The Health Care Provider's Role in Supporting Positive Health Behavior Change: Developing an Effective and Supportive Communication Approach

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ABSTRACT

Non-communicable diseases (NCDs) are the leading cause of death and disability worldwide. Four chronic NCDs, including cardiovascular disease, cancer, chronic respiratory disease, and diabetes are responsible for more than 80% of NCD-related deaths. Unhealthy behaviors, such as physical inactivity, smoking, poor nutrition, and excessive alcohol consumption are significant causes of chronic NCDs. However, even when faced with potentially debilitating effects associated with chronic NCDs, it is difficult for individuals to change their behaviors and adopt more healthful practices, such as being physically active, refraining from smoking, eating a healthful diet, and refraining from excess alcohol intake. Sometimes barriers seem insurmountable, and affected individuals need guidance. A potential resource that can help individuals overcome personal barriers and successfully improve their health behaviors is the health care provider. However, while health care providers are being tasked to address patients' health behaviors, they often feel ill-equipped to assist their patients to engage in meaningful, sustainable, health behavior change. Promising approaches to providing efficient and effective support for patients' behavior change revolve around provider-patient communication. Health coaching, for instance, is a process whereby health care providers follow a standardized communication approach in working with patients that integrates health behavior change theories such as the Transtheoretical Model and Self Determination Theory, utilizes conversational tools such as motivational interviewing, and incorporates evidence-based strategies to foster health behavior change. In so doing, the provider's role shifts from that of an expert to that of a partner, which results in improved satisfaction in the provider-patient relationship for both the provider and the patient, and improved health outcomes for the patient. Communication strategies that build provider-patient partnerships increase patient autonomy and self-efficacy, thereby enabling providers to better support their patients in adopting sustainable behavior change and addressing the burden caused by NCDs.

Keywords: behavior change, health coaching, non-communicable disease, communication

1. INTRODUCTION

Non-communicable diseases (NCDs), i.e., non-infectious or non-transmissible diseases, are the leading cause of death and disability worldwide.[1] In 2012, NCDs accounted for 38 million deaths (68% of total deaths),[2] up from 36 million (63% of total deaths) in 2008.[3] Most NCDs are chronic diseases characterized by a slow progression and long duration.[4] In fact, four chronic diseases – cardiovascular disease, cancer, chronic respiratory disease, and diabetes – are responsible for more than 80% of NCD-related deaths.[5] The United States is not immune to these global patterns, with 7 out of 10 deaths each year caused by chronic diseases.[6]

The risk factors for NCDs include behavioral, environmental, economic, and other social health determinants.[7] While the prevalence of each of these risk factors varies by geographical region, the steady rise in most NCDs worldwide is attributed, in large part, to increases in the prevalence of behavioral risk factors.[3] This is certainly true for the United States. While it is well-known that tobacco use, poor nutrition, physical inactivity, and excessive alcohol intake are significant contributors to the incidence of NCDs,[8] national trends illustrate little progress in adoption of healthy behaviors.[9] For instance, 50% of US adults currently do not meet physical activity guidelines and the average US Healthy Eating Index score, a standard measure of diet quality, is 59/100.[9,10]

Clearly, changing and maintaining healthy behaviors is challenging and complicated.[11,12] An integrated, socio-ecological approach involving many levels – individual, interpersonal, organizational, community, and policy – is required,[13] as individuals' health behaviors reflect mutual influence and coordination among these different elements of their environment.[14] The medical community, in particular, has the potential to significantly impact positive health behavior change and maintenance. Health care providers can and should address behavioral risk factors with their patients. In fact, research has shown that, at the very least, advice from a health care provider to change lifestyle habits can indeed incite positive health behavior change.[15,16] Despite such positive results, health care providers often do not adequately address behavioral risk factors with their patients for many reasons, including lack of time, inadequate training on health behavior change, skepticism about patients' willingness to change, and concern about alienating patients.[15,17,18]

In light of these challenges, tools to help facilitate provider-patient conversations, thereby successfully promoting health behavior change, have been and continue to be developed and tested. For instance, the Five A's – Assess, Advise, Agree, Assist, and Arrange - is a brief, feasible intervention tool designed to assist health care providers in primary care settings with behavioral counseling.[15,19,20] Another promising approach that has garnered attention in recent years is health coaching.[15,21] Though more involved than the Five A's, this approach can be learned by health care providers and easily integrated into routine office visits. Health coaching allows health care providers to effectively and efficiently address health behavior change without sacrificing provider-patient trust.

Given the enormity of the burden of NCDs, health care providers need to be part of the solution, in particular, by addressing behavioral risk factors associated with NCDs with their patients. To do so, they must be equipped with tools that will move them beyond increasing their patients' awareness of the need to improve their health behaviors to actually teaching patients how to

successfully adopt and maintain positive health behaviors. The purposes of this paper are to: (1) describe the theoretical foundation upon which effective and supportive communication is based, and (2) provide practical communication strategies, including motivational interviewing and health coaching, that health care providers can easily integrate into routine patient visits.

2. HEALTH BEHAVIOR CHANGE THEORIES

There are numerous theories that explain health behavior change.[22,23] Basic knowledge of health behavior change theories can help health care providers better understand that health behavior change is complicated, that simply raising awareness among patients is not sufficient to instill behavior change, and that informed guidance is critical to bringing about successful health behavior change. In this section, the Transtheoretical Model and Self-determination Theory are presented. These theories inform contemporary health behavior change strategies.[22,23]

2.1. Transtheoretical Model

The Transtheoretical Model, developed by James Prochaska in 1979, integrates key constructs from several theories into a single comprehensive theory to explain intentional behavior change. The Transtheoretical Model posits that health behavior change involves progress through six stages of change,[24] and per this model, ten processes of change, decisional balance, and self-efficacy are instrumental in bringing about this progression.

The central organizing construct of the Transtheoretical Model is stage of change. Stage of change follows the notion that time and readiness are important components of health behavior change, and that most behavioral changes take place gradually over time rather than immediately as discrete events.[25] Individuals move through the six stages of change, progressing and regressing as they move forward in the process of adopting long-term positive health behaviors. These stages include pre-contemplation, contemplation, preparation, action, maintenance, and termination. The stages and their descriptions are included in Table 1.

Table 1: Transtheoretical Model Stages of Change and Corresponding Strategies to Improve Health Behaviors[24,26,27]

Stage of Change	Description of Stage	Strategies
Precontemplation	Not intending to change in the near future	• Use motivational interviewing • Provide educational resources • Increase awareness of consequences of unhealthy behavior • Express concern
Contemplation	Thinking about change but ambivalent; weighing the pros and cons ("I want to change, but…")	• Use motivational interviewing • Empathize with the ambivalence • Discuss benefits of changing • Praise for considering change seriously • Build self-efficacy
Preparation	Intending to take action very soon or making small changes; have identified a plan to help improve the behavior	• Set S.M.A.R.T. goals • Praise and reinforce behavioral changes • Encourage identification of social support or a buddy with whom to change • Problem solve how to deal with barriers
Action	Engaged in making a change within the last 6 months that is sufficient to reduce risk for disease	• Reinforce efforts • Probe how the behavior is positively impacting the patient's life and roles • Identify additional environmental supports • Encourage and praise
Maintenance	Has been engaged in the behavior for 6 months or longer and working towards sustained engagement	• Discuss another behavior and apply change strategies that were successful to future success with the next behavior • Discuss the risk of relapse and how to prevent it
Termination	The behavior has become permanent; there is no risk of relapse (applies to addictive-type behaviors but not behaviors such as physical activity and dietary intake)	• Not applicable

S.M.A.R.T. = specific, measureable, action-oriented, realistic, time-referenced.

Per the Transtheoretical Model, there are 10 different processes that describe how people progress through the stages of change associated with a particular health behavior. These processes include both overt and covert strategies and techniques that an individual may use to modify his/her thoughts, feelings, or environment in order to move forward from one stage to the next. Five of these processes are experiential and include: increasing knowledge, being aware of risks of continuing negative health behaviors, caring about consequences to others, understanding benefits of change,

and increasing healthy opportunities. Five of these processes are behavioral and include: substituting alternatives for usual less healthy behaviors, enlisting social support, rewarding oneself for performing the healthy behavior, committing oneself to the healthy behavior, and reminding oneself of the healthy behavior.[26] To successfully progress through the stages of change and ultimately attain the desired behavior change, different processes are used at different stages. In general, experiential processes are used in the earlier stages of change (precontemplation and contemplation) when patients are thinking about change. The behavioral processes are used in the later stages (preparation, action, and maintenance) when patients are engaging in the healthy behavior. For example, Marcus et al.,[28] identified a relationship between stage of change and process of change for engaging in exercise, wherein progression towards the action and maintenance stages of change was accompanied by replacing the experiential processes of change with the behavioral processes.

A unique aspect of the Transtheoretical Model is that it focuses on the individual's decision-making process, rather than on social and biological factors that might influence health behavior.[25,29] Decisional balance, a core construct of the Transtheoretical Model, posits that the decision to change behavior is made by weighing the pros and the cons of changing the behavior.[30] In order for a health behavior to be adopted, one must see more positives (pros) than negatives (cons) to changing that health behavior. Thus, as one moves through the stages of change, his/her decisional balance also changes. In the precontemplation and contemplation stages, the cons of changing behavior outweigh the pros. As one moves into the preparation stage, the pros and the cons are roughly equivalent. In the action and maintenance stages, the pros outweigh the cons.[25] Considering an individual's stage of change is particularly salient with regard to tailoring health messages to appeal to his/her personal circumstances, as well as to potentially stimulating progression through these stages towards behavior change.[31]

Research on the effectiveness of the Transtheoretical Model in producing behavior change is limited due to poor theoretical fidelity,[32] as well as to inconsistent methodological quality and poor application of the model.[33] Some researchers have concluded that the Transtheoretical Model may not be sufficient by itself to support behavior change, suggesting that combining it with techniques, such as motivational interviewing, may yield better results.[32] Broadly speaking, because behavior change is complex, the literature suggests that no single theory is adequate to guide behavior change. Therefore, providers should recognize that to effectively counsel their patients about making lifestyle-related behavior changes, their recommendations need to be theoretically-based and drawn from several theories.[34]

Self-efficacy stems from Bandura's Social Cognitive Theory and refers to the level of confidence an individual has about performing a particular health behavior even when faced with barriers such as feeling tired, being in a bad mood, and not having enough time.[35] Similar to the other Transtheoretical Model constructs, self-efficacy changes as one moves through the stages of change. In the precontemplation and contemplation stages, self-efficacy is low. As one moves into the preparation stage, self-efficacy increases. In the action and maintenance stages, self-efficacy continues to increase, peaking at about 18 months of maintenance. Self-efficacy is behavior-specific and has been shown to

affect: the acquisition of new health behaviors, the inhibition of existing unhealthy behaviors, the amount of effort a person is willing to commit to a particular health behavior, and the persistence a person will demonstrate when faced with road blocks.[36] In short, a person with low self-efficacy is unlikely to expend much effort towards adopting a health behavior, whereas a person with high self-efficacy is much more likely to do so.

Taken together, health care providers are more likely to be successful in helping patients improve health behaviors if they have a working knowledge of the constructs of the Transtheoretical Model and consider the patient's stage of change from the start. To do so, the health care provider would first need to assess both the patient's stage of change and the patient's self-efficacy regarding the targeted health behavior. A simple survey could be administered to the patient in the waiting room and quickly evaluated by office staff before the patient sees the health care provider. Then, the health care provider could discuss strategies tailored to the patient's stage of change and level of self-efficacy during the office visit. Table 1 includes such strategies. For instance, a health care provider could task a patient in the precontemplation stage with identifying the pros of behavior change, perhaps paving the way for changing decisional balance. The provider could also discuss time management, which is a practical skill that has been shown to increase individuals' belief that they can perform the behavior by helping them feel they can better control potential obstacles.[37] More specific strategies will be discussed in the next section.

2.2. Self-Determination Theory

Self-Determination Theory (SDT), developed by Edward Deci and Richard Ryan, provides a framework for the study of human motivation.[23] This theory examines the role of motivation in initiating and maintaining positive health behaviors. Broadly, SDT categorizes the motivation that regulates one's behavior as autonomous or controlled.[38] People with *autonomous* motivation are either intrinsically motivated or self-determined (i.e., integrated and identified regulation). These individuals incorporate the value of a behavior into their sense of self, gain self-support and self-advocacy through their own actions, and are thereby more likely to adopt and maintain the positive health behavior. More specifically, persons who are intrinsically motivated are likely to regularly engage in a positive health behavior because they enjoy it and feel a sense of accomplishment. Persons who are self-determined are likely to regularly engage in a positive health behavior because the behavior has been assimilated into their sense of self (i.e., integrated regulation) or because they want to improve their physical health or appearance (i.e., identified regulation). People with *controlled* motivation (i.e., introjected and external regulation), to a large extent, do not recognize the inherent value of a health behavior and instead their behavior is influenced by external factors. More specifically, persons with controlled motivation are likely to initiate, but not necessarily maintain the behavior, because they want to avoid feeling guilty or shameful (i.e., introjected regulation) or because they want to be noticed and receive compliments during social engagements (i.e., external regulation).

Given its association with sustained health behavior change, fostering autonomous motivation is key. Therefore, understanding fundamental influences on autonomous motivation may be helpful. Autonomous motivation is strengthened when three basic psychological needs – autonomy (being self-governed),

competence (ability to function in a particular way), and relatedness (feeling connected to others) – are met.[38,39] In a meta-analysis of 184 studies in health care and health promotion settings, promotion of patient autonomy, in particular, was found to be very important to improving mental and physical health and to predicting the performance of healthy behaviors and psychological well-being across a wide variety of behaviors.[40] In short, the literature indicates that when health care providers support patient needs for autonomy, competence, and relatedness, patients become more engaged in the treatment process and experience better long-term outcomes.[40,41]

Health care providers are more likely to be successful in supporting positive health behaviors in their patients if they understand the pivotal role that autonomous motivation plays in sustaining health behavior change. For example, health care providers can enhance their patients' autonomous motivation by discussing how to link personal values and goals to their health.[42] More specific strategies will be discussed in the next section.

3. COMMUNICATION STRATEGIES

3.1. Motivational interviewing

Motivational interviewing is a conversational tool that health care providers can use to facilitate discussion about health behavior change among their patients. It incorporates elements of both the Transtheoretical Model and SDT. For example, for patients who are not yet ready to change (i.e., in the precontemplation stage), motivational interviewing elicits intrinsic motivation for healthy behavior adoption within the patient,[43] thus potentially stimulating progression through the stages of change. Further, motivational interviewing fosters autonomous motivation by helping patients resolve dissonance between their personal values and their health behaviors. For example, an important value, like being a good parent, is a more sustainable motivator for the performance of healthy behaviors than is a health care provider's recommendation to exercise more, or the desire to lose weight to look better in anticipation of a wedding or high school reunion.[44] Referred to by the acronym, RULE, the four guiding principles of motivational interviewing include:

- ***R****esist the righting reflex*. The righting reflex is a natural desire of health care professionals to want to make things right when there is a problem. For example, it is common for health care providers to communicate to their patients that their behavior is unhealthy and attempt to persuade them to change. Consistent with reactance theory,[45] such efforts often backfire and produce resistance from the patient, a natural response to perceiving interference from others.
- ***U****nderstand your patient's motivations*. Patients are persuaded by their own reasons for change, rather than by the provider's rationale and goals. Instead of telling a patient why he/she should change, a better approach is to ask the patient about the benefits of adopting a health behavior and why he/she should change. People have more confidence in self-generated arguments,[46] and therefore can persuade themselves to change.
- ***L****isten to your patient.* A key to using motivational interviewing effectively is to listen more than talking, educating, or advising. Empathic listening is a primary skill involved in developing a patient-centered

partnership to support behavior change.[47]

- ***E**mpower your patient.* Health outcomes are improved when patients actively engage in managing their own health. Through motivational interviewing, a provider can partner with the patient to explore how the patient can improve his/her own health. Patient empowerment is crucial to the development of patient self-efficacy to make healthy changes.[43]

By collaborating with the patient, the provider creates an atmosphere that is cooperative rather than coercive, recognizes that the patient possesses the resources and motivation to change, and respects and affirms the patient's right and capacity for self-direction. The primary skills of motivational interviewing include:

- *Asking open-ended questions*, which allows the patient to guide the conversation, prevents yes/no answers, and respects patient autonomy.
- *Affirming and supporting*, or actively listening for patient values, strengths, aspirations, and positive qualities, and reflecting these back to the patient in an affirming (nonjudgmental) manner.
- *Reflective listening*, or mirroring what the patient says, to keep the conversation focused on the patient, to dive deeper into the patient's story, and to confirm mutual understanding between the patient and the provider.
- *Summarizing* periodically during the conversation to reinforce the patient's motivations to change, to transition between topics, to point out progress, and to ensure the provider understands the patient.[43]

While motivational interviewing has been used and studied in non-medical settings for four decades,[48] its use in medical settings spans only the last two decades.[49] A recent systematic review and meta-analysis determined that motivational interviewing can be used by a variety of health care providers efficiently and effectively for a variety of types of patients to promote behavior change related to physical activity, weight loss, blood pressure and cholesterol management, and substance use.[49] Specifically, compared to control groups, patients who received motivational interviewing had, on average, a one and a half times greater chance of improving.[49] Thus, it is fairly evident that motivational interviewing has the potential to be a powerful tool that health care providers can use when broaching the topic of behavior change with their patients.

3.2. Health Coaching

While motivational interviewing alone is not sufficient to bring about health behavior change, health care providers can use this strategy to initiate a conversation about personal health behaviors. Motivational interviewing should be a component of a more comprehensive communication approach to improving health behaviors – health coaching.[50] Much has been written about effective communication strategies with patients that focus on patient-centeredness, humanism, meaning, and mindfulness.[51–54] Learning and applying health coaching (counseling) skills can effectively shift a health care provider's focus from expert to partner in the mutual quest for improving the patients' health behaviors, thereby improving satisfaction in the provider-patient relationship and patient health outcomes.[50,54]

Given that most health care providers are educated and experienced in the Western medicine approach to patient care, which involves collecting and interpreting information, forming a diagnosis, and

prescribing medications or interventions, a shift towards health coaching requires education and practice.[50] Competencies necessary to effectively coach a patient include:

- Applying a patient-centered approach wherein the patient feels self-directed rather than provider-directed,
- Assisting patients in identifying their goals and motives for change,
- Using a self-discovery process in which patients explore achievable intervention strategies and engage in active learning about their health,
- Helping patients establish self-accountability and monitoring practices, and
- Building relevant health knowledge to assist the patient in changing unhealthy behaviors.[55]

Health care providers not trained in health coaching often try to motivate patients by connecting health behaviors with disease prevention. For example, a health care provider might educate a patient about the role of good nutrition and physical activity to lower blood pressure and/or reduce the risk for cardiovascular and metabolic disease. Providers may rely on resources, such as Exercise is Medicine,[56] which provide patients with pre-established exercise programs. This approach meets the needs of the provider in improving patients' health, but does not incorporate patients' unique needs. Ample evidence suggests that most patients are not motivated to be physically active for the long-term factors that coincide with providers' goals, such as preventing disease and improving health. Instead, patients are motivated by positive affective experiences, such as having fun, improving overall well-being, and attaining a high quality of life.[44] In other words, while health-related reasons to change behavior are important, providers should partner with patients to identify patient-centric goals and motivations for change that are aligned with patients' needs and desires in an effort to sustain behavior change over time.

Consistent with the notion of partnering with the patient, providers can instill a "trial and learn" approach in lieu of the more common "trial and error" approach to behavior change.[50(p.74)] A "trial and learn" approach entails experimenting with various strategies and approaches to learn which ones work best for each individual, while avoiding the blame and shame that a "trial and error" approach can yield. Building healthy habits can and should be a positive experience, and refraining from references to making mistakes, errors, and failure is more likely to build self-efficacy and success.[50] Encouraging self-discovery allows patients to identify their readiness to change, as well as the relative effectiveness of different approaches to behavior change, which can lead to greater investment and long-term success. For example, while patients in the precontemplation stage of change are not ready to actively improve their behavior, they may derive value from identifying benefits of the health behavior, problem-solving identified barriers, and seeking social support. Rather than the provider simply giving this information to the patient, he/she can "prescribe" homework, encouraging the patient to brainstorm about the benefits of behavior change, options for overcoming barriers, potential sources of social support, and strategies for marshaling support. In this way, patients themselves identify suitable strategies for engaging in meaningful behavior change instead of merely following directions from their provider. This approach allows for tailored communication between providers and patients that is focused on unique patient

experiences,[31] which could ultimately lead to behavior change.

Adopting a standardized approach to health coaching can help reduce the provider's apprehension about communicating with patients during office visits. With the abatement of apprehension, the provider will become more facile at using health coaching on a routine basis. Table 2 displays a process, incorporating the Transtheoretical Model, Self Determination Theory, and elements of motivational interviewing, that can be adopted and modified as needed to guide behavior change conversations with patients. This approach is designed to avoid resistance and defensive responses from patients. While patient defensiveness or resistance could mean that the patient is not ready to address the behavior, it could also be a signal from the patient that the provider's communication style reflects an expert approach rather than a coaching approach. For example, asking questions that begin with "why" can result in a defensive response from a patient; therefore, rather than asking, "why do you find regular physical activity difficult?", a provider could say "tell me about your experience in trying to make physical activity regular." To the extent that the provider can elicit responses from the patient rather than directing the patient, the patient will become engaged, interested, and successful in making health behaviors habitual.[50]

A recently published compendium of the health and wellness coaching literature indicates that health coaching can be a valuable tool to improve behavior change as it relates to addressing chronic disease.[21] Articles included in this review met criteria recommended in this paper, including that: (1) the health coach was a trained health care professional and used behavior change theory and coaching processes; (2) the patient determined the behavior change or health goals either in part or in whole; (3) there was an element of patient accountability included in the coaching interaction; and (4) a patient-clinician relationship was established (at least 3 visits occurred).[21] Based on the reviewed literature, the authors suggested that health coaching is a worthwhile intervention for patients with cancer, diabetes and heart disease, and it is especially effective in addressing obesity, high cholesterol, and hypertension.[21] Furthermore, the US Preventive Services Task Force rates behavioral counseling a grade of B in the treatment of adults who are overweight or obese with risk factors for cardiovascular disease, indicating that there is high certainty that the net benefit of counseling is moderate or that there is moderate certainty that the net benefit is moderate to substantial.[57] Based on these reviews, health coaching is an intervention approach that health care providers should consider utilizing to stem the growth of chronic disease.

Table 2: Communication Process to Discuss Behavior Change

Step	Example
Ask permission to discuss a behavior	"I noticed you indicated that you are not regularly physically active on your medical history form. Would it be okay for us to discuss this behavior?"
Ask about history with the behavior	"Was there a time in your life when you were regularly physically active? Tell me about that time. What was different in your life then?"
Ask about the benefits of the behavior	"If you were regularly physically active now, how would your life be different? What are the benefits of regular physical activity for you now?"
Ask about the barriers to the behavior	"What is getting in the way of being regularly physically active? How can you problem-solve to reduce these barriers?"
Identify environmental and social supports	"What resources do you have that would help you to be regularly physically active? Are there individuals in your daily life who would support your efforts to be regularly physically active?"
Assess readiness to change	"How ready are you today to become more physically active?" (1 to 10 scale)
Assess confidence to change	"How confident are you today that you could become more physically active? (1 to 10 scale)
Ask if patient is ready to take a first step	"If you were to take a step toward being more regularly physically active, what would that first step be?"
Create a S.M.A.R.T.* goal	Example goal: I will ask my spouse to walk with me after dinner for 30 minutes on two evenings next week.
Inquire about confidence in achieving goal	"How confident are you that you will accomplish this goal?" (1 to 10 scale)
Express appreciation for the patient's willingness to make positive changes	"I'm glad we had this conversation and that you have created the start of a plan to become more physically active. I am confident that you will be successful."
Arrange for follow-up/accountability	"At your next visit I look forward to discussing your progress in making physical activity a regular habit."

S.M.A.R.T. = specific, measureable, action-oriented, realistic, time-referenced

3.3. Specific Strategies for Enhancing Self-Efficacy and Autonomy

In addition to following the process outlined in Table 2, the health care provider can mindfully employ communication strategies that foster empowerment, patient self-regulation, and autonomy, thereby avoiding the guilt, shame, and social pressure often experienced by patients. Indeed, self-efficacy and autonomy, the two major goals of health coaching, can be cultivated by a variety of strategies.

Strategies to increase self-efficacy can be categorized in four ways, including: (1) performance accomplishments, (2) vicarious experience, (3) verbal persuasion, and (4)

emotional arousal.[58] Performance accomplishments refers to breaking a behavior into small, achievable, yet challenging steps. For example, in line with the sample S.M.A.R.T. goal in Table 2, a patient might ask his/her spouse to walk after dinner for 30 minutes on two nights per week. While fitting in one hour of exercise per week is a small and achievable step, at the same time it can be challenging to alter one's routine and to include one's partner in healthy behavior change. It is important to identify achievable goals like these because achieving small goals invites further progress; in contrast, failing to achieve ambitious goals can deplete self-efficacy. Ensuring that patients are challenged *and* supported to accomplish a behavioral step is crucial in trying to enhance self-efficacy and promote behavior change.

Vicarious experience, also known as observational learning, involves observing someone else succeed in changing a specific, or target, behavior, thus confirming that the target behavior is attainable. For example, observing that a friend has been able to stop smoking or attend an exercise class on a weekly basis may help convince an individual that change is doable. The success of the friend can serve as a point of reference for successfully changing the target behavior.

Verbal persuasion includes both social and self-persuasion. Patients invest more effort in behavior change to the extent they believe they can succeed and that they have the requisite support to succeed.[58] Consequently, a health care provider's expression of confidence in a patient's ability to be successful combined with an emphasis on positive experiences versus struggles or failures can result in a patient persuading him- or herself that he/she can successfully change the target behavior. Mental practice and imagery can also aid in persuading patients that they have the capacity to be successful. Together, these approaches can ameliorate patients' self-doubt, while also promoting their behavior change.

Finally, emotional arousal calls attention to how patients feel as they experiment with behavior change. Although behavior change is often physically and emotionally beneficial (e.g., improved sleep, mood, and energy), patients might not readily make connections between their behavior change and these positive outcomes, perhaps focusing on the physical and emotional challenges associated with behavior change instead. As such, health care providers should highlight these connections and benefits in an effort to enhance patient motivation and self-efficacy.[50] It is imperative that patients make connections between the health behavior change and positive outcomes, as intrinsic motivation is necessary to sustain behavior change. When health behaviors are aligned with a patient's values, they become more natural to perform and serve to enhance life roles. For example, when a patient recognizes that regular physical activity enhances his or her ability to care for his or her children or grandchildren, the value of engaging in regular physical activity is compounded. This realization is consistent with the suggestion from Segar et al. that patients will be more motivated to perform healthy behaviors when practitioners promote them through "cultivating choice, featuring emotions/affect instead of logic, and prescribing [them] for vitality, enjoyment, and well-being."[44(p.101)] Providers are challenged to find non-health-related reasons to adopt healthy behaviors; however, when they do identify these reasons, communicating them to their patients can promote greater success in health behavior change.

4. CONCLUSION

All health care providers are being tasked to address the burden of NCDs by promoting the adoption of healthy behaviors, like regular physical activity, consuming a nutritious diet, not smoking, and refraining from excess alcohol intake with their patients.[15] Despite the time restraints experienced by health care providers and the skepticism that patients will take action, providers can change the conversation they have with their patients from a health-focus to a patient-focus and produce improved results and outcomes. By partnering with patients to identify intrinsic motivators and applying strategies to intentionally improve self-efficacy, health care providers can reasonably address health behavior change, invariably reducing the burden of disease and improving the health of members of society.

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