CHAPTER 1
The dietitian

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
>
> *World Health Organization, 1948*

In this chapter, we discuss:

- The role of the dietitian
- Using a prescriptive approach
- Changing approaches to providing health care
- Developing a patient-centred approach
- Introducing counselling skills
- Developing a counselling approach
- Qualities for a dietitian to develop
- Personal and professional development
- Different approaches to counselling and psychotherapy
- Overview of the evidence concerning the use of communication skills in dietetic practice.

The role of the dietitian

Whether working in a hospital, the community, private practice, the media or academia, a large amount of a dietitian's time is spent interacting with other people, such as patients, students, colleagues and professionals from other disciplines and walks of life. The role is therefore varied and challenging. Dietitians need to provide tailored, practical nutritional advice based on the latest scientific research, while at the same time considering carefully how best to communicate with a diverse range of people in many different contexts.

Counselling Skills for Dietitians, Third Edition. Judy Gable and Tamara Herrmann.

Companion website: www.wiley.com/go/gable

The manner in which dietitians communicate their knowledge is gaining increasing attention. The Curriculum Framework for the Pre-Registration Education and Training of Dietitians, launched in 2013, includes communication as a key subject (British Dietetic Association 2013). The ability of dietitians to communicate effectively on nutrition matters and dietary management with a broad range of people in a variety of settings is now seen as crucial (Health and Care Professions Council 2013). The change in the National Health Service (NHS) from a prescriptive approach towards a more patient-centred one has emphasised this. Nowadays, many dietitians describe their role as one of facilitating behavioural change or of nutrition counselling (Cant & Aroni 2008b), and they see themselves as guiding others to make appropriate and healthy choices with regard to diet. In order to facilitate this process, a number of dietitians have undertaken various introductory courses in counselling skills, and some have undertaken advanced training.

Effective communication lies at the heart of counselling skills. However, an understanding and appreciation of the value of these skills and competence in using them only develops with practice. Therefore, to become competent and confident in their role as patient-centred practitioners, dietitians need to consciously apply these skills in their daily work.

Using a prescriptive approach

Traditionally, the communication skills used by dietitians have centred around advising, teaching, informing and instructing in order to pass on knowledge to others. This approach fits well with a medical model of health care, in which patients are expected to comply with dietary advice given by a dietitian, in order to improve their condition. When using the prescriptive approach, the relationship between patient and health professional is based on the authority and expertise of the latter. Dietitians using this approach are therefore in a position where they have most control over what takes place. They may not always find this satisfying, however; especially when a patient does not respond to the prescribed therapy.

When faced with an authoritative figure, patients may be anxious, outwardly acquiescent and in awe of the health professional. On the other hand, they may be openly or covertly rebellious. Recent research into dietetic practice shows that most patients prefer an individualised and empathic approach (Hancock *et al.* 2012). Nevertheless, while considering possible problems with a prescriptive approach, we also acknowledge that there are some patients who state that they prefer a practitioner-led consultation, where information-giving and an educational approach is sufficient (Hancock *et al.* 2012; Endevelt & Gesser-Edelsburg 2014). It therefore seems crucial that the dietitian possesses the *flexibility* to adjust to the patient's preferred style (Hancock *et al.* 2012), as addressed later in this chapter.

Control, compliance and responsibility

The prescriptive approach, as already explained, and as applied in Scene 1 of the video accompanying this book (www.wiley.com/go/gable), raises issues to do with compliance and responsibility. This approach allows and encourages patients to relinquish responsibility for their actions. Patients may comply in order to please the dietitian. If they do not comply, then they are in a position to blame the dietitian for the apparent failure of the treatment plan. Dietitians can then find themselves accepting this as their responsibility, or, alternatively, blaming the patient for their non-compliance. In effect, they assume a parental role, while the patient assumes the role of a child. The psychology of this is best explained with the model of ego states used in transactional analysis (TA) (see Transactional Analysis, p.).

When faced with a problem, many helpers, as the experts with authority, feel a responsibility to come up with a solution for the person they are helping, and see it as their job to use persuasion as a means get their solution adopted. Dietitians who think they should be the ones to provide the solution to a problem are also likely to associate compliance on the part of the patient with their own effectiveness. It is then tempting for the dietitian to resort to a variety of strategic communications in an attempt to feel better. If the patient does not follow their advice, dietitians are likely to use methods which allow themselves to be in control, such as lecturing the patient on the importance of modifying their diet. They are also more likely to resort to manipulation, for example allowing the patient to think that they also have difficulty in restraining their intake, as a way of inviting the patient to disclose their own dietary indiscretions, or persuading the patient to comply in the future 'for their own good'. They may even covertly or directly threaten the patient with the consequences of poor health. This approach raises an ethical question: is it the dietitian's responsibility to persuade a patient to change, or is it the role of the dietitian to provide factual information and allow the patient to choose what to do, even if that choice is not in their best interest? These issues have been much debated in the field of health promotion.

Changing approaches to providing health care

Since the 1980s, evidence has accumulated for a connection between risk factors such as poor diet and the increasing global incidence of diseases such as diabetes and heart disease. As a result, much work has centred on finding more effective ways of helping people make changes in their diet and lifestyle (Department of Health 2004; World Health Organisation 2004; National Institute for Health and Care Excellence 2007). Definitions of health based on the medical model of 'an absence of disease' have been broadened to be more in line with that of the World Health Organisation (see quote at the beginning of the chapter). More

holistic models of health care now take into account the complexity of psychological and social factors contributing to an individual's health, and a number of models have been developed to help people change their behaviour, which have been embraced by many dietitians.

The model Helping People Change, initially applied to help people stop smoking, was launched by the Health Education Authority in the 1990s and used by dietitians to help people lose weight. The model introduced the concept of different psychological phases in the process of change and explained the value of identifying them (Prochaska & DiClemente 1986) (Chapter 4). Another model, the continuum of control, usefully showed different methods of communication in relation to the degree of control held by the health professional (Ewles & Simnett 1985); it has been adapted as shown in Figure 1.1 to demonstrate how the dietitian can shift from didactic to facilitative methods by exerting more or less control.

Figure 1.1 Methods of communication related to the degree of control held by the dietitian. Source: Adapted from Ewles & Simnett (1985).

Later, motivational interviewing (MI) began to be used by many dietitians to provide a framework for exploring and resolving the ambivalence people feel about implementing change (Chapter 4). MI draws on some principles of client-centred counselling and is based on the concept of using a collaborative conversation to strengthen an individual's motivation and commitment to change by addressing the common problem of ambivalence about change (www.motivationalinterviewing.org). MI is considered an example of an Empowerment Model for Health Promotion. Models in this category are based on a dietitian and a patient working together to agree realistic targets, while respecting the principles that value the patient's right to make choices about their own health and to be responsible for their own well-being. Their effectiveness depends upon the helper being able to assist the person they are helping to develop their own resources for change (Valentine 1990; Funnell *et al.* 1991; McCann & Weinman 1996).

More recently, cognitive behavioural therapy (CBT) programmes have been developed, which give patients strategies that can help them implement change. They are now widely used in the NHS in treating anxiety and depression, as well as obesity, diabetes and eating disorders. Interest is currently growing in mindfulness-based CBT (see Different Approaches to Counselling and Psychotherapy, p. 15).

These developments have provided dietitians with resources to:

- track the change process;
- explore and resolve ambivalence;
- introduce people to strategies for implementing change.

These models, together with greater understanding about the factors that help or hinder someone in changing their behaviour, have contributed to the development of a more patient-led approach to health care.

Developing a patient-centred approach

'Patient-centred medicine', as opposed to illness-centred medicine, was a term first coined by Balint and colleagues in the 1970s. It required an approach to the patient that was considered to have much in common with Rogerian person-centred counselling. This was in contrast to the traditional medical approach, which was delivered in a didactic manner, without giving much importance to communication skills. Interest in what lay behind non-compliance by patients identified the following as significant factors: a lack of satisfaction with the consultation, a lack of understanding by the patient, and a failure by the practitioner to meet expectations (Ley 1988). One of the specific components of the patient-centred approach was defined as 'enhancing the doctor–patient relationship', and it included developing good listening/counselling skills, demonstrating caring and developing a rapport with the patient. There was also an acknowledgement of the importance of self-awareness on the part of the doctor and of the possibility of transference and counter-transference developing in the relationship (Chapter 3). Essentially, this more holistic approach 'demands a sharing of power and control between doctor and patient and results in an increase in the patient's sense of self-efficacy which is widely recognised to be one of the key dimensions of health' (Stewart *et al.* 1995).

There has been a profound change in the NHS since the 1970s, with the Department of Health directing a move to more patient-centred health care (Department of Health 2004, 2005, 2008, 2010a), which takes into account the reasons that patients have for seeking help, their concerns and their need for information. Patient-centred health care also seeks to understand the emotional needs of patients in the context of what is happening in their life, by placing emphasis on understanding how they experience their disease, understanding the whole person and finding common ground in managing their condition. It is also recognised that patients want a continuing satisfactory relationship with their practitioner and want to be able to reach a mutually agreed upon course of management for their condition that prevents deterioration and promotes better health (Stewart *et al.* 2003). In a recent survey of patients' experience of dietetic consultations, it was concluded that patients like a patient-centred approach in which their needs are taken into account (whether in terms of the patient leading the consultation or of the dietitian directing these needs; Hancock *et al.* 2012) and that patients report it as a positive experience when the dietitian builds rapport and communicates well (Hancock *et al.* 2012; Endevelt & Gesser-Edelsburg 2014).

A patient-centred approach has been explicitly linked to communication skills in key government documents (Department of Health 2010b; National Institute for Health and Care Excellence 2012). This highlights the need for training to help staff (National Institute for Health and Care Excellence 2007, 2014):

- treat the patient as an individual;
- consider psychological and emotional support;
- enable patients to actively participate in their care and treatment decisions;
- develop skills of:
  - demonstrating empathy;
  - reflective listening;
  - building rapport;
  - developing motivation;
  - delivering behaviour change techniques.

It is not easy for dietitians who are accustomed to using a prescriptive approach to adopt an approach whereby they conduct a consultation centred on the patient's needs (Chapter 2). Training staff to work in a more patient-centred way requires a focus on developing 'skills which enable patients to make appropriate choices, express their thoughts and feelings, feel heard and understood, valued, respected and supported' (Whitehead *et al.* 2009).

As well as initial training, dietitians require practice and personal and professional support. In addition, they need ways to regularly assess their ability and opportunities to update their skills (National Institute for Health and Care Excellence 2014). More on training and assessment is included in Chapter 16.

In addition to the necessary skills just listed, dietitians also need to develop counselling skills, so that they can:

- assess and meet patients' needs and expectations;
- provide a supportive relationship in which the patient feels able to make small changes for themselves at a pace they can cope with;
- work within limited time boundaries;
- handle ambivalence when a patient is unsure about changing;
- cope with the emotions expressed by a patient;
- know what to say or do when a patient raises a non-dietetic problem.

Introducing counselling skills

Counselling skills incorporate a way of working in which attentive listening, reflection and discussion are used to promote the client's autonomy and well-being. The intention of the user is to enhance the performance of their primary professional role (e.g. as nurse, doctor, line manager, psychologist, social worker). It is important for the client to see them in that role, and not as someone whose primary professional role is that of a counsellor. Although professional counsellors use counselling skills in their interactions with patients, their work involves a lot more than this. Therefore, people who hold only a counselling skills qualification

may not call themselves counsellors and should not be referred to by others as counsellors (British Association for Counselling and Psychotherapy 2014). More on counselling is given in Chapter 16.

Counselling skills offer dietitians the means to provide high-quality support for patients. These skills are demonstrated in Scene 5 of the video accompanying this book (www.wiley.com/go/gable) and are fully examined, using many examples, throughout the following chapters. Competency in using these high-level communication skills is essential if dietitians are to be able to respond to their patients' emotional needs and manage appropriately the non-dietetic problems that emerge during their work together.

In addition to the method of communication, the nature of the relationship between the counsellor and the client (and the process that occurs within that relationship) is also central to the counselling approach (Chapter 3). This is very different from the relationship developed by an instructor, teacher or adviser, in which they assume control. Instructing, teaching and advising centre around a one-way relationship, in which the helper is in the powerful position of being the expert. Discussing and counselling centre on a two-way relationship, in which the helper chooses to exert less control and supports the person being helped to gain a sense of power and control for themselves. However, dietitians using counselling skills may also, at times, and with awareness of what they are doing, use methods such as instructing, teaching, advising and discussing. Table 1.1 highlights the differences between these methods.

Dietitians are limited when they have only one or two methods of delivery. As has been mentioned, there is evidence to show that patients want dietitians to treat them as individuals and provide empathy using a patient-centred approach, but some patients prefer a practitioner-led and some a patient-led consultation (Hancock *et al.* 2012; Endevelt & Gesser-Edelsburg 2014). In addition,

Table 1.1 Methods of communication.

Method	Purpose	Skills	Approach
Instructing	To get the helper's message across	Ordering	Practitioner-led
Teaching	To ensure the person being helped understands the material	Explaining Demonstrating	Practitioner-led
Advising	To tell the person being helped what to do	Persuading	Practitioner-led
Discussing	To exchange points of view	Expressing oneself Listening	Combined approach
Counselling	To understand another To help someone move towards making changes	Listening Responding helpfully	Patient-led

within one interview, the dietitian needs the flexibility to move to and fro along the continuum of control (Figure 1.1), from counselling or discussing to teaching and advising, depending on what is appropriate at the time. When making this momentary, sophisticated judgement, the dietitian will consider whether the patient is keen to receive nutritional information right now or whether more understanding of their situation needs to be demonstrated. Dietitians who can choose to assert control or let go of it, depending on their purpose and the perceived needs of the patient, will be highly competent in their work. However, in order to become proficient in counselling skills, dietitians also need to develop a counselling approach.

Developing a counselling approach

Involving patients more directly and encouraging personal responsibility for health requires dietitians to examine their perception of themselves and their attitudes towards patients. Dietitians who perceive themselves as someone who knows what is best for the patient reflect a different attitude from those employing a person-centred approach. Dietitians using this latter approach think of themselves as someone who is available to share their professional knowledge with patients in order that they may make use of this if they choose. They will endeavour to provide, to the best of their ability, an environment in which their patients can feel safe, acknowledged and supported as worthwhile human beings (Chapter 3).

Counselling skills therefore require an approach in which dietitians choose to exert less control. Instead of taking on a parental role, as happens when teaching, advising and instructing, they focus on maintaining an Adult ego state (see Transactional Analysis, p. 17), and the manner of their communication invites their patients to do likewise. When this happens, a patient is encouraged to take responsibility for their actions and choices and so is aware that it is their own choice whether or not to follow the information given. As described more fully in Chapter 3, the relationship between dietitian and patient is one of partnership, in which both are engaged in solving a problem; namely, how to improve the patient's health by modifying their diet.

Portrait of a dietitian using a counselling approach

Sally is a dietitian who encourages her patients to take control and responsibility for themselves. She sees herself as someone whose role is to enable the patient to make their own choices.

She believes that human beings are unique, that each one knows best how they feel and what they think and believe, and that although these values may not be in accord with her own, they are worthy of her respect. The respect she has for herself and others enables her to trust that her patients are able to use her information in whatever way is best for them.

Exercise 1.1

How would you describe your philosophy about helping others? Which method of communication do you feel most comfortable using with different people?

Method	Colleagues	A patient	A group of patients	A student	A group of students
Instructing					
Teaching					
Advising					
Discussing					

In doing this, she is neither naive nor irresponsible in her attitude. She is realistic and able to respond to her patients. She accepts that each individual has their own difficulties. Some of these are known to her and others are unknown. Likewise, she knows her patients are aware of some difficulties themselves and unaware of others. She sees her role as one of offering support in helping her patients understand and deal with the difficulties they have with regard to their diet (see Exercise 1.1).

Qualities for a dietitian to develop

Dietitians frequently describe someone who is effective at helping others as being:

- trustworthy;
- honest;
- reliable;
- a good listener;
- caring;
- knowledgeable;
- competent;
- professional.

These are qualities which come readily to mind to most people working in the caring professions, but how are they conveyed? Someone who is trustworthy and honest is thought of as someone who can be believed and relied on to do what they say they will. In his groundbreaking work on person-centred therapy, written more than 50 years ago, Carl Rogers recognised that we trust someone and consider them honest and reliable when we experience them as being authentic, real and genuine (Rogers 1951). Genuineness (Chapter 3) is a quality that counsellors strive continually to develop. It is demanding to be honest with oneself and to trust oneself. However, the more able we are to be this way with

ourselves, the more able we are to be so with others. Openness and honesty are key characteristics of a person who is perceived to be trustworthy and reliable. Trust is also conveyed in someone's professionalism, including their knowledge, appearance, competence and confidence in managing a situation. Thus, the way in which dietitians dress, their overall body language and the manner in which they meet and greet their patients, as well as the way in which they verbally communicate their knowledge, will either enable or prevent their patients from believing the advice they give.

Providing care

Many actions are taken which are said to be caring because they are thought to be in the best interest of another. In truth, these actions are often in the best interest of those giving the 'care', and as a result the recipient feels unheard, manipulated and disempowered. We demonstrate true caring towards another when we feel empathy towards them (Chapter 3) and are willing to place ourselves at their service. We show caring by:

- giving time and attention to another;
- being fully present when listening to another;
- doing what is needed to meet the needs of another;
- helping another in the process of resolving their difficulties.

Caring is demanding, yet empowering, both of oneself and of the other. Our ability to be available to another in this way is closely linked with our ability to establish our own boundaries, which in turn is dependent on knowing our own limits in terms of competency and physical and emotional availability.

When providing care, the dietitian will be offering the patient:

- empathy;
- consideration;
- acceptance;
- time to talk within the limits of the appointment;
- appropriate information;
- practical ways to make changes;
- opportunities to ask questions;
- support.

Personal and professional development

Acquiring new information and monitoring competence are continual requirements for any health professional. Usually, these are thought of as involving keeping up to date with technical and scientific developments. It is also the responsibility of the health professional to develop their interpersonal and self-management skills, for without these they are unable to provide true quality care for their patients. In this way, there is an overlap between personal and professional development.

Self-awareness

A dietitian who wants to develop the qualities mentioned earlier will be particularly concerned with developing self-awareness. This is the key to developing the core conditions for a helping relationship (Chapter 3). Increasing self-awareness enables us to learn how we respond emotionally, which is a prerequisite if we want to help others effectively. With self-awareness, we can learn to recognise our own feelings and those of others, and to distinguish between them. In doing so, we are less likely to attribute our own emotional response to the person to whom we are listening. In other words, we are less likely to become angry, fearful or confused in response to these emotions in another person, and more able to take in what they are saying, without interpreting and distorting their words.

Developing self-awareness is about becoming more wholly ourselves. As Verena Tschudin (1995) succinctly said 20 years ago in *Counselling Skills for Nurses*, 'when we can hold the doubtful and the certain, the strong and the weak sides of ourselves in balance, then we can use ourselves positively'. Ways of increasing self-awareness are described in Chapter 15.

Frame of reference

As self-awareness grows, so does 'a greater openness to and acceptance of others' (Rogers 1961). During this process, we question and clarify our beliefs and experiences. These form our 'frame of reference', or the position from which we view our world. Each of us holds a different frame of reference. Using counselling skills necessitates being able to step into the frame of reference of another, in order to provide empathy with someone whose experience and beliefs are different from our own. However, we do not have to have been in exactly the same situation before we can empathise with someone. For example, we do not have to be widowed before we can empathise with someone whose spouse has died. What is important is that we can draw on our experience of loss and suffering for the benefit of another.

Self-worth

Developing self-awareness is closely related to developing self-worth. An ability to value and respect oneself leads to self-acceptance and trust in oneself. As a result, self-confidence grows. Patients will place greater trust in someone they sense they can rely on to be open and honest with them, and will be more able to be open and honest in return. Relating in this way develops a mutuality. For the dietitian, acting in a professional capacity, it is important to distinguish the difference between openness and honesty and self-disclosure (Chapter 7).

Imagination and intuition develop with self-trust. Empathising and stepping into another's world require the dietitian to use their imagination. As an ability to be empathic and genuine develops, so also does an ability to sense or intuit. Hunches provide potent material when used in an appropriate way. It is important to distinguish between hunches and assumptions; to be aware when we are sharing a hunch and when we are treating an assumption as a fact.

An important part of building self-worth, self-value and self-respect lies in learning to care for and about oneself, in mind, body and spirit. Caring for others stems from being able to care for ourselves. We may look to others to fulfil our needs if we do not feel cared for ourselves. Caring for the carer is therefore essential (Chapter 15).

Those who are considering using a counselling approach in their work face the challenge of examining their reasons for choosing to be a member of the caring professions. Is it the hope that, in providing for others, they will fill their own needs? If so, what are these needs? Is it a need for acknowledgement and recognition? Is it a desire to be thought of as 'kind', 'helpful' and 'doing something worthwhile'? Is it to understand more fully their own relationship with food? A dietitian's professional practice is in question when their personal needs are mainly fulfilled by their patients.

An integral part of a counsellor's training involves exploring their commitment to their own personal development. Dietitians who are thinking of using counselling skills in their work also need to explore their commitment to themselves. See Part 4 for more on personal and professional development.

Reflective practice

Personal development involves being able to reflect upon how one has experienced a situation. Reflective practice means doing so in a structured way, in order to understand and acknowledge any insight gained and enable theory and practice to come together. Based on the concept of experiential learning, it has long been a crucial part of counselling training. A number of models have been developed to help practitioners give meaning to their reflective process. Reflective practice is now widely adopted in education and the health professions, including the British Dietetic Association (BDA). Nowadays, dietitians are familiar with the procedure of recording their continuing professional development (CPD) activities, including evidence of how they have applied reflective practice, in order to maintain their registration to practice. More information about the reflective process in dietetics is available in the CPD section of the BDA website (www.bda.uk.com), which includes a pro forma tool for use by dietitians, based on the model developed by Rolfe *et al.* (2001).

Some people find the process of reflective practice uncomfortable and challenging, as well as time-consuming. However, the benefits that the practice can bring will develop as the process becomes more familiar. Hopefully, dietitians can get support through discussion and in supervision. More on this topic is given in Chapters 4 and 16.

Benefits of reflective practice

As outlined by Davies (2012), reflective practice provides:

- increased learning from an experience or situation;
- promotion of deep learning;

- identification of personal and professional strengths and areas for improvement;
- identification of educational needs;
- acquisition of new knowledge and skills;
- further understanding of one's own beliefs, attitudes and values;
- encouragement of self-motivation and self-directed learning;
- a potential source of feedback;
- possible improvement of personal and clinical confidence.

Reflective practice is probably the main tool enabling dietitians, whether in training or qualified, and whatever their particular speciality, age or experience, to greatly improve upon their communication and counselling skills. For example, we are often better able to clarify and express our thoughts succinctly as a result of a discussion or of writing in a personal journal or diary. As shown in Scenes 3 and 7 of the video accompanying this book (www.wiley.com/go/gable), a dietitian will gain much rich material to reflect upon both from situations that go well and from those that are less successful.

Use of the word 'reflection'

It is important at this stage to distinguish between two similar terms referred to throughout this book, in order to avoid confusion. The term *reflective practice*, as described in this section, concerns a dietitian's own thoughts and reflections about their work. The term *reflective responding*, as described in Chapter 7, involves reflecting the words, feelings or meaning conveyed by a patient back to them, much like a reflection in a mirror, and demonstrates to the patient that they have been heard and understood. The meaning will depend upon the context; for example, 'I used reflection in my response to the patient' or 'I later reflected on the patient interview'.

Different approaches to counselling and psychotherapy

There are many different approaches within counselling and psychotherapy, based on different beliefs about human nature. These can be broadly categorised under three headings: psychoanalytic, behavioural and humanistic. Details of books describing each approach more fully are available on the companion Web site (www.wiley.com/go/gable).

Psychoanalytic approach

Psycho-dynamic counselling comes under this heading, as it is based on Freud's belief that unconscious motives and drives lead us to behave in certain ways. Past experiences, of which we are unaware, can be relived when we encounter a similar experience in the present. Psycho-dynamic counselling encourages the client to explore their past in relation to the present problem.

Anxiety is reduced when clients are able to fully make sense of their patterns of behaviour. The principles and practice are clearly explained by Michael Jacobs (2010) in his book, *Psychodynamic Counselling in Action*. This approach is useful in health care when the patient has long-term emotional problems, suffers anxiety and talks of an unhappy childhood (Burnard 2005).

Behavioural and cognitive approaches

The behavioural approach, based on the belief that all behaviour is learned and so can be unlearned, aims first to identify an undesirable behaviour, and then to replace it with a desired behaviour by a scheme of positive reinforcement. The focus is on the behaviour, and not on the reasons behind it. The combination of cognitive approaches with behavioural therapies led to the development of CBT (Beck *et al*. 1987). Today, it is recommended that a form of CBT-guided therapy be offered to patients with mild to moderate depressive symptoms (National Institute for Health and Care Excellence 2009). CBT is based on the principle that our perception of ourselves and the world around us – that is, our point of view – shapes our thoughts (opinions, beliefs, ideas) and feelings, and that by learning to change our thoughts, we change how we feel and behave (Beck 1989). Chapter 8 provides examples of how aspects of CBT can be used by dietitians. The potential for CBT to be misused in a coercive way has provoked criticism (Stickley 2005). Therefore, in describing how dietitians can apply the principles of CBT, we have carefully considered their integration within a person-centred approach.

Humanistic approach

The aim of a humanistic approach is to 'increase the range of choices and encourage and enable the client to handle this successfully' (Rowan 1998). A humanistic approach is concerned with a client's thoughts, behaviour and feelings, and it is useful for problems concerning self-image and when someone believes they are powerless to change their circumstances (Burnard 2005). It is based on the existential philosophy that people are unique individuals who are essentially responsible for the choices they make in their lives; this is in opposition to the idea that their actions are determined by their unconscious, as in the psycho-dynamic approach, or learned, as in the behavioural approach. In the period from 1940 to 1970, the late Carl Rogers formulated his theory of person-centred counselling. This was based on his knowledge of psychoanalytic and behavioural theories, his clinical experience and a vast amount of research (Thorne 2013). A fundamental tenet of the person-centred approach is the realisation that a move towards change will occur when the qualities of empathy, acceptance and genuineness are present in a relationship (Rogers 1951).

For a more detailed exposition of the humanistic approach, the dietitian is recommended to read Philip Burnard's (2005) *Counselling Skills for Health Professionals*.

There are many schools of therapy within each of the approaches described in this section, and many counsellors describe themselves as having an *eclectic approach*, drawing on aspects from several different ones, in the belief that no one approach suits every situation, and that individuals benefit from the approach that most suits their needs at a particular time.

The *person-centred approach* forms the foundation of the counselling skills described in this book. It is concerned with:

- demonstrating to patients that they have been heard and understood;
- enabling patients to feel valued and respected;
- helping patients express their thoughts and feelings;
- enabling patients to make appropriate choices;
- supporting patients in the actions they choose to make.

Aspects of the following four models are included where appropriate throughout the book.

Transactional Analysis

The founder of TA, Eric Berne, developed the concept of ego states, which he termed Parent, Adult and Child (Lapworth & Sills 2011). Understanding and recognising ego states can be useful as a framework for analysing an interaction when there are difficulties in communication. For example, a dietitian in Parent ego state might say to a patient, 'You shouldn't go without your breakfast'. The patient might respond from a Child ego state, with, 'Well, I've never had breakfast up to now so I don't see why I should start at my age'. This conjures up an impression of a rebellious child. Alternatively, the dietitian, when in Adult ego state, might say, 'It is generally recognised that having some breakfast is a healthy way to start the day'. The patient who replies, 'I understand that it is healthier for me to eat something in the morning rather than start the day on an empty stomach', is then also responding from an Adult ego state.

Systemic therapy

The aim of systemic therapy is to help those taking part to develop a different perspective on their problems and discover alternative strategies for coping. In systemic therapy, a group or a family is considered as a dynamic system, in which the members explore together the ways in which communications between them are unclear. It is not concerned with apportioning blame to an individual within the group; it is about learning to recognise mixed messages and develop other ways of behaving towards one another. Examples of a dietitian applying concepts from systemic therapy are described in Chapters 10 and 13.

Neuro-linguistic programming

Neuro-linguistic programming (NLP) was developed by the linguist John Grinder and the mathematician and therapist Richard Bandler (Bandler & Grinder 1979). Techniques from NLP are applied in this book where they can aid communication;

for example, mirroring can be used to great effect in creating rapport (Chapter 5). A practitioner of NLP pays great attention to detail and observation. A dietitian familiar with NLP who closely observes the words a patient uses to represent the way they think can mirror these words to demonstrate understanding (Chapter 7).

Mindfulness

This is an approach centred around bringing the focus of attention into the present moment, without judgement. It can be a valuable way for the dietitian to increase self-awareness (Chapter 15). It is usually cultivated through formal mindfulness meditation practices and their incorporation into daily living. For those looking to change health-related behaviours, mindfulness can help them recognise the emotions and thoughts that drive their behaviours from a more objective perspective, and allow them to feel less 'swept along' by their thoughts and feelings and to respond to difficult situations in a skilful way.

Mindfulness-based CBT is a recommended treatment for adults with recurrent depression (National Institute for Health and Care Excellence 2009), and mindfulness-based interventions have been used with adults who have Type 2 diabetes (Miller *et al.* 2013). Mindfulness can be viewed as a new approach to eating that may help some individuals and can be used with specific eating difficulties (Chapter 14). Using mindfulness-based approaches requires specialist training, ongoing supervision and regular personal mindfulness practice. The emphasis is on embodied teaching, with the practitioner drawing on their personal experience of mindfulness. Personal mindfulness practice is a key requirement if one is to be competent to guide someone else (www.mindfulnessteachersuk.org.uk).

Overview of the evidence concerning the use of communication skills in dietetic practice

The evidence for the use of communication skills in health care is extensive, but it is only in recent years that many studies have been undertaken specifically in dietetics. A comprehensive review has been made of the evidence now available relating to the role and development of counselling skills by dietitians (Whitehead 2015).

Alongside the policy and professional requirements discussed in this chapter, several studies have demonstrated the value of showing empathy (Goodchild *et al.* 2005; Brug *et al.* 2007; Cant & Aroni 2008a; Parkin *et al.* 2014). Patient satisfaction has been used as a measure of outcome, and has been shown to be affected both by the way in which staff present themselves (Vivanti *et al.* 2007; Cant 2009a) and by their interpersonal skills (Cant & Aroni 2008b). Non-verbal communication has also been shown to influence the development of trust between dietitian and patient (Cant 2009b). A lack of a common understanding

of what has happened in a consultation has been identified in many cases. However, it has been shown that where patients are given more autonomy, they are better able to care for their diabetes, which is an important outcome (Parkin & Skinner 2003). There remains a limited evidence base relating to specific clinical outcomes in dietetics, and further research is required.

Some barriers that make it harder for dietitians to use their counselling skills have been identified. These include a lack of confidence (Hambly *et al.* 2009), a lack of time (MacLellan & Berenbaum 2007; Whitehead *et al.* 2009), a need for further training (Rapoport & Nicholson Perry 2000; Barr *et al.* 2004; Holli *et al.* 2009) and a lack of management support (Whitehead *et al.* 2009). It appears that pre-registration training may not equip dietitians beyond a minimum level (Cant & Aroni 2008b), and many dietitians have identified the need for further training (Whitehead *et al.* 2009). Dietitians' views about their pre- and post-registration training needs have been explored (Cant & Aroni 2008b; Whitehead *et al.* 2009), and a tool that can assess communication skills for behaviour change within the context of a dietitian–patient consultation has been developed and validated (Whitehead *et al.* 2014). Training needs and development are discussed further in Chapter 16.

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