

Health promotion theory in practice: an analysis of Co-Active Coaching

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Abstract

According to the World Health Organization (1986), “health promotion is the process of enabling people to increase control over, and to improve their own health.” To bring this process and its desired outcomes to fruition, many theories and models for understanding and altering health behaviours have been designed and utilized (Ajzen, 1988; Bandura, 1986; Fishbein & Ajzen; 1975; Freire, 1973, 1974; Jessor & Jessor, 1977; Prochaska, 1979). Practitioners of behaviour change implementation are legion, as therapists, counsellors, social workers and so forth. Coaching (in various iterations such as life coaching, personal coaching, executive coaching) is a recent and growing behavioural intervention. As trained health behaviourists with professional coaching practices, it is our contention that the Co-Active coaching method is an effective and efficient approach for ‘doing health promotion’. Furthermore, the success of the Co-Active coaching approach as a tool for health promotion is based, in part, on its integration of key health behaviour change elements such as: personal values; goal setting; self-defined issues; empowerment; self confidence; reinforcement; and self-efficacy. This position paper will examine the relationship of the Co-Active coaching method with several well-established behavioural theories.

Key Words: life coaching, health promotion, application of theory

Introduction

In the short time we have been trained as Co-Active coaches and opened our practice, we have been intrigued by and curious about the seemingly prompt and meaningful health-related behaviour changes that have transpired within our clients. Our curiosity has led us to the literature, where we found that in fact, research studies have confirmed that coaching has been associated with a positive impact on some modifiable risk factors (Vale et al., 2001, 2002). Lacking both the client base to support an adequate quantitative assessment of behavioural indicators pre- and post-coaching, and a suitable familiarity with validated measurement tools appropriate to evaluate the impact of coaching, we chose to delve deeper into our successful coaching observations in a different manner. As trained health behaviourists, we set out to explore why and how a

model of coaching (the Co-Active coaching model) may work to facilitate health promotion from a theoretical perspective. That is, the Co-Active coaching model is an a-theoretical model, one founded in practical application and not derived from a theoretical base. And yet it is our conviction that existing behavioural theories do, in fact, underpin the Co-Active model of coaching. Our hope is that this exploration will not only help to explain, from a theoretical perspective, why coaching works, but also add to the growing body of evidence around coaching for health gains and thereby contribute to coaching's validation as an 'evidence-based' practice.

Health behaviour theories provide insights into what influences health; why people are or are not engaging in various health-promoting behaviours; how people's behaviours are influenced; and what should be considered when evaluating an intervention's focus. In essence, such theories provide valuable insights and directions about what needs to be in place to create fertile ground for behaviour change (McKenzie & Smeltzer, 2001). According to the World Health Organization (1986), "health promotion is the process of enabling people to increase control over, and to improve their own health." To bring this process and its desired outcomes to fruition, many theories and models for understanding and altering health behaviours have been designed and utilized (Ajzen, 1988; Bandura, 1986; Fishbein & Ajzen, 1975; Freire, 1973, 1974; Jessor & Jessor, 1977; Prochaska, 1979). Health promotion interventions tend to be categorized as either macro-based interventions, with a focus on large groups of people and an intention to affect population health, or micro-based interventions, with a focus on the health and health behaviours of individuals (McKenzie & Smeltzer, 2001). Micro- or individual-based health promotion programming will be the unit of analysis for the purpose of this investigation. The remainder of this position paper will explore the Co-Active coaching method as a theoretically grounded approach for effective health promotion. That is, we will consider the Co-Active coaching method as informed by a variety of health behaviour theoretical constructs, taken from three formal and well-established theories.

We have chosen to explore theoretical constructs from the following behavioural theories because of their apparent relevance to the Co-Active coaching method: Social Cognitive Theory (Bandura, 1986), Theory of Reasoned Action (Fishbein & Ajzen, 1975) and the Theory of Planned Behaviour (Ajzen, 1988). This is *not* intended to be an exhaustive overview of the Co-Active coaching approach (see Whitworth, Kimsey-House and Sandahl, 1998); nor is it intended to be an extensive list of theories or components of theories relevant to the Co-Active coaching method. Rather, the purpose of this paper is to provide an exploratory overview as to the reasons, from a theoretical perspective, Co-Active coaching seems to work. In doing so, we provide a "taste" of some theoretical components from some theories that seemed most obviously connected to the Co-Active coaching method.

The Co-Active Coaching Method

The term coaching is multi-faceted in its meaning and implications. There are a large number of different coach-training schools currently in existence; for each school, there are a wide variety of definitions and conceptualizations about the nature of coaching.

Thus, the whole concept of ‘coaching’ is multi-layered and complex. Some definitions and schools teach that the primary purpose of coaching is to advise clients. In this tradition, the coach is an ‘expert’ to whom the client comes for guidance and counsel. Similarly, some of the health-related studies concerning the efficacy of coaching consider a coach to be any support person who ‘coaches’ someone who is going through an illness or health-related issue. The truth is that coaching does not denote a specific phenomenon; instead, it connotes a behavioural intervention that has many dimensions and a number of styles. Thus, it is important in attributing behavioural change to ‘coaching’ that the particular method of coaching is clearly identified. We have isolated a style of coaching called Co-Active coaching in order to examine its theoretical underpinnings. The Co-Active model looks like this:



At the heart of the Co-Active coaching model above (extracted from Whitworth, Kimsey-House and Sandahl, 1998) is the 5-star configuration that encompasses the **A** of the client’s agenda. According to this style of coaching, the client is not broken, or in need of fixing, or advice. Instead, each client is held as ‘naturally creative, resourceful, and whole.’ In short, the client is the expert about his or her whole life and has the answers to their own life questions. The coach’s role is to help the client access those answers; the coach then is completely in service of the client’s needs and agenda. In order to coach effectively, the coach and client design an alliance at the outset of the coaching. That alliance, a dynamic one, is the container for the coaching relationship. The Co-Active coach is trained in using the skills of intuition, listening, and curiosity in every coaching session. And, it is important for the coach to practise self-management, that is, the Co-Active coach has to learn not to bring his or her beliefs or understandings or personal agenda about a topic or issue. Instead, the coach must manage personal insights and find out what is true about topics or issues from the client’s agenda and perspective. The expression used in this method is ‘staying over there’ right with the client and his/her perspective. If anything, the Co-Active coach acts as a kind of interrogative mirror and amplifier for the client with a view toward either deepening the client’s learning and/or forwarding some action that the client chooses to do.

The aforementioned skills are utilized in three different “principles” of Co-Active coaching: fulfillment coaching which is about working with clients in their quest toward the most fulfilling life for them; balance coaching which concerns opening up clients’ perspectives on different areas of their lives in order to make choices and turn those choices into action; and process coaching which focuses on clients being in the experience of their whole lives. One of the assumptions of this coaching method is that the three principles reflect central aspects of the client’s life, that is, clients are living into and toward their personal fulfillment, balance, and process. Co-Active coaching, depending upon the skill and experience of the coach, utilizes one or more of these three principles in coaching sessions.

Models are frameworks or ways of representing elements or practices that are in existence. The model under discussion here is that which is attributed to Co-Active coaching. It is important that we know if a particular intervention works and how it works. To that end, what this paper assesses is how theoretically sound is the Co-Active coaching method within health behaviour interventions.

Methods

Inductive content analysis, a technique that identifies major themes that emerge from data (as described by Patton, 1987), was used to identify the main principles (fulfillment, balance, and process) of the Co-Active coaching model (Whitworth, Kimsey-House and Sandahl, 1998). Then, the same analytic process was utilised to identify the health behaviour-related constructs predominant within the behaviour change models chosen for this assessment (i.e., Social Cognitive Theory, the Theory of Reasoned Action, and the Theory of Planned Behaviour). The two authors independently assessed the Co-Active coaching model and the three theories, and then compared and contrasted their individual findings. The following results of that assessment represent the findings that both authors identified. While there was no formal quantitative, inter-rater reliability assessment conducted, the authors agreed on the majority of the results. Our analysis is presented through applying coaching examples (principles and technique) within the context of each behaviour change model. Our intent, at this stage is to explore this set of theoretical perspectives; there is no intent to be exhaustive.

Social Cognitive Theory and the Co-Active Coaching Method

Born out of Social Learning Theory (Bandura, 1977), Social Cognitive Theory (SCT) (Bandura, 1986) explores the psychosocial dynamics of behaviour and the techniques used to foster change. SCT focuses on the influence of both reinforcement and personal expectations (Parcel & Baranowski, 1981) and offers a strong foundation upon which to understand behaviour. The constructs identified as most relevant to health promotion efforts with consideration to the Co-Active coaching method include expectations; expectancies; self-efficacy; and reinforcement and acknowledgement (McKenzie & Smeltzer; Parcel & Baranowski, 2001). Each construct is discussed below.

Expectations and Expectancies

As a construct, expectations represent the cognitive capacity of people to anticipate the probable consequences of their behaviours in specific situations (Bartholamew et al., 2001; McKenzie & Smeltzer, 1997; Parcel & Baranowski, 1981). Expectancies are the values that people place on the outcomes that they expect (Bartholamew et al., 2001; Parcel & Baranowski, 1981). If an outcome is valued highly by an individual, it is more likely that the person will engage in the desired behaviour than if the outcome holds little value (Bandura, 1986). For example, if a person expects that engaging in a running program will result in weight loss, but does not value weight loss (or what they anticipate weight loss will give them, such as more social contacts), then that person is not likely to engage in a running program. On the other hand, if a person places a high value on weight loss (or what he anticipates weight loss will give him, such as a better appearance) and expects that running will result in weight loss, that person is more likely to engage in the program.

Co-Active coaching focuses on clients' aspirations, desires and values. The coach's role is to work in partnership with the client to elucidate and articulate what those desires are and help clients to achieve their desired outcomes. It is the client's agenda, the client's whole life, and the client's feelings and values that are the focus of the coaching relationship. Through *fulfillment* coaching - which is about clients attaining their absolute potential - clients can determine what is really crucial to them in their lives. Coaching helps clients "take a stand and make choices based on their values and what is fulfillment to them" (Whitworth et al., 1998, p.119).

Taking the time and making the effort to explore what is and is not important to the client provides a solid foundation from which to coach clients toward honouring their values. Whereas health promotion programs typically attempt to understand and utilize a client's expectations and expectancies for the purpose of achieving specific health-related results, fulfillment coaching is about the client's involvement in and commitment to achieving those results in the context of his/her whole life. Nevertheless, from a theoretical perspective, we propose that fulfillment coaching is, in part, related to uncovering, exploring and honouring, a client's expectations and expectancies.

Self-efficacy

Self-efficacy is described as the internal state of competence that individuals experience with respect to engaging in desired behaviours (Bandura, 1986). Adequate self-efficacy is considered a critical component for health behaviour change (or maintenance) (Bandura, 1977; Strecher et al., 1986). One method often utilized to increase a health promotion client's self-efficacy is called verbal persuasion (McKenzie & Smeltzer, 2001). A client who receives positive encouragement and support about her new health-related behaviour by respected others is likely to experience an elevation in self-efficacy.

The tenet of *championing* within the Co-Active coaching approach suggests a solid understanding and effective application toward increasing a client's perception of self-efficacy. Championing by a coach is about standing up for clients when they are hesitant about their abilities. "Despite the client's self-doubt, the coach knows clearly who the client is and that he or she is capable of much more than the client thinks. When the client is in the valley, the coach is on the next hill, waving a flag and saying, 'Come on. You can make it!'" (Whitworth et al., 1998, p.254). In our estimation, championing and verbal persuasion are similar concepts with the same goal of helping clients access their inner knowing and abilities to accomplish what they set out to do or experience.

Reinforcement

Reinforcement is critical for behaviour to be learned, and it can be achieved through three means: (a) direct reinforcement, (b) vicarious reinforcement, and (c) self-management (Bandura, 1986). Direct reinforcement occurs when favourable feedback is directed toward and received by an individual following a particular behaviour. For instance, if a person who values praise joins a walking group, and each time she comes out for a walk her fellow walkers praise her for this behaviour, her walking with the group is directly reinforced. Vicarious reinforcement occurs when someone receiving reinforcement for behaving in a desirable manner is observed by another person who, in turn, might model that desirable behaviour. A person who observed the praise received by the walker for coming out for a walk may also feel more inclined to join the group after witnessing the praise. When individuals monitor their own behaviour, and upon engaging in the desired behaviour, give themselves a reward, they are practising reinforcement through self-management (Bandura, 1986). A person who wants to increase his frequency of walking may keep a physical activity log and when he has recorded 4 or more walking sessions per week, he may reward himself with an evening out at the movies.

Reinforcement is a powerful tool for initiating and maintaining a health-related behaviour. As described above, reinforcement is a component of many (health) behaviour change theories (Hall, 1942; Pavlov, 1927; Skinner, 1953; Green & Kreuter, 1999). In like manner, we propose that reinforcement is a pervasive concept deeply embedded within the Co-Active coaching method. For instance, with the purpose of helping clients excel, Co-Active coaches are encouraged to include *challenges*, *accountability*, *acknowledgement*, and *championing* (discussed earlier) among other tools, in their professional repertoire. Each of these tools can and do work to prompt and reinforce the clients' desired behaviours. For example, *accountability* refers to clients accounting for what they said they were going to do; "the coach holds the client accountable to the client's vision or commitment and asks the client to account for the result of the intended action" (Whitworth et al., 1998. p. 253). As a reinforcing factor in the client's commitment to change, accountability serves to "empower the change" the client desires and provides the opportunity to acknowledge his successes (p. 81).

Acknowledgement

Acknowledgement is a Co-Active coaching tool that, quite literally, refers to the coach overtly acknowledging the client both for who she is and for who she had to be to attempt to move forward in her life. For example, consider a client who is obese and uncomfortable revealing her body. In professing that she wants to be physically healthier, she shares with her coach that she attended a swimming class. In so doing, her coach would have a great opportunity and professional duty to acknowledge this action. He might acknowledge the client by saying, “Good for you! It took a lot of courage for you to attend that class and I really admire you doing whatever it takes to honour your desire to improve your health.” By acknowledging a client’s action and, perhaps more importantly, reflecting on how that action honoured her values, the client gains greater access to those values, to her inner character and therefore, to her new behaviour (Whitworth et al., 1998).

On their own, each of the above-mentioned tools can serve as a method for reinforcing the client’s desired behaviours. When combined, these tools offer powerful potentials for reinforcing the desired behaviours. For example, clients’ self management, as described above, is encouraged and is undertaken Co-Actively within the Co-Active coaching method; often a coach will *challenge* a client to engage in his or her desired behaviour; will *champion* the client reminding him of past successes, sincerely reflecting on why the client can succeed and nudging him forward into action or deeper into learning; will request that the client follow-up with *accountabilities* (e.g., a daily email); and will *acknowledge* the client’s efforts. All of these tools, when well used, have a synergistic effect in coaching clients effectively.

The Theories of Reasoned Action and Planned Behaviour and the Co-Active Coaching Method

The Theory of Reasoned Action (TRA) was created to explain individuals’ voluntary or volitional behaviours (Fishbein & Ajzen, 1975). This theory has been adopted in a variety of health promotion programming settings because the vast majority of health-related behaviours are considered “voluntary” (e.g., exercising, changing situations to manage stress, engaging in healthy communication strategies, eating healthfully). The Theory of Planned Behaviour (TPB) (Ajzen, 1988) is an extension of the Theory of Reasoned Action. The TPB expands on the TRA in that it offers room to address those behaviours considered somewhat questionable with regard to being under volitional control of the individual. Together, the TRA and TPB emphasize the importance of behavioural intention and the subjective norm.

Intention and Subjective Norm

The crux of the TRA is that an individual’s intention to carry out a given behaviour results from her attitude toward engaging in the behaviour and normative beliefs about what significant others believe she ought to do (in combination with her level of motivation to comply with these significant others) (McKenzie & Smeltzer, 2001). For example, a person who smokes may perceive that a lot of people do not smoke and most of the friends he values want him to quit. The subjective norm in this case would be a

favourable attitude toward quitting smoking. Therefore, according to the TRA, this individual is likely to take action to quit smoking if he believes doing so will have health benefits, is socially advantageous, and feels social pressures to quit. If the social pressures are strong enough, the intention to quit smoking will transfer into the actual behaviour being performed. But, the subjective norm can also work against positive health behaviour. This might eventuate when an individual perceives that his friends want him to consume a lot of alcohol, and he greatly values his friends and their opinions. An intervention strategy that takes into account the omnipresent and often un-stated subjective norm may be one in which the behavioural practitioner explores the client's perspective of the subjective norm and then has him simply articulate it. Then, the client can examine the impact this perception is having and how it is consistent or inconsistent with the client's personal agenda.

The unique contribution of the TPB can be seen by continuing with the example of quitting smoking. Even if the individual perceives that it is important, other persons he values want him to quit, and he wants to quit, he may perceive that he does not have the *behavioural control* to do so. Perceived behaviour control recognizes that there are confounding factors (or confounds) that seem to the individual to be beyond his control when it comes to engaging in a desired behaviour. Our contention would be that this is precisely where Co-Active coaching might be viewed and effectively utilized as an intervention strategy. Thus, for example, if a client is 'stuck' on a single perspective (a confound) that he has 'made up' about his inability to move toward quitting smoking, then balance coaching might be a suitable coaching intervention. The seven steps of balance coaching delineated by Whitworth et al (1998, p 129-132) are: 1) help the clients see that they are stuck on one way of looking at the issue, 2) uncover additional perspectives, 3) help the client experience the various perspectives, 4) have the client choose the perspective, 5) create a plan that addresses the situation, 6) commit to the plan, and 7) take action. In balance coaching, the coach is able to coax her client toward envisioning a variety of perspectives including the one in which the client is rooted. By 'naming the wheel' (the focus to which the various perspectives pertain) in balance coaching, the client and coach can try on new and even outrageous (to the client) perspectives. Such coaching allows clients and coaches to move toward desired behaviours. We propose that the concept of behavioural control is closely linked to self-efficacy and has implications for both understanding and facilitating health-related behaviour changes.

The TRA and the TPB offer a basis from which to understand the value of a client being in a place of choice, and the benefit of exploring other perspectives when that client does not see any other choice, as may be the case when the subjective norm is so clear to the coach and so important to the client. The subjective norm and intention to behave provide us with a basis for understanding a client's current perspective and/or offering reflections about a possible perspective. Balance coaching is about making choices and these choices are rooted out from mining a client's assumptions and beliefs that so intricately form client perspectives. Once a client is able to perceive 360 degrees of choice instead of one narrow tunnel of habitual behaviour, a wide variety of potential actions or planned

behaviours may and do eventuate. We propose that these two theories (TRA and TPB) offer some insights into the utility and validity of *balance* coaching.

Although a main component or principle of the Co-Active coaching method, *process* coaching is a little less apparent in its application to theories concerning the reasons people are or are not engaged in various health promoting behaviours. At the same time, process coaching is a highly effective method in doing health promotion. Process coaching is in the moment, the “now” of clients’ lives (Whitworth et al., 1998). Part of Social Cognitive Theory (SCT) focuses on anticipation and expectations and is therefore more appropriately related to balance and fulfillment coaching as we have illustrated above. Self-efficacy is an important SCT construct and is visible within process coaching. We know that in process coaching, the goal is to explore the territory where the client is right now – to take the client where he or she is in that moment of his or her life. All of the client’s *gremlins*, or internal judges, work to avoid any turbulence, any uncomfortable experience. Consider the case of a client who is avoiding confronting a relationship in which she has been miss-treated. It is conceivable that her self-efficacy is low; even more, that she feels responsible for inducing the miss-treatment. An important role for the process coach is to encourage the client to be in the moment, to get her to experience the ‘now’ as merely where she is in her life without judgment, without detracting from her self-efficacy.

Discussion

This paper represents a preliminary attempt to explore and explain the important theoretical underpinnings that highlight the effectiveness of Co-Active coaching. Theories help us to understand individuals’ health-related behaviours, and yet on their own, theories have limitations when it comes to implementing effective health-related behaviour change. Co-Active coaching is an intervention model that implicitly draws on established theoretical constructs. We wholeheartedly concur with Whitworth et al when they stated, “Coaching works because it’s not easy maintaining momentum alone” (1998, p.79), and yet what is important in our exploratory study is that the Co-Active model of coaching can clearly be linked to existing behavioural theories thereby validating the utility of Co-Active coaching model with good possibilities as a useful intervention in behavioural change theory and practice. If such links were made more explicit in the Co-Active coaching model, it would facilitate its evaluation and comparisons with other coaching models within the growing body of knowledge concerning evidence-based coaching.

References

- Ajzen, I.** (1988) *Attitudes, personality, and behavior*. Chicago: Dorsey Press.
- Bandura, A.** (1977) *Social learning theory*. Jew Jersey: Prentice-Hall, Inc.
- Bandura, A.** (1986) *Social foundations of thought and action: a social cognitive theory*. New Jersey: Prentice-Hall, Inc.
- Bartholamew, L.K., Parcel, G.S., Kok, G., & Gottlieb, N.H.** (2001) *Intervention mapping: designing theory-and evidence-based health promotion programs*.

London: Mayfield.

Fishbein, M., & Ajzen, I. (1975) *Belief, attitude, intention and behavior: An introduction to theory and research*. Reading, MA: Addison-Wesley.

Freire, P. (1973) *Education: The practice of freedom*. London: Writer's and Reader's Publishing.

Freire, P. (1974) *Pedagogy of the oppressed*. New York: Seabury Press.

Green, L.W. & Kreuter, M.W. (1999) *Health promotion planning: an educational and ecological approach, 3rd Edition*. London: Mayfield.

Hall, C.L. (1943). *Principles of behavior*. New York: Appleton-Century-Crofts.

Jessor, R., & Jessor, S.L. (1977) *Problem behavior and psychosocial development: A longitudinal study of youth*. New York: Academic Press.

McKenzie, J.F. & Smeltzer, J.L. (2001) *Planning, implementing, and evaluating health promotion programs, 3rd Edition*. London: Allyn and Bacon.

Parcel, G.S., Baranowski, T. (1981, May/June) Social learning theory and health education. *Health Education*, 14-18.

Patton, M. (1987) *How to Use Qualitative Methods in Evaluation*. Sage: London.

Pavlov, I. (1927) *Conditional reflexes*. Oxford: Oxford University Press.

Prochaska, J.O. (1979) *Systems of psychotherapy: A transtheoretical analysis*. Homewood, IL: Dorsey Press.

Skinner, B.F. (1953) *Science and human behavior*. New York: Free Press.

Strecher, V.J., McEvoy DeVellis, B.M., Becker, M.H., & Rosenstock, I.M. (1986). 'The role of self-efficacy in achieving health behavior change'. *Health Education Quarterly*, 13(1), 73-91.

Vale, M.J., Jelinek, M.V. & Best, J.D. (2001) How many patients with coronary heart disease are not achieving their risk-factor targets? Experience in Victoria 1996-1998 versus 1999-2000. *MJA*, 176, 211-215.

Vale, M.J., Jelinek, M.V., Best, J.D. & Santamaria, J.D. (2002) 'Coaching patients with coronary heart disease to achieve the target cholesterol: A method to bridge the gap between evidence-based medicine and the "real world"—randomized controlled trial'. *Journal of Clinical Epidemiology*, 55, 245-252.

Whitworth, L., Kimsey-House, H., & Sandahl, P. (1998) *Co-Active Coaching: New skills for coaching people toward success in work and life*. Davies-Black Publishing, California.

World Health Organization. (1986) *First International Conference on Health Promotion*. Ottawa, Canada.

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