

Motivate Healthy Habits:

Helping Yourself and Your Patients Change

**A Leadership Guide for Educators, Practitioners,
Learning Organizations and Communities**

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Preface

As health practitioners and lay health guides, your communication and counseling (inter-personal) skills can help your patients change their unhealthy habits. But what's missing from this process for your patients? The internal change process for patients remains implicit. In other words, patients are unaware of how you are working to help them change.

Patients are often unaware, to varying degrees, of their emotional resistance to change. They rarely get explicit guidance in how to address their internal (intra-personal) processes that caused their resistance and their failure to change. This is like trying to understand why an airplane crashed without gaining access to the data inside the black box to understand the cause of the accident.

This self-guided change (SGC) book transforms an implicit (inter-personal) counseling process into an explicit (intra-personal) learning process. This shift can help your patients look inside of their black box before they crash. Using learning exercises, they can develop new ways of communicating about health behavior change with themselves and with others. Such internal and external dialogues can help patients fly more safely on a healthier course. They can identify what is not working right and make appropriate adjustments along the way.

SGC learning exercises will help both you and your patients change unhealthy habits. These exercises will help you and your patients achieve your behavior change goals with greater ease and effectiveness, more satisfaction, and less frustration and wasted energy. If you experience this SGC learning process for yourself, you can improve your health habits. In turn, this learning experience can help you guide your patients more effectively through the same learning process.

One of the greatest compensations in life is that
no one can help another without helping themselves

Ralph Waldo Emerson

This SCG book is derived from the skills development guidebook, *Motivational Practice; Promote Healthy Habits and Self-care of Chronic Disease*. The six-step model described in this guidebook provides a framework for developing micro-skills that can help communicate and counsel your patients more effectively about healthy behavior change.

The six steps include

- Partnership-building
- Agenda-setting
- Assessing resistance and motivation
- Enhancing mutual understanding

- Implementing a plan
- Following through

The continuing professional development (CPD) model of motivational practice will enhance your skills at changing behavior as part of a lifelong learning process (for more details, refer to the Acknowledgment and About the Author sections). This model consists of four-phases:

- Self-focused—improve your health habits and adopt a professional role that meets your patient’s needs
- Method-focused—learn the principles and techniques of motivational practice
- Learner-centered—expand your repertoire of motivational skills
- Patient-centered—create individualized interventions for your patients

The development of motivational skills can have a cascade of benefits:

- Reduce your frustrations with resistant patients
- Develop effective partnerships with them
- Engage patients in meaningful dialogues
- Enhance your patients’ readiness to change
- Improve patients’ outcomes
- Enrich your professional work

This SGC book integrates effective counseling methods into a reflective learning process. It is best used when working with others as part of a learning collaboration or community. This discovery process may involve reading, responding to questions, journaling, mutual support and discussions involving family and friends, and social support including professional, community and online resources. Individuals can select a blend of learning options that accommodate their needs and preferences, and additional resources and supports that are available to them.

In effect, this guidebook de-mystifies a counseling process and helps your patients develop behavior change skills for their every day life. In other words, you can make the internal change process transparent to your patients and their families. In effect, this process de-professionalizes the counseling role and makes the process of internal change more accessible to the general public.

This does not replace the need for counseling services. Individuals can use SGC learning methods with a blend of external supports in order to expand the reach and impact of behavior change interventions. Given that there will never be enough counseling services to address the epidemics of unhealthy habits, your health care setting can use such limited services much more effectively when used alongside SGC learning methods.

Counseling services are often time intensive. Furthermore, patient appointments predominantly fit into the counselor's schedules, and not necessarily when patients are in their most receptive moods for learning about deep change. In short, health care settings clearly lack the time and resources to address the magnitude of this overwhelming challenge.

How can you work more effectively with patients and invite them to consider change, without persuasion or coercion? To be more effective in assisting your patients, you can use this learning process on yourself. After all, how can you act as a change agent or guide in helping others if you cannot lead yourself towards improved health? With mindful attention to your own internal dialogues and reactions about behavior change, you can develop more of an authentic relationship to yourself. Being genuine and non-judgmental can assist you to:

- Create your own vision about your healthy habits and well-being
- Navigate effectively through your ambivalence and internal conflicts about change
- Generate commitment and personal accountability toward healthful change
- Develop personal evidence about deep change and achieve your goals

This attentive process can help you learn how to free yourself from your own perceptual distortions and self-deceptions that jeopardize your health. For example, you may maximize the benefits and minimize the risks of your unhealthy habit and reverse these perceptions about change: minimize the benefits and maximize your concerns about changing your unhealthy habit. Self-deceptions can take the form of sophisticated rationalizations supported by defense mechanisms and unhelpful beliefs. These self-deceptions can create deeply ingrained forms of resistance that are more difficult to overcome.

Why is it so important to begin with oneself? The only difference between yourself and your patients may be the degree of health risk: for example, a practitioner who does not exercise enough and a patient who smokes. It is much easier to see the need for behavior change in your patients than it is to recognize this need in yourself. Almost everyone trades in some long-term losses against short-term emotional gains.

No one has perfect health. You are invited to consider whether to strive for it or make small health improvements. When you share your learning experiences of improving your own health habits with your colleagues and co-workers, you can gain a more diverse and deeper understanding about behavior change. These group sharing experiences can begin a process of learning more efficiently from your ongoing experiences in working with your patients and their family members. You can enhance your capacity to develop empathy and humility in partnering with patients in addressing their challenges of change. Hopefully, this guidebook will also spark a fascination within you about how you can motivate and inspire your patients to change their unhealthy habits.

What matters the most is not the learning method or even this book. What matters the most is your work in making sense out of experience-based learning exercises for yourself and your patients. You can develop a learning portfolio and gather your own personal evidence about what works and does not work for you and your patients. After all, the only person who can change you is you, ideally in a setting of a supportive learning organization.

What matters even more is creating healthy learning communities that support families in developing healthier habits and environments, within, along side and independent of the health care system. After all, how can we create healthier environments (such as reversing global warming, pollution, environmental degradation and water contamination) if we cannot change our own unhealthy habits? We need to develop a higher global consciousness about our own health and our environment.

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Acknowledgments

As a lifelong learner, educator, family physician and professor, I have learned much about behavior change from my patients, students, clinical work and current scientific evidence, together with different theories, models and concepts. I have synthesized this learning and developed the continuing professional development (CPD) model of motivational practice. This model builds on the shoulders of cutting-edge theorists, researchers and clinicians. The major influences that shaped the development of this model include the following:

- Transtheoretical Model of Change (Jim Prochaska and Carlo DiClemente)
- Self-Determination Theory (Ed Deci and Rich Ryan)
- Motivational Interviewing (William Miller and Steve Rollnick)
- Social Learning Theory (Albert Bandura)
- Cognitive Behavior Therapy (Aaron Beck)
- Rational Emotive Therapy (Albert Ellis)
- Relapse Prevention (Allan Marlatt)
- Solution-Based Therapy (Steve De Shazer)
- Patient-centered approaches (Ian McWhinney)

This synthesized model is based on integrating multiple theoretical perspectives in ways that create a learning platform that can accommodate individual needs and preferences. In the spirit of patient-centeredness, you invite your patients to consider which learning exercise will help them work effectively on healthy behavior change. With their consent, you help them discover what they need and select theories, models and concepts that meet their needs rather than making individuals fit into your preferred theory, model or concept. In this way, this CPD model is not theory-centric and therefore side-steps the trap of practitioners acting in behaviorally controlling manners

Furthermore, this model also incorporates elements of complexity, ecological, organizational theories and improvement sciences to address how social influences affect individuals in positive and negative ways, and vice versa. This learning process extends beyond an individual orientation to incorporate family, community and cultural aspects of health behavior change.

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Introduction

The common denominator that determines the effectiveness and overall performance of your health promotion, disease prevention and disease management programs is the extent to which your organization, your practitioners and your patients can change behavior. Changing behavior across these three levels is a complex educational and clinical task. Resistance to change is expected and a normal part of human nature, to varying degrees. Organizational and individual resistance makes these behavior change goals challenging to put into practice.

Understand the Principles of Motivational Practice

The continuing professional development (CPD) model of motivational practice (as summarized in preface) can enhance the cultural humility of your organization in addressing the differences in worldviews and life circumstances among your colleagues, staff and your patients. Cultural humility involves taking the one-down or egalitarian position in which you take a non-judgmental, open stance of curiosity and learn from others about what helps them to change, with support as needed. The principles and operational tenets of motivational practice (summarized in the table on the next page) can help you enhance your ability to engage others more effectively in change dialogues.

If you adopt these motivational principles, the boundaries between teacher and learner become blurred. It is not clear who is the teacher and who is the learner. Your relationship with others becomes reciprocal learning partnerships. If you adopt these principles, you can enhance your communication and counseling skills and develop more effective partnerships in helping family members, colleagues, staff and patients change. The development of these interpersonal skills among practitioners and staff within your healthcare settings can initiate a process of cultural transformation that facilitates the development of a health-promoting learning organization.

Motivational Practice: Micro-level Principles and Tenets
<p>A. Support and respect autonomy</p> <ul style="list-style-type: none"> Invite participation Gain consent Be nonjudgmental Offer choice
<p>B. Understand patients' perspective</p> <ul style="list-style-type: none"> Develop empathic relationships Clarify roles and responsibilities Clarify patients' issues about change Work at a pace sensitive to patients' needs Understand patients' perceptions, motives and values Reduce resistance before increasing motivation
<p>C. Adopt a positive stance</p> <ul style="list-style-type: none"> Focus on strengths rather than on weaknesses Focus on health rather than on pathology Focus on solutions rather than on problems Provide constructive feedback Help patients believe in healthy outcomes Encourage patients to do emotional work
<p>D. Elicit patients' problem-solving skills</p> <ul style="list-style-type: none"> Enhance patients' confidence and ability Increase supports and reduce barriers Negotiate reasonable goals for change Develop plans to prevent relapses Use "failures" as learning opportunities
<p>E. Maintain long-term engagement</p> <ul style="list-style-type: none"> Maintain a learning partnership Monitor resistance and motivation Negotiate frequency of follow-up Adjust goals to changing circumstances

Understanding Differences in Worldviews

You and your patients are on different orbits and view the risks, benefits and harms of unhealthy habits versus changing it, from different perspectives. Your patients may maximize the benefits and minimize the risks and harms of their unhealthy habit. In contrast, you may minimize the benefits and maximize the risks and harms of your patients' unhealthy habit. If you have not been trained to ask about the benefits that your patients gain from their unhealthy habits, you may not be fully aware of the differences in perceptions between you and your patients. Given these differences, your patients typically resist change when you try to promote healthy behavior change.

Even when your patients know that they should change their unhealthy habits, they may not fully understand what is holding them back and why they emotionally resist change. They think that they should but don't really feel like it, but they may only have varying degrees of awareness (known, subconscious and unconscious) about their emotional resistance. Emotional resistance is often a hidden force in your patient encounters, and you may only have varying degrees of awareness about the intrapersonal and interpersonal dynamics of resistance.

Resistance is a pejorative, value-laden word that means that you disagree with the direction of the patient's behavior. Your patients are often simply motivated in the opposite directions to your pro-health value system. For example, patients enjoy the pleasure of smoking, but you want your patients to protect their health. Like the term "compliance", its clinical antonym, it can imply a hierarchical relationship between the one-up practitioner who knows best and the patient who has different priorities. This one-up position cannot force authentic change to occur.

To break unhealthy habits, you and your patients may have to go deeper than exploring emotional resistance and analyzing perceptions about the benefits, risks and harms of staying the same versus changing. Underlying values are also an important determinant of health behaviors. Furthermore, family, socio-economic, community, cultural factors can make individuals compromise their health values and behaviors for a variety of legitimate reasons. But what about your resistance to changing your own behavior?

Understand Your Resistance to Behavior Change

To what extent did your professional education help you understand why:

- You resist improving your own health habits and well-being?
- You resist changing your professional role in order to work more effectively with your patients?

If you try to improve your own health habits and do not lower your resistance, it will feel like an internal tug of war. You will experience ambivalence and internal conflicts. On the other hand, if you try to change and have no resistance, you can experience effortless motivation. For example, you may go dancing just because you love to do it. What kinds of physical activities generate the least and the most resistance to change in you?

A fundamental principle underlying the questions above is that you first need to learn how to lower your own resistance before you can develop effective motivation to change. To what extent was this principle a "blind spot" in your own personal life and in your professional education? And to what extent did your professional education help you learn how to put this principle into practice, for yourself and for your patients?

The process of learning how to lower your own resistance to healthy behavior change can also prepare you for professional change. In addition to being a health adviser delivering evidence-based interventions, you can also learn how to become a motivational guide to your patients when evidence-based interventions do not work. If you do not shift your professional role from the “fix-it” health advisor to a motivational guide, you run the risk of using motivational skills and techniques in mechanistic ways that does not establish effective empathy with your patients. This role shift is essential for accelerating the development of your motivational skills so that you can engage your patients more effectively in dialogues about change. Such empathic dialogues will enable you to develop more individualized interventions that meet your patients’ changing needs over time.

Understand the Limitations of Scientific Evidence

What do you do when patients do not respond to evidence-based interventions? How well did your training prepare you for those all too frequent occasions when patients resist changing their unhealthy habits in response to your health information and advice? So where do you begin to learn more about behavior change?

Evidence-based guidelines that promote healthy behavior change work for up to 20% of patients in primary care. Their recommendations typically involve practitioners giving health information and advice, negotiating goals for change and selecting methods to change. Such action plans are only helpful for those individuals who are both motivated and have the confidence to change. Regrettably, this only appeals to a minority of patients.

Evidence-based interventions only tell us what works for the “average” patient. They do not provide us with any specific guidance about what works, in particular, for our individual patients. Furthermore, these interventions (such as in the Tobacco Cessation guidelines) are static and predominantly prescriptive. Such guidelines provide no assistance in how we can engage our patients in meaningful dialogues when these interventions do not work.

Understand a Double Standard

So what can you do to get unstuck with your so-called resistant patients? There is no simple prescription for addressing this poor response rate. A 20% drug response rate for treating a life-threatening disease would be regarded as unacceptable. It would generate demands to develop new drugs that would vastly improve the response rate.

Such a proactive response is not the case for developing individualized behavioral innovations for our patients. In effect, we have double standards in healthcare in terms of treating diseases with drugs versus preventing diseases with behavioral interventions. To

what extent do we value drugs and procedural interventions for treating diseases more than talking to our patients about behavior change to prevent diseases?

We are so short sighted when we only rescue our drowning patients downstream. We need to take the time to look upstream and address what is causing the people to fall into the treacherous rapids. Our time-pressured, attention deficit and multi-tasking society makes the complex task of developing a long-range vision for addressing the epidemics of unhealthy habits even more challenging.

Understand the Need for Complex Process Interventions

Our professional altruism and sense of duty to care for others may make us minimize attending to our own self-care needs. When taken to an extreme, such self-sacrifice can lead to professional burn-out. The baby boomer generation, in particular, have been the most vulnerable to being victims to the tyranny of work. Unbalanced lifestyles contribute to neglect of self-care. In turn, a lack of self-care is not an effective strategy for creating health-promoting cultures at work.

In many health care settings, it is a taboo to discuss our own health behaviors at work. To address this professional shortcoming, leaders and educators have a responsibility to improve the learning experiences of students and practitioners. This calls for creating learning organizations, communities and environments to help individuals (leaders, educators, practitioners and patients alike) discover their own personal path to healthy habits and well-being.

To address the epidemics of unhealthy habits, we need complex process interventions ranging from the macro-level (changes in public policy), meso-level (changes in organizational culture) and micro-level innovations (self-guided change learning process for individual behavior change). To address this complex, overwhelming problem, we can begin this change process by focusing on ourselves; in other words, think globally, act locally.

Understand the Need for Personal Evidence

To overcome the limitations of evidence-based guidelines, you have to go beyond surface change—increasing knowledge about your unhealthy habit, having your good intentions about change and setting your goals. Evidence-based interventions use an outside-in, teaching approach that does not address why you resist change and what it means for you to change. To develop your own personal evidence about change, you can drive an inside-out learning process to explore the meaning of deep change.

To experience this learning process, you can use critical thinking and reflective practice to explore the cognitive and emotional aspects of making deep change. This discovery process may involve you in any combination of the following activities in order to achieve your goals for change:

- A. Explore your thoughts and feelings about deep change
 - Explore your thoughts and feelings about your goals for change
 - Address discrepancies in your values between what you say and what you do
 - Alter your perceptions about the risks, benefits and harms of your unhealthy habit in favor of healthful change
 - Assess the strength of your resistance and motivation to change based on what you think and how you feel
 - Explore how your feelings block change and lower your emotional resistance
 - Discover what will inspire and motivate you to change
- B. Prepare yourself for deep change
 - Assess and address your competing priorities and energy level to change
 - Analyze and change your motives in favor of intrinsic motivation
 - Assess and increase your confidence and abilities to change
 - Develop specific coping, problem-solving, time management and/or emotional regulation skills
 - Reduce your barriers and increase your support to change
- C. Put your goals into action
 - Develop healthy identities and connections to healthy communities
 - Put your health values into practice
 - Select appropriate methods for putting your goals into actions
 - Anticipate how you can prevent lapses and relapses

Why is it helpful for you to directly experience this learning process? The rationale for beginning with self-focused change is quite simple. There is no substitute for direct experience. It is like having children. Do you think that you would be (or are) a better practitioner in providing care to parents and children before or after having your own children? Of course, you can still learn through the experiences of your patients, but direct experience adds a unique personal dimension to the learning process that allows you to relate to others with the same experience in more meaningful ways.

Understand Resistance to New Ways of Learning

Some resistance to using new ways of learning is expected to varying degrees. Such resistance can provide you with invaluable information about what might make it more difficult for you to change your unhealthy habits. Is your resistance giving your clues about how to select better ways for you to learn? For example, what blend of journaling and talking to others is the right combination for you? And to what extent do you respond to the idea of developing personal evidence with dismissive or healthy skepticism?

Dismissive skepticism can create negative expectations, biases and beliefs about the potential of learning how to develop personal evidence. For example, “I have tried all of the self-help approaches and none of them work for me”. Such unhelpful beliefs can

negate the benefits of learning about self-guided change. Furthermore, cynicism and self-defeatism can close the door to new ways of learning about healthy behavior change. These issues can apply to both practitioners and patients.

What helps to open up to new ways of learning? Open-minded neutrality and curiosity can cultivate healthy skepticism. The best way to honor your healthy skepticism is to experience the learning process of developing personal evidence for yourselves, ideally in a setting of a supportive learning organization or community.

A meaningful learning experience can convert your healthy skepticism into positive expectations about the power of developing personal evidence. A shift from neutral to positive expectations can also help change unhelpful beliefs into helpful ones. Such a switch in belief systems can transform self-fulfilling prophecies about not changing into self-fulfilling prophecies about the potential of change.

Understand the Need for Collaborative Learning

The learning exercises in this guidebook will help you discover your own personal path to healthy habits. You, your family, friends and trusted colleagues can share your positive experiences of developing personal evidence with each other. Your interactions with others can act as mirrors that can reflect light onto your blind spots. Conversely, your interactions with them can shed light on their blind spots. Such collaborative learning can make the change process less challenging for yourself and help you become a more effective guide to others.

Your direct, first-hand experience of this learning process will help you understand how personal evidence can overcome the limitations of evidence-based guidelines. Evidence-based guidelines cannot give you the experience of developing personal evidence. Both evidence-based guidelines and experience-based learning methods are equally important for improving organizational performance.

Understand the Organizational Performance Equation

Evidence-based guidelines and experience-based learning methods represent equal halves of the performance equation. Evidence-based guidelines can raise the floor of organizational performance, but only personal evidence can raise the ceiling of your performance. This SGC book deals with the second half of this equation, the personal evidence or “inside-out” perspective. In other words, what, in particular, works for the individual patient, in terms changing unhealthy habits?

Do your behavior change and disease management programs wait for the next updates of evidence-based guidelines to improve your overall performance? Or does your health care setting integrate continuous improvement methods into these programs to create your own practice-based evidence and further raise the level of

your overall performance? Does your health care setting want to go beyond being a floor-raiser to become a ceiling-breaker too?

Experience-based learning methods can help your patients become the principal investigator or lead researcher of their own behavior change. They can develop their own personal evidence about changing their unhealthy habits. This will help your organization break through the ceiling of organizational performance.

Understand the Leadership Challenge

The epidemics of unhealthy habits are a tsunami. With no additional preventive measures, this tsunami will wash ashore one billion dead smokers in the 21st century. And smoking is only one of many unhealthy habits. Behind this tsunami are multiple tidal waves of interrelated issues that are propelling these unhealthy epidemics forward across the generations. Like the tectonic forces that create a tsunami, the contributing factors for understanding this complex phenomenon lie deep beneath the surface.

A real tsunami cannot be reversed. We can minimize the negative consequences of this natural disaster, but we cannot address its causes. However, the epidemics of unhealthy habits are not a true tsunami. They are not a natural disaster but a man-made phenomenon. Multiple environmental, cultural, family and individual factors shape the development of unhealthy habits. We can address both the root causes and minimize the negative consequences of unhealthy habits. Better still, we can work toward reversing this man-made tsunami to develop epidemics of healthy habits. How can your health care setting(s) become a learning organization to work toward this goal?

Understand the Need for New Leadership Capacities

The tsunami of unhealthy habits calls for new kinds of leaders, leadership capacities and leadership networks to develop more effective behavior change and disease management programs that promote healthy habits and self-care of chronic conditions. With a greater understanding about the complexity of behavior change, leaders and educators can develop the innovative stewardship needed for creating cost-effective, high-touch, high-tech and low-tech, behavior change programs. Changes in organizational culture, systems of care, team work and professional roles are essential for developing learning organizations and communities that develop effective behavior change and disease management programs in proactive, population-based ways.

You can co-opt the leaders within your health care setting to offer experience-based learning methods to all of your practitioners and staff. This initial step can help you begin a process of assuming a leadership role in developing a health-promoting, learning organization. Collaborating together with your colleagues and staff, you can continually learn from your ongoing clinical experiences and develop a vital, dynamic learning organization that adapts to changing times, cultures, contexts and market trends. With such an organization, you can continually improve your behavior change and disease

management programs over time. Furthermore, your organization can develop a network of health guides who can establish learning communities in schools, educational institutions, work sites, and religious and community organizations. These dissemination strategies can contribute toward reversing the epidemics of unhealthy habits.

Understand the Need for Innovation and Dissemination

Unraveling the psychosocial genome of unhealthy habits will do more good for humankind than the mapping of the human genome. To reverse the epidemics of unhealthy habits, motivational innovations for behavior change must become more individualized than the 21st century advances in the drug treatment of diseases. This calls for highly scalable and effective dissemination of innovative learning processes that motivate individuals to develop healthier habits.

To move beyond the current constraints of the healthcare delivery system, we can use innovative SGC learning processes to help individuals change. To get outside of the box of clinical encounters, we can move beyond the competing priorities and resource scarcity in clinical environments to create an abundance of learning opportunities outside of time-pressured health care settings.

To make this shift, we need a diverse array of learning methods that combine SGC learning processes with a variety of support options: online and offline courses, individual and group telephonic coaching, facilitator led groups, one-on-one counseling, and peer support groups. A multiplicity of learning methods can support and facilitate SGC learning processes. Individuals can do most of the “change” work outside of clinical encounters, with lay people (family and friends) professional, community and environmental support as needed.

Furthermore, such SGC learning processes can be disseminated through a variety of different networks; health care organizations, schools, work sites, churches, social groups and community organizations. Online SGC learning programs can help individuals, working in groups and by themselves, wherever and whenever they feel ready to learn about and work on the change process. We need highly scalable, online learning platforms that can help professional and lay audiences develop learning organizations and communities that can generate the leadership capacities to create epidemics of healthy habits.