Cristina Vaz de Almeida

The evidence shows that different patterns of behavior are deeply rooted in the social and material aspects of people, as well as in their circumstances and cultural context (NICE, 2007, p. 6), economic, political (WHO, 2019).

Human beings are cultural beings, with an enormous capacity to survive adversity, who repeat behaviors often influenced by the behaviors of others (modeling) (Bandura, 1963, 1986). Social and economic contexts influence the degree of access, understanding and use of health services (Espanha, Ávila & Mendes, 2016).

In their experience, and among the behaviors that lead to various performances, the beliefs of individuals have an important role in their action for change. Beliefs are a potential of two ways, which act positively for change, when for example an individual believes that only Y food can improve health, or instead, beliefs serve as resistance and constraints preventing change, such as believing that only human faith cures the contamination of a virus, or that children's urine is curative for some skin diseases (situations reported by several health professionals).

Why is it important to understand the concepts? So that we can act on reality in its various dimensions.

Culture influences individual and collective behaviors. Tylor (1920) in the current of cultural evolutionism defined "culture" as a complex set comprising the knowledge, beliefs, customs and all other skills and habits that man, as a member of a society, acquires ".

When we talk about culture, we are referring to an emic and etic dimension, which are perspectives that interfere in cultural care: emic refers to the way individuals of a culture understand their own world, and the study of a culture without cross-cultural focus; etic, is associated with the interpretation of experiences lived in the reference culture, after having experienced certain cultural factors, so there is a study of a culture with a cross-cultural focus here (Vijver, 2010).

And also for this reason we have a "patient-system" (Vaz de Almeida, 2018) that balances what is proposed by its influencers (family, peers, community) its values, and the assimilation of the experiences that it is going through in the territories and people wherever he goes,

and in this case, for the health experiences he has. These health experiences, often a poorly used resource (Espanha et al., 2016), have a powerful influence on the health professional, in his interpersonal relationship, and that, if he is endowed with knowledge and communicative and technical tools, they contribute decisively to shape their behaviors towards a healthier life. The health professional is an educator.

It is in the therapeutic relationship that behavior change is also built. And health coexists with this "patient – system" (Vaz de Almeida, 2018, p. 36; Koh, 2010) in a constant, permanent, challenging way.

And to achieve the essence of this patient system, the health professional benefits when he uses an "etic" strategy, understanding the individual within his culture and the influences that his cultures (of origin and relational ones) have on his health. The development of health professional skills contributes decisively to the improvement of the therapeutic relationship, and among the technical (healing) behaviors are the care skills (relational, communicative).

The health professional's goal is to constantly seek better health results, in addition to satisfying the therapeutic relationship and the quality of the relationship, which is filled by a set of elements that are part of the healing and care conversation (Greenhalgh & Heath, 2010).

There is, however, an uneven but positive power between the health professional and the patient, especially when there are barriers in terms of language, culture and social class (The King's Fund, 2010, p. 25), so the more strong of this "scale" is always the health professional (Almeida, 2018, p. 36).

When we reflect on changing individuals' behaviors, it is an added value to think about psychological models that pay attention, in addition to their individual, cognitive, emotional and behavioral dimensions, to the context in which the individual moves, in the more or less open dynamics between him, his family and peer group, the community, society in general and the world.

Mcleroy et al. (1988) and Engel (1981) remind us of the rational holistic approach of seeing the world and the individual, especially the patient, as a system patient. The interventions that drink from social psychology and health reflect on the best ways to obtain results. Also adapting Kim & Grunig's (2011) problem solving theory, it is possible to obtain a path for

behavior change.

What these authors say (Kim & Grunig, 2011) is that it is necessary to invest in 4 dimensions:

1. Knowledge
2. The beliefs and constraints that people have
3. The necessary motivation that needs to be instilled for change
4. The context and cultural dimension in which the person is

Thus a patient who needs to change his behavior must know what he needs to change. And knowledge begins with improving the subject's information on this subject.

Second, the individual lives his beliefs. Is it necessary to know which favorable beliefs can help with change? And what unfavorable beliefs can prevent or be an obstacle to change.

Thirdly, the motivation for change also presupposes the discovery of what is significant for this individual, the importance it attaches to the theme and its effectiveness in behavior.

Fourth, attend to the habits, customs, and contexts in which the individual moves and what are the influencing factors.

Considering a group of authors who have profusely reflected on ways of changing behaviors, we collect ideas on self-efficacy (Bandura), change by stages / levels (Prochaska et al., 1994), problem solving (Kim & Grunig, 2011), assertiveness , clarity of language and positivity in the consultation (Vaz de Almeida, 2016, 2018; 2019, 2020), motivation (Sørensen et al., 2012; Wonca, 2002) and we present in table 2 a summary of potential actions, interventions that contribute to changing health behaviors.

Table 2 – Change in health behaviors

CHANGING HEALTH BEHAVIORS
1. Personal relevance – highlight the importance of individual health behaviors
2. Positive attitude – promoting positive feelings regarding the results of behavior change

3. Self-efficacy – increasing people’s belief in their ability to change
4. Descriptive standards – promote the visibility of positive health behaviors in people to the reference groups, that is, in the groups to which they compare or aspire
5. Subjective intervention – improving social approval for positive health behaviors in other reference groups)
6. Personal and moral standards – promoting personal and moral commitments to change behavior
7. Formation of intent and concrete plans – helping people to form plans and goals for changing behaviors over time and in specific contexts
8. Share success stories – ask people to share their plans and goals with others. Share at least one success case per week in the various services and work groups
9. Helping people to develop accurate knowledge about the consequences for their health and behavior
10. Relapse prevention – helping people to develop skills, that is, ways of “acting”, as well as knowledge, ways of “knowing” to deal with difficult situations and conflicting objectives
11. Realize what activities are “meaningful” for that person to change behavior. (understand what level of change the person is in)
12. Develop cultural skills. Know the habits, attitudes, behaviors, stigmas, states of happiness that are found in each culture to be able to act on the individual
13. Prepare the entire team with knowledge about the positive interventions of health literacy, namely in the dimensions of access, understanding and use of health information and navigability in the system

14. Use the ACP Model – Assertiveness, Language Clarity and Positivity during the therapeutic relationship (Vaz de Almeida, 2016, 2018, 2019, 2020)

Source: Vaz de Almeida, 2020.

References:

Bandura, A. (1963). *Social learning and personality development*. New York (NY): Holt, Rinehart, and Winston.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs: Prentice-Hall.

Espanha, R., & Ávila, P. (2016a). Health literacy survey Portugal: Contributions for the knowledge and health and communications. *Procedia Computer Science, 100*, 1033-1041.

Espanha, R., Avila, P., & Mendes, R. M. (2016b). *A literacia em saúde em Portugal*. Lisboa: Fundação Calouste Gulbenkian

Greenhalgh, T., & Heath, I. (2010). *Measuring quality in the therapeutic relationship. An Inquiry into the quality of general practice in England*. UK: The King's Fund.

Kim, J.-N., & Grunig, J. E. (2011). Problem solving and communicative action: A situational theory of problem solving. *Journal of Communication, 61*, 120-149.

Koh, H.K. (2010). Foreword. In U.S. Department of Health and Human Services. *National action plan to improve health literacy* (pp. iii-iv). Washington, DC: Author.

McLeroy, K.R., Bibeau, D., Steckler, A. and Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, *15*, 351–377.

NICE. (2007). Behaviour change: the principles for effective interventions. Retrieved from: guidance.nice.org.uk/ph6

Prochaska, J.O., Redding, C.A., Harlow, L.L., Rossi, J.S., & Velicer, W.F. (1994). The transtheoretical model of change and HIV prevention: A review. *Health Education Quarterly, 21*(4), 471-486. doi: 10.1177/109019819402100410 40

Tylor, E.B. (1920). *Primitive culture: researches into the development of mythology, philosophy, religion, art, and custom*. London: Jonh Murray, Albemarle Street, W. Retrieved from:

https://archive.org/stream/primitiveculture01tylouoft#page/n7/mode/2up

WONCA. (2002). Definição europeia de medicina geral e familiar *(Clínica Geral/Medicina Familiar).*Barcelona, Espanha: WONCA.

Vaz de Almeida, C. (2018). Literacia em saúde: Capacitação dos profissionais de saúde: O lado mais forte da balança. In C. Lopes & C. V. Almeida (Coords.), *Literacia em saúde: Modelos, estratégias e intervenção* (pp. 33-42). Lisboa: Edições ISPA.

Vaz de Almeida, C. (2016). Acolher, Capacitar, Encaminhar – Literacia Em Saúde: Os Caminhos Para Uma Maior Capacitação Dos Profissionais De Saúde. In Congresso da Associação Científica de Enfermeiros (ACE). *Revista En Formação*, pp 8-15 *Retrieved from:* http://www.acenfermeiros.pt/ficheiros/uploads/6011fa933c32bfb94c5cc8388fcb30e6.pdf

Vaz de Almeida, C., & Belim, C. (2019a). Good Steps to Safety: Guidelines for Communication and Health Literacy. P*atient Safety & Quality Healthcare*

Retrieved from: https://www.psqh.com/analysis/good-steps-to-safety-guidelines-for-communication-and-health-literacy/

Vaz de Almeida, C. (2019b). Communication determines safety. *Patient Safety & Quality HealthCare,* 1-6. *Retrieved from:* https://www.psqh.com/analysis/communication-determines-patient-safety/

Vaz de Almeida, C. (2019c). Capacitação dos profissionais de saúde. Literacia em saúde e competências de comunicação dos profissionais de saúde. O modelo de comunicação em saúde ACP. *Revista Nephros, 21*(1), 25-28.

https://www.researchgate.net/publication/335327823_LITERACIA_EM_SAUDE_CAPACITACAO_DOS_PROFISSIONAIS_DE_SAUDE_DESENVOLVIMENTO_DE_COMPETENCIAS_DE_COMUNICACAO_O_MODELO_ACP

Vaz de Almeida, C. (2020). Modelo de Comunicação em Saúde – ACP. *Revista Enformação, 10*, 20-22. *Retrieved from*: https://issuu.com/ace-enfermeiros/docs/10__revista_ace.pdf_1

Vijver F.J. (2010). Emic–Etic Distinction. In Clauss-Ehlers C.S. (eds). *Encyclopedia of Cross-Cultural School Psychology.* Boston, M.A. : Springer.
DOI: https://doi.org/10.1007/978-0-387-71799-9_158

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