COACHING *for* HEALTH

THE HEALTH COACHING TOOLKIT

What is health coaching and how does it differ from wellbeing coaching? What are the best models to use and can anyone do it? Health coaching expert **Professor Stephen Palmer** gives us the answers in this five-part health coaching toolkit.

Part 1: Setting the scene: definitions, theory and practice

Health and wellbeing coaching is not rocket science, although it is a specialism within the field of coaching and health. Somewhat surprisingly, studies have shown that the layperson can be successfully trained to become an effective health coach to work in primary care settings, although ongoing monitoring is important[1].

Health and wellbeing coaching, therefore, does not have to be the exclusive domain of licensed health professionals, although the latter may be involved in the training and supervision of lay health coaches.

Health and wellbeing coaching is becoming popular, with organisations employing external providers to offer these services to their employees by phone or online, especially in North America. Looking after employees' wellbeing could have positive outcomes for the employer, too.

Training providers in the US, UK and Australia have been delivering health and wellbeing coaching courses for health professionals and coaches for over a decade, and even in a recession there are signs of growth.

So what is health coaching?

One of the original definitions of health coaching was developed by pioneers in the field:

"Health coaching is the practice of health education and health promotion within a coaching context, to enhance the wellbeing of individuals and to facilitate the achievement of their health-related goals[2]."

This definition links health education and promotion to the key elements of coaching. A crucial aspect is the distancing away from the traditional medical model whereby the practitioner instructs the 'patient' and provides them with their targets. In contrast, the health coach actively encourages the 'client' to develop their own goals.

Some practitioners make a distinction between health and wellness/wellbeing coaching. The latter generally focus on education about health-related issues such as weight management, exercise programmes, smoking cessation, alcohol reduction and nutrition.

On the other hand, health coaching may deal with specific disease management or better health outcomes, such as reducing blood pressure, lowering cholesterol levels, controlling diabetes or managing pain[3].

Health coach, Susie Burrell, provides a useful case example, illustrating the differences between the dietetic and the coaching model[4] (see *Table 1*).

The example highlights the supportive and facilitative nature of the coaching approach. The focus is on discussing a range of factors from the client's perspective. These go beyond the measurements and suggested dietary and exercise changes of the more traditional approach.

Theory and practice

Generally in coaching it is not essential for the coach to have expertise or an in-depth knowledge about the issues that the client wants to explore and work on. However, in health coaching it is strongly desirable that the coach has an understanding of the health and wellbeing topics that most clients want to tackle.

A lay coach should consider taking a health education course or a health coaching training programme. There are also many resources such as information sheets, booklets and websites on a wide range of health-related topics.

Table 1: Dietetics vs coaching model*

Juliet: A dietetics model	Juliet: A coaching model
● Measurements taken	● Discussion of past weight loss attempts
● Current diet assessed	● Discussion of support at home
● Explanation of dietary variables needing change (chocolate at night, wine)	● Discussion of dietary changes required and mapped-out plan of easy changes to implement
● Suggestion of dietary changes to be made	● Client to direct review needs
● Suggested exercise programme	● Client to direct measurements
● Review scheduled for 4-6/52 and referral for mood	● Addition of 'feel good' times for client

**adapted Burrell, 2006*

> "Surprisingly, studies have shown that the layperson can be successfully trained to become an effective health coach to work in primary care settings"

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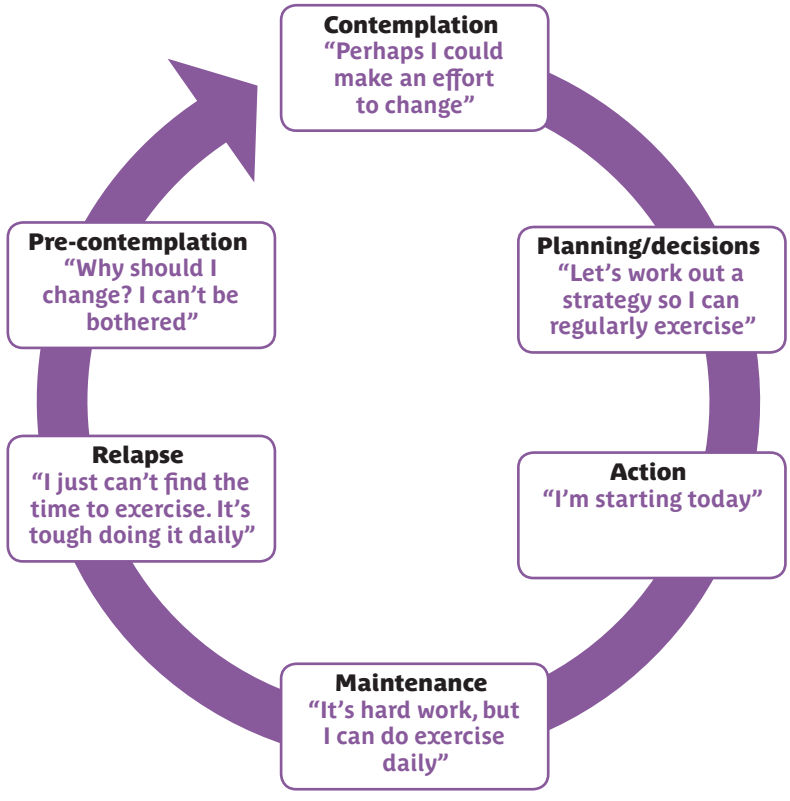
Some psychological theories are also worth understanding, and a couple of these are covered briefly in this section.

Professor Albert Bandura developed social learning theory[5]. He noted that people can learn through observation, modelling and imitation, although learning something does not necessarily lead to behaviour change. Bandura also developed social cognitive theory, which was underpinned by the important construct of self-efficacy, ie, your belief in your own ability to succeed at a certain task[6].

Positive encouragement (sometimes described as Social Persuasion) from others, such as a coach, can often influence and enhance self-efficacy and subsequent goal achievement.

Changing health behaviours can be a challenge for the client – a supportive and facilitative health coach can make all the difference.

Sometimes clients attend their first coaching sessions and are really keen to start work immediately on developing and achieving their goals. Others, however, seem reluctant to engage in the coaching process.



Transtheorectical model of Stages of Change: health coaching example

> "Changing health behaviours can be a challenge for the client – a supportive and facilitative health coach can make all the difference"

Prochaska and DiClemente developed the Transtheoretical Model of Change, which helps the health coach to become more aware of where their client is in the process[7]. It sequentially links six key stages: pre-contemplation, contemplation, planning/decisions, action, maintenance and relapse.

It's at the pre-contemplation stage that the client may be reluctant to engage because they may not see the need to change their health behaviours.

Figure 1 shows the stages expressed in the client's language. In this example, it also highlights the importance of preparing the client for a possible lapse. An action plan can be developed near the end of the process that focuses on how to prevent the lapse – or tackle it.

Models and approaches

Goal-focused models or frameworks such as GROW, have been used for health coaching as well as the proprietary models developed by health coaching providers. Specific approaches include: solution focused, cognitive behavioural and multimodal coaching.

Some health coaches use Motivational Interviewing as their main approach, although it was not originally developed for this purpose, and is usually used in combination with one of the main coaching approaches. ■

● ***Next issue: Motivational Interviewing***

COACHING *for* HEALTH

THE HEALTH COACHING TOOLKIT

In Part 1 of the Heath Coaching Toolkit we considered key theories which inform health coaching, including the Transtheoretical model of Change, or Stages of Change model. In Part 2, health coaching expert **Professor Stephen Palmer** focuses on **Motivational Interviewing**, a form of guiding to help the reluctant client become more motivated.

Realistically, changing health inhibiting behaviours (HIBs) and habits of many decades can be quite a challenge for most people. The health coach needs to time interventions carefully to avoid clients prematurely dropping out of coaching.

From a client's perspective, a goal-driven health coach could be perceived as very demanding and not particularly concerned about the needs of the client, especially if that client is in the pre-contemplation or contemplation stages of coaching.

Definition

Miller and Rollnick's[8] definition of Motivational Interviewing (MI) is: "Motivational Interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change" (p137).

It was developed to help clients deal with ambivalence about making health-related choices. In effect, the coach facilitates the client in persuading themselves into change. MI has been described as an "evolution of client-centred counselling" as it is moved beyond this approach by being "consciously goal-orientated, in having intentional direction toward change" (p135).

MI has been used for a wide range of health-related issues including: alcohol reduction, dietary management, exercise, medication adherence, sexual health, smoking and substance misuse.

So how may it be used in health coaching? If a client starts the first meeting with clearly stated health-related goals, is optimistic and confident in achieving them and there has been little or no history of failure on similar goals, then using models and approaches such as GROW, solution-focused, behavioural and cognitive behavioural coaching are likely to facilitate success. However, if clients are not ready for change, they may still be in the pre-contemplation or contemplation stages of change.

The health coach may choose to use MI to help explore the issues concerned at the client's pace. The coach 'rolls with resistance' and does not challenge the client, but prefers to enhance the client's self-efficacy in their belief that they can achieve behavioural change.

> "The health coach needs to time interventions carefully to avoid clients prematurely dropping out"

The coach listens out for and elicits this 'change-talk' during the conversation.

Ready for change

If the coach is unsure if the client is ready to work on their health-related issue, then it is helpful to use the Readiness to Change scale. This is on a scale of 0 – 10, where 0 is 'not at all interested in changing', and 10 is that the client has 'already made the change'.

This can be depicted graphically so the client can point to where they are on the scale. A low score indicates ambivalence and the need to use MI.

Rule

Miller and Rollnick[9] use an acronym, RULE, which can guide the coach:

- ***R**esist the righting reflex*

Avoid problem solving for the client, eg: "It's obvious to me that you need to stop eating the three 'C's: cakes, crisps and chocolate and also stop snacking in between meals and start an exercise programme if you want to lose weight."

- ***U**nderstand your client's dilemma and motivations*, eg, share your understanding of their issues: "It sounds as if you are finding even the idea of tackling your weight issue as too challenging and perhaps you are wondering what's the point of starting."
- ***L**isten to your client*, eg, use a range of listening skills (see ***OARS***).
- ***E**mpower your client,* eg, facilitate self-efficacy and confidence: "I recall from our last session that you mentioned you did successfully tackle your weight issue a couple of years ago", and "Yes, I agree with you. If you break down your goals into smaller manageable steps you will find it easier to achieve them."

RULE conveniently summarises in a nutshell the basic principles of MI. Miller and Rollnick[10] also use the acronym ***OARS,*** which represents:

- ***O**pen-ended questions*
- ***A**ffirmations*
- ***R**eflective listening*
- ***S**ummaries*

These basic, but essential, coaching skills, facilitate the conversation. By using them the coach demonstrates they are listening to the client in a non-judgmental manner.

Oars

Open-ended questions:

- gather broad descriptive information
- facilitate dialogue
- require more than just 'yes' or 'no'
- often start with words like 'how', 'what', 'tell me about' or 'describe'

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- usually go from general to specific
- convey that our agenda is about the consumer.

Affirmations:

- must be done sincerely
- support and promote self-efficacy
- acknowledge the difficulties the client has experienced
- validate the client's experience and feelings
- emphasise past experiences that demonstrate strength and success.

Reflective listening:

- begins with a way of thinking
- includes an interest in what the person has to say and a desire to understand how they see things
- is essentially hypothesis testing
- what you think a person means may not be what they mean

Types of listening:

- Repeating – simplest
- Rephrasing – substitutes synonyms
- Paraphrasing – major restatement
- Reflection of feeling – deepest

Summaries:

- reinforce what has been said, indicate you have been listening carefully and help the client move on
- can link a client's feelings of ambivalence and promote a perception of discrepancy

Adhering to OARS helps the coach show their understanding of the issues from the client's perspective. The application of both OARS and RULE help build a collaborative and constructive relationship in health coaching that allows the client to question their own ambivalence towards health behaviour change, and develop goals if they wish.

Ten useful questions

Rollnick and colleagues[11] suggest 10 simple questions to aid the conversational process that can be used:

- *What changes would you most like to talk about?*
- *What have you noticed about…?*
- *How important is it for you to change…?*
- *How confident do you feel about changing…?*
- *How do you see the benefits of…?*
- *How do you see the drawback of…?*
- *What will make the most sense to you?*
- *How might things be different if you…?*
- *In what way…?*
- *Where does this leave you now?*

Case study: Looking after baby

Jayne was pregnant and feeling very guilty about smoking and drinking alcohol in case she caused any harm to her unborn child. While on an executive coaching programme she shared her predicament with her coach.

Although health-related issues were not part of the coaching, they agreed to put aside 15 minutes per meeting to 'chat' about them. Jayne had used smoking and drinking to reduce stress and used alcohol to 'switch off' at the end of the day. Instead of suggesting that she use another method to relax, the coach 'rolled with resistance' and agreed she could continue to use them to cope with stress if she so wished: "It's up to you."

He didn't challenge whether or not her approach was a good strategy or if her consumption was a habit or addiction. In addition to using OARS, he asked her questions to help her reflect on the importance of change: How important is it for you to change your smoking and drinking behaviour? In the big picture, she didn't believe it was important. However, the next question was time-bound: How important is it for you to change your smoking and drinking behaviour for the next six-month period only? This was different – the short-term change was for her future child. Jayne realised that she "might just" be able to stop smoking and drinking for the duration of her pregnancy. The coach then returned to the presenting problem and asked: "If you stopped or moderated your smoking and drinking for the next six months, what would happen to your guilt?"

"It will disappear", she responded.

In order to enhance self-efficacy and confidence, the coach asked if she had on some occasions been able to cope with stress and the pressures of work without needing to smoke and drink. She recounted a couple of times when she was more interested in finishing a good book in the evening than worrying about work.

Jayne decided that she, and hopefully her partner, would have a go at reading books about pregnancy to see if this was a distraction. By the next meeting, she had stopped drinking alcohol and had only smoked a couple of times.

A health professional may have chosen to focus on encouraging the client to stop smoking and drinking alcohol completely, and possibly permanently, too. This is likely to have been met with strong apparent resistance from the client. However, using MI, the coach stayed with the client and allowed her to develop her own goals and strategy. The coach hoped that after the child was born Jayne may stop smoking completely, but that would have been his goal not hers.

MI is evidence-based and has been applied to a wide range of health-related issues, though it is not a technique in itself.

Some health coaches use MI as their main coaching approach, although it was not originally developed for this purpose. However, it is best used in combination with one of the main approaches or incorporated in health education. ■

- ***Next issue: Cognitive behavioural health coaching***

COACHING *for* HEALTH

THE HEALTH COACHING TOOLKIT

Part 3: health coaching expert **Professor Stephen Palmer** focuses on the **cognitive behavioural approach** to health coaching

The cognitive behavioural approach[12] to health coaching is based on helping a client to examine Health Inhibiting Thinking and strengthen Health Enhancing Thinking so they can achieve their desired Health Enhancing Behaviours and goals. It uses an overall structure to coaching meetings to maintain a business-like approach. A typical structure is:

1 ***Check in*** *with the client to see how they are.*
2 Collaboratively ***develop an agenda*** *for current meeting (eg, develop health-related goals and action plan).*
3 ***Feedback and link*** *to previous meeting and review progress.*
4 ***Discuss the agenda*** *for the session.*
5 Collaboratively ***develop an assignment*** *related to the health coaching goals (eg, join a gym).*
6 ***Seek feedback*** *about the session at end of meeting.*

Structures should be applied in a flexible manner. For example, if the client is in the pre-contemplation

The HIT List

- **All-or-nothing thinking?** (*If a task is worth doing, it's worth doing well. As I can't achieve all my health goals, what's the point of continuing this health programme*)
- **Mind reading** (*My health coach doesn't think I can achieve my goal*)
- **Assuming my view is the only possible one** (*Achieving my goals is just impossible*)
- **Disqualifying the positive** (*Achieving that goal was nothing. Anybody could have started walking for 15 minutes each day*)
- **Focusing on the negative** (*Although I've changed my lifestyle, I still haven't lost any weight*)
- **Magnification/awfulising – blowing things out of proportion** (*This new exercise regime is really terrible*)
- **Perfectionism – expecting myself or others to be perfect** (*I must achieve my health goals otherwise it will be really awful*)
- **Blame** (*It's my partner's fault that I drink too much alcohol*)
- **Personalisation** (*It's all my fault*)
- **Minimisation** (*It's only one cream cake and a doughnut*)
- **Fortune-telling** (*I can see it all going wrong. I'll be a butt of jokes*)
- **Labelling or totally condemning oneself or another on the basis of an event or illness** (*Not achieving my goals proves I'm a total failure*)
- **Fretting about how things should be instead of accepting and dealing with them as they are** (*My health programme should be a lot easier to tackle*)
- **Low frustration tolerance** (*I really can't stand this hard work any more – I need a cigarette now to take the edge off things*)
- **Using ultimatum and demanding words such as shoulds, musts** (*My partner really should support my attempt to stop smoking,* or: *I should eat all the food on my plate*)
- **Not being bothered** (*I can't be bothered to continue this health programme*)
- **Deservingness/entitlement** (*It's been a tough day – I deserve a good drink*)
- **Permission/permissive beliefs** (*It's okay to treat myself to more chocolate*)
- **Compensatory beliefs** (*As I eat a healthy diet, it doesn't matter if I have an extra glass*)

stage, more time is spent addressing ambivalence to change and less on assignments.

Scaling

Once health-related goals have been developed, the client should note down on two 0 to 10 scales how important achieving the health goal is to them, and how confident they are in achieving it. If the scores are low, the client may have low self-efficacy. It could be an indicator that more Motivational Interviewing is still necessary.

HITs and HIBs

Once the health coaching has started, the client sometimes has a psychological block. Cognitive behavioural techniques can be used to raise awareness of the Health Inhibiting Thinking (HIT) that may be blocking them. One of the easiest methods is to ask the client if they recognise any HITs from the 'HIT List' (*see box, left*).

Clients can also consider the impact HITs have on them having Health Inhibiting Behaviours (HIBs). For example, "I can't stand hard work" (HIT) could lead to procrastination and the avoidance of an exercise programme (HIB).

To counter the HITs, it is important to develop Health Enhancing Thinking (HET). Once a key HIT has been elicited, the health coach can use Socratic questioning to assist the client to reflect on it and subsequently modify it if they so wish. Questions focus on whether or not a belief is logical, realistic (and empirically correct) or pragmatic (ie, helpful). An illustrative case is shown (*right*). ■

● *In The Health Coaching Toolkit part 4, we focus on additional cognitive thinking skills to help clients strengthen their HETs.*

Case study: All-or-nothing thinking

Client Since I last saw you, I've haven't walked as much as we'd planned. I've totally wrecked my exercise regime! What's the point of continuing?
Health coach Do you recall what type of thinking this is?
Client Not sure.
Health coach You may recognise it from the list I gave you last time. Here's another copy.
Client: Probably the first one on the list. All-or-nothing thinking.
Health coach I agree. Let's examine this a bit more in-depth. Are you still doing some walking in your lunch breaks each day?
Client: About 15 to 20 minutes each day.
Health coach Which is good, however, I realise it's not the 30-minute walking programme you devised for yourself.
Client Yeah, and that's the problem!
Health coach I wonder if it is the problem? Let's focus on you, in your own words, having "wrecked your exercise regime". How does it logically follow that you have totally wrecked your exercise regime by not keeping rigidly to it since our last meeting? *(Socratic question based on logic)*
Client Not sure.
Health coach Logically, what would you have to do to wreck your regime?
Client I suppose, never do it again.
Health coach Does walking 15 to 20 minutes each day instead of 30 for about two weeks, mean you have wrecked your exercise regime?
Client I suppose not. It's not as much as I'd hoped.
Health coach Yes, that's true, but at least you are still doing more daily exercise then you were a month ago. What could you think instead? *(Encouraging the client to develop a HET)*
Client Perhaps that I'm still keeping to my exercise regime, but I could do a bit more every day.
Health coach Sounds right to me. Your next idea was also all-or-nothing thinking. You asked: "What's the point of continuing?" Do you find that idea motivating or demotivating? (*Pragmatic question*)
Client Demotivating, I suppose.
Health coach What could you think instead if you want to motivate yourself? *(Encouraging the client to develop a HET)*
Client There are lot of benefits to me if I continue.
Health coach Such as? *(Coach prepares to write down the benefits to encourage the client to maintain the programme)*
Client Well, I feel good when I walk; it gives me a break from the office; it's good for my health.
Health coach I agree, and there are probably others too, such as it gives you time to think about solving problems at work. So, to summarise, you are still largely keeping to your exercise regime, but you could do a bit more every day; and there are good reasons to continue. However, let's go back to your original goal and see if walking for 30 minutes every lunch time, was a realistic goal. Perhaps you could do some walking after work as well. *(Having dealt with the HITs the coach then decides to re-examine the goal just in case it needs revision.)*

COACHING *for* HEALTH

Part 4: health coaching expert **Professor Stephen Palmer** expands on cognitive behavioural health coaching. This issue: **cognitive thinking skills**

Thinking skills help a client develop Health Enhancing Thinking (HETs). Some health-inhibiting styles of thinking develop over many years and become ingrained and resistant to change. In specific situations, such as smelling one's favourite fatty food, the client need only think, "That smells great. I must have it now", and next thing, they are eating it! Or with tasks they fail at, instead of thinking, "I've failed to reach my health goals today, I'll have another go tomorrow", they have a more unhelpful ending to their Health Inhibiting Thinking (HITs): "I've failed to reach my health goals today; this proves I'm a total failure."

By labelling themselves a "total failure", they become demotivated. These thoughts can be so fleeting that the coach needs to help the client recognise them. HITs undermine health coaching programmes as they give permission to the client to lapse into Health Inhibiting Behaviours (HIBs).

The coach uses cognitive thinking skills with the client. It is useful for the client to be given a copy of the Thinking Skills list *(adapted, 13)*, so they can tackle their HITs outside the session.

Influencing outcomes

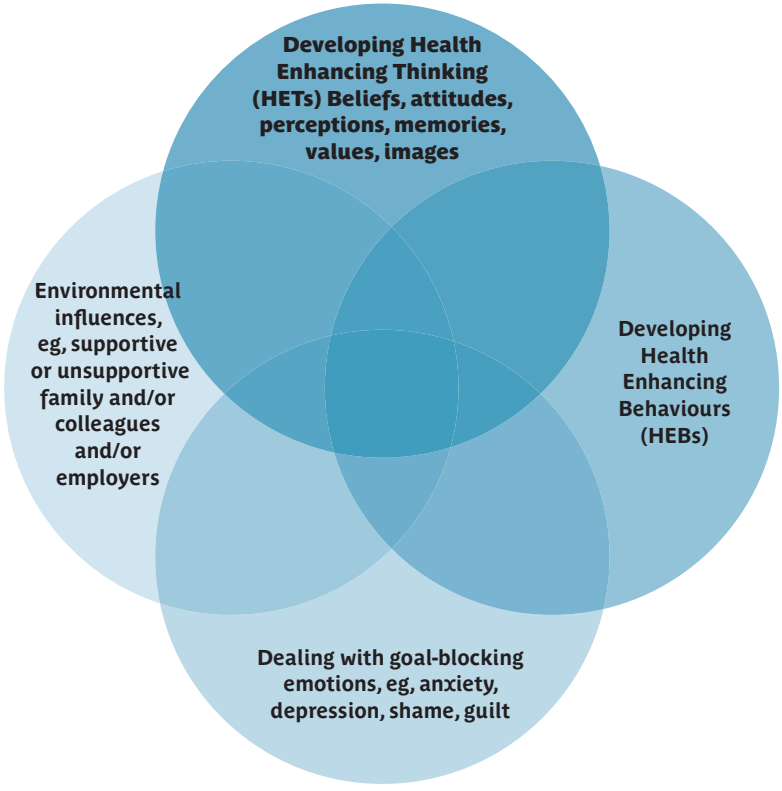
By tackling HITs and then developing HETs, the client can develop their Health Enhancing Behaviours (HEBs). The diagram (*see p39*) can be used in discussion with the client to highlight reciprocal interaction between HETs, HEBs, environmental influences and goal-blocking emotions.

Environmental influences can greatly influence outcomes. For example, quit smoking programmes can be very difficult for clients to adhere to if they live with family or partners who continue to smoke in the home.

If the client lives by themselves they will still need to apply environmental stimulus control, in this example, by removing packets of cigarettes and ashtrays from their home.

As the health coaching programme progresses successfully, the coach may suggest that if the client wishes to become more resilient, then they could undertake a behavioural experiment and see if they can tolerate the stimulus.

For example, being exposed to the sight and smell of cigarettes without giving into their craving to smoke. However, before the



Developing Health Enhancing Behaviours (HIBs)
(Palmer, 2004)

behavioural experiment is undertaken, it is important the coach and client develop a coping strategy that will enable the client to manage their cravings. Often clients will suggest using a relaxation technique or an imaginal distraction such as visualising themselves lying on their favourite beach.

Goal-blocking emotions such as stress/anxiety and depression can lead to increased comfort eating, smoking and drinking to take the edge off things. The cognitive thinking skills can be used to reduce stress and goal-blocking emotions. ■

● *In The Health Coaching Toolkit part 5, we focus on additional health coaching skills*

Top tips on how to hone your thinking skills*

● **Befriend yourself** So often, we are unfairly critical of ourselves. If you make an important error, think about what you would say if a colleague or friend had done the same thing. Chances are, you would not be so critical. So instead of thinking, "I can't stop smoking. I'm weak", think about it more realistically. "Although I have continued to smoke, it is likely that I will be able to stop soon. It doesn't mean I'm weak."

● **Thinking more 'coolly'** Instead of holding inflexible and rigid beliefs, such as musts, shoulds and have tos, for example, "I must reach my daily targets", introduce more flexible and realistic beliefs, such as wants, desires and preferences, for example, "I strongly prefer to reach my daily targets but realistically I don't have to."

● **De-labelling** If you find yourself saying: "I'm a total failure", do you find this helpful in dealing with your goals or a situation? Does this thinking motivate or de-motivate you? As you use these phrases do they decrease or increase your stress levels? Are they an accurate description? For example, to be a 'total failure', you would need to be a total failure at everything you did, every single day. This would be extremely hard to achieve. It would be more accurate to state: "Although I may encounter difficulties in maintaining my health programme, it doesn't mean I'm a total failure. It just means I'm fallible like everybody else."

● **Relative thinking** If you find you are evaluating a situation in extremes, such as dreadful versus fantastic, then relative thinking helps you find the middle ground. On the whole, people and most situations are too complex to view and categorise in such extreme terms. For example, if you are saying, "I will never be able to keep to my health coaching programme", think about the aspects you can do, for example, "Most days, I'm reaching more than 80 per cent of my coaching targets."

● **Look for evidence** Challenge your unhelpful ideas by looking for evidence for and against them. Perhaps ask your friends, family or colleagues You can also test assumptions by deploying behavioural interventions, for example, if you believe "I can't stand exercising every day", see how long you *can* "stand it". This will prove if you are able to do exercise, even if you don't really like it.

● **Broaden the picture** If things go wrong, we often apportion total blame to ourselves (*personalisation*) or another (*blame*). However, if you do blame yourself or others, remember that problems are often not the total responsibility of one person.

● **Demagnification or 'deawfulising'** It is very easy to blow a situation out of all proportion, but this will only increase your stress levels. Events and tasks may be difficult to deal with, but ask yourself, "Is it really awful?", "Is it the end of the world if I don't achieve my health goals?"

**(adapted Palmer, Cooper & Thomas 13)*

Part 5: health coaching expert **Professor Stephen Palmer,** and **Professor Cary Cooper** and **Kate Thomas,** examine multimodal health coaching

Multimodal health coaching can be used for a wide range of health-related issues, such as undertaking and maintaining exercise programmes, weight management, stop smoking, managing stress, enhancing resilience and alcohol reduction.

It is also a useful approach to assist clients who relapse, which often occurs when they become stressed. For example, many of us will use comfort eating or drinking to help us cope with work overload, and this can increase our calorific intake, yet we are too busy to counter this by taking more exercise.

This is not very useful if you want to maintain your existing body weight, especially as our choice of comfort food, when stressed, can be of a high calorific value.

Others, when stressed, will either start smoking again or smoke more if they have not already stopped. Not surprisingly, this can have a negative impact on their health coaching programme. In these cases, it may be preferable to have a more comprehensive understanding of the different issues that may be having an impact on the client. The multimodal approach, originally developed by Arnold Lazarus, literally takes us back to basics, where the coach assesses the different factors involved.

Multimodal: BASIC I.D.

Multimodal Health Coaching *(14)* encourages the client (and coach)

Case study: trying to quit smoking

Jayne had tried on three occasions to stop smoking. The first two times she started smoking again after only a couple of weeks. On her last attempt, she was progressing well until she hit a crisis at work. As soon as the pressure was on, she just "had to have a smoke". She was determined to give up this time. However, more preparation had to done to help her deal with the possible causes of lapse.

MODALITY	ISSUES/PROBLEM	PROPOSED TECHNIQUE
Behaviour	Smokes at meal times	Use stimulus control techniques by removing cigarettes, ashtray and lighters from the house
		Select a Stop Smoking Day
		Cut down smoking to 10 per day for one week prior to the Stop Day
	Increases smoking when under stress	Learn a range of strategies to manage my stress
Affect/emotional	More easily irritated and quick to feel angry when not smoking	Learn to count to five and breathe slowly when in stressful situations
Sensory	Unpleasant feelings of tension when not smoking	Remember, with time this will pass. Start practising relaxation training before the Stop Day to help me cope with the tension when it occurs
Imagery	Can picture parents who both smoked	When this picture comes to mind, imagine my parents not smoking
	Picture of father dying in hospital of lung cancer	When I think of smoking again, remind myself of my father dying in hospital
Cognitive/ thoughts/ideas	I must have a cigarette when I want one (Demandingness)	Dispute unhelpful beliefs: Why must I have a cigarette? Just because I want one doesn't mean I must have one!
	I can't stand unpleasant feelings and tension (Low frustration tolerance)	This is not true, I don't like it but I'm living proof I can stand these feelings
	I can't stand not smoking (Low frustration tolerance)	I stood not smoking for four weeks the last time. I can do better this time
	If I have one cigarette, then I've blown it. What's the point! (All or nothing thinking)	Just because I have one cigarette, it doesn't mean I've blown it. I don't have to give up
Interpersonal	Smokes in social situations	For the first six weeks avoid social situations with friends/ colleagues who are smokers
		In role play at home, I'll practise being assertive and saying, 'No, thank you. I don't smoke.' Only when I'm adequately prepared, enter social situations
Drugs/biological	Smokes 40 cigarettes a day	Stop Smoking programme. Remind myself of the damage it is doing to my body. Use nicotine patches if necessary
	Smokers cough	Check this out with GP in case of undiagnosed problems
	Lack of exercise	If I stop smoking, it may be a good idea to increase daily exercise as I do not wish to put on additional weight. I can walk up the stairs at work instead of using the elevator. Take a 30-minute walk during my lunch break

© Palmer, Cooper and Thomas (15)

to focus on seven key modalities: Behaviour, Affect (ie, emotion), Sensory, Imagery, Cognitions (ie, thoughts, beliefs, ideas, and attitudes), Interpersonal and Drugs/biology. This framework forms a memorable acronym: BASIC I.D.

The coach and client collaboratively develop a Modality Profile that includes relevant items or problems from the BASIC I.D. and possible solutions/interventions taken from the same modality, eg, disputing unhelpful beliefs in the cognitive modality. This profile can be drawn up on paper or on a pre-prepared three-column blank word document.

Palmer, Cooper and Thomas *(15)* illustrate a stop smoking case study, Jayne, where she had previously experienced relapse. Jayne's completed Modality Profile is shown in the case study *(see previous page)*. Note that a comprehensive approach is taken in order to help Jayne tackle different health-related issues.

Motivated clients are often keen to develop and modify their own Modality Profiles, which can be considered as work in progress.

Multimodal health coaches actively encourage clients to read, listen and watch relevant health-related material that will assist them in understanding the issues involved with their health coaching programme. These are usually undertaken as in-between session tasks. ■

Health-related bodies

Health and wellbeing coaches may find it useful to join health-related professional bodies in order to attend relevant conferences and receive their journals.

- Institute for Health Promotion and Education: **www.ihpe.org.uk**
- Royal Society for Public Health: **www.rsph.org.uk**

- ***Professor Stephen Palmer*** *is director of the Coaching Psychology Unit, City University London, and founder director of the Centre for Coaching:* **www.centreforcoaching.com**
- ***Professor Cary Cooper*** *is Distinguished Professor of Organizational Psychology and Health, Lancaster University Management School:* **www.lums.lancs.ac.uk**
- ***Kate Thomas*** *is director of the Stephen Palmer Partnership:* **www.stephenpalmerpartnership.com**

> The multimodal approach literally takes us back to basics, where the coach assesses the different factors involved

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