women with an average age of 55.8 years ($SD=10.1$ y) and a breadth of sociodemographic background. Five lived in Philadelphia, Pennsylvania, and seven in the Durham, North Carolina, area. Two self-identified as black, nine as white, and one as having multiple racial origins. In general, they were highly educated: three participants had less than a college education, two had a college degree, and seven had done some level of postgraduate work. One reported an annual household income between \$15 000 and \$30 000, four indicated between \$50 000 and \$75 000, and seven noted an annual household income above \$75 000.

The two maintenance partners in the EMPOWER condition were both well trained in mindfulness as well as IHC: One had a master's degree in health psychology, and the other had a master's in rehabilitation counseling. Both had between 64 and 97 hours of coach-specific training, at least 6 years practicing and teaching mindfulness-based stress reduction techniques, and at least 6 years of experience coaching lifestyle change using this IHC approach.²⁴

Data Analysis

To address issues of quality, we operated out of a position of “intense methodological awareness,”³⁷ maintaining written memos and records of our decisions about the coding process and how to proceed. Recordings were transcribed by master's level counseling graduate students, and accuracy of the transcriptions was checked by one team member (KC) who also listened to the original recordings. The coding scheme was developed initially through a review of a little more than half of the transcripts (37 transcripts from seven participants) by KC and JG. We began by reading transcripts for key words or phrases. Two initial coding schemes were developed independently. One focused on the major structural elements of the sessions and was developed by one team member (KC) with terms and definitions, and a second separate coding scheme that focused on the communication strategies of the coaches with terms, definitions, and exemplar quotes was developed by another team member (JG). These initial schemes were reviewed by all three authors and modified through consensus. Using this more complete coding scheme then, all transcripts were subsequently coded using standard procedures for coding qualitative data.³⁸ Segments of dialogue often were coded with more than one code, so the codes and themes were overlapping. Only two additional codes were added when the remaining data were analyzed (33 transcripts from the remaining five participants), confirming that the original coding scheme represented the data adequately. The new codes were then applied to the initial dataset. Coding and data management were facilitated through the use of the NVivo8 computer program (QSR International, Melbourne, Australia).

We engaged several strategies for establishing credibility, transferability, and dependability.³⁹ We were a team of three members with varied perspectives: One member had participated in designing and delivering the EMPOWER program (RW), and two had not been associated with the program (KC and JG). Our varied roles allowed us to engage the transcripts and coding from very different points of view. We made decisions about coding and thematic analysis through consensus. We also established a coding scheme with half of the transcripts that we then tested for dependability on the second half of the transcripts. During our coding process, we searched for negative instances that did not fit our interpretations and developing coding scheme and resolved any instances we found. We also maintained an audit trail of memos on our team process. We engaged each other in a process of reflexivity by acknowledging biases and assumptions informally during our conversations related to the data analysis process. With regard to authenticity,³⁹ we operated from a position of social constructivism, acknowledging that there were several ways to present the health coaching process represented in the recordings and transcriptions, and our interpretations were shaped by the questions we brought to the analysis.

RESULTS

Coding of the structure of the session resulted in identification of three basic phases of each coaching session and identified topics covered in the discussion of participants' goals related to weight maintenance such as exercise, eating processes, or mindfulness practices. Initial coding of the communication strategies used by the health coaches identified 23 different strategies. These strategy codes were examined for possible overlap and consolidated into two themes: (1) Exploring Participant's Experience and (2) Active Interventions. Two of the strategies (Setting Immediate Goals and Scheduling Next Call) functioned together as the final step in the structure for the sessions.

Structure of a Session

The coaching sessions generally followed a consistent structure that involved three basic sections. First, there was usually a brief check-in to see how things were going in general for the participant. Second, the coach discussed with the participant the progress he or she was making toward previously set goals. This section also included discussion of barriers to meeting the goals and how to overcome these barriers. Finally, participants set goals with their coaches based on their previous discussion and set an appointment time for the next coaching session. Expectation of the next appointment encouraged accountability on the client's part to follow through on the goals set in the session. Domains for goal-setting included the following: (1) food intake goals involving discussion of nutrition-related topics such as adequate protein intake or eating specific food groups; (2) eating process goals involving

topics such as the speed at which the participant was eating or eating as a result of emotionally based cues rather than hunger based cues; (3) exercise goals involving topics related to the timing and type of exercise; (4) mindfulness goals involving incorporation of the mindfulness strategies and approaches learned in the group sessions; (5) participant-initiated discussion of target weight goals; and (6) health-related goals involving discussions of topics such as attendance at healthcare appointments or the need for additional stress management tools to address health concerns of the participants. The first sessions were slightly different than subsequent sessions because they included an orientation to the coaching process, and the last sessions were slightly different because they included questions asking for feedback on the entire EMPOWER program.

The individual coaching calls were approximately 30 minutes each every other week starting during the ninth week of a group intervention and continuing for 6 months. The individual coaching process referred to and built upon the goal-setting process initiated in the group setting. Individual sessions with 11 of the 12 participants involved references to the group at some point during the entire sequence of calls. These group references were related to goal setting, group support, and skills and information learned in the group sessions.

In addition to elucidating the general structure described above, we examined the number of talking turns the participant and the health coach each took. As the recordings were transcribed, the words *patient* and *coach* clarified who was speaking, allowing us to use a word frequency count for the words *patient* and *coach*. The word *patient* appeared 9499 times, and the word *coach* appeared 9415 times. This confirmed the visual inspection of the transcripts that the turns at speech were fairly even between patient and coach.

Communication Strategies Used by the Integrative Health Coaches

Exploring Participant's Experience. Most of the codes were consolidated into a theme we called "Exploring Participant's Experience." These codes included facilitative types of strategies such as "Encouragement/Affirmation," "Focusing on Progress," "Nonjudgmental Approach," "Personal Talk/ Rapport Building," "Reflection to Check Understanding," and "Overlapping of Speech" (eg, often with "uh-huh" as a positive utterance). All of these are concepts described in literature based in counseling and psychology⁴⁰⁻⁴² linguistics,⁴³ patient-provider communication,⁴⁴ and social support communication.⁴⁵⁻⁴⁸

The entire process was characterized by a casual, friendly tone. The process was patient-directed with the goal setting based on the patient's ideas, experiences, and choices. Coaches often asked participants for their goals using an open-ended question such as, "What do you want your plan to be for the next couple of weeks?" Occasionally the coach would ask the participant to recall goals previously set rather than stating goals for

the participant as a way of communicating the participant's control over the process. Coaches were also non-judgmental and refrained from evaluating the patient's choices whether or not he or she had met the goals set. For example, after discussing progress on one goal, one patient brought up an instance of emotional eating:

Patient: So, that, so that is, good. And the other, the only thing, I have to say that I only fell backwards once with that old habit of [brief pause] avoidance. I call it like avoidance eating, that I have to do something and I ate something instead, even though I wasn't hungry. I ate something and still had to do the project that I had to do, but I knew that even after I eat I still have to do the project, so why bother eating. It's that whole cycle that's in my head now.

Coach: Uh-huh [positive utterance].

Patient: I still ate, and I wasn't able to get control of that. But that was only once and it's not like a bad thing and, and to tell you the truth, the food wasn't even that good.

Coach: Uh-huh [positive utterance].

Patient: It was some crackers, so it was um . . .

Coach: Well, and that's something to realize at this point is that you did make a choice to go ahead and eat and that's going to happen sometimes and, you know, it was only once out of a 2-week span of time.

Patient: Uh-huh [positive utterance].

Coach: Another thing to take away is that the food itself wasn't that good. Um and so, you know that might be helpful next time. You know, it might be another way of looking at it next time. "Well, last time, when I decided to go ahead and eat, the food wasn't really that good and it didn't really help me with the problem that I had to handle and manage, so why go that route? Why don't I just look at what I can do to better manage this?"

Patient: Exactly. Exactly. It was such a silly thing, and then I was saying, "But you really do want that crunch," and I just didn't feel like chewing gum. I didn't, it was just like the wrong, it was the wrong choice, but I still made the choice, and it was all very conscious.

Coach: Well, let's . . .

Patient: [overlapping] I mean, I'm not beating myself up for it, but I have to say that I found it sort of, a little entertaining.

Coach: Uh [negative utterance].

Patient: Just to go through that whole thing.

Coach: Well, and [name], I just want to stop you for a moment and just take the judgment out of it. It was a choice.

Patient: Yeah.

Coach: Wrong choice? You know, that's really debatable about whether it's right or wrong. You know, the issue is, does that choice lead to other things that could be problematic for you, could it get in the way of meeting your goals? And the answer to that may be yes, at some times, no, at other times and so as you work with developing this mindfulness, developing the piece of it, to just observe it without judgment, with non-judgment. A piece of that is, can you kind of find the humor in that, too?

Patient: Uh-huh [positive utterance]. Yeah.

Coach: Does that make sense to you?

Patient: Absolutely, it makes sense. You said a couple of key things. One is, as I'm developing this mindfulness, and in the past I would not have had so much of a thought process with it. I would've just maybe realized that I still had the problem afterwards or the whatever it was that I was delaying or the habit, but this time I went through the whole process and even came out with, "I still have to do my project and uh, the food was not good." So, I think that it was a positive.

Coach: Uh-huh [positive utterance].

Active Interventions. The second theme describing the communication strategies used by the coaches were Active Interventions on the part of the coach. These included "Reframing," "Tentative Suggestions/Advice," "Offering Information/Rationale," and "Guiding to Specifics."

Reframing. We labeled one type of active intervention used by the coaches as "Reframing." These were situations in which the coach added a different interpretation, often to broaden participants' perspectives to help them find a positive spin or to overcome a barrier or ambivalence. The concept and process of "reframing" and broadening perspective to create possibilities has been well described in the cognitive-behavioral therapy literature⁴⁹ and in the hypnosis literature.⁵⁰ Reframing is used in the example below:

Coach: And how long has this been a behavior pattern of yours?

Patient: You mean eating? [at night to get to sleep]

Coach: Uh-huh [positive utterance].

Patient: Oh my goodness. Oh, 10 years.

Coach: Okay, okay.

Patient: Ten years. So, this is a very, very hard habit to break, and in all, I have to say that I think that I'm doing pretty well. I slipped back this week, but I would say, I would laugh about it to myself and sometimes to my friends, is that some of these companies are going out of business because I'm not buying this stuff at 7 o'clock in the morning. [laughing].

Coach: [laughing]. Well and I was just going to say, you know, it's been a pattern of yours for many years and yet you were successful this week. At least 50 percent of the time, you were successful.

Patient: Right.

Coach: You know, and that is huge when it's something that's been a habit that you've had for a long period of time.

Patient: Uh-huh [positive utterance].

Tentative Suggestions or Advice. The second type of active intervention involved tentative suggestions or advice offered by the health coaches. Notably, when these suggestions were refused by the patient, the coach did not pursue that advice offered. Suggestions were either prefaced by a request for permission to offer them—"Can I give you a suggestion there?"—or posed as questions such as "Do you want to set that as one of your goals, too?", "Is there something maybe you could add in addition to the [prepared food] because it sounded like that wasn't really filling enough for you?" or "Anything along those lines [with healthy fats and protein] that you could generally snack on that you could have at the same time?" Sometimes the coach would comment, "A thought just came to me. What about . . ." Sometimes the suggestions were very direct, yet still phrased in the form of question or as very tentative: "Have you considered a trainer?", "What about another time of day [for your workout]?", or "Maybe you could add strength training to your work out?"

Offering Information or Rationale for an Approach. The third active intervention is closely related to offering suggestions or advice but involved the offer of information or a rationale for a particular approach to a barrier to a goal. Sometimes the health coaches offered other resources, referring to information offered in the group sessions or information offered

from other sources. Note that as with offers of advice, offers of information were often phrased as tentative. Examples of such offers by the health coaches included the following: "There's a couple of things that you might do to increase your 'calories out' . . . part of the equation" and "There is a website that I would recommend."

At other times, the health coaches prompted the participants to explore or remind them of information or a motivating rationale that the participants already had; the health coaches asked questions such as, "How does that help you?", "What do you know about that?", and "What else could you do?" To help participants strengthen the rationale for investigating other alternatives, the health coaches also referred to experiences the participants reported. For example, one participant noted feeling hungry by the end of the day to the extent that she engaged in overeating at the evening meal. The health coach responded with this offer:

Okay, you just said something that I think we need to talk about a little more. So if you're really starving by the end of the day then I'm thinking you're not getting enough calories at lunchtime. So that's what, um, think about what else you could do.

Another patient with diabetes and heart problems had not followed up on rescheduling an appointment with his cardiologist:

Coach: Okay, remember what it was you were going to talk to the cardiologist about?

Patient: Um, yeah, it was about me getting to do more exercise.

Coach: Cardiac rehab. A cardiac rehab program . . .

Patient: Yeah.

Coach: . . . where maybe you could go into a pool.

Patient: Yeah.

Coach: You could have supervision while you exercise.

Patient: Right.

In another example, a participant was having a very stressful time at work, and the health coach was encouraging an increase in the participant's practice of mindfulness:

Coach: Anything that you can do, any other thing that you can do to sit quietly and meditate or read something that can kind of quiet your mind or inspire you? I mean whatever you need, but sometimes, you know just a little regular practice of doing that, even if it's five minutes a day to start out the day can make a difference in how your day goes.

Patient: I do have a friend who does it every single morning and she really, she really likes it so . . .

Coach: Yeah?

Patient: Yeah, maybe I'll try to start doing it before I get out of bed. That's a great suggestion.

Guiding to Specifics. The fourth type of active intervention salient in the transcriptions was to guide participants to specific goals. During the group sessions, participants were introduced to the skill of setting a SMART goal—a goal that is specific, measurable, action-oriented (the action is completely under the participant's control), realistic, and time-bound. This is not necessarily an easy process, and participants often needed assistance in setting SMART goals. For example, one participant was struggling with the death of a family friend. After listening to the patient process the events surrounding the death and the progress the patient was making in meeting her goals related to eating and exercise, the health coach redirected the conversation:

Coach: Okay, so we need a plan for the next couple of weeks.

Patient: The plan is back to Plan A.

Coach: Okay.

Patient: Nobody's allowed to die, okay.

Coach: Well, that's not what the plan is about. The plan is about what you're going to do to take care of yourself.

Patient: Right. Right. I cannot be sidetracked.

Coach: Hum, well. [encouraging]

Patient: Everything has to go well.

Coach: All right, so that's unrealistic. So, let's go with a realistic plan.

Patient: So realistically—realistically—

Coach: Yeah, a SMART Goal.

Patient: I need to go walking every workday.

Coach: Okay.

Patient: I need to return to the pool on weekends.

Coach: Uh-huh [positive utterance].

Patient: And I need to return to planning better what I'm eating.

DISCUSSION

Health coaching is a unique, theoretically supported form of facilitating health behavior change that is increasingly garnering empirical support for health outcomes.^{25,51,52} Health coaching occurs within a partnership between a client and a coach in a supportive environment focused on client-directed goal setting. While multiple publications have explained the theory of this process, we are aware of very little empirically derived exploration of this process. This analysis of randomly selected health coaching sessions offers an empirically derived evaluation of both the structure and process of health coaching as it was provided in the EMPOWER program. Categorization of specific communication techniques used, as well as exemplars, detail the process through which health coaches help participants learn to plan, act, self-assess, and support themselves in changing their behavior. Attention to theory in this setting informs planning, implementation, and evaluation of research and programmatic endeavors, as it offers a guideline or map of sorts for measuring relevant variables, developing appropriate programs, and replicating procedures and effects.⁵³ Further, common practice allows for generalizations to be made and common standards to be created. Such standards are needed to further research on health coaching and move toward a national certification.⁵⁴

Health Coaching: What Is It? What Is It Not?

As evidenced by the analysis of the 69 transcribed health-coaching sessions presented here, health coaching does not direct with prefabricated education based on the patient's presenting problem.^{21,24} Additionally, health coaching is not provider-directed health education that stems from the instinct to convey rather than discuss and to create consensus around medical knowledge associated with particular problem presentations.^{21,24} For instance, in conventional medicine, treatment of hypertension is typically associated with particular directives, such as telling the patient to lose weight, eat less salt, and take certain medications. In integrative health coaching, on the other hand, the focus is on the goals the patient sets to address a particular health concern, and the focus of interaction is on generating and trying out potential solutions rather than focusing on the problem itself. Importantly, health education is inserted as needed by the coach, but this analysis confirms that education is offered tentatively either by asking permission to provide information or by phrasing the educational suggestion in the form of a question or tentative statement. As described in health communication literature on patient-provider communication, this aspect of health coaching is aligned with the idea of compliance vs concordance.⁵⁵ Compliance with treatment recommendations implies provider-directed and -controlled health care with little patient responsibility or volition. Concordance, however, implies a mutual responsibility, a negotiation of course of action between provider and patient, or in this case, between health coach and client.⁵⁵ While the role of an expert in medical care is obviously

still important, it is not the role of the health coach. Patients bring to the coach information and recommendations from their treatment providers and work with the coach to decide which ones to enact and most importantly how to do so in a way they can sustain given all they know about their lives. This is a very important distinction that is not well appreciated yet in common practice. In fact, health coaches in many settings are limited to licensed treatment providers who are considered content experts. Research is not yet clear on the degree to which this potential dual role enhances or detracts from client abilities to change.

This analysis clarifies that the concordant style seen in integrative health coaching occurs through several structural and process elements. From a structural perspective, the goals themselves are identified or chosen by the patient, recalled by the patient at each session, and the structure allows the focus to stay on the clients' action (or inaction) rather than on what the provider believes the action "should be." This focus on client behaviors occurs throughout the check-in, the exploration of progress or of experienced or potential barriers, and the generation of possible solutions. The amount of turn-taking also supports how patient-centric the coaching process is: The number of times the patient spoke was slightly greater, but roughly equivalent to how often the health coach spoke. This is distinct from the typical medical visit during which the provider talks quite a bit more than the patient.⁴⁴ From a process perspective, the communication strategies that support the patient-centric focus fall into two themes: exploration of the patient's experience and the active interventions used.

Exploration of the patient experience entailed a number of specific processes including encouragement/affirmation, focus on positive progress (no matter how small), a nonjudgmental stance throughout the exploration, rapport-building through personal chat, reflective listening to confirm accuracy of the provider's understanding, and overlap in speech. While these specific processes are discussed in other therapeutic literature such as counseling and psychology, significant exploration of the patient's experience is almost never included in a typical patient-provider encounter in medicine,^{44,56} likely because there is not time allotted for such and most providers are not trained to lead a nonjudgmental exploration of patient experience.

Similarly, the active intervention strategies used by the health coaches are seen in other literature, but are not typically packaged together in this way in medicine. For example, reframing⁴⁹ and the importance of the health coach guiding the client to specifics in goal setting have been well described in the behavioral change literature.^{57,58} Similarly, other strategies not typically observed in the practice of medicine or even health promotion include the following: the use of powerful questions to help patients clarify intrinsic motivation; the importance of asking patients permission before offering educational information; and the counterintuitive process of providing suggestions in a tentative "I

don't know if this will work for you" way. These structures and processes taken together appear to synergistically create "health coaching."

This concordant style of health coaching is also aligned with motivational interviewing (MI),⁴⁰ a therapeutic style developed to aid patients in overcoming ambivalence to behavior change. The strongest commonalities between IHC and MI include the tendency to use open-ended questions and the use of a Rogerian therapeutic stance that conveys confidence to patients that they indeed have the internal resources to best direct their own change processes.⁴¹ While some professionals are actually using the terms *health coaching* and *MI* synonymously, this analysis suggests there are overlapping but also distinct elements to health coaching. A full exploration of these differences is beyond the scope of this paper, but several observations merit mention. First, there is a more directive element in MI that is usually not seen in health coaching. Second, MI often helps patients target a social or provider-determined goal (eg, abstinence from substance use) as much as a patient-driven goal. Third, while in MI, the central focus is on overcoming ambivalence to change, the overarching aim of IHC is broader, though elements of MI may be used in the process. A broader discussion of the relationship between IHC and MI will appear in the July 2013 issue of *Global Advances in Health and Medicine*.

Importance of Role Clarity

Health coaching entails a specific structure and provider relationship that reinforce each other. The coach-patient relationship is specifically centered on the patient's health goals and supporting the patient in those goals, whereas functions in a therapist-patient or a medical provider-patient relationship are far more numerous and diffuse. The professional role drives the structure of the interaction, and the structure created in health coaching allows for a focus on these patient-centered goals within a supportive environment/relationship. The structure reinforces the practices and techniques employed. For instance, a focus on a patient's goal to add strength training to an exercise regimen is discussed and negotiated with her coach during one session and then revisited with the next biweekly session. The goal may be discussed openly given the supportive nature of the coach-patient relationship and the nondirective exploration of her experience. Moreover, patient-centric aspects of the coaching discussion convey that the patient is resourceful and capable of coming up with and following through on solutions; these aspects include encouragement, focusing on positive progress, nonjudgmental attitude, overlapping, powerful questioning to elicit rationale, advising tentatively, and guiding to specifics. The patient builds and maintains the efficacy needed to continue pursuit of this goal given the support of the coach and the salience of that self-created goal.

Another provider could use these same communication skills and strategies, but given the structure of his or her particular professional role, the process may be

more difficult to define as patient-centric. For example, the structure of a session with a nurse may involve also taking a patient's temperature and giving a flu shot. Once the structure of a session shifts to one involving having the provider "do" something to the patient or even evaluate the patient, it becomes difficult for the provider to shift out of the "expert" stance and into a fully patient-centric interaction. Dual roles (eg, that of an expert then a coach) can pose challenges and confusion for patients.^{44,59}

Patient-centeredness and Patient Control

The major tenets of the health coaching process, then, are patient-centeredness and patient control focused around patient-originated health goals that are accomplished within a supportive coaching partnership. These components are supported by various theories and frameworks. Carl Rogers' framework of person-centered therapy is based in his concept of the self-actualizing tendency, the active controlling drive that all individuals have toward fulfillment of their potential; through a supportive, nondirective relationship, a therapist or, in this case, coach may aid a patient in meeting his or her goals.⁴¹ Patient-centeredness is widely espoused in the literature on patient-provider communication. Beach et al define patient-centered care as that in which the provider "responds to patients in such a way that allows him/her to express all of the patient's reasons for coming, including symptoms, feelings, thoughts, and expectations."^{60(p894)} Patient-centered communication, which facilitates patient expression, contains elements of data gathering, patient education and counseling, partnership building, emotionally responsive communication, positively interacted nonverbal behavior, positive exchange, and social exchange.⁶¹ This type of communication contains many of the elements exhibited by the coaches in the transcripts presented here and are elements that have been linked to various healthful outcomes; physicians who show more sensitivity to patients' concerns and offer more reassurance and support tend to have patients who are more satisfied with care, have a greater understanding of health issues, and are more committed to treatment recommendations.⁶²

Such patient-centric behaviors within the coaching practice allow for not only a supportive relationship but also one that conveys that the patient has control. In fact, a central aspect of supportive communication is the assurance of control to the other party; support helps one to reappraise a situation and cope with it more effectively, leading to a reduction in stress due to more self-efficacy and greater perceived control over a stressor.⁶³ Power relations are expressed through the communication techniques of the health coaching sessions; the patient is in control and has power while the coach is not disinterested or weak but an active, supportive partner. For instance, the large amount of patient talk vs coach talk in the examples in this article illustrates client direction and control. Various studies of interactions in patient-provider literature measure

amount of talk as illustrative of power and control of interaction, with more provider-centered interactions exhibiting more provider talk than patient talk.⁵⁶

Control is also given by the feature of choice: The client chooses goals and may change them along the way. Clients in EMPOWER exercised choice throughout the program in multiple aspects of health.³⁴⁻³⁶ Control and self-efficacy are cited as components of the vast majority of health behavior models and theories, such as the theory of planned behavior, the health belief model, and social cognitive theory.⁵³ Control appears to be a central predictive feature of behavioral change in health.

The patient-directed nature of health coaching offers control for patients, in that the sessions are structured around their own goals, making the sessions inherently salient, interactive, and hence persuasive for health change. When communication is salient to individuals, it is more likely to be processed deeply, to be persuasive, and to elicit behavior change.⁶⁴ A focus on goals and barriers to meeting goals further offers control and self-efficacy to patients because it breaks down seemingly unmanageable health outcomes (losing weight, for example) into smaller, manageable, measurable goals that are more attainable perceptually and realistically. In addition, there is smoother and more satisfying communication when goals of participants are understood by each party and aligned⁶⁵; the goals in a coaching session are aligned because they are directed by the patient and checked and understood by the coach. The relationship and supportive environment of the coaching session is further strengthened by this smoother communication, leading to greater support and a stronger sense of control and efficacy for the patient in meeting his or her health goals.

CONCLUSION

Chronic illness, such as obesity and diabetes, has largely replaced an earlier focus on acute illness in healthcare. As such, there is a need for effective strategies to motivate individual behavior change and modification. Furthermore, emerging healthcare delivery models rely on engaged and empowered patients to create and maintain such behavior change, as well as communicate their needs and stay highly involved in decision-making processes. Health coaching offers a promising approach for helping to engage and empower patients in this way. As the field of health coaching continues to define itself, an important ongoing question involves how the structure of the session, shaped by the role of the healthcare provider, shapes the empowerment process. As the practice emerges, explication of its tenets, strategies, and theoretical and conceptual underpinnings, such as those noted in this article, should lead to standardization to facilitate more widespread study and employment, furthering healthful outcomes in various settings.

REFERENCES

- Centers for Disease Control and Prevention. BRFSS prevalence and trends data. 2008. <http://apps.nccd.cdc.gov/brfss/page.asp?cat=AC&yr=2008&state=US#AC>. Accessed November 7, 2012.

Acknowledgments
This paper was supported in part by National Institutes of Health grants AT-001-4158 and AT-001-4159. We would like to thank the health coaches Jessica Wakefield, MS, and Jeanne Gresko, MS, as well as Michael Baime, MD, and Mara Wai, MS, for leading the University of Pennsylvania site of the original study from which some of the coaching participants were enrolled. We would also like to thank Michelle Fisher, Cathy Gruman, Miranda Reddick, and Marlena Wilson for transcribing tapes.

2. Centers for Disease Control and Prevention. Cigarette use among high school students—United States, 1991-2009. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5926a1.htm?s_cid=mm5926a1_w. Accessed November 7, 2012.
3. Centers for Disease Control and Prevention. Prevalence of self-reported physically active adults—United States, 2007. *Morb Mortal Wkly Rep*. 2008;57(48):1297-1300.
4. Eaton D, Kann L, Kinchen S, et al. Youth risk behavior surveillance—United States, 2007. *Morb Mortal Wkly Rep*. 2008;57(SS04):1-131.
5. Centers for Disease Control and Prevention. The power to prevent, the call to control: at a glance 2009. Available at: <http://www.cdc.gov/chronicdisease/resources/publications/AAG/chronic.htm>. Accessed November 7, 2012.
6. Centers for Disease Control and Prevention. Trends in intake of energy and macronutrients — United States, 1971-2000. *Morb Mortal Wkly Rep*. 2004;53(04):80-2.
7. Miller JW, Naimi TS, Brewer RD, Jones SE. Binge drinking and associated health risk behaviors among high school students. *Pediatrics*. 2007;119(1):76-85.
8. Naimi TS, Brewer RD, Miller JW, Okoro C, Mehrotra C. What do binge drinkers drink? Implications for alcohol control policy. *Am J Prev Med*. 2007;33(3):188-93.
9. Centers for Disease Control and Prevention. Health, United States, 2007 with chartbook on trends in the health of Americans. Hyattsville, MD: US Department of Health and Human Services, National Center for Health Statistics; 2007.
10. Nutting PA, Crabtree BF, Miller WL, et al. Transforming physician practices to patient-centered medical homes: lessons from the national demonstration project. *Health Aff (Millwood)*. 2011;30(3):439-45.
11. Stange KC, Nutting PA, Miller WL, et al. Defining and measuring the patient-centered medical home. *J Gen Intern Med*. 2010;25(6):601-12.
12. Snyderman R, Dinan MA. Improving health by taking it personally. *JAMA*. 2010;303(4):363-4.
13. Snyderman R, Yoediono Z. Perspective: prospective health care and the role of academic medicine: lead, follow, or get out of the way. *Acad Med*. 2008;83(8):707-14.
14. Gruman J, Rovner MH, French ME, et al. From patient education to patient engagement: Implications for the field of patient education. *Patient Educ Couns*. 2010;78(3):350-6.
15. Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: The chronic care model, part 2. *JAMA*. 2002;288(15):1909-14.
16. Hung DY, Rundall TG, Tallia AF, et al. Rethinking prevention in primary care: applying the chronic care model to address health risk behaviors. *Millbank Q*. 2007;85(1):69-91.
17. The Patient Protection and Affordable Care Act (PPACA). 124 Stat. 119 through 124 Stat. 1025 (906 pages). 2010.
18. Garber AM. How the Patient-Centered Outcomes Research Institute can best influence real-world health care decision making. *Health Aff (Millwood)*. 2011;30(12):2243-51.
19. Patient-Centered Outcomes Research Institute. Patient-Centered Outcomes Research Institute seeks applications to fund \$120 million in comparative clinical effectiveness research in 2012. 2012. Available at: <http://www.pcori.org/2012/pfa-news/>. Accessed November 7, 2012.
20. McDonald HP, Garg AX, Haynes RB. Interventions to enhance patient adherence to medication prescriptions: scientific review. *JAMA*. 2002;288(22):2868-79.
21. Huffman MH. Health coaching: a fresh, new approach to improve quality outcomes and compliance for patients with chronic conditions. *Home Healthc Nurse*. 2009;27(8):490-6; quiz 496-8.
22. Newnham-Kanas C, Gorczynski P, Morrow D, Irwin J. Annotated bibliography of life coaching and health research. *Intl J Evid Based Coach Mentor*. 2009;7(1):39-103.
23. Whittemore R, Melkus GD, Sullivan A, Grey M. A nurse-coaching intervention for women with type 2 diabetes. *Diabetes Educ*. 2004;30(5):795-804.
24. Wolever RQ, Caldwell KL, Wakefield JP, et al. Integrative health coaching: an organizational case study. *Explore (NY)*. 2011;7(1):30-6.
25. Wolever RQ, Dreusicke M, Fikkan J, et al. Integrative health coaching for patients with type 2 diabetes: a randomized clinical trial. *Diabetes Educ*. 2010;36(4):629-39.
26. Sheldon KM. The self-concordance model of healthy goal striving: when personal goals correctly represent the person. In: Deci EL, Ryan RM, editors. *Handbook of self-determination research*. Rochester, NY: University of Rochester Press; 2002. p. 65-86.
27. Grant AM. An integrative goal focused approach to executive coaching. In: Stober DR, Grant AM, editors. *Evidence based coaching handbook: putting best practices to work for your client*. Hoboken, NJ: John Wiley & Sons; 2006:153-92.
28. Deci EL, Ryan RM. Self-determination theory: when mind mediates behavior. *J Mind Behav*. 1980;1(1):33-43.
29. Deci E, Ryan R. Hedonia, eudaimonia, and well-being: an introduction. *J Happiness Stud*. 2008;9(1):1-11.
30. Sheldon KM, Elliot A. Not all personal goals are personal: comparing autonomous and controlled reasons for goals as predictors of effort and attainment. *Pers Soc Psychol Bull*. 1998;24(5):546-57.
31. Stober DR, Grant AM editors. *Evidence based coaching handbook: putting best practices to work for your clients*. 1st ed. Hoboken, NJ: Wiley; 2006.
32. Wolever RQ, Webber DM, Meunier JP, et al. Modifiable disease risk, patient engagement, and psychosocial functioning improve with integrative medicine immersion model. *Altern Ther Health Med*. 2011;17(4):38-47.
33. Smith LL, Lake NH, Simmons LA, Perlman A, Wroth S, Wolever R. Integrative health coach training: A model for shifting the paradigm toward patient-centricity and meeting new national prevention goals. *Global Adv Health Med*. 2013;2(3):52-60. DOI: 10.7453/gahmj.2013.034.
34. Caldwell K, Baime M, Wolever RQ. Mindfulness based approaches to obesity and weight loss maintenance. *J Ment Health Couns*. 2012;34(3):269-82.
35. Fikkan J, Baime M, Sanders L, et al. Mindfulness in the maintenance of weight loss: a randomized controlled trial of the EMPOWER program. Paper presented at: 11th International Congress of Behavioral Medicine; August 2010; Washington, DC.
36. Wolever RQ, Caldwell K, Fikkan J, et al. Enhancing mindfulness for the prevention of weight regain: impact of the EMPOWER program. Paper presented at: 33rd Annual Meeting & Scientific Sessions of the Society of Behavioral Medicine; April 2012; New Orleans, LA.
37. Seale C. *The quality of qualitative research*. Thousand Oaks, CA: Sage; 1999.
38. Patton MQ. *Qualitative research and evaluation methods*. 3rd ed. Thousand Oaks, CA: Sage; 2002.
39. Lincoln YS, Guba E. *Naturalistic inquiry*. Beverly Hills, CA: Sage; 1985.
40. Miller W, Rollnick S. *Motivational interviewing: preparing people for change*. 2nd ed. New York: Guilford Press; 2002.
41. Rogers C. *Client-centered therapy*. Boston: Houghton Mifflin; 1951.
42. Hubble MA, Duncan BL, Miller SD, editors. *The heart and soul of change*. Washington, DC: American Psychological Association; 1999.
43. Tannen D. *Gender and discourse*. New York: Oxford University Press; 1994.
44. Roter DL, Hall JA. *Doctors talking with patients, patients talking with doctors*. 2nd ed. Westport, CT: Praeger Publishers; 2006.
45. Goldsmith DJ. *Communicating social support*. New York: Cambridge; 2004.
46. Albrecht TL, Goldsmith DJ. Social support, social networks, and health. In: Thompson TL, Dorsey AM, Miller KI, Parrott R, editors. *Handbook of health communication*. Mahwah, NJ: Lawrence Erlbaum Associates; 2003:263-84.
47. Burleson BR, MacGeorge EL. Supportive communication. In: Knapp ML, Daly JA, editors. *Handbook of interpersonal communication*. Thousand Oaks, CA: Sage; 2002. p. 374-424.
48. Goldsmith DJ, Fitch K. The normative context of advice as social support. *Hum Comm Res*. 1997;23(4):454-76.
49. Beck AT, Rush AJ, Shaw BF, Emery G. *Cognitive therapy of depression*. New York: The Guilford Press; 1979.
50. Yapko MD. *Trancework: an introduction to the practice of clinical hypnosis*. 4th ed. New York: Routledge; 2012.
51. Appel LJ, Clark JM, Yeh H-C, et al. Comparative effectiveness of weight-loss interventions in clinical practice. *N Engl J Med*. 2011;365(21):1959-68.
52. Edelman D, Oddone EZ, Liebowitz RS, et al. A multidimensional integrative medicine intervention to improve cardiovascular risk. *J Gen Intern Med*. 2006;21(7):728-34.
53. Glanz K, Rimer BK, Lewis FM. Theory, research and practice in health behavior and health education. In: Glanz K, Rimer BK, Lewis FM, editors. *Health behavior and health education: Theory, research, and practice*. 3rd ed. San Francisco: Jossey-Bass; 2002.
54. Wolever RQ, Eisenberg DM. What is health coaching anyway?: Standards needed to enable rigorous research: comment on "evaluation of a behavior support intervention for patients with poorly controlled diabetes." *Arch Intern Med*. 2011;171(22):2017-8.
55. Bissell P, May CR, Noyce PR. From compliance to concordance: barriers to accomplishing a re-framed model of health care interactions. *Soc Sci Med*. 2004;58(4):851-62.
56. Rimal RN. Analyzing the physician-patient interaction: an overview of six methods and future research directions. *Health Comm*. 2001;13(1):89-99.
57. Locke EA, Latham GP. Building a practically useful theory of goal setting and task motivation: a 35-year odyssey. *Am Psychol*. 2002;57(9):705-17.
58. Pearson ES. Goal setting as a health behavior change strategy in overweight and obese adults: a systematic literature review examining intervention components. *Patient Educ Couns*. 2012;87(1):32-42.
59. du Pré A. *Communicating about health: current issues and perspectives*. 3rd ed. New York: Oxford University Press; 2010.
60. Beach WA, Easter DW, Good JS, Pigeron E. Disclosing and responding to cancer "fears" during oncology interviews. *Soc Sci Med*. 2005;60(4):893-910.
61. Roter DL, Hall JA. Physician gender and patient-centered communication: a critical review of empirical research. *Annu Rev Public Health*. 2004;25:497-519.
62. Suarez-Almazor ME. Patient-physician communication. *Curr Opin Rheumatol*. 2004;16(2):91-5.
63. Lazarus RS, Folkman S. *Stress, appraisal and coping*. New York: Springer; 1984.
64. Petty RE, Cacioppo JT. *Communication and persuasion: central and peripheral routes to attitude change*. New York: Springer-Verlag; 1986.
65. Thompson TL, Parrott R. Interpersonal communication and health care. In: Knapp ML, Daly JD, editors. *Handbook of interpersonal communication*. 3rd ed. Thousand Oaks, CA: Sage; 2002.