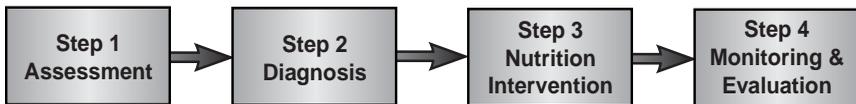# PART I

THE BASICS OF COMMUNICATION AND COUNSELING SKILLS FOR NUTRITION: INTERVENTIONS IN THE NUTRITION CARE PROCESS

Part I, The Basics of Communication and Counseling Skills for Nutrition: Interventions in the Nutrition Care Process, covers theoretical aspects of communication and counseling. The entire nutrition care process involves four steps: nutrition assessment, nutrition diagnosis, nutrition intervention (the step focused on in this book), and nutrition monitoring and evaluation.

Step 1 Assessment	Step 2 Diagnosis	Step 3 Nutrition Intervention	Step 4 Monitoring & Evaluation

Step 1, nutrition assessment, is the process of interviewing the client to determine whether a dietary problem exists and interpreting this data to identify a nutrition diagnosis. Without appropriate nutrition assessment, the entire nutrition care process breaks down, often headed in a direction that is not tailored to the needs of the client. Step 2, the nutrition diagnosis, describes a problem that the nutrition counselor labels and is responsible for treating. This label is independent of the medical diagnosis that identifies a disease or pathology of organs or body systems. The nutrition diagnosis will change as intervention proceeds. The medical diagnosis does not change and is often a descriptor of a lifelong condition. This nutrition diagnosis step includes a PES statement with three distinct elements: the problem (P), the etiology (E), and the signs and symptoms (S). Information from Step 1, nutrition assessment, is used to determine the PES statement. Step 3, nutrition intervention, follows the first two steps and provides strategies to remedy a nutrition diagnosis or problem. The goal is to change a nutrition-related

1

behavior to improve lifestyle and related health outcomes. Within the intervention, planning and implementation occur. Planning is a tailored process that involves prioritizing the nutrition diagnoses, establishing negotiated goals when appropriate, and defining the nutrition strategies needed to implement the intervention. The client and nutrition counselor are in the action phase when implementing the nutrition intervention. This phase involves carrying out and communicating the plan of care. Using cues from the client the intervention is revised and tailored to lifestyle and associated needs. Finally, Step 4, nutrition monitoring and evaluation, allows for reviewing which nutrition intervention strategies are working and which must be retooled. The nutrition care process is distinct from medical nutrition therapy (MNT). The nutrition care process defines specific steps a practitioner uses when providing MNT. MNT is just one aspect of the nutrition care process.[1]

Within Step 3 of the nutrition intervention process, the terminology is classified into four sets: Food and/or Nutrient Delivery, Nutrition Education, Nutrition Counseling, and Coordination of Nutrition Care. This text will focus on two of the sets: nutrition education and nutrition counseling.

In Part I, the first chapter provides an historical perspective of counseling for the nutrition care process. Chapter 2 discusses basic communication skills that provide strategies to facilitate our interactions with clients. These skills are particularly important for both nutrition assessment and nutrition diagnosis. Learning to listen to the client's perspective will help assure that an appropriate diagnosis is identified. With an appropriate diagnosis, the nutrition intervention that follows forms the basis of the third chapter, which focuses on the client's readiness to change as an essential element in dietary behavior modification. This chapter on motivational interviewing departs from assigning blame to the client for past adherence problems and focuses on constructive ways to provide the client with feedback that can result in positive dietary change.

Reference

1. American Dietetic Association. *Nutrition Diagnosis and Intervention: Standardized Language for the Nutrition Care Process.* Chicago: American Dietetic Association, 2008.

CHAPTER 1

OVERVIEW OF NUTRITION COUNSELING

Chapter Objectives

1. Discuss the influence of counseling on the client.

2. Describe three theories that influence the nutrition counselor.

3. Discuss two ways in which counseling within the nutrition care process is important to the work of the nutrition counselor.[1]

4. Identify the components of counseling skills.

5. Diagram the counseling spectrum.

Definition of Nutrition Counseling

Nutrition is both a science and an art. The nutrition counselor converts theory into practice and science into art. This ability requires both knowledge and skill.[2]

Nutrition counseling is a combination of nutrition expertise and psychological skill delivered by a trained nutrition counselor who understands how to work within the current medical setting. It focuses on both foods and the nutrients contained within them, emphasizing our feelings as we experience eating.

Nutrition counseling has moved from a brief encounter as the patient leaves the hospital with suitcase in hand to an in-depth discovery of tailoring dietary change to individual situations and emotions. Today nutrition counseling sessions include analysis of factors such as nutrition science, psychology and physiology, and an eventual negotiated treatment plan followed by an evaluation. Research has shown that this in-depth approach can produce excel-

lent dietary adherence based on biological markers, even with complicated dietary regimens that are difficult to accommodate in the real world.[3,4] Large long-term randomized controlled trials (RCT) have shown the importance of nutrition counseling in reversing dietary adherence problems.[5-7]

History of Nutrition Counseling

Over the years, nutrition advice has been a part of nearly every culture. Early Greek physicians recognized the role of food in the treatment of disease.[8] In the United States in the early 1800s, Thomas Jefferson described his eating habits in a letter to his doctor in what may be one of the first diet records (Exhibit 1–1).[9] After World War II, advances in chemical knowledge allowed nutrition researchers to define metabolic requirements.[10] This marked the beginning of the study of patterns of nutrients needed by all persons in relation to their age, sex, and activity. These patterns are vital to the assessment phase of counseling.

Exhibit 1–1   A Colonial Era Diet Report

". . . I have lived temperately, eating little animal food, & that . . . as a condiment for the vegetables, which constitute my principal diet. I double however the doctor's glass and a half of wine."

—From Thomas Jefferson to his Doctor

Source: Original in Jefferson Papers, Library of Congress, Washington, DC.

Selling and Ferraro, in discussing the psychology of diet and nutrition in 1945, recommended what at that time must have been an unconventional view:

1. knowing the client's personality
2. knowing the client's psychological surroundings
3. eliminating emotional tension

4. assisting the client in knowing his own limitations
5. arranging the diet so that it has the effect of encouraging the client
6. allowing for occasional cheating [on the diet][11]

In 1945, the flood of scientific knowledge relating nutrition to disease obscured this advice. Nutrition counselors expended only minor efforts to put these critical ideas into practice.

Over the years, the counselor's role has changed. In the past, the role fell more on the authoritarian side of a continuum; today a counselor must be able to function in all roles at appropriate times (Figure 1–1). Ivey et al. describe the role of counseling as knowing which strategy to use for which individual given specific conditions.[12]

Pioneers in the Field

In the early 1900s, Frances Stearn started a nutrition clinic at the New England Medical Center. Her work continues today with dietitians who emphasize the counseling aspects of nutrition.

In the mid-1940s, Selling and Ferraro stated that there was no longer justification for prescribing a diet without also recognizing the psychological factors in a case. They recommended a diagnostic study to determine the right psychodietetic approach.[11] Indeed, they argued that the thrust in counseling should be matching the treatment to each individual case.[12]

In 1973, Margaret Ohlson stressed the importance of creating an interviewing atmosphere in which the client can respond freely. Ohlson warned against a common problem in dietetic counseling sessions: speaking at the expense of missing important factors during the interview.[10]
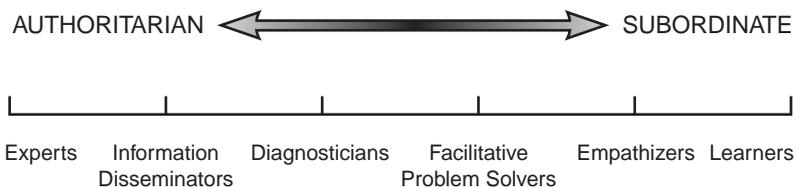
AUTHORITARIAN ⟷ SUBORDINATE

| Experts | Information Disseminators | Diagnosticians | Facilitative Problem Solvers | Empathizers | Learners |

FIGURE 1–1 Roles of the nutrition counselor today.

Theories of Nutrition Counseling

Theories form the basis for developing counseling skills to change eating habits. Both clients and nutrition counselors use theories and beliefs in determining what will take place during an interview.

Theories Influence Clients

In assessing and determining a nutrition diagnosis (steps 1 and 2 in the nutrition care process), nutrition counselors must rely on their ability to identify the client's perspective on counseling and the role of the counselor. Without this knowledge, the nutrition counselor is forced into a position of mandating an intervention without the ability to negotiate strategies that are tailored to the client. The concepts below illustrate types of preconceived ideas that clients may have prior to a counseling session. These ideas shape the direction of the session and determine the success of the eventual necessary dietary behavioral change.

Clients approach nutrition counseling sessions with mindsets about themselves and the world around them. They present "a history of being healed or hurt by others, of being accepted or rejected, or of dominating others."[13] They come with a positive or negative self-image and a record of success or failure in diet modification. From this personal background stems their personal theories of what counseling is and should be.

Most nutrition counselors have faced a client who slouches down in the chair, slams a diet instruction sheet on the desk, and demands: "Well, what are you going to do to get me to follow this diet?" This client sees the counselor as an expert, the person with all the answers—and an adversary. Another client may walk into the office, sit down, and speak only in response to direct questions. Still another client may arrive commenting, "Well, how can we work out this problem I've been having with my diet?"

All three clients see the world through different eyes. The first does not want any responsibility for his diet and nutrition. The second may be afraid of authority figures. The last sees the counselor as an advocate, as someone who can help increase self-directed solutions to dietary problems. Experience has shown that, although written many years ago, Lorr's listing of five descriptors

of clients' perceptions of counselors was correct: (1) accepting, (2) understanding, (3) independence encouraging, (4) authoritarian, and (5) critical-hostile.[14] These identifiers have proven to be accurate in work with clients in need of dietary and lifestyle changes. Nutrition assessment, step 1 in the nutrition care process, requires an understanding of the feelings a client has toward the counselor.[1] The client's perceptions may affect the nutrition counselor's ability to determine a nutrition diagnosis that adequately describes the nutrition problem.

Communication skills are imperative when assessing and identifying a nutrition diagnosis. Assessing the client's perception of you as a counselor initiates your understanding of how open the client will be when discussing nutrition problems. Prior to the interview, clients may see the nutrition counselor as rejecting, dominating, or hostile. Consequently, they resort to behavior they have used in the past in dealing with an unapproachable person. Other clients, on the basis of past experience, see counselors as friendly, supportive, respectful, and positive. Both of these perceptions can create self-fulfilling prophecies. Counselors can become trapped into behaving in accordance with the clients' views of the world. Thus, it is important to be open with a client and to discuss interpersonal factors that may influence both client and counselor. Many years ago, Gerber recommended frank, open discussion of any interpersonal factors that may negatively affect counseling for dietary change.[15] This is still noteworthy advice today in using the nutrition counseling process.

Clients also come to a nutrition counseling session with feelings about themselves. Some may want to succeed in changing yet seek to sabotage any efforts toward change so their routines will stay the same.[13] Clients may say, "New eating habits may be healthy, but what changes will they make in my family life?" A familiar image of themselves as overweight can give obese persons a sense of identity and security that they can lose when the pounds come off. A client may say, "Why should I change my feeling of security to a feeling of having to shape up to what people want me to be?" Clients may come to counselors feeling confused, disturbed, and self-defeated by new knowledge that their health is threatened.[15] Identifying and tagging these feelings is a primary method of assessment prior to making the nutrition diagnosis.

In summary, clients come to counseling with:

- attitudes and beliefs about people
- ideas and feelings about counselors and counseling
- self-images
- basic incongruities in desired outcomes:
    1. a desire to continue along a familiar course
    2. a desire to make changes to improve health and well-being[13]

Counseling and communication skills provide the potential to correct or validate clients' preconceived beliefs. They enable counselors to behave as empathic persons in spite of the "provocation to be less or the seduction to be more than they are."[13]

Theories Influence Counselors

Many theories influence the way a nutrition counselor conducts a session. This text will focus on the following specific theories:

1. behavior modification
2. cognitive-behavioral theory and rational-emotive therapy (RET)
3. social learning theory
4. standard behavioral therapy
5. transtheoretical model
6. person-centered therapy
7. theory of planned behavior and theory of reasoned action
8. Gestalt therapy
9. family therapy
10. self-management approach
11. the health belief model
12. developmental skills training.

An analysis of their characteristics as they apply to the nutrition counseling session follows. Many concepts within these theories overlap.

Behavior Modification

Behavioral counseling, as described by Pavlov, Skinner, Wolpe, Krumboltz, and Thoreson, states that people are born in a neutral

state. Environment, consisting of significant others and experience, shapes their behavior.[16] Three modes of learning are basic to behavioral counseling:

1. Operant conditioning holds that if spontaneous behavior satisfies a need, it will occur with greater frequency. For example, a person who switches to a high-fiber eating pattern and finds that constipation problems decrease will probably increase fiber in all meals.
2. Imitation does not involve teaching a new behavior; instead, the emphasis is on mimicking. For example, a client with elevated lipids selects a snack low in saturated fat after a spouse or friend has just ordered one in a restaurant.
3. Modeling extends the concept of imitation, which tends to be haphazard, by providing a planned demonstration. Modeling implies direct teaching of a certain behavior.[17] For example, an overweight client watches a videotape of someone who has lost a large amount of weight. The model's description or demonstration of successful weight loss behaviors helps the client begin a weight-loss program.

Behavioral counseling obviously varies from client to client, as each individual is responsible for shaping the environment to accommodate changes in behavior. Problem behaviors result from faulty learning, and the goal is to eliminate faulty learning and substitute more healthful patterns of behavior.[12]

Behavior modification is often described by using the ABCs of behavior: A is the antecedent of a behavior or the environmental cue that triggers an act. B is the behavior itself. C is the consequence of that behavior.[18] A person who eats while watching TV would identify the antecedent of this behavior or the trigger as television watching with a bowl of candy nearby. The behavior then is the act of eating. The consequence is the weight gain associated with eating. The goal in changing a behavior is to stop this chain of events by modifying components within the chain. For example, by eliminating the bowl of candy the chain of events would stop prior to the behavior of eating. The consequence of weight gain would be averted.

Cognitive Behavioral Therapy, Rational-Emotive Therapy, and Disinhibition

Cognitive behavioral therapy (CBT) focuses on the way we think about actions we take. Dobson describes this form of therapy as focusing on thinking and its effect on behavior.[19] When changing behavior, relevant beliefs may be identified and altered. Desired dietary behavioral change may be the result of changing thought processes or cognitions.[20,21] For example, negative thoughts that tell clients that they have failed may trigger unhealthy eating behaviors that require change for a more healthy lifestyle. Cognitive restructuring is a concept that requires the client to change the way he or she thinks about slips in positive dietary habits.[22] For example, the client who says, "I might as well give up—I just ate that forbidden cake. What is the use in even trying?" This client might restructure his/her internal monologue by saying, "If I have one piece at this special event, that is fine. I will just stop with one slice. This can still be a positive experience." This example of cognitive restructuring avoids the all-or-nothing concept of always having to be perfect.

Rational-emotive therapy (RET) was founded by Albert Ellis. As one of many models of CBT, it has definite similarities to Dobson's approach. Ellis determined that irrationality is the most frequent source of individuals' problems. Self-talk—the monologues individuals have with themselves—is the major source of emotion-related difficulties.[23] The major purposes of RET are to demonstrate to clients that negative self-talk, the cause of many of their problems, should be reevaluated and eliminated along with illogical ideas.[23] Clients' major goals in RET are to look to themselves for positive reinforcement of behaviors. In one commentary contrasting CBT and RET, the writer states that while there are strong similarities in the two theories, RET is a more unified theory of rational thinking and living.[24] RET sets therapeutic goals beyond small very specific behavioral changes. It focuses on sustained changes in emotions, life philosophy, and behavioral changes designed to emphasize overall values.[25] For example, in dietary counseling, a client with hyperlipidemia might say: "I know that I need to cut down on saturated fat to maintain a healthy lifestyle overall. But it is hard to think of avoiding all of those foods I love for the rest of my life. Is that really living?" The RET counselor in this case can help change

negative self-talk to more positive thoughts by questioning what the changes in eating patterns might do relative to overall lifestyle. The client might respond: "I know that in the long run, eating in a healthful way is best. It will allow me to be more active with my grandchildren, something very dear to me. Yes, my goal will be to focus my thoughts on how changes in eating will affect my entire life, and especially those things I value most."

In working with clients seeking weight reduction, the concept of disinhibition as a part of CBT surfaces as an important indicator for sustained weight loss. In this context, disinhibition is defined as overeating triggered by emotional and external factors. One study supported the use of only moderate caloric restriction in clients with a high risk of disinhibition. Data from this study showed that rigid caloric regimens fostered feelings of hunger and disturbance of healthy eating behaviors. These researchers found that disinhibition can be diminished by enhancing self-control without a focus on restrained eating, and by negotiation of more appropriate ways of dealing with feelings than overeating.[26]

Four theories or models that have developed from the cognitive behavioral theory are the PRECEDE-PROCEED model,[27] social cognitive theory,[28] and two similar theories, the theory of reasoned action[29] and the theory of planned behavior.[30]

The PRECEDE-PROCEED Model

The PRECEDE-PROCEED model included factors that precede a behavior or those that allow it to continue, or proceed. It proposes three factors driving behavior: predisposing factors, enabling factors, and reinforcing factors. The predisposing factors are those that drive a behavior and include knowledge, beliefs, attitudes, and values. Because these factors are considered the motivation for many behaviors, it is important to examine these factors during the assessment phase of the nutrition care process. For example, knowing what a client values in life often can assist in generating the desire to make changes in dietary practices. Enabling factors are basically those aspects of daily living that allow a positive eating behavior to occur. For example, the thought that it would be a good idea to walk more often may need the enabling factor of knowing what type of shoe is best for walking and where it might be purchased. Reinforcing factors are those things that promote mainte-

nance of a dietary behavior. This aspect of the PRECEDE-PROCEED model focuses on family members, peers, and health care providers who help in sustaining a positive lifestyle change.[27]

Social-Cognitive Theory

Social-cognitive theory emphasizes the importance of factors around us that influence our social environment. Each client's interpretation of behavioral outcomes can affect his or her ability initially to achieve that outcome and ultimately to maintain it. The expectations of what an outcome should be influence the client's ability to achieve that outcome. For example, the client who expects to always eat perfect meals may be disappointed at the actual outcome of lifestyle change-related dietary patterns. This disappointment may result in failure to continue trying to make changes.[28]

Theory of Reasoned Action and Theory of Planned Behavior

The theory of reasoned action proposes that behavior is shaped by the beliefs and attitudes of a person.[29] A later version of this theory, the theory of planned behavior, adds the concept of personal control as a predictor of eventual behavioral change.[30] For example, the person who believes that he/she *can* make a dietary behavioral change (self-efficacy) will be more likely to achieve that change.

Standard Behavioral Therapy

A review of most lifestyle change programs reveals that both cognitive and behavioral strategies are used simultaneously to promote diet and exercise change. During the process of tailoring the programs to each client's needs, different components of the program may be emphasized. This process often involves a mixture of both cognitive and behavioral strategies—and with the melding comes the new label, *standard behavioral therapy*. Fabricatore and Foster discuss the collapsing of cognitive and behavioral strategies into this one overall category.[31,32]

Social Learning Theory

Social learning theory builds on the idea of modeling. The concept is that people learn through seeing someone model a positive behavior. In group counseling, one participant who is doing well might describe or model her experiences. By seeing how someone else handles a difficult situation, it becomes more feasible for a client to take on that experience and succeed.

Bandura has written about this theory and focuses on the importance of self-efficacy.[33-35] The client who is able to say, "I can do this," is more likely to achieve success in changing dietary behaviors. Those clients who see the task as too monumental will have difficulty realizing success.

Transtheoretical Model

The transtheoretical model focuses on the concept of behavioral change and occurs in stages of motivation as clients move to a more healthful lifestyle. Clients may begin in initial precontemplation stage with thoughts like: "I really don't need to change my diet. Things are fine as they are." They may then move to contemplation, in which the client looks at the pros and cons of making a behavioral change. A third stage is preparation, in which planning and motivation to commit to a behavioral change occur. A fourth stage is action, in which actual behavior in a positive direction is observed. The fifth and final stage is maintenance, in which the behavioral change has become a habit and is sustained as a long-term part of daily life.[36,37] Motivational interviewing[38] draws from this model and will be discussed in depth in Chapter 3.

Person-Centered Therapy

Carl Rogers is the founder of person-centered therapy, originally client-centered therapy.[39] His work is still apparent in many of the theories related to behavioral change, including motivational interviewing, that emphasize many Rogerian concepts. Three major concepts form the basis of this theory.

1. All individuals are a composite of their physical being, their thoughts, and their behaviors.
2. Individuals function as an organized system, so alterations in one part may produce changes in another part.
3. Individuals react to everything they perceive; this is their reality.

When counselors try to change dietary behaviors, they also must be concerned with clients' thoughts. Behavioral alterations may produce changes in the clients' physical being as well as the cognitive (thoughtful) being. Counselors must also assess client perceptions thoroughly because what clients perceive as reality influences their ability to follow an eating pattern. The skill of listening is very important to this therapy.

The goals of client-centered therapy include the following:

- promoting a more confident and self-directed person
- promoting a more realistic self-perception
- promoting a positive attitude about self[16]

Rogerian, person-centered therapy focuses on each person's worth and dignity. The emphasis is on the ability to direct one's own life and move toward self-actualization, growth, and health.[12]

Ockene has reestablished the concept of person-centered therapy with her emphasis on the client. Her focus is on tailoring interventions to each client's needs.[40] Her ideas revolve around the concept that work toward modifying behavior in lifestyle change areas requires a thorough assessment of where the client's priorities lie. Her ideas on this topic are key to the nutrition assessment step (step 1) in the nutrition care process. Without a tailored assessment of nutrition behaviors in step 1, the client's needs will not be central to the intervention as it proceeds through the other steps in the nutrition care process.

Nutrition counselors can provide the tools to help clients solve their own problems by assessing their current dietary behavior and establishing realistic goals for change. Also, practitioners can assess clients' thoughts about their body image and food behaviors. Changing thoughts from negative to positive is a first step toward the client's mastery of positive self-reinforcement skills.

Gestalt Therapy

Gestalt counseling, a form of therapy made popular in the 1970s, emphasizes confronting problems. Steps toward solving them involve experiencing these problems in the present rather than the past or the future. The major goal in Gestalt therapy is to make clients aware of all the experiences they have disowned and to recognize that individuals are self-regulating. Being aware of the hidden factors related to a problem is the key to finding an eventual solution.[16]

Using Gestalt therapy to help clients with dietary change involves asking them to recognize how many "disowned" factors can contribute to their dietary problems. Showing clients how to be responsible for regulating their behavior is a practical application of the Gestalt approach to counseling. The goal is for clients to take responsibility for making dietary changes.[12] For example, adolescent clients with diabetes who continuously blame poor glucose control on parents who don't help them control foods or teachers who cause them to be under stress are disowning behaviors that they could control. Helping clients set reasonable behavioral goals when they are ready to change can aid in solving the problem of disowning.

Family Therapy

In family therapy, the family is considered a system of relationships that influence a client's behavior, which is examined as a component of the system. The individual client is always seen in the context of relationships, with emphasis on understanding the total system in which the inappropriate behavior exists. The goal is to help individuals and families to change themselves and the systems within which they live.[41]

One of the major techniques used in family therapy is to involve the client's entire family in solving problems through open and closed questioning. Role-playing may be used to illustrate both the negative aspects of "blaming" and the positive aspects, in which praising behavioral change is emphasized.

Self-Management Approach

Researchers have found that behavioral approaches support short-term change[42] but usually fail to maintain change in the long run.[43,44] Leventhal proposed several reasons for this failure: behavioral techniques fail when contact with a health care professional is less frequent or absent, when initial symptoms of illness lessen, and when relapse into a previous behavior pattern does not provoke any symptoms.[45] Leventhal's theory of self-regulation is based on concepts from the behavioral approach and the health belief model,[46] self-efficacy,[35,47] and self-management.[48] The basic premise in self-regulation allows individuals to choose their own goals based on their perceptions of their illness and related challenges. Individuals seek, discover, and select coping behaviors and evaluate the outcome in emotional and cognitive terms. The nutrition counselor is a guiding expert who reinforces, supports, and encourages individuals as they select, evaluate, and adjust goals and strategies for behavioral change. [49–52]

In the contemporary self-management approach, nutrition counselors and clients are partners. Clients problem solve and use resources beyond those of the nutrition counselor. Clients develop skills and confidence (belief in personal efficacy) through guided mastery experiences, social modeling, social persuasion, and the reduction of adverse physiological reactions. Health care professionals and a social network encourage self-management practices.[53,54]

Health Belief Model

The health belief model focuses on the individual's ability to envision success while moving toward better health by changing behavior. This model includes several assumptions:

1. A person will adopt a behavior if failing to do so has consequences that are a critical threat to lifestyle as it exists. Tied to this is the idea of being in a situation where, without change, the client feels defenseless.
2. Changing a behavior depends on a balance between barriers versus benefits to change.[55]

For example, a client decides to follow a diet low in saturated fat after a heart attack. He feels very vulnerable, and the consequences of not changing to healthier eating behaviors are very real. When he looks at the scale of pros and cons to changing dietary habits, the positive aspects of living a longer life outweigh the barriers of socializing with friends and eating food high in saturated fat.

Developmental Skills Training

Mellin has devised a combination of theories while focusing on what she calls the brain-based intervention program designed to promote two skills: self-nurturing (recognizing feelings and needs and providing support) and effective limit-setting (setting reasonable expectations, accepting difficult situations, and experiencing the reward and benefit of such acceptance). Mellin's writings focus on promoting resilience to daily life stressors and decreasing vulnerability to stress. She emphasizes the tie between daily stressors and their negative effects on mind and body which leads to the onset and progression of chronic disease.[56]

The theories described above are only a few of over 200 orientations to helping clients change their behavior. The communication and counseling skills presented in the next two chapters provide a format through which counselors can consider and use ideas based on these theories. All theories are concerned with change—the generation of ways of thinking, being, deciding, and behaving. When a client changes a dietary behavior in a small way, the nutrition counselor has a foundation upon which to support further change. Integrating tenets of many theories into the treatment of a client's dietary problems is the goal. One theory may work best in promoting change at one stage in a client's treatment; another may work well at a different point. Chapter 3 discusses the client's readiness to change and provides ideas on ways to apply the theories described in this chapter.

Importance of Nutrition Counseling in the Nutrition Care Process

Why is counseling important? Within the nutrition care process model, nutrition counseling provides a logical structure using

strategies based on a variety of counseling theories. It has a place in each of the four steps in the model: step 1, assessment; step 2, nutrition diagnosis; step 3, intervention; and step 4, monitoring and evaluation. Nutrition counseling sets the stage for optimum dietary adherence within step 3, intervention.

Dietary adherence should be the ultimate goal of all nutrition counseling sessions. Researchers have found that there are many deterrents to dietary adherence:

- the restrictiveness of the dietary pattern
- the required changes in lifestyle and behavior
- the fact that symptom relief may not be noticeable or may be temporary
- the interference of diet with family or personal habits
- other barriers:
  1. cost
  2. access to proper foods
  3. effort necessary for food preparation[57]

Glanz has found that two positive counseling techniques appear to increase dietary adherence: (1) employing strategies that influence client behavior and (2) involving clients more during the session.[58] She further specifies several strategies for maintaining dietary changes: (1) tailoring the dietary regimen and information about the regimen; (2) using social support inside and outside the health care setting; (3) providing skills and training in addition to information, such as assertiveness training skills and weighing and measuring skills; (4) ensuring effective client provider communication; and (5) paying attention to follow-up, monitoring, and reinforcement.[57]

Hosking lists conditions that increase dietary adherence in hypertensive clients on salt-restricted eating patterns:

- diet programs that are individualized, fully explained, and adapted to the client's preferences and lifestyle
- regular revisits to the same nutrition counselor
- involvement of the family
- reinforcement of the eating pattern from every member of the treatment team[59]

Several research studies have reported that adherence is better when the counselor is warm and empathetic and shows interest ("Call me

if there is a problem") and demonstrates genuine concern ("I will call in a week").[60–70] Counselor-client relationships are essential to maintaining dietary change. In a large scale RCT, Jackson showed that counseling staff turnover was directly and negatively correlated with study participant adherence.[71] This relationship between counselor and client is immensely important to maintenance of improved dietary behavior.

Counseling skills help eliminate the hit-or-miss philosophy that allows little assurance for success. This hit-or-miss philosophy tends to be inefficient, because the nutrition counselor must backtrack when strategies fail. To provide structure and organization, Figure 1–2 shows the nutrition care process. This text will focus on the nutrition intervention portion of the nutrition care process. Figure 1–3 provides a simplified schematic of nutrition counseling as it occurs with in this process.

Systems Approach to Nutrition Counseling

Models provide a sequenced path for counselors to follow and list essential components in each step of the process. Figure 1–3 shows one model by which nutrition counselors can avoid missing a vital
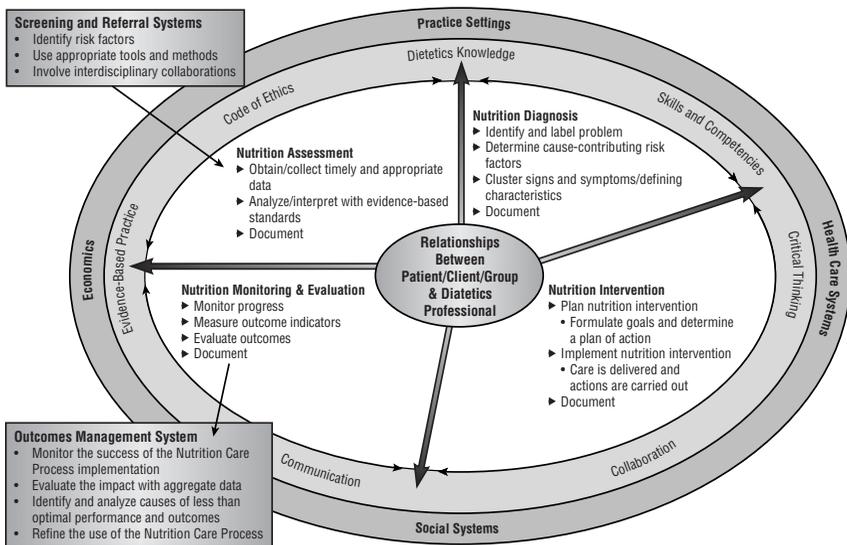

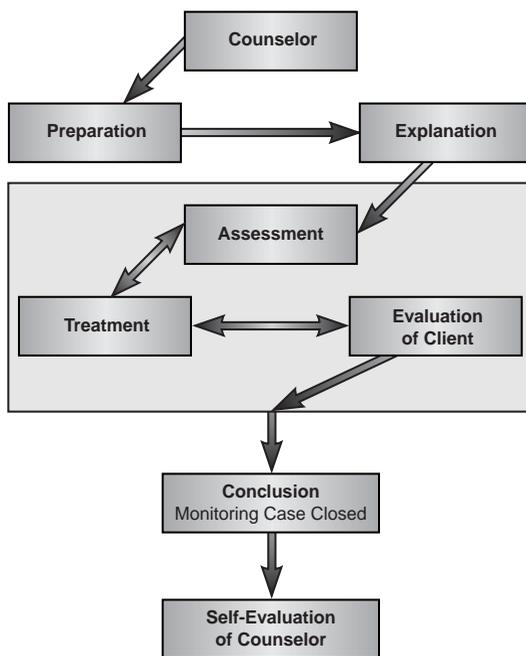**FIGURE 1–2**   Nutrition Care Process.[1]

FIGURE 1–3   Model for nutrition counseling.

part of the process. In this model, the counselor wears many hats. The first is that of a diagnostician preparing for the interview by reviewing all available data in the medical record, diet records, diet recalls, diet histories, interviews with family members, and other sources.

The session begins with an explanation of the counseling relationship with enough detail that the client knows precisely what will take place. In this stage, the practitioner is a teacher defining the relationship for the client.

During the assessment and diagnosis phase, once again in the role of diagnostician, the counselor evaluates the client's nutrition status and relates food intake data to behavioral indicators. The practitioner also must establish a safe, trusting, and caring environment, acting as empathizer. In the nutrition intervention portion of the nutrition care process, the counselor's roles are those of expert and mutual problem solver, roles that usually can be combined only through diligent study and practice. Most novices at counseling tend to be either expert or empathizer. When the two

roles are used in combination, they can facilitate adherence to diet, but used singly, each can be detrimental to effective client-centered counseling. Steve Berg-Smith has said in reference to counseling for lifestyle change, "The quality of our listening is far greater than the wisdom of our words."[5,72]

Many practitioners are familiar with the all-knowing counselor who approaches clients with an air of authority. Clients are overwhelmed by these experts' self-confidence and taken in by the appearance of wisdom. However, when clients return home, they find it very difficult to follow the diet. They tend to forget much of what was said during the counseling session and are incapable of self-direction in adhering to the new regimen. The clients' solution in such a case is to continue with old eating habits.

On the other hand, counselors who are empathizers can become so involved with the client's problems that they lose sight of their other role of information disseminators. Counselors can run into conflicts when they see a client is in error but feel that revealing the mistake may damage the individual's pride and ability to follow the diet. "Eating cheesecake out a few times won't matter," the counselor says. To the client on a low-saturated-fat diet, this may be a signal to go ahead and continue poor eating habits. Back at home, the client may comment to a family member, "The nutritionist said eating cheesecake in a restaurant just a few times wouldn't hurt. Three nights a week doesn't seem too often."

In evaluating clients, counselors once again become diagnosticians. If no solution to the problem has been reached, counseling reverts to the assessment phase. In some cases the clinicians may decide to refer a client to another practitioner more experienced with the problem.

The intervention phase allows the client to offer ideas with the counselor focused on using those ideas to tailor the strategies for dietary change.

In concluding the counseling session, the counselor should share a few words of wisdom, in which case the counselor becomes the expert again. Ending the program involves more than just closing the case. Monitoring the client's performance in the real world is important to continued dietary adherence. This means calling to check on progress and, with the individual's permission, checking with significant others to determine how they feel the client has progressed.

The last step involves self-evaluation of the counselor's performance. In this case, the counselor becomes the learner, building on past experience to improve present skills.

Counseling Skills

The basic steps just discussed are a part of counseling, but the complexities go beyond what Figure 1–3 indicates. Chapters 2 and 3 review these skills and ways to use them.

Communication Skills

Basic to all counseling is knowledge of communication skills. Without these skills, treatment cannot and will not take place.

Counseling

Once clinicians have acquired this foundation, they then can learn various counseling skills to aid clients in achieving dietary goals. These skills involve nutrition assessment, diagnosis, intervention, and monitoring/evaluation.

Nutrition Assessment

Nutrition counseling involves a process of targeting behaviors involving eating habits. Initially, a careful assessment of current eating behaviors is important. Knowing what food habits exist prior to making a change allows the individual to target specific foods and behaviors.

Assessment involves more than asking clients, "Do you have a problem?" It is a carefully considered plan to determine areas in which problems occur. Assessment in nutrition counseling includes ascertaining what clients are eating and why they make certain food selections.[2] The example that follows illustrates several potential responses to a weight-control client.

A client returns for a visit following the diet instruction and reports a problem: "I just haven't lost any weight on the diet you recommended." There are several counselor responses:

1. "Did you follow all of my advice?"
2. "Well, what have you been eating?"
3. "What is your typical day like?"

These three questions indicate various levels of communication skills. The first question is stated in a way that immediately places the client on the defensive. The client feels compelled to give a glowing picture or a multitude of excuses. The second question focuses only on eating behaviors, disregarding the surrounding circumstances that may have instigated the behavior. Depending on the tone of voice, it also may make the client feel compelled to reply with what the counselor wants to hear. The third question is a sensitive statement that shows caring, characteristic of Rogerian style. It does not imply a reprimand, allows the client time to elaborate on what actually happened, and gives the counselor the information necessary to assess the situation. It sets the stage for client-centered counseling.

For practicing nutrition counselors, the most frequent problem during an interview is a rush to give advice. It is important to stop and take time to assess the situation first. Only after assessment should counselors provide advice, allowing the client to assist by suggesting and describing how he or she expects to apply those recommendations in a true-to-life situation. It is important to remember that the quality of our listening is paramount in achieving successful behavioral change.

Nutrition Diagnosis

The diagnosis of nutrition problems involves identifying and labeling a problem, determining the cause or contributing risk factors, listing signs and symptoms, and documenting the nutrition diagnosis. There are three distinct parts to each nutrition diagnosis:

1. Problem (Diagnostic Label): The diagnostic label defines alterations in the client's nutritional status. The label is an adjective describing the human response: altered, impaired, ineffective, increased/decreased, risk of, acute or chronic.
2. Etiology (Cause/Contributing Risk Factors): Etiology is the term applied to factors that contribute to the existence of the problem. The words "related to" link the etiology to the diagnostic label.
3. Signs and Symptoms (Defining Characteristics): These defining characteristics are identified during the assessment phase. They quantify the problem and describe its severity. The words, "as evidenced by" link these defining characteristics to

the etiology. Signs are objective identifiers of observable changes in health status. Symptoms are subjective changes that the client feels and expresses verbally.

The nutrition diagnosis is written in a PES Statement that states the problem, etiology and signs and symptoms. An example might be: Elevated blood glucose (problem) related to frequent consumption of large portions (etiology) as evidenced by daily intake of calories exceeding recommended amounts by 500 kcal and a 20-pound weight gain in the past 5 months (sign). The client complains of feeling tired and lacks the energy to do daily tasks (symptoms). The client states that her husband is upset because she has no energy to do those things that they previously did together as a couple (symptom, feeling related).

Nutrition Intervention

Beyond understanding initial eating habits, counselors and their clients then make decisions about how to manage change. They determine which foods to modify or substitute to achieve a change in a targeted nutrient. Self-monitoring is crucial.[73,74]

In giving clients strategies to remedy nutrition problems or provide treatment, counselors once again must proceed slowly and focus on the clients in planning and setting attainable goals. Counselors frequently decide before the interview how the problems should be solved and try to force clients into preformed molds. They do not give clients an opportunity to participate. In this phase, mutually decided goals will achieve the most success. Counselors should use the following sequence of steps in setting goals:

1. Identify nutrition goals by listening to the client's ideas.
   - Define desired nutrition behaviors (what to do).
   - Determine conditions or circumstances (where and when to do it).
   - Establish the extent or level (how much or how often to do it).
2. Identify nutrition subgoals (a subgoal for a long-term goal of eliminating snacks would be to eliminate the morning snack and determine a workable substitute behavior).
3. Establish client commitment, which includes identifying obstacles that might prevent goal attainment and listing resources needed for goal achievement.[75]

The strategy chosen to help implement these goals once again requires listening skills to involve the client in reaching solutions. Counselors should ask the following questions to help tailor strategies to each individual's situation:

1. Why is the client here?
2. Is the problem the client describes all or only part of the problem? Many nutrition counselors have thrown their hands up in despair, saying, "He just isn't motivated to follow this diet." In such a case, the real problem may hinge on emotional stress that must be treated before nutrition counseling can take place. The client might be referred to a psychologist or other professional for help before or concurrent with the nutrition counseling session. For those clients who are ready to change the following questions may be helpful:
   - What are the problematic nutrition behaviors and related concerns?
   - Can I describe the conditions contributing to poor nutrition adherence?
   - Am I aware of the present severity and intensity of the nutrition problem?[76]

Chapter 3 discusses motivational interviewing and the importance of identifying readiness to change. Goal setting may be counter productive if the client is not ready to change. The client will fail and the counselor will feel defeated if goals are set when the client is not ready to change. For the client who is not ready, it will be best to send the client home to think about the possibility of change.

For some clients, the problem may be lack of sufficient information to follow the desired regimen. For example, a person with renal disease who follows a low-protein eating pattern routinely has elevated urine urea nitrogen levels inconsistent with diet records that show excellent compliance. After requesting that the cook in her favorite restaurant slice one ounce of chicken off the actual portion of "Chicken Oscar" (her favorite entree), she is surprised: one ounce is much smaller than she guessed. For weeks, her concept of one ounce of meat has been much greater than the actual amount. Providing enough information for the client to follow a new eating pattern is the first step.

The second step may involve solving a problem of a different

nature—lack of planning. For example, a guest at a party realizes that he has no idea what ingredients are in the main dish. If before going to the party he has placed a cue on the refrigerator, "Call hostess to check on what is being served for the party tomorrow," the client can avoid a potentially awkward situation. Many clients comment that one of the most important ways to avoid drops in dietary adherence is to plan ahead.

The third step in treating dietary problems is much more difficult. It involves diagnosing a problem involving lack of commitment to a dietary regimen. The term "lack of commitment" is not meant to reflect badly on the client but to diagnose accurately poor dietary adherence. For example, a person with diabetes may decide, "I just want to be free from dietary worries for a while. Life is so complicated. I want to forget my diet and splurge." The counselor cannot say, "Fine, don't worry about it for a week," but the counselor can say, "What can we do to streamline your dietary efforts? Let us begin by identifying when diet is most frequently a problem." Identification may require that the client records in a diary those thoughts related to eating before and after meals. For example, "I ate that chocolate cake even though I knew it would be too high in calories after that huge dinner." If a pattern of negative thoughts seems to occur frequently at dinner time, the client needs strategies to help make that meal a more positive experience.[76–78] By identifying a major problem time, the client may be able to work out menus in advance, elicit help from family in meal preparation on specified nights, rely on precalculated exchanges for each meal, build in time to relax before each meal, and work on more positive self-thoughts. Using the client's suggestions and the counselor's experiences allows for a joint solution to the problem of lack of commitment.

Monitoring and Evaluation

The last phase, monitoring and evaluation, provides a reassessment of progress for both clients and counselors. Much of the questioning used during the assessment phase can be reused here, focusing on the desired objective and whether it was met. The counselor should monitor the client for a time in the client's environment.

Counselor self-evaluation frequently does not take place because of time constraints. It can be very important to review

what went on in an interview and then to determine what made it a success and what might have improved its efficacy or quality.

Counseling Spectrum

Nutrition counselors assume a variety of roles. During the sessions some role changes take place automatically; others require a great deal of practice and effort. The role of the counselor falls on a spectrum such as that in Figure 1–4, including some of the positions on both ends. When counseling is totally dominated by client requests and tangential topics, little behavioral change will take place. A session totally dominated by a counselor who only provides information without listening to client concerns can be equally unproductive. The ideal is a mix of client and counselor interaction. Making a trial run of a counseling situation by role-playing with a fellow nutrition counselor can be helpful. When one counselor plays the part of client, he or she will be able to sense where changes in counseling style might be appropriate. For example, after playing the roles, the counselor playing the client might say, "You did a great job, but really asked me too many questions."

In summary, using skills that involve behavioral change may seem unnatural to those who have been mainly involved in providing information to clients. Nutrition counseling strategies elevate the counselor/client interaction to a level that increases self-management and potentially ensures dietary behavioral change success.
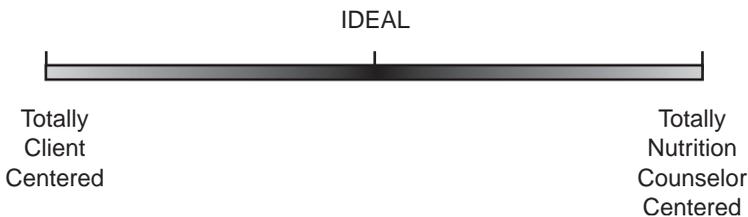
IDEAL

Totally
Client
Centered

Totally
Nutrition
Counselor
Centered

FIGURE 1–4   The nutrition counseling spectrum

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