

Exploring the potential of telephone health and wellness coaching intervention for supporting behaviour change in adults with diabetes

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Article points

1. An evidence-based health and wellness coaching intervention is described.
2. The intervention was highly acceptable to people with type 2 diabetes.
3. Coaching training should be offered to healthcare professionals and further evaluation of the impact on client health behaviour should be undertaken.

Key words

- Health behaviour
- Health and wellness coaching

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The purpose of this article is to outline the development of a telephone-based health and wellness coaching intervention for people with type 2 diabetes. A specifically modified health and wellness coaching intervention underpinned by the transtheoretical model of behaviour change, motivational interviewing and appreciative enquiry was delivered by telephone to 10 people with type 2 diabetes over 3 months. The coaching showed high acceptability, low cost and effectiveness in increasing patient autonomy and self-efficacy. Coaching training may be useful to healthcare workers, and coaching interventions for people with type 2 diabetes may be effective and warrant further exploration in a large clinical trial.

Traditional methods of support for behaviour change among people with lifestyle-related illnesses have relied heavily on education and persuasion, and typically work only in the short term (Hayes et al, 2008). This suggests a need for a conceptual shift in providing educational support. Coaching is a possible mechanism to incorporate all the suggested aspects required to support people to become active participants in self-management (Lindner et al, 2003).

As there have been recent calls in the literature to develop coaching within a behaviour change framework to facilitate enhanced support of people with type 2 diabetes in the primary care setting (Hayes et al, 2008), this article outlines the development of a wellness coaching educational intervention to support behaviour change for these people.

Wellness coaching: Theoretical underpinnings

Wellness coaching draws on a number of theories, including motivational interviewing (Miller

and Rollnick, 2002), the transtheoretical model of behaviour change (Prochaska, 2005) and appreciative inquiry (Cooperrider and Whitney, 2005). The aim is to help individuals develop their vision for wellness and to clarify areas for improvement or development. Coaching is defined by Moore et al (2015) as:

“A close relationship and partnership with a coach, providing the structure, accountability, expertise and inspiration to enable an individual to learn, grow and develop beyond what s/he can do alone.”

A one-to-one personal approach that can be easily facilitated by phone is used. Clients choose the behaviour they want to change and verbalise the required changes. In the first session, a wellness vision is developed. A wellness vision coaching tool is summarised in *Table 1*.

Using this tool as a prompt to elicit information, vision and goals for the client, goals are set to achieve the desired changes. Issues discussed and individual goals are recorded in a “coaching log” after the session (*Figure 1*).

Sessions occur weekly, and weekly goals are

Table 1. Protocol for designing a wellness vision. Adapted from Moore et al (2015), page 131.

Value	Explain the value of creating a wellness vision: A vision is a compelling statement of who you are and what health-promoting, life-giving behaviours you want to do consistently.
What's working now	Ask about strengths and current successes: What are you currently doing to support your health and well-being? What elements of your life do you feel best about? In what way did you contribute to making those true and/or possible?
Strengths	Collaborate to identify the client strengths: What are your success stories? What gives you pride? What qualities do you most appreciate about yourself?
Thrive	Identify ways a client can thrive: What makes you thrive? When are you most alive?
Important	Ask what is most important to the client right now: Given all that is going well, what are you wishing? What elements of your health and well-being do you want to improve?
Motivation	Discover the client's motivators: What are the benefits of making changes now? What is the driving force behind the desire to change now? What do you treasure most about potential change?
Visualise	Support the client in visualising his or her vision, and describe it in detail: What are the most important elements in your vision? Tell me what your vision looks like. Paint me a picture. What would you look and feel like at your ideal level of wellness? What kind of person do you want to be when it comes to your health and well-being?
Past successes	Discover previous positive experiences with elements of the vision: What have been your best experiences to date with the key elements of your vision – times when you felt alive and fully engaged? Tell one or two stories in detail.
Strengths to realise vision	Identify the strengths and values that could be used to reach the vision: Without being modest, what do you value most about your life? What values does your wellness vision support? What strengths can you draw on to help you close that gap and realise your vision? How can the lessons from your successes in life carry over to your current situation?
Major challenges hurting confidence	Identify obstacles to boosting confidence: What challenges do you anticipate having to deal with on the way to reaching your vision? (Talk through multiple possibilities and express empathy.) What concerns you most?
Strategies	Explore the strategies and structures (people, resources, systems, and environments) needed to navigate challenges and ensure success: On what people, resources, systems, and environments can you draw to help you realize your vision and meet your challenges? What strategies may be effective in helping you realise your vision and meet your challenges? (Brainstorm and clarify multiple possibilities before focusing.)
Recap	Reflect and summarise what you have heard the client saying about his or her vision. Collaborate on a first draft statement that captures the vision in a way that is meaningful and compelling for them.
Commit	Ask the client to state and commit to the vision.

discussed and set. At each coaching session the previous week's goals are reviewed and the strengths that led to success are highlighted. These are also documented (*Figure 2*). Clients then choose the area they want to work on that week and once again they are coached on that issue. Obstacles and strategies to overcome these are also identified and discussed.

Motivational interviewing

Motivational interviewing is an important skill for this intervention. Principles that underpin this are expressing empathy, developing discrepancy,

rolling with resistance and supporting self-efficacy. These principles can be explained as follows.

Ambivalence towards behaviour change or feeling stuck is expected in consultations (Miller and Rollnick, 2002). The development of discrepancy is a key goal in which ambivalence is addressed and the practitioner aims to increase the importance of change to the person. This is achieved through selective reflections that focus the client on the discrepancy between behaviour and personal values. The practitioner elicits the reasons to change from the individual, and if resistance is expressed it is a cue to change

direction or “roll with the resistance.” Miller and Rollnick (2002) point out that many people who seek support are already aware of this discrepancy between what they want to happen and what is happening but that they are also ambivalent or stuck. Motivational interviewing is directed

towards helping people to become unstuck, so that they can move towards the desired behaviour.

Confidence in the ability to change is termed self-efficacy and is central to motivation to change (Bandura, 1994). Development of self-efficacy is related to the individual’s previous successes. Failure undermines self-efficacy. However, if only easy successes are experienced then the person comes to expect fast results and is easily discouraged. Overcoming obstacles through perseverance builds a more resilient sense of efficacy.

Empathy is a stance taken by the coach and is underpinned by acceptance. Acceptance involves accepting and understanding the client’s position without judgement, and respectfully and actively listening to the client’s perspective without endorsing it or agreeing with it (Miller and Rollnick, 2002).

The motivational interviewing coaching tool used in this wellness coaching is outlined in *Table 2*.

The transtheoretical model of behaviour change

This model provides a framework for identifying each individual’s stage in relation to the chosen health behaviour (Prochaska, 2005; Moore et al, 2015). It proposes that people progress through five stages when changing behaviour: precontemplation, contemplation, preparation, action and maintenance.

Appreciative inquiry

Appreciative inquiry is defined as the “cooperative, co-evolutionary search for the best in people, their organisations and the world around them” (Cooperrider and Whitney, 2005). It originated from organisational change research in which, instead of problem solving, the team was encouraged to look at strengths, skills and competencies. It holds that change is more effective if it occurs as a continuation of those strengths and competencies (Cooperrider and Srivastva, 1987). Unconditionally positive questioning is used to bring out the best in people. Appreciative inquiry allows people to rise above and move beyond the conditions of their present problems (Stake, 2005). Existing alongside the problems are hopes, dreams and joy, and

Client name:	<input type="text"/>
Coach name:	<input type="text"/>
Session schedule	
Session 1:	<input type="text"/>
Session 2:	<input type="text"/>
Session 3:	<input type="text"/>
Wellness vision	
My wellness vision is ...	
My motivators are ...	
My obstacles are ...	
My strategies to overcome my obstacles are ...	
Three-month goals	
Month started:	<input type="text"/>
Section (Fitness, Nutrition, Stress, Weight, Health, Other):	
Goal:	
Comments:	
Priority:	Completed %:
Section (Fitness, Nutrition, Stress, Weight, Health, Other):	
Goal:	
Comments:	
Priority:	Completed %:

Figure 1. Coaching log for the first session. From Wellcoaches Core Coach Training Program. Reprinted with permission from Wellcoaches Corporation, 2015.

This week’s goals: Week 1	
Date goals set:	<input type="text"/>
Section (Fitness, Nutrition, Stress, Weight, Health, Other):	
Goal:	
Comments:	
Priority:	Completed %:
Section (Fitness, Nutrition, Stress, Weight, Health, Other):	
Goal:	
Comments:	
Priority:	Completed %:

Figure 2. Weekly coaching log. From Wellcoaches Core Coach Training Program. Reprinted with permission from Wellcoaches Corporation, 2015.

Table 2. Motivational interviewing coaching moment tool. From Wellcoaches Core Coach Training Program. Reprinted with permission from Wellcoaches Corporation, 2015.

Clarify and summarise issue	Please drill down to the issue you would like to explore in the next 10–15 minutes. Summarise and clarify so that we're clear and focused on what we're working on.
Revisit vision and goals	Describe your vision, values, and goals as they relate to this issue.
Decisional balance	Pros: Explore reasons (benefits) to making the change and how they serve your vision. Which one is the most important and energising? What will your life be like if you change? Cons: Describe reasons (benefits) to stay the same. Describe the challenges to change. What will your life be like if you don't change? Which has more weight – the pros or cons?
Discrepancy	Sounds as though the pros and cons are well-balanced. What does it feel like to live with this ambivalence? What would it be like to tip the balance toward the change? Away from the change?
Importance	Rate the importance of making the change now on a scale of 1–10. Why is it x and not a lower number? What would make it more important?
First steps	What do you want to do about this? What's your first step?
Confidence	Rate your confidence on successfully making this change on a scale of 1–10, with 10 being the most confident and 1 being the least. Why is it not lower than x? What would it take to increase your confidence? What strengths can you use to be successful?
Summarise and confirm	Summarise the situation and next steps.
Ready and committed	Are you ready to commit to moving forward?

appreciative inquiry allows people to create a new identity in relation to these. This enables them to rise above problems by acknowledging strengths and imagining possibilities (Moore et al, 2015). All of these principles are observed in coaching, through the use of conversation to construct a new reality. Instead of asking what went wrong, the coach asks “what's the best thing that happened in the past week?” and, rather than focusing on the problem, draws on past successes by asking “could you describe a time when you had a very healthy lifestyle?” Coaching the clients to consider their strengths opens up new possibilities and focuses on previous successes. See *Table 3* for an outline of the technique.

Integration of the underpinning theories

These theories are integrated into the delivery of the coaching intervention. The transtheoretical model is used to identify the stages of change for each behaviour chosen by the client. Principles

of motivational interviewing are observed throughout. Motivational interviewing techniques are then used to help resolve barriers and obstacles. Appreciative inquiry is used as necessary to transform a negative stance or as an alternative to help shift stuck behaviour.

Implementing the model of coaching intervention

Becoming a coach

Before coaching, training is required. A certified training programme is provided in the US by Wellcoaches Corporation. This certification is endorsed by the American College of Sports Medicine. Training entails 18 weeks of online instruction, including learning about the transtheoretical model, motivational interviewing and appreciative inquiry. There are online examinations and practical skills assessment. Training occurs via live teleclasses via Skype to incorporate the skills training. In addition, peer

Table 3. Appreciative inquiry obstacle coaching tool. From Wellcoaches Core Coach Training Program. Reprinted with permission from Wellcoaches Corporation, 2015.

Clarify and summarise issue	Please drill down to the issue you would like to explore in the next 10–15 minutes. Summarise and clarify so that we're clear and focused on what we're working on.
Discover best experience	When were you doing your best in relation to this issue? Describe the circumstances. What factors enabled you to be at your best? What strengths were you using? What values did you have at the time to support this best experience?
Describe dream, vision or three wishes	What is this situation calling you to become? What does your dream or vision for this situation look like? Or what three wishes would you ask a genie to grant you? What values do your dream, vision or three wishes reflect?
Energy	How would it feel to realise your dream, vision or wishes? What is most exciting and energising about your dream vision or wishes? What stories, metaphors, images or symbols can you use to bring more life to your dream?
Strengths	What core strengths support you in your journey to your dream/vision/wishes?
Design	What next steps do you want to take to bring your dream, vision or wishes alive? If you were your best self now, what would you do next? What can you do to build confidence?
Destiny	How can you keep the fire burning – stay on track to reach your dreams, make your dreams your destiny?
Summarise and confirm	Summarise the situation and next steps.
Ready and committed	Are you ready to commit to moving forward?

groups meet weekly via conference call rooms to practise the key skills. This is useful as it role-models the implementation of client coaching via the telephone.

In this study, Helen McGloin trained as a coach as part of a PhD study and implemented the coaching with clients with diabetes.

Piloting the intervention

A telephone coaching intervention was piloted using an instrumental case study approach (Whitney and Trosten-Bloom, 2010). While rigorous empirical methods are favoured for testing interventions, there is a school of thought that favours the subjective view (Flyvbjerg, 2006). This can be particularly useful for the early development of new innovations.

Clients were recruited by the DSNs and coaching was offered free of charge. Following consent, 10 people with type 2 diabetes were coached by telephone on a weekly basis for 4 weeks and fortnightly for 8 weeks, up to a period of 3 months. Further description of the methodology may be found elsewhere (McGloin et al, 2015). The first phone call was 60–90 minutes long and weekly phone calls thereafter were 30–45 minutes

long. The coaching relationship developed through five phases, as outlined below.

Phase one

In phase one, a client assessment form was completed (*Figure 1*). This served as a baseline assessment for the areas of weight, exercise, health status, stress and mental health.

Phase two

In this phase, participants were facilitated to develop a wellness vision. They also identified specific 3-month behavioural goals and obstacles that may have prevented them from achieving these. Strengths and strategies that they wished to use to overcome the obstacles were also explored.

The technique of reflective listening was used to address ambivalence and to respond to resistance. The core skills that underpin motivational interviewing – open questioning, affirmations and reflective listening, and summarising – were utilised throughout all coaching conversations. Reflective listening took a number of formats. These included simple reflection, amplified reflection and double-sided reflection. Simple reflection paraphrases what the client said, whereas

amplified reflection is an exaggerated version of the clients' words that tends to elicit the other side of ambivalence (Miller and Rollnick, 2002). Double-sided reflection gives both sides of the clients' ambivalence if they have already given the other side; for example, "you want to measure your blood sugar but you are afraid of the result". In addition, the underpinning principles of expressing empathy, rolling with resistance and taking a non-judgemental stance were observed throughout all conversations. This phase ended with the setting of 3-month SMART (specific, measurable, action-based, realistic and timely) goals.

Phase three

In phase three the coach helped the clients move forward in the attainment of goals through weekly SMART goal setting. The clients were coached in identifying strategies to overcome barriers and to increase self-efficacy. Self-efficacy was scored for each goal to assess the clients' confidence in achieving the goal for that week. Open questioning and reflective listening was used to explore ambivalence and to examine discrepancy between participants' wishes and actual behaviour (Miller and Rollnick, 2002). Affirmations and appreciative inquiry were used to recognise past achievements and build confidence. Strategies for achieving change were discussed with the client at this point (Prochaska, 2005).

Phase four

Phase four was the longest phase of the coaching relationship, in which specific weekly goals were set and reviewed the following week. At each session the clients chose the sequence of review and awarded a percentage achievement score to each goal. Successes were focused on, and the strengths and strategies that led to success were highlighted. The technique of focusing on the positive outcomes is underpinned by appreciative inquiry and is a powerful method of increasing self-efficacy (Orem et al, 2005).

Obstacles that prevented goal achievement were also discussed, and ambivalence and challenges were explored using reflective listening. In this phase the coach helped the client to come up with new strategies for managing challenges based on the processes of change in the transtheoretical

model. Rewarding oneself, substituting alternatives for the problem behaviour, helping relationships and controlling situations and other cues for the behaviour are all processes used by people in the action and maintenance stages of change. Connecting and talking with like-minded people to support the change was used by participants across all stages. However, all processes of change were used, as in each conversation participants could be in many stages of change for different health behaviours (Prochaska, 2005).

Once the previous week's goals were reviewed, the participants picked the goal they wanted to focus on, which was usually the goal that was the biggest challenge for them. Using the principles outlined, the goal was discussed and strategies for goal achievement were put forward. Obstacles and strengths were discussed and a score on a scale of 1–10 was attributed by the participants. Depending on the score, the participants were asked what would make it higher or why was it a nine, for example, and not a three. In this way, they visualised the obstacles and facilitators for the coming week.

Following each conversation, the goals and goal review were written up and posted or emailed to the participants, along with any resources they needed which were identified in the call.

Phase five

The final stage of the coaching relationship involved the evaluation of the coach, adherence to the programme and general satisfaction of the participants with the process.

Findings

Choice emerged as a core requirement for successful coaching. The right to choose the specific behaviour and change strategies emerged as an important core concept in the coaching intervention. Participants chose to change the behaviour that was most important to them.

Stages of change were used by the coach to guide the intervention. Enrolling in a coaching intervention had the effect of moving people along the stages prior to the first coaching call, showing the recognised effect of commitment. All processes of change were apparent in the coaching conversations.

The five phases of the wellness coaching intervention

1. Client assessment.
2. Development of a wellness vision and setting of 3-month SMART (specific, measurable, action-based, realistic, timely) goals.
3. Setting of weekly SMART goals.
4. Weekly review of goal achievement and setting of new goals.
5. Evaluation of the programme and the coach.

“Telephone coaching emerges as a cost-effective method of assisting with behaviour change for people with type 2 diabetes. It fosters independence and shifts responsibility from the medical authority to the client.”

Ambivalence to change was common throughout all stages of the intervention, showing that it is a normal aspect of human behaviour change and arises in response to internal conflict and changes in the person’s social context. The most common method used to resolve ambivalence in this intervention was the use of reflection and an emphasis on choice. Motivational interviewing thus proved useful in this context.

The use of appreciative inquiry underpinned the coaching conversations, and this technique, based largely on the positivist principle, had the power to shift conversations. The distinction in appreciative inquiry is that the technique is used to trigger the person to look at the problem from a positive angle and assumes that everybody has some level of competence from past experience. Increases in self-efficacy and confidence were observed. The elements of the coaching relationship that clients found helpful were encouragement, no judgement, empathy, choice and listening.

Conclusion

It appears that coaching may cause a shift in role identity through the nature of the relationship between the coach and client. People with diabetes find self-care difficult (Keers et al, 2006); however, with this approach the client’s perception of the level of medical authority can shift, with responsibility and power going to the individual. The coach’s non-judgemental stance and empowerment of the client may have assisted participants to move towards increasing responsibility and power in relation to health. Telephone coaching emerges as a cost-effective method of assisting with behaviour change for people with type 2 diabetes. It fosters independence and shifts responsibility from the medical authority to the client. In order to develop this intervention further, however, large randomised controlled trials will be necessary to establish efficacy. ■

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