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'Getting things done': an everyday-life perspective towards bridging the gap between intentions and practices in health-related behavior

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SUMMARY

In this paper, we aim to add a new perspective to supporting health-related behavior. We use the everyday-life view to point at the need to focus on the social and practical organization of the concerned behavior. Where most current approaches act disjointedly on clients and the social and physical context, we take the clients' own behavior within the dynamics of everyday context as the point of departure. From this point, healthy behavior is not a distinguishable action, but a chain of activities, often embedded in other social practices. Therefore, changing behavior means changing the social system in which one lives, changing a shared lifestyle or changing the dominant values or existing norms. Often, clients experience that this is not that easy. From the everyday-life perspective, the basic strategy is to support the client, who already has a positive intention, to 'get things done'. This strategy might be applied to those cases, where a gap is found between good intentions and bad behavior.

Key words: health communication; health planning; health-related behaviours; behaviour change

INTRODUCTION

Many interventions in health promotion start from the assumption that the client has to be moved in a more healthy direction. Therefore, a number of determinants are selected and manipulated: within the clients, their knowledge or attitudes, and outside, the social and physical contexts that help or hinder desirable behavior.

These approaches offer valuable ways to organize health promotion activities, often have a sound scientific base and are structured according to a carefully developed working plan, such as the Precede Proceed model [(Green and Kreuter, 2005), p. 372]. New initiatives such as intervention mapping (Bartholomew *et al.*, 2001; Brug *et al.*, 2005) enrich the quality of these attempts.

Notwithstanding these approaches, a lot still has to be done. We are faced with a number of serious health problems, such as alcohol and drugs abuse, risky sexual behavior or unbalanced eating habits that call for fresh ideas to combat them.

One such idea could be to abandon the notion of acting on the client and the system in which he/she lives disjointedly, and take the client and his/her behavior within the dynamics of the everyday context as the point of departure. By this we mean that a client should be active in promoting his/her own behavior. The basic strategy is then to support the client in what he/she is already contemplating, but experiences that dealing with everyday reality is not that easy.

The idea of refraining from trying to change the client him/herself stems from an old proposition of Lemert (1981), in which he introduces the term 'mobilizing information', referring to the ability of mass media to deliver any information that allows people to act on attitudes they already have. Of particular interest is a category of information, relating to the effectiveness of behavior in a certain situation, so-called 'tactical information'.

The concept of mobilizing information is applied to the general field of mass communication, especially in the political realm. Recently, the concept has been used to gain insight into how citizens in their everyday interactions via the Internet get to know how to participate effectively in the legislative process (Hoffman, 2006). Some research has been undertaken in the field of health (McDonald and Hoffman-Goetz, 2001; Hoffman-Goetz *et al*., 2003), but this research, like Lemert's, is strongly linked to mass media activities. We propose to use this concept in a more general sense: helping people to design and perform the activities on the base of attitudes that they already hold.

Informing people about how to take action is again not a new idea, either in general or in health communication. For instance, it could form part of the efficacy of the recommended preventive behavior (the perceived response efficacy) in Rogers' (Rogers, 1983) protection motivation theory. If individuals know exactly what they can do to overcome a risk, they are more willing to take action. However, we propose to problematize precisely this point, by questioning what it means to change behavior in a certain social context. For this is where we start our analysis of how to 'get things done' from a different perspective On the one hand, we take an optimistic stance in assuming that many people have positive attitudes toward a more healthful behavior and that they have the essential knowledge about the risks of an unhealthful lifestyle, together with the essential knowledge about what has to be changed; but, on the other hand, we are very much concerned about the task at hand: to really *change* unhealthful behavior implies a lot more than is often considered. This concern is our central focus point lies in the heart of the 'everyday-life perspective'.

We propose to add a new strategy to existing ones that could be worth considering in those cases where people are willing to change (and have often tried to do so more than once) but are unable to succeed. Thus, our approach may contribute to a better explanation of the differences quite often found between good intentions and bad behavior (cf. Sheeran, 2002; Webb and Sheeran, 2006; Amireault *et al*., 2008) and to new practical ideas about how to cope with this difference. For instance, it could lead to better implementation intentions, more suited to the situation at hand (Ajzen, 1992; Gollwitzer and Brandstatter, 1997; Gollwitzer, 1999), or to more concrete proposals to raise self-efficacy (Bandura, 1997).

In this article we outline what it means to change health-related actions, the theoretical foundations for the everyday-life perspective and possibilities for applying these principles to program development. Lastly, we address the question of why the application of this perspective until now has not yet been mainstreamed.

CHANGING BEHAVIOR TO IMPROVE ONE'S HEALTH

Before clients consider behavior change, the following is required:

(i) *problem awareness*: clients must be convinced that an imbalance exists between goals and the current situation, on the basis of which they can develop readiness for action.
(ii) *behavioral objectives*: clients must have a keen idea about the behavior that has ideally to be installed to prevent illness or to improve the quality of life.
(iii) *a process orientation*: clients must have a view about the way this healthful behavior could be organized in their own situation.

In the everyday-life perspective, the focus is on the third prerequisite, on the process of finding and executing a new route to desirable outcomes. The first and second prerequisites are seen as important or even crucial, but not as sufficient. Many clients know the basics about health problems and what has to be achieved behaviorally. However, they are utterly incompetent in achieving this. The assumption is that we can gain a lot by concentrating particularly on this process of 'getting things done'. Therefore, we have to consider three principles that form the basis of our perspective:

(i) healthful behavior consists of a chain of activities, routines that are

(ii) embedded in social practices,
(iii) and deserve therefore individually induced social change, including the required discursive work.

We now discuss these principles.

Ad 1: Healthful behavior consists of routines

Research has showed clearly that habits are an important part of our daily activities, also regarding health behavior (Aarts and Dijksterhuis, 2000). What we like to stress is the sequential character of the activities involved. Many unhealthful behavior is not restricted to one specific, clearly distinguishable action, but to a routinized sequence of related actions, repetitive and habitual (Bennett *et al*., 1995). For instance, the act of eating is linked to a chain of activities and decisions made at different points in time: making a plan to purchase food (or not), making a selection in the supermarket, planning when and what to eat in which proportions, selecting ways of preparing the meal and deciding to finish your plate (or not). People do not make conscious decisions along this chain every day or week, but rather rely on routines in these activity chains. Changing an eating habit means therefore changing the routines of planning, purchasing, selecting, preparing and enjoying.

In the same way, increasing physical activities can be viewed as a collection of body movements leading to a behavioral pattern, linked to certain repetitive situations rather than only a simple, discrete action such as 15 min on an exercise bike at the sports centre. Changing physical activity relates to going to and returning from work, gardening, shopping, spending one's free time, of which sports can be part. In this case also, we see routines during which a lot of physical energy is spent or spared. Therefore, becoming more physically active means changing these routines. The norm of 30 min of exercise has to be translated into these routines in order to be effective.

Ad 2: Healthful behavior is a social practice

Health-related behavior is the concept used to indicate that health behavior cannot encompass all the relevant activities that are at stake in promoting health. The health aspect generally forms part of a motivationally complex whole, serving a lot of other functions. The fact that this health-related behavior is socially inspired adds to the dilemmas about how to organize change in order to improve one's health.

Here, we are confronted with what we call 'social practices'. The term 'social context' is more common, but this is linked to a more deterministic approach, being just a 'set of mediating variables explaining individual choice' (Poland *et al*., 2006). What we wish to envisage is an *acting* group of people.

In those social practices, health can be more or less of an issue, depending on many other concerns. For instance, eating is not simply a behavior of the individual to maintain metabolism but has many subsidiary functions that often take precedence over nutrition (McQueen, 1996; Bouwman *et al*., 2009). Enjoying tasty food together in the family is one of these functions.

In the case of eating, drinking or smoking, it seems clear that social practices model (health-related) behavior; but, in physical activity, stress management, having enough sleep and solving relational problems, the social part is also evident.

Therefore, changing behavior to improve one's health means changing the social system in which one lives, changing a shared lifestyle or changing the dominant values or existing norms.

Ad 3. Individually induced social change

An individual who intends to work on his/her health has to change his/her routines and practices and often those of others as well. The question is how to do so.

We stress an important part of the change process that is at stake here: the discursive work that has to be accomplished in order to achieve new standards of health behavior. For instance in the case of changing eating habits, a number of concrete actions may be required. Those who are responsible for buying food, so-called 'nutritional gatekeepers' (Wansink, 2006) have to be convinced that the usual selection has to be altered. The cook has to be persuaded to use less fat. In social gatherings, one has to learn to refuse snacks or drinks. The practice of sharing a bag of potato crisps and a bottle of cola while watching television has to be questioned. The same holds true for the custom in primary schools that every child brings in sweets to their schoolmates to celebrate birthdays. It all entails

discursive work, and one's discursive competence decides the result.

So, we look at the process of changing routines and practices from the viewpoint of an individual with an intention, who is often uncertain about how others will react, uncertain about the procedure, about how to 'get this done' and uncertain about the outcome. These uncertainties differ from medical uncertainties for which formal assessment procedures are available. Yet, these uncertainties play a big role in promoting health from the perspective of everyday-life activities.

It is especially here that the everyday-life perspective is likely to contribute, by helping to reduce these uncertainties. Clients can be informed about problems and behavioral solutions, and may be motivated to change their behavior. However, they have to be equipped with the social tools to organize the new situations needed to improve their health situation. Of course, these tools cannot be produced from behind a desk, aiming at standard solutions, because they have to fit the specific context of use. In a sense, every individual has to shape his/her own means to act in his/her own situation. Nevertheless, help from outside can help, as we now try to show.

THE EVERYDAY-LIFE PERSPECTIVE

Before giving some examples to illustrate the perspective, we make some preliminary remarks, taking into account the three principles sketched above.

The *first* is that the answers to supporting effective client's strategies can be found in classical theory about social change. From as far back as the 1950s, a research tradition has been devoted to the question of how individuals influence others in a given social setting. For instance, Katz and Lazarsfeld's (Katz and Lazarsfeld, 1955) classic book, subtitled *The part played by people in the flow of mass communication*, stresses the importance of interpersonal influence in social change. Kadushkin (Kadushkin, 2006) sees this book as one of the foremost landmarks of a 'theory of action'. This influence can take the form of advice but can also attempt to change the norms of a group, where one individual acts as the change agent of the group as a whole. In the Netherlands, Brouwer (Brouwer, 1967) has presented his 'myceleum model', suggesting that mushrooms are not represented properly by the shape seen above the ground, but by the totality of thin threads below the surface, contrary to the common imagination. In the same way, the dynamics of mass communication systems are better described by looking at the informal interactions between people than by the more visible exponents: television, newspapers and so on. We can translate this picture to health. Healthcare is >90% concerned with what happens between people (within families, between friends, in neighborhoods), and health communication is predominantly communication about health-related issues not with, but *between* clients.

The effects of professional health communication depend on this word-of-mouth. Again, this idea is not new, but is over a century old. At the end of the 19th century, Tarde wrote: 'without people's conversation, the journals would be useless' [(Clark, 1969), p. 307]. They would be like a vibrating string of which factors might influence this unhealthful behavior, without a sounding board (Van der Vorst *et al.*, 2005). The consequence of this idea is that the messages produced by health professionals resonate more clearly if they are recognized as socially relevant, resembling the talk of people in their own circles. If people feel supported in their own attempts to install better, healthier conditions in their own lives, they will listen carefully.

The *second* remark is that empirical research should be directed at the repertoire of strategies that are used to improve health in a social context. How do people engage to organize this? Are these different strategies available, what are they and why do some people choose one alternative and not another? Instead of directly trying to influence the social system in which clients live by using models of attitude and behavioral change, we could try to use empirical research on what people already do and mirror these strategies to a wider audience.

A *third* remark is that this beneficial behavior could be the object of in-depth research as to what is going on here. One of the promising research traditions in this realm is labeled as discursive psychology (Edwards and Potter, 2005). The basic idea is that an utterance by an individual is not just a presentation of a particular idea or opinion, but meant to achieve something, interactionally. In this way, researchers

are able to link what people say to the division of responsibility or their attempt to gain credibility. For instance, as has been found in the analysis of an Internet discussion forum for and by depressed persons, clients try to present themselves as highly affected by this disease (they are 'really depressed') but still quite competent to handle their life. In this manner, they also show their ability to help each other (they are not only victims) with information and (emotional) support (Lamerichs and Te Molder, 2003). These findings show the embeddedness of health-related behavior in the total social situation, not only in the sense indicated earlier (eating is not only nourishing healthily; it is also enjoyment, a reason to come together, etc.) but also communicatively. If we talk about health, we (also) perform actions linked to our relationships with others. Our identity as a healthy person (or as a person that does not care) is discursively produced vis-à-vis the others in ongoing interactions.

This discursive psychological approach is one way to get a deeper insight into the mechanisms of informal health behavior, starting from the client-in-action perspective. Another interesting research tradition is the ethnographic approach, used by anthropologists, mainly to study health behavior in third-world settings (Kitsao and Waudo, 2002) and nowadays also in Western countries, often in specific 'scenes', (e.g. drugs users, see Moore and Maher, 2003). Other qualitative research strategies are also worth considering (cf. Smith, 2004).

THE EVERYDAY-LIFE PERSPECTIVE TOWARDS PROGRAM DEVELOPMENT

In this section, we present two examples of strategies that are linked with the theoretical framework proposed in the perspective. We start from the point where individuals have consciously tried to introduce more a healthful behavior into their everyday lives, but have failed to adopt this practice.

Example 1: stimulating interaction by using Internet Forums

In many health campaigns, the main vehicle is a set of messages composed by a team of health professionals who are acquainted with the latest scientific evidence concerning the relation between behavior and health outcomes, and communication specialists who can handle a medium effectively. In line with the everyday-life perspective, we propose introducing another type of knowledge: that based on the experiences of clients themselves, especially about practical strategies required to create space for change in a social setting.

The Internet is a channel suited for assembling and exchanging such knowledge, and is already used for this purpose. In relation to healthful eating advice, we propose to construct a website prototype where clients can help each other achieve their desirable behavior in the relevant social context. The site can contain success stories, written by clients who managed to improve their health situation (experiential knowledge), or of posted questions and matching reactions, with the possibility of a more general discussion about the subject.

There are already promising initiatives in this field that indicate how informational (and support) needs can be fulfilled, where these cannot be met easily through conventional professional healthcare (Ziebland *et al*., 2004). Another possibility is to incorporate small videos in such a site showing the (discursive) work that has to be done (Bouwman and van Woerkum, 2009).

Example 2: the Discursive Action Method: learning clients new discursive skills

The discursive action method (DAM) is meant to stimulate clients to develop their own health-related activities (Lamerichs *et al*., 2009). It is grounded in the discursive psychology tradition (see above). The DAM aims to invite participants to reflect on their way of dealing with everyday-life dilemmas in health-related issues, using their own conversational material.

The method has been developed and used in a participatory health project called LIFE21. In this project, youngsters in three secondary schools in the Netherlands were asked to tape their own informal conversations over a 5-month period, using a digital voice recorder. An assumption was that naturally occurring conversations could elicit the many dilemmas related to health. Eleven hours of conversation were collected. Parts of these conversations were, in transcribed form, returned to the youngsters for closer attention and reflection. With this, the researchers tried to make them aware of the social function of language and to

have them discuss what they would do in a similar case. Such a critical examination, based on real material, could give them an extended repertoire about how to address health issues, with a deeper insight into the functions and consequences of certain discursive strategies.

The DAM is not directed at the problem of what has to be finally achieved to improve one's health, but at the interactional problem that corresponds with health-related behavioral change. For instance, an individual who wants to influence a nutritional gatekeeper, by saying that he has to buy A instead of the usual B, must deal with the problem that this question can be seen as an accusation ('you always buy the wrong thing, B') or as a comment on the agreements about who is responsible for what.

What is essential in this method is that participants, in using real-life taped discussion material, take the perspective of an observer, looking carefully at what speakers do, and to what effect on the other, instead of making inferences about intentions or what the speaker really thinks. From this observer perspective, they can move to the allocation of discursive strategies and to an evaluation of these strategies for themselves.

These interventions, which fit our everyday-life perspective, illustrate its use and applicability in quite different situations. Of course, the approach is not entirely new. Elements of it are found in the community approach (the importance of informal social networks) (Bracht, 1998) or in the empowerment approach, mainly that part of it that concentrates on one's capacity to control one's own life (Rissel, 1994), stressing the point that the client has the responsibility as an entrepreneur to foster his/her own social life. Or in entertainment-education strategies, where for instance in soaps the main characters can show how they succeeded in changing their lives in a more healthy direction, in a given social setting, sharing also discursively, what kind of work the must be done (Bouman *et al*., 1998; Mutsaers *et al*., 2007). We can clearly see here also the additional value of those related approaches, covering the direct institutional context of clients' actions (as in the community approach) or the wider psychological notion of being in control (as in the individual empowerment tradition). Our approach is also linked to a guiding or supporting style in health communication (Rollnick *et al*., 2005), away from mere informing or persuasion. The everyday-life perspective is special, however, in eliciting in detail the process of changing one's life in a given social context.

The question arises as to why the everyday-life perspective is not already a clear-cut strategy in health promotion. We give some explanations for this.

WHY NOT? SOME CRITICAL CONSIDERATIONS

The reasons for the relative neglect of the principles of the everyday-life perspective may be found in the development of social psychology, the preferred supplier for intervention strategies in health promotion—particularly, in the focus of the dominant tradition of cognitive psychology on internal mental processes and laboratory experiments to assess these. This tradition has brought forward a lot of very useful intervention instruments, but has unavoidably also certain restrictions.

In the words of (social psychologist) Fischer (Fischer, 2006):

> Studies on traditional social psychological topics like attitudes, person memory, impression formation, cognitive dissonance, attribution, and stereotyping have been typically conducted without taking into account in which social or cultural setting this opinion or evaluation was formed or would be expressed. In the typical social psychological experiment the manipulated independent variable is intended to gain insight into the individual cognitive or motivational processes underlying these phenomena, such as the striving for mastery, the need for consistency, self-esteem maintenance, or one's prosocial motivation. The social setting and one's engagement with others in this social setting are not manipulated, as these are seen as relatively unimportant to the phenomena under study.

In her eyes, the cognitive revolution in social psychology has shifted the focus of attention to the social world from within, as *perceived* by the individual.

We can find this tendency, for instance, in the famous theory of planned behavior, where the social context is conceptualized in the subjective norm, meaning (i) the beliefs about the expectations of others and (ii) the motivation to comply (with the attitude towards behavior and the perceived behavioral control as alternative factors) (Ajzen and Madden, 1986). This theory

is not developed as a change theory but serves often as a starting point for the development of interventions (Fife-Schaw *et al*., 2007). Yet, this model can be extremely useful in setting up health promotion programs but does not stimulate a strong process orientation: how to cope with the social environment effectively for better and healthier conditions. For this, another social scientific perspective is needed.

Another, but related reason why the everyday-life perspective has not so far received much attention is the inability to be accountable for the effects that have to be achieved. If we stress the complexity of health behavior, the embedding in social life and the manifold strategies of clients in organizing healthier conditions in their different situations, we consequently have to be modest about any predictable results of our supportive actions. A reliable prediction is after all dependent on the knowability of the concrete situation, overseeing the main mechanisms and their relation. However, this pretention is utterly unrealistic, as out earlier description has shown.

Many health-behavior models in the cognitive tradition do have, on the contrary, an 'if-then' character. Although empirical research, for instance the relationship between attitudes or intentions and behavior, often shows mixed results (Armitage and Christian, 2004), it seems to suggest that basically this is the preferred route to an evidence-based practice. The limitations of this route are also discussed by Green (Green, 2006). He points at the lack of methods and theories in social and behavioral sciences to adequately deal with the broader contextual understanding of health-related issues in his plea to complement evidence-based practice with practice-based evidence. Philosopher Horstman (Horstman, 2010) questions the relevance and applicability of 'context-controlled' evidence and proposes collaborative, context-sensitive learning to guide public health

Being modest on predictability of course does not mean that one is unwilling to develop useful programs, just as we do not refrain from raising children because of the huge uncertainties about the exact outcome. We argue in favor of an extended model for accountability, beyond informative, outcome-oriented accountability, by delivering theoretical and empirical information about the arguments for a specific method, following the everyday-life perspective, including a clear overview of formative research to optimalize the steps to be taken and based upon elaborated planning strategy, which will include processual planning (step-by-step) and systemic planning (in collaboration with the actors involved) (Stacey *et al*., 2000; Whittington, 2001). We call this type of accountability 'decisional accountability' (van Woerkum and Aarts, 2011). These arguments have to be approved by a group of well-chosen experts who can judge the theoretical base as well as its applicability in a given context. Evaluation research may offer insights into the process and may explain the outcomes, as a stepping stone in the development of effective strategies. In this way, the everyday-life perspective can assemble a body of knowledge to guide further applications.

One may wonder if we don't put too much burden on the shoulders of individuals who have to pursue health behavior which is not the norm within their social context. This challenges individuals to choose for their own interests, against the prevalent patterns of behavior. We can help them to sustain in that uncomfortable position. Yet, what seems more effective is to help them how to legitimize their new behavior vis-à-vis their family or friends or even to gather social support, key for change in everyday life. We may try to help them in these efforts. However, the preferment strategy should not look at individuals, one-by-one, but preferably at families or friends as units for interventions. In fact, a lot of health behavior, especially in the field of food, has to be 'joint action'.

In our view, however, this is not a matter of 'responsibility' in the negative sense, yet as a request for social support, key for change in everyday life. For instance this can mean finding an approval for new behavior by relatives or friends ('legitimizing new behavior'). In practice it may also mean asking them to join the consultation room, a strategy sometimes already applied.

Yet, bringing the everyday-life perspective to health practice requires substantial investments in the training of professionals on communication skills and context-sensitive consultation. The recent Cochrane review on this topic (Lewin *et al*., 2012) concluded that evidence on the effectiveness of strategies for encouragement of practitioners to use a patient-centred-approach, as well as the effect on patient care have a limited and mixed nature.

Van Weel (Van Weel, 2011) summarizing the views and opinions of the World Organization of Family Doctors (WONCA) states that the clients' social, cultural and economic living

characteristics should be better understood, in order to enhance the effectiveness of primary care. This understanding creates a starting point for person-centered medicine, building trust between a client and the family doctor.

With respect to manpower, the 'work to be done' is partly the task of the clients themselves. Pressure on the health professionals could be lowered by using platforms for sharing everyday problems and solutions between clients. These discussion groups can be real life or virtual, as can already be found at the Internet.

Indicators for evaluation could encompass these interactional challenges, if one succeeded in getting support from others, and how this could relate to the buying of healthy food, to the refusal of sweets or alcoholic drinks, or to the discursive action of parents who have to teach their children to eat vegetables. In all these cases the interaction between individuals and their social environment is key to successful behavioral change.

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